LEARNING COLLABORATIVE PRESENTATION

Trinitas Regional Medical Center
8/14/14
(2:00P – 3:00P)

I   Project Description   (Attachment I)

II   Monthly Survey Response   (Attachment II)

III Project Achievement to Date   (Attachment III)

IV   Observation Challenges and Surveys to Date   (Attachment IV)

Project Achievement To Date

- Full implementation started 4/1/14 and 90% of all admissions are being screened.

- For the first 4 months of the implementation, 44 patients have been referred to treatment and 11 patients have initiated and engaged in treatment within 30 days of the new diagnosis.

- Patient feedback about the project from those in treatment is as follows. We just started patient satisfaction surveys and two respondents felt that treatment has helped them start to change their drinking habits.

- Partners - Several partners are actively engaged in accepting and treating patients

- Physicians Support - Physicians support has been strong as acceptance and implementation of the withdrawal order set has gone well.

- Information Systems - Linked Medical and Behavioral Information Systems to allow for reporting results, which are provided monthly.

Observations, Challenges and Surveys

- Pressure to discharge patients from acute care create initiation, engagement, and follow-up challenges.
  Substance Abuse staff are actively countering the anticipated quick discharge by identifying significant others, families, and social service agencies, who may facilitate follow-up and treatment referral.
- Complex picture of these patients (medical, mental health, substance use disorders and basic support deficits (housing, employment, food) requires extensive case management and multisystem coordination.
- Profiling now the acute medical care (Inpatient and ED) of 100 to 200 of these patients to better design population health management approach which integrates social services systems, which are frayed to say the least.
- Non Engagers (33 patients of 44 didn't initiate treatment):
  - ➢ Approximately 20% are senior citizens going into long-term care
  - ➢ Another 235 are individuals coming in on CIWA/Alcohol Withdrawal Protocol ("frequent flyers") who agree to an intervention. However, they discharge from the Hospital AMA while a discharge plan is being implemented.
  - ➢ Approximately 18% are patients who start the process to attend inpatient treatment, but are discharged before a bed opens up. Based on the past four months of DSRIP data, patients who discharge before receiving an intake are exponentially less likely to engage in treatment.
  - ➢ 39% of patients had an intake appointment at another treatment facility, but they did not attend the appointment.
- Other Challenges/Responses
  - ➢ Specialized geriatric psychiatric services will be utilized when providing interventions and making referrals for senior citizens. Kathy Mickel, Psychiatric Nurse Practitioner, will be consulted to assist in outreach efforts. In addition, the Addiction Specialist will offer level of care assessments to cater to individual client needs. Likewise, we will involve family members in helping with engagement.
  - ➢ Once an individual is placed on CIWA protocol, the Addiction Specialist immediately initiates the discharge planning process in conjunction with the Hospital Social Worker. Motivational interviewing will be employed by the Addiction Specialist to increase the likelihood of follow-through.
  - ➢ Improve relationships with residential affiliates to improve patient access. To bridge this treatment gap, patients are being seen in the Partial Hospital Program at Trinitas while waiting for inpatient beds to become available. Also, Substance Abuse Services will continue to improve communication with Trinitas inpatient socials workers regarding discharge planning. Lastly, Addiction Specialists will more closely review SCM to gain a deeper understanding of each patient's biopsychosocial and treatment history – prior to providing the brief intervention.
  - ➢ Ensure that we have active contact information for patients and their family members as well as signed release of information forms; this will allow the Addiction Specialist to immediately contact a patient's social network if they do not attend the appointment with one of our residential partners – to move patients into treatment within 14 days.

TRMC's participation in DSRIP

Screening, Brief Intervention, and Referral to Treatment

❖ TRMC projects 23% (3,000) of our acute medical patients will screen positive

❖ Less than 1% of acute medical admissions visit TRMC Outpatient Addiction Service after discharge

❖ Patients screening positive will receive a brief onsite intervention to assess for severity of their use/abuse

❖ Those who are at risk for withdrawal will be managed with algorithm-related protocols for withdrawal

❖ Those who are in need of a more intensive treatment will be referred to an affiliated agency (community partner).

