Utilizing a Focus Driven Model of Care in an Urban Public Health Hospital

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Thank you…

- To all of you present today for your willingness to promote interest in this topic…discussion promotes vision for improvement in a given system, wellness in ourselves and ultimately, those we serve.
- Especially to all of the organizers of today for their hard work & tireless efforts to make today happen for all of us.
- To Lemuel Shattuck Hospital for their

  their commitment to the community

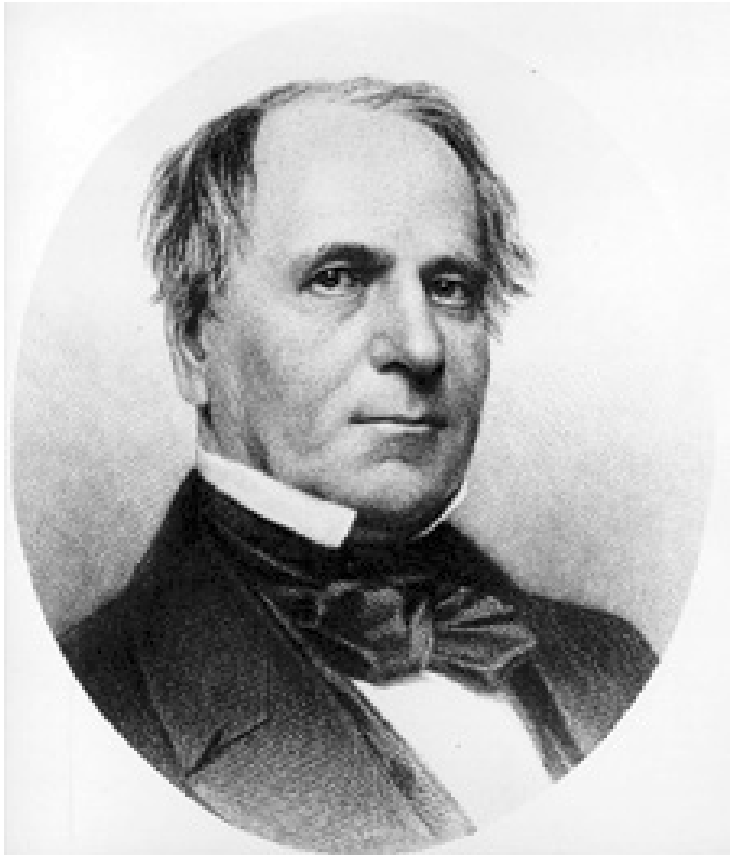
Lemuel Shattuck Hospital

Agenda

Introduction

- Who we are - who we serve
- Agency Mission
- Developing a ***Vision of Change***
- Creating a ***Center of Excellence***
- Discussion & evaluation

The Mission of Lemuel Shattuck Hospital



The Lemuel Shattuck Hospital delivers compassionate medical and psychiatric care to patients requiring multi-disciplinary treatment and support which promotes their health, well-being, rehabilitation and recovery.

The Hospital strives continuously to improve the quality of life for our patients through the delivery of collaborative treatment and a patient-focused continuum of care. The support of agencies and programs of the Commonwealth of Massachusetts make this possible

An Overview of Hospital History and Services

- The Lemuel Shattuck Hospital was built by the Commonwealth of Massachusetts in 1954 as a Public Health Hospital.
- Long utilized as a facility to treat chronic and terminal conditions.
- Utilized by Tufts, Harvard and Boston University Schools of Medicine.
- Had its own School of Nursing, which closed in 2000.
- Opened an on-site daycare in 1969.
- Corrections Department began utilizing healthcare services at the hospital in 1969.
- Shelter opened on the Hospital Campus to address crisis of Boston homeless-1983
- Opened the first dedicated HIV Unit in New England – 1984.
- TB Unit opened to address new outbreaks of the disease in 1988.
- Public Detoxification Unit relocated to the Campus in 1991.
- Vendors that provide extended treatment for Addictive Disorders are located on the campus of the Hospital

History and Services continued…

- Department of Mental Health relocates 5 psychiatric units to the hospital.
- Hospital opens a unique *secure* unit for Public Health patients.
- Needle Exchange Van is sited on the Campus.
- Out-Patient Behavioral Health Services launched.
- HIV/HEP-C Co-infection Program begins…LSH joins MGH, BWH for AIDS Research program.
- Increased utilization of health services by Department of Corrections.
- Addictions Consultative Services integrated into clinical services.
- MRI services established
- Massachusetts Mental Health Center relocated to the Campus.