**The desired outcome is to put patients on a path to recovery and help them avoid future dependencies.**

Interdisciplinary Team Approach to Patient Centered Care
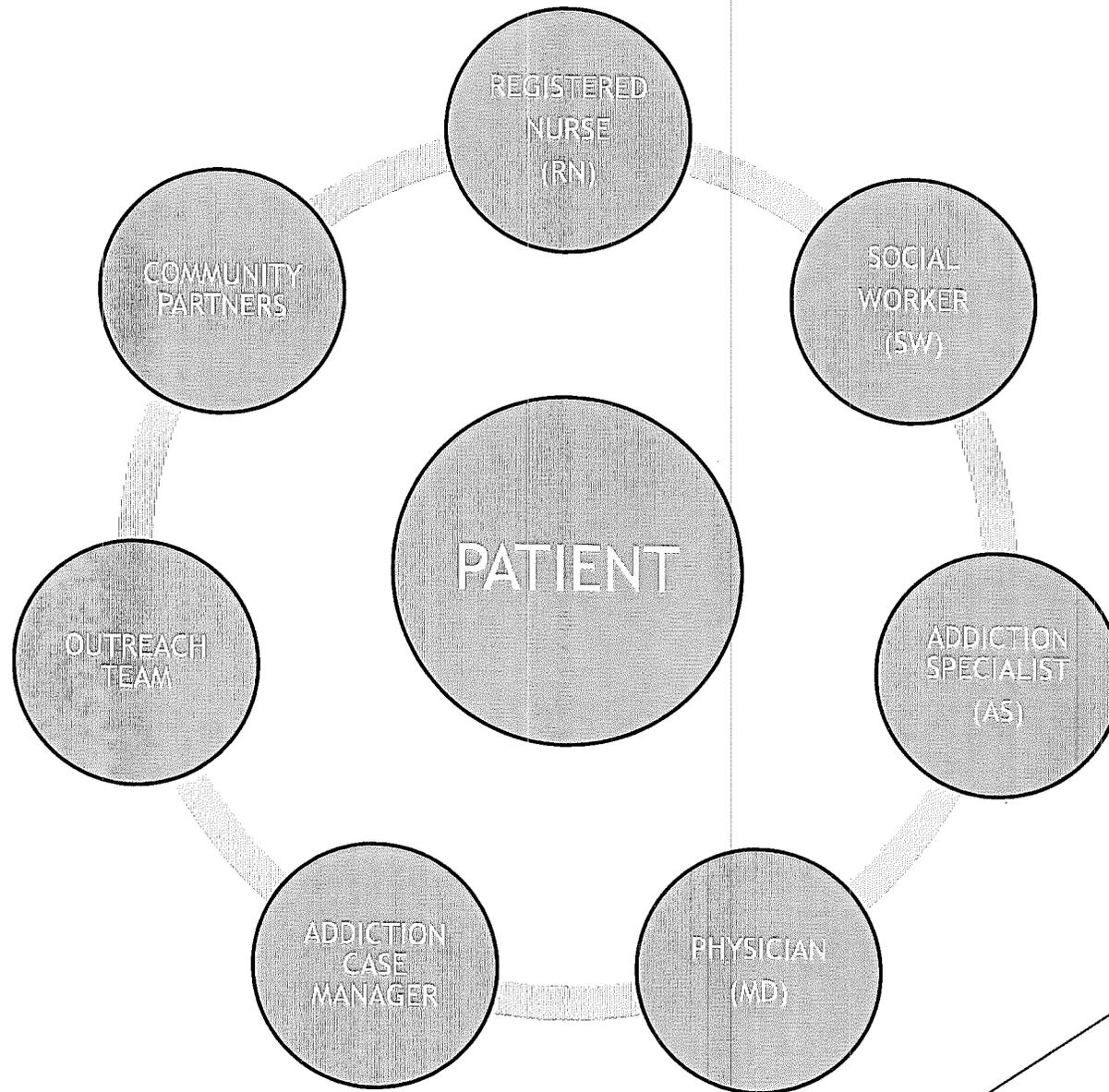
# RN Role

▶ AUDIT screening on admission
  ▶ Simple advice

  ▶ Patient education

  ▶ Referral to AS and SW

  ▶ Administer CIWA (Clinical Institute Withdrawal Assessment Tool)

  ▶ Initiate Alcohol withdrawal protocol
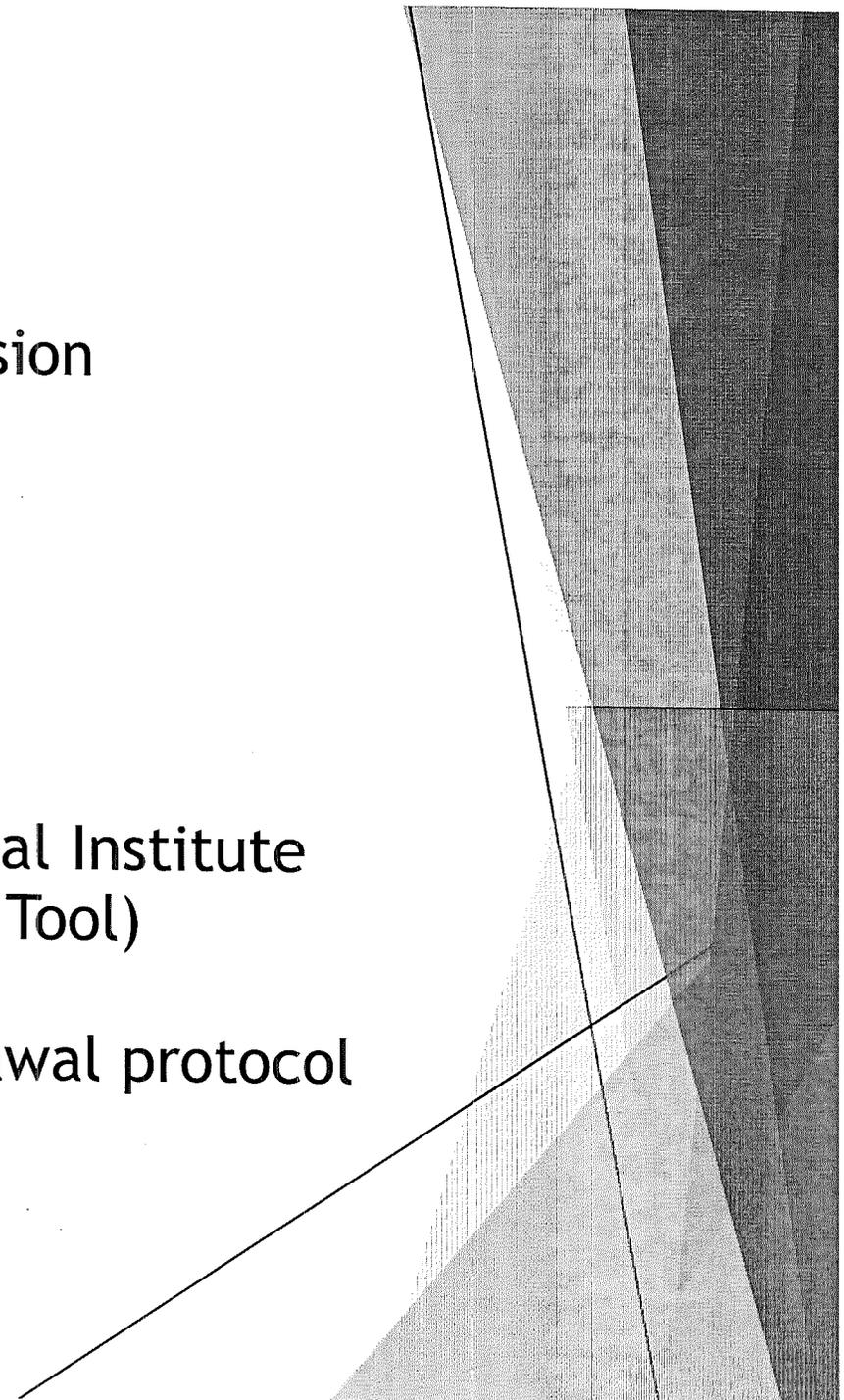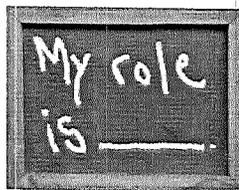
Social Worker (SW) Role

- ▶Receive referral
    - ▶Review patient risk level
    - ▶Consent for release of information
    - ▶Simple advice before discharge
    - ▶Discharge planning with referrals as needed