Clearly a long and noble history of service

Core Issues in Public Health

- Over $250 million is spent for substance abuse services annually in the Commonwealth.

- Existing prevention and treatment programs are haphazard and do not fully rely on scientifically proven approaches. Prevention programming accounts for only 11% of funds expended.

- Drug and alcohol abuse is increasing the burden on criminal justices systems (courts, prisons, parole), with over 80% of individuals in the criminal justice system abusing drugs.

- Little data currently exists on which to build a substance abuse strategy or to measure its success.

Bureau of Substance Abuse Services

Commonwealth of Massachusetts

Why treating this population concurrently is important

- The cost of substance abuse treatment is recouped within 2-3 years of treatment through reductions in other healthcare costs (Center for Substance Abuse Treatment).
- Average annual crime-related costs to society fell by $8,600 per client following treatment (Koenig et al., 1999).
- A major study done in California reported that the economic benefit of treatment outweighed the cost of treatment by 7:1 (CALDATA, 1997). In this study,
  - Treatment costs were $209 million.
  - The more than $1.49B in savings resulted from, among other things, reductions in hospitalization and ER admissions by one-third and crime reductions.

Who does the Commonwealth serve for addiction treatment?

BSAS latest reports show 82,449 people received publicly-funded treatment services in Massachusetts representing 102,226 admissions

Adult Admissions

In FY04, there were 80,642 adults (18 and older) served representing 100,110 admissions

- 70.2% male, 29.8% female
- 72.9% white, 10.3% Black, 13.4% Latino, and 3.5% other racial categories
- Average age at admission – 35 years
- 74.2% were unemployed
- 18.6% were homeless
- 42.8% reported alcohol as a primary substance of abuse
- 38.5% reported heroin as a primary substance of abuse

Commonwealth statistics

Adolescent Admissions

In FY04, 1,807 adolescents (17 and under) served representing 2,116 admissions

-71.5% male, 28.5% female
-74.1% white, 7.9% Black, 12.5% Latino, 5.5% other racial categories
-Average age at admission – 16.1 years
-55.9% reported marijuana as primary substance
-27.1 reported alcohol as primary substance of abuse
-Average age of first use – 13.1 years for alcohol and 12.9 years for marijuana
-16.5% of admission reported oxycontin use in past year

Why are these figures important?

- This population is who we serve at Lemuel Shattuck Hospital and the numbers are increasing.
- Therefore *all* staff must be competent and compassionate in the delivery of care, treatment and services to this population. Congruent with the *Hospital Mission*.
- Continuing using an outdated model of treatment is unrealistic for the current population.
- Many avenues need to be navigated as the shifting of a philosophical paradigm began and continues.

Who are the patients?

- **All**
  - Need short-term, sub-acute care (6-8 weeks on average) such as intravenous therapy, wound care, and physical/occupational therapies
  - Have MH/SA issues that have not been fully addressed and that contribute to increased #'s of hospitalizations and longer lengths of hospital stay (LOS)

- **Many**
  - Are admitted to acute hospitals through the ED; and regularly get non-emergent services in EDs
  - Have repeat hospitalizations for potentially preventable conditions
  - Have behavioral issues related to their MH and/or SA issues
  - Meet criteria for poverty level and are homeless
  - Are often non-compliant to prescribed medical regimes

LSH Difficult to Place Pilot Program

Who are the patients?

- **Many others:**
  - Have Medicaid applications in progress
  - Are undocumented and ineligible for Medicaid
  - Are on methadone maintenance, which many other facilities are not allowed to provide per federal regulation
  - Have difficulty accessing housing in the community due to +SORI, + CORI and MH/SA complexities

Patient example #1

52-year-old, divorced, homeless male with criminal record.