- ▶ Case Managers (acute care)
   - ▶ MDR rounds

My role is ____
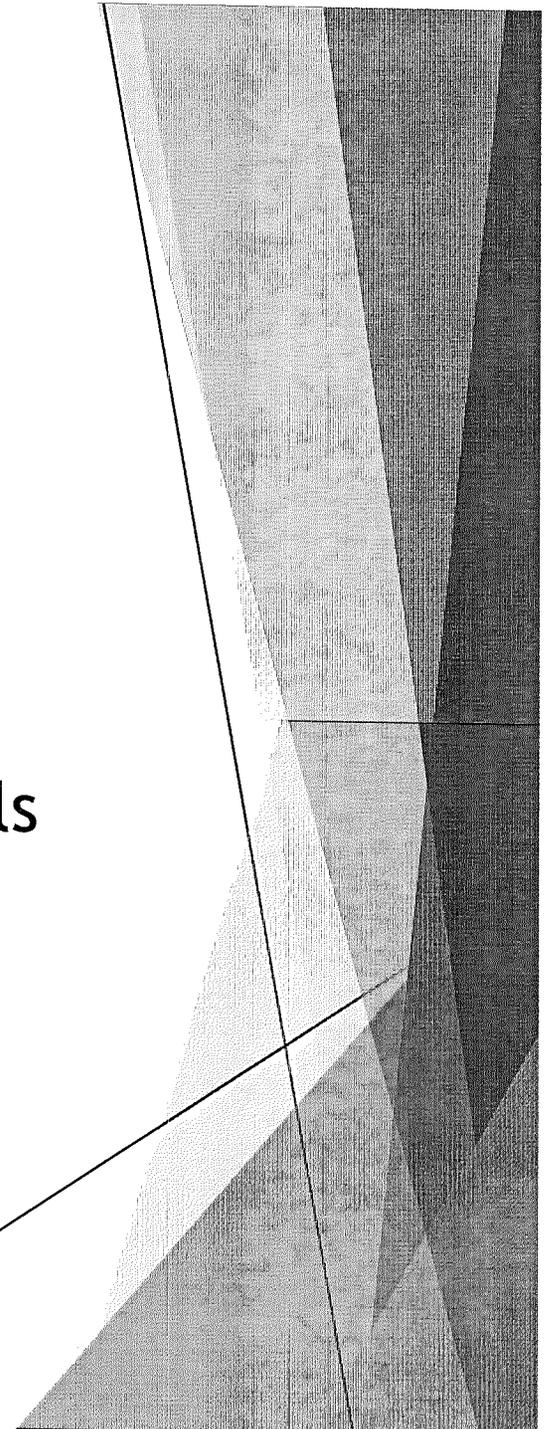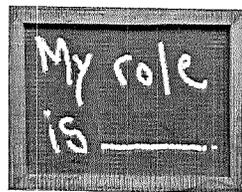
Addiction Specialist (AS) Role

- ▶ Receive referral
  - ▶ Brief Intervention
  - ▶ Patient Health Questionnaire(PHQ-9) depression screen
  - ▶ Psychiatrist referral
  - ▶ American Society of Addiction Medicine (ASAM)—placement criteria
  - ▶ Diagnosis
 - ▶ Recommend referral to treatment
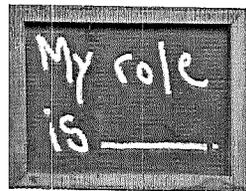
Physician Roles

- ▶ Physicians/medical residents
  - ▶ Order alcohol withdrawal protocol as appropriate
    - ▶ Prevention
    - ▶ Treatment
    - ▶ Manage alcohol withdrawal

- ▶ Psychiatrists
  - ▶ Receive referral AS's
    - ▶ Establish diagnosis
   - ▶ Treatment recommendations