- Medicare insurance.
- Medical history: laryngeal cancer, TB, asthma, chronic aspiration.
- Substance abuse: alcohol, opiates and cocaine.
- Admitted to acute hospital with shortness of breath, respiratory failure and aspiration pneumonia. Underwent tracheotomy.
- Followed by Psychiatry: Non-compliant with treatment plan (Haldol and Zyprexa).
- Clinical team planned to pursue guardianship
- Hospitalized for 6 weeks.

Patient example #2

56-year-old male, Spanish-speaking, wheelchair-bound.

- Medicaid insurance.
- Admitted from YMCA for diagnosis of mental status changes and hyponatremia (low sodium).
- Status/post motor vehicle accident with sub-dural hematoma, and back and hip fractures.
- Medical history includes hypertension, agitation, hyperlipidemia, and type 2 diabetes (diet controlled.) Placed on strict fluid restriction.
- Substance abuse: alcohol and cocaine.
- After lengthy acute hospitals stay, eventually discharged to SNF on several medications with plan for return to YMCA where he had been residing.

What happens to these patients now?

- Many remain in the hospital and receive sub-acute care, until they can be discharged to a home, halfway house, treatment facility or other settings.
- Many are denied admission to other facilities; however, even when they meet the level of care because of their MH/SA co-morbidities or criminal histories. Those that get admitted may not have their MH/SA issues addressed.
- Some of the homeless also are eventually admitted to respite beds at Homeless Program facilities after an extended acute hospital stay for non-acute care
- Many do not get services that address their MH/SA issues, contributing to the ongoing and recurrent use of the local EDs and acute hospital inpatient units

Problem Areas

- Patients do not receive the right care in the right setting at the right time
- Acute care hospitals do not have the capacity to handle the complex needs of these patients as their condition progresses
- Patients are treated by med-surg staff with little or no MH/SA expertise
- Extended hospitalization produces patient-staff conflicts that create safety issues and can be detrimental to the care of other patients
- Extraneous costs are incurred by the hospital and health care system.

Success Measurements

- **Patients are compliant with prescriptive treatment**
- **No. of patients become more actively engaged with *recovery services* while hospitalized**
- **Fewer complaints to the Patient Advocate and Human Rights Officer**
- **Decreased outbursts of patient aggression and *Code Greens***
- **Improved patient satisfaction by survey**
- **No. of patients discharged to appropriate settings that meet patient MH/SA needs**
- **Changes in utilization of hospital services, including the recovery clinics & out-patient services**

Creation of a Center of Excellence

"It is not enough to know…we must apply"

-anonymous

Background

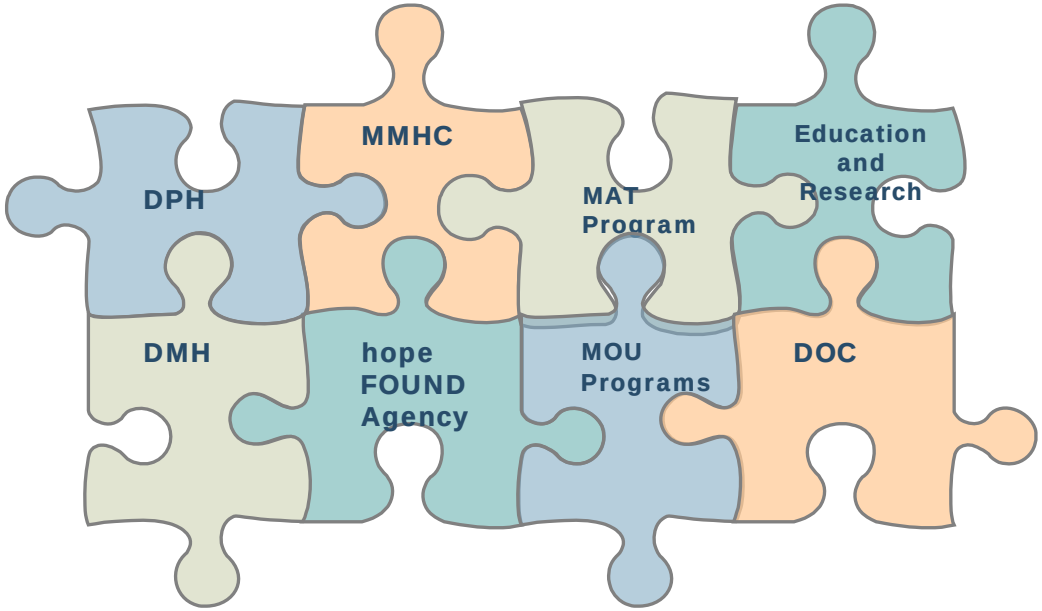
- One of the main challenges in developing a *new vision* was to address entrenched belief systems and thinking…in particular attitudes of the staff in caring for this population.

- The idea was to recreate the identity of the hospital campus and provide a full comprehensive program that serves this population. This would be achieved by collaborating with on-site vendors that are focused in provision of care to substance abuse patients/clients.

- Changes in hospital mechanisms would provide a model of care that fully integrates medical, MH and SA care with discharge planning services.

Piecing it together…

- **Our view is to make the hospital intersect with all state facilitated and vendored programs on Campus.**
- **A cohesive mission and working partnerships create a unified path towards a Center of Excellence in the Public Health System that has particular expertise in Addictive Disorders and Behavioral Health.**



Background

The proposed changes to shift the existing paradigm required that we:

Provide a full-range of integrated medical and discharge planning services for patients with MH/SA co-morbidities who need short-term, sub-acute medical care.

To achieve this we need:

- Improved assessment tools and data gathering techniques
- Improvement in the Medical Record-IT systems
- Coordinated informational relay systems
- Identification of system gaps in meeting these needs
- Provision of increased education and supervision to all disciplines
- CAI and competencies
- Measurement of the model's effect on care through rigorous evaluation
- Effective and fully empowered Case Management capability

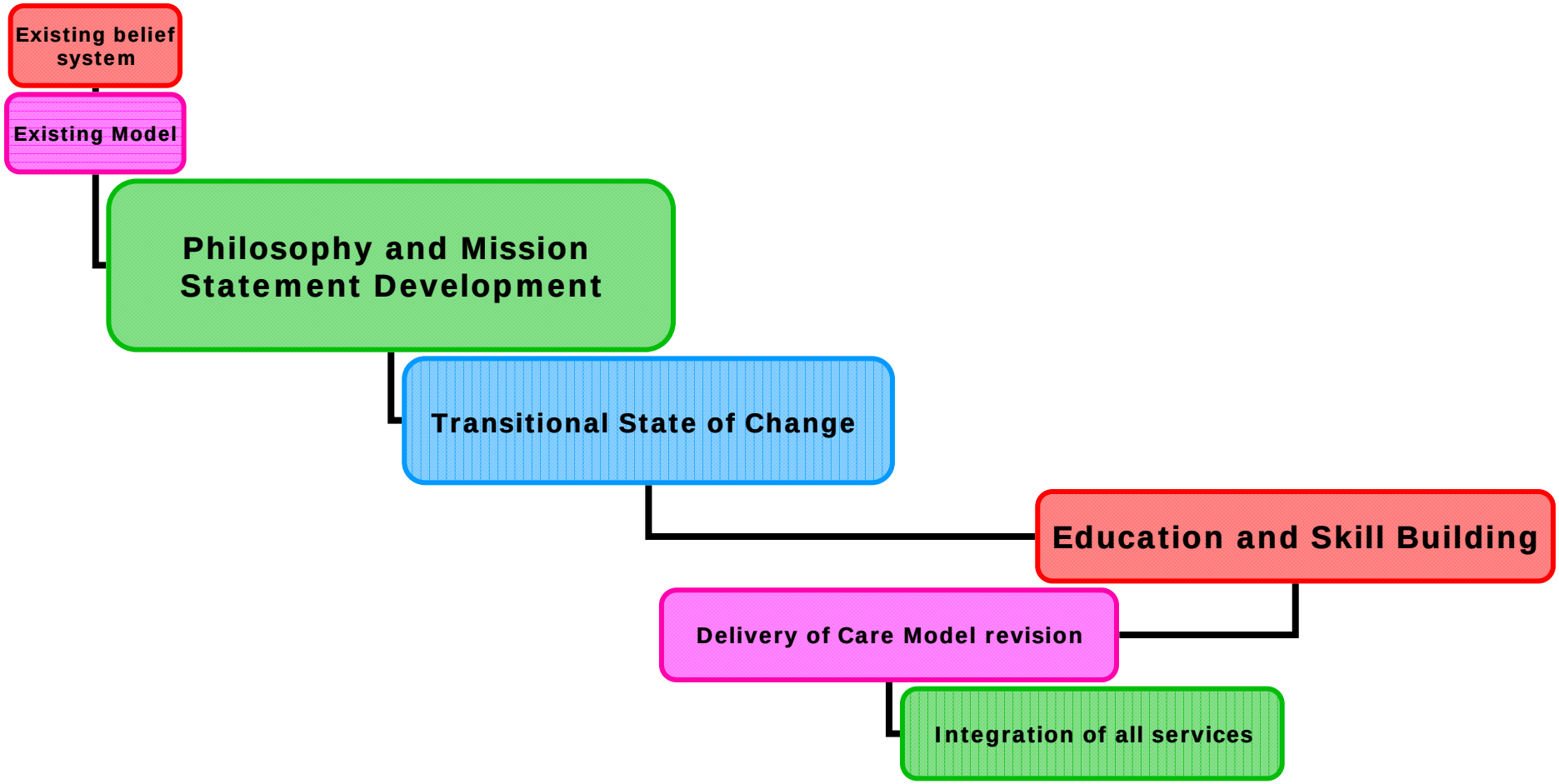
What does it take to change a paradigm in an entrenched system of care?

Would it take *Superman* to achieve this?

Shifting the way we did business required:

- Rewrite of philosophy & mission
- Changes in the wording of care*
- Identification of the population is that the hospital serves
- Embracing an identity and recognizing what *we do well* and what we *do not do well*
- Engaging leaders and all staff in having *crucial conversations* towards a momentum of change