My role is ____
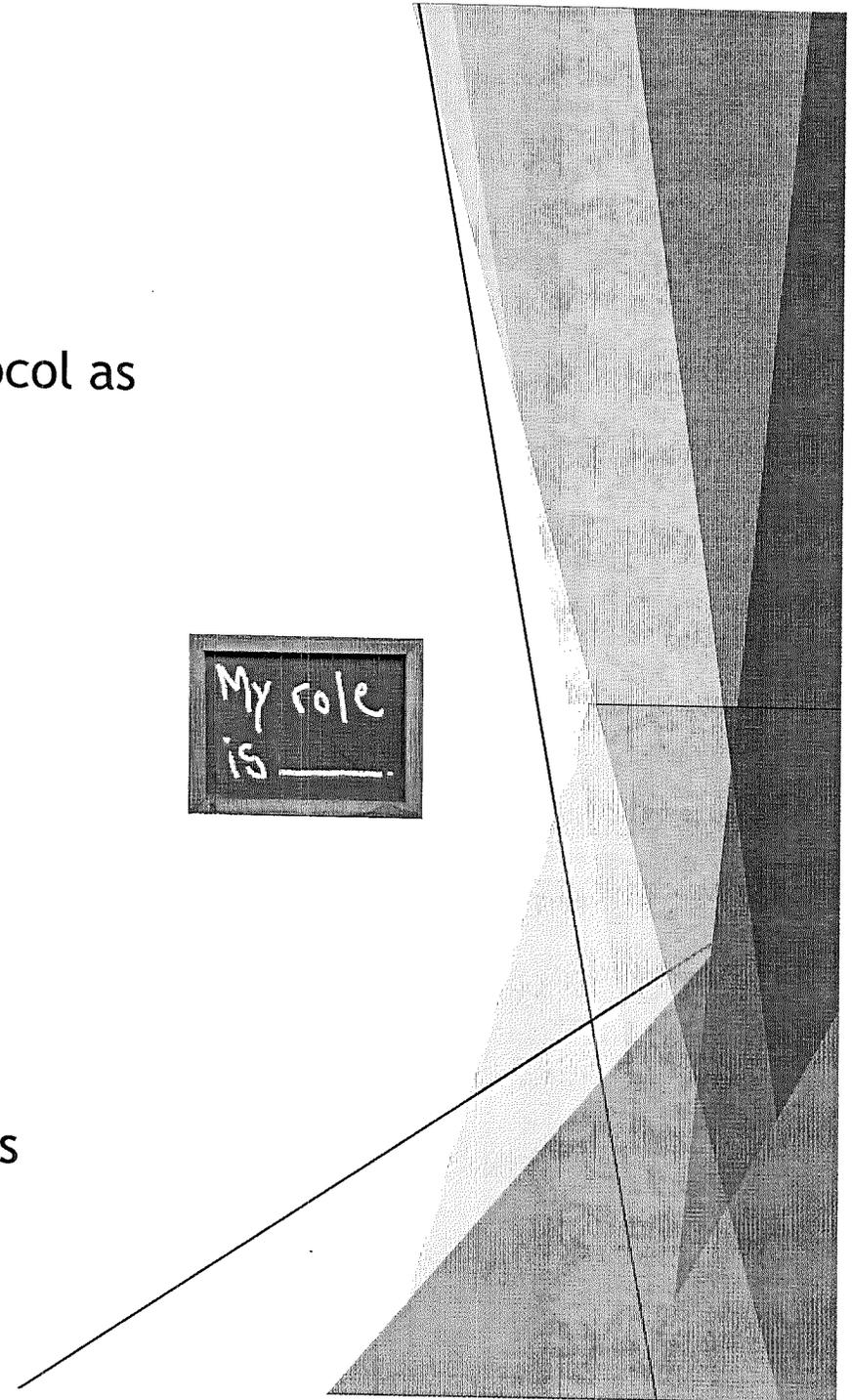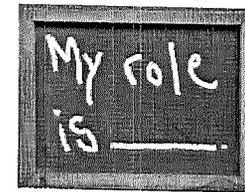
Case Managers (BEHAVIORAL HEALTH) Role

▶ Receive referrals

▶ Coordinate initiation of treatment post discharge

▶ Monitor patient engagement post discharge
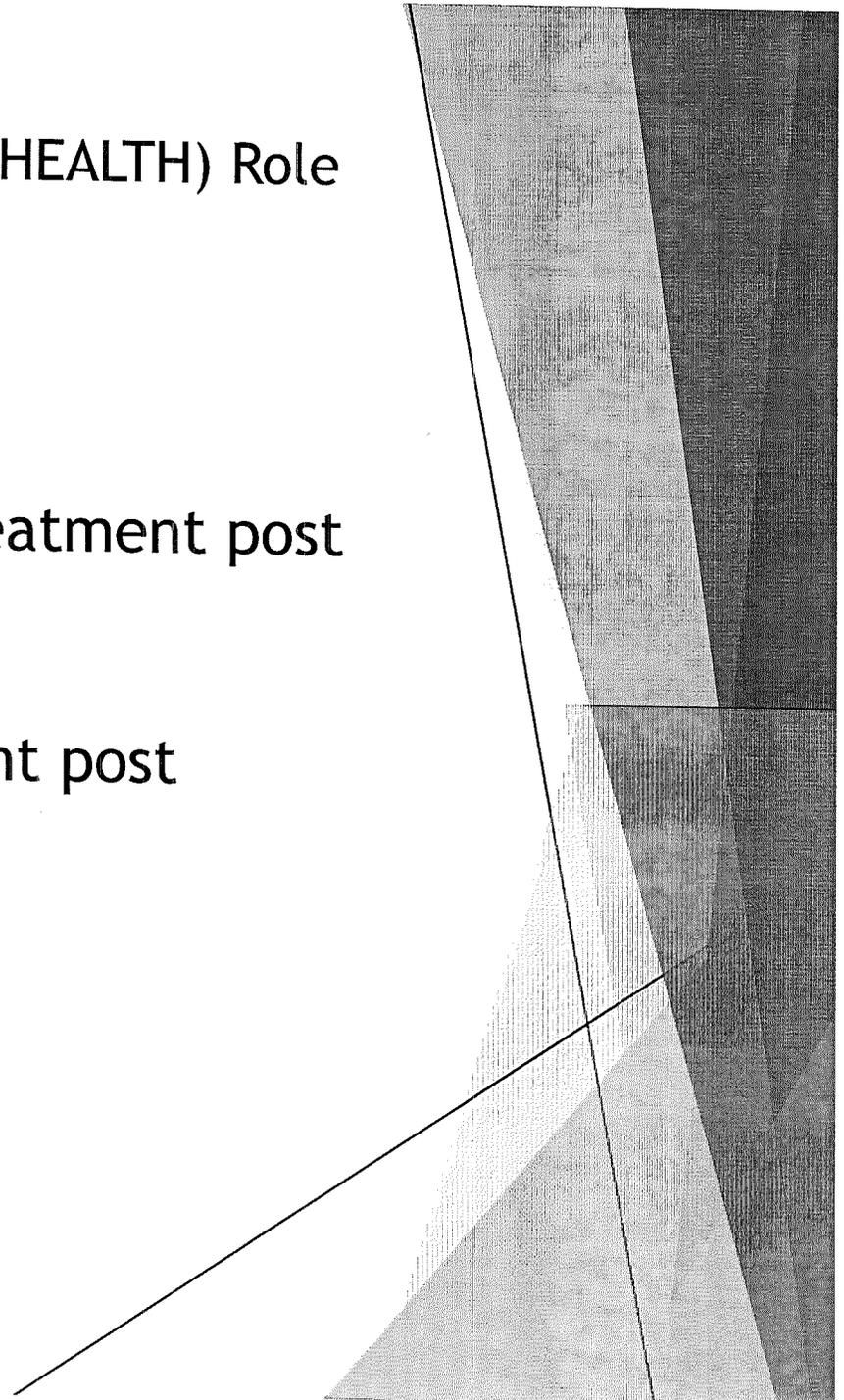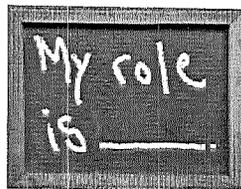
# Outreach Team Roles

▶ Outreach Team

    ▶ Conducts home/community visits to re-engage patients into recommended treatment

▶ Community Partners

    ▶ Provide community-based treatment services
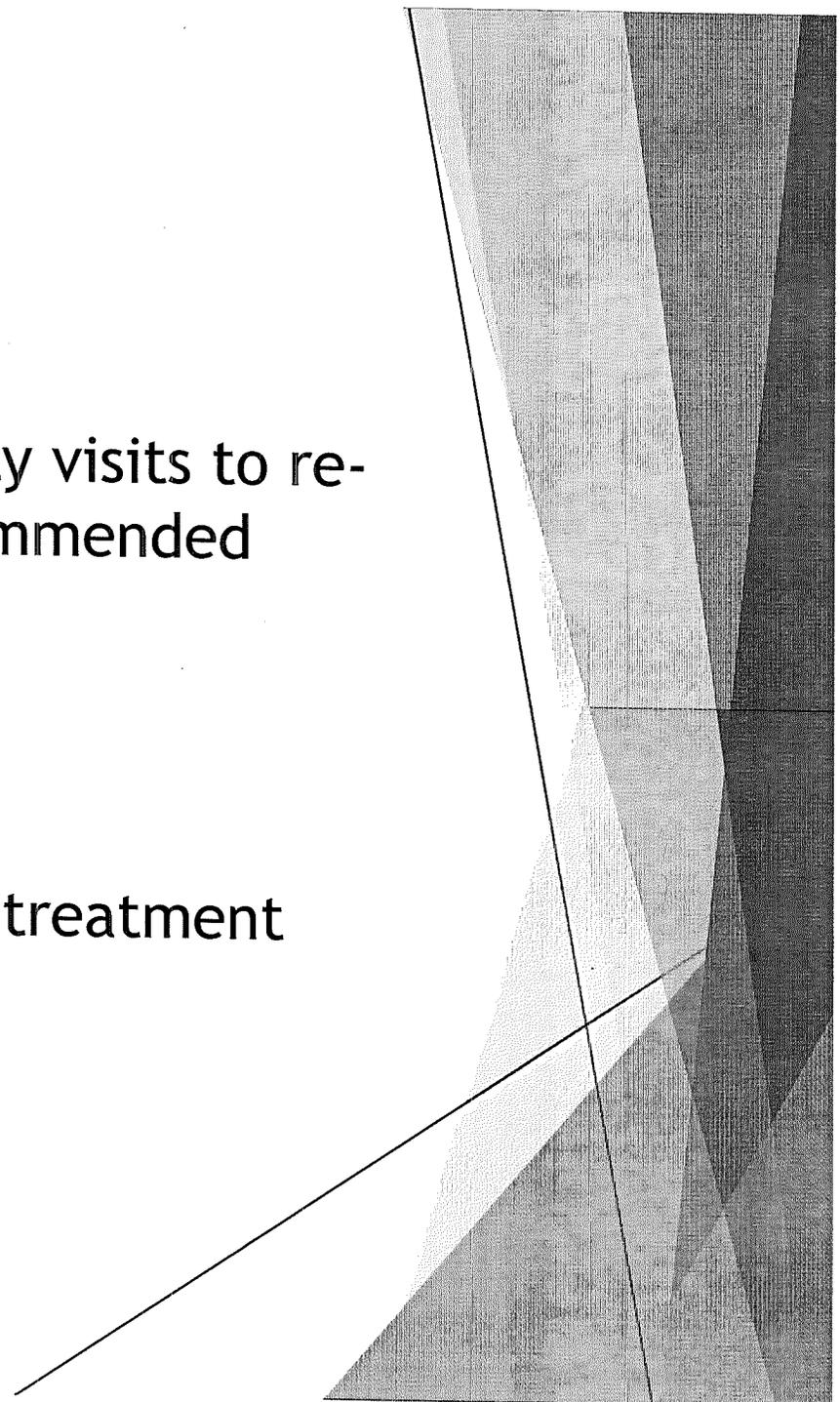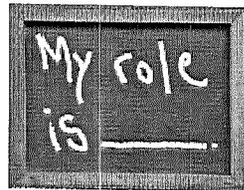
Community Partners

- Prevention Links

- TRMC Substance Abuse Services

- Turning Point, Inc

- New Hope Foundation

- YMCA/Eastern Union County

- PROCEED

- Flynn House
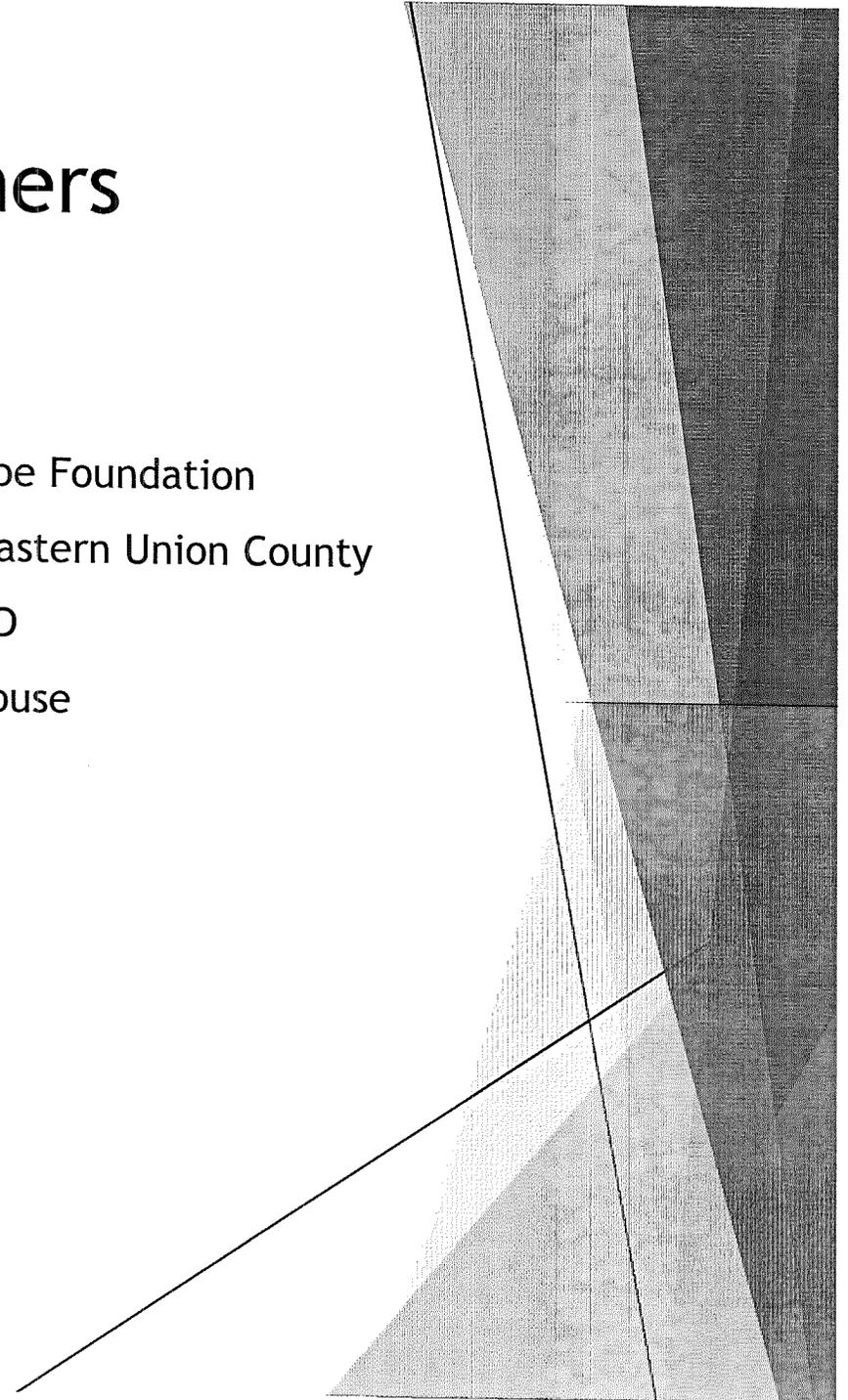
Hospital Specific Project Outcomes

TRMC has identified the following hospital-specific goals for our target patient population:

- TRMC will screen 100 percent of the individuals admitted to the hospital for SUDs

- Decrease length of stay by .3 days for patients admitted with a substance abuse diagnosis

- Decrease transfers to ICU with delirium tremors or other alcohol related complications by 25 percent.

- Decrease Use of Restraints.

- Increase referral/admissions to substance abuse treatment programs/facilities from 31 referrals in 2012 to 150 referrals (5%) .

Submitted 7/16/14
ATT II

Learning Collaborative (LC) Monthly Survey

ATTACHMENT II

SECTION I
DSRIP Hospital Information

Hospital Name:	Trinitas Regional Medical Center	Contact Name:	Jim Lape
Learning Collaborative:	LC: 2	Contact Title:	SVP, Behavioral Health & Psychiatry
Project Name:	Hospital Wide Screen SUD	Contact Number:	908-994-7060
LC Date:	7/16/2014	Contact Email:	Jlape@Trinitas.org
List Additional Hospital Participant Attendance; as applicable	Debbie Durand		

SECTION II
Project Implementation - Support

Questions		Enter Response Below
1.	Is your hospital's project team in place? *If not, briefly explain.*	Yes
2.	Is your hospital's quality improvement plan developed? *If not, are there challenges to address?*	Yes
3.	Briefly describe any activities with your external partner(s) this month.	Actively working with 3 Partners on patient treatment from the Project
4.	Briefly describe any hospital leadership engagement activities this month.	Presented to the Board of Directors (7/2/14) & Leadership Council 7/17/14; Conducted Hospital-Wide Project Steering Committee Meeting 7/11/14

SECTION III
Project Implementation - Tracking

Questions		Enter Response Below
5.	What stage of the PDSA cycle would you consider your project to be in? If you are currently doing more than one PDSA cycle, briefly describe stages for each.	We are in ACT cycle and making rapid changes on a regular basis
6.	What is the overall estimated completion percentage for your project's Stage 1 activities?	90%
7.	What is the overall estimated completion percentage for your project's Stage 2 activities?	90%
8.	Are there project activities that have changed, or need to change, in order for the project to be successful?	Referral process was modified by some patients either not being administered the A.U.D.I.T. due to illness or not screening, as in need of assistance. In the latter, patient may be doing heroin or RX drugs.
9.	Briefly describe how your hospital is tracking DSRIP performance data to date.	Monthly report generated from Information Systems

SECTION IV
Project Implementation - Observations

Questions		Enter Response Below
10.	Has your project encountered any implementation challenges to date? *If so, briefly describe.*	See #8
11.	Was your hospital able to overcome these challenges? If so, how? *If not, would you like suggestions from your Collaborative?*	Yes, by utilizing IT system that identified patients in withdrawal
12.	Has your project encountered any notable successes to date? *If so, please describe.*	Yes, we had several patient initiate and engage in treatment
13.	Has your project team identified any lessons learned or best practices to date? *If so, please describe.*	Be flexible and stay focused on getting patients the services and support they need.

SECTION V
Learning Collaborative Meeting Summary

From peer to peer feedback in LC2, sounded like most others hadn't implemented project yet.

NOTE: If your hospital is presenting on your project status to your Learning Collaborative, in addition to these Survey responses, describe at a high-level what project intervention(s) your hospital is implementing and discuss the achievement to date for each activity.