Mapping out the plan…



Ideas won’t work unless we do!

Anonymous

So how do we get staff to think differently?

A *four-pronged methodology*

- **Assessment**
- **Education**
- **Compliance**
- **Accountability**

Assessment

- Ask questions and invite ideas
- Utilize surveys and questionnaires
- Engage in crucial conversations
- On-site discussions with staff
- Review minutes of Leadership meetings, Ethics Committees and Safety Committees to extract and highlight major concerns and problem areas
- Crystallize the issues to address
- Examine the cost ($) of new ideas

BOA Leadership Model

Education

- Inspire commitment and *followership** by example and on-site teachable moments
- Provide continuous structured education in the domain of Addictive Disorders to all disciplines and departments
- Develop competency requirements for all clinical disciplines
- Establish coaching, mentorship and preceptorship programs
- Communicate **c**risply, **c**andidly and consistently to foster dialogue
- Move quickly to address poor performers or negative forces in the workplace.

Compliance

- Motivate and engage constituents
- Require adherence to standards of care
- Address resistance by discussion and conversations
- Manage talent
- Create competencies and expectations for employment
- Deal constructively with negativity and failure

Improving Clinical Performance in Hospitals

Ettinger, W. (2008) Prescriptions for Excellence in Health Care

Accountability

- Recruit and select *A Team* players
- Establish benchmarks to monitor and evaluate outcomes
- Ask questions and examine barriers
- Explore alternative ways to make challenges happen
- Build partnerships outside of the original team
- Expand data resources for informed policy and resource decisions
- Establish performance-based monitoring & contracting system
- Report to all staff and communicate consistently

Scholarship of Quality – *the basics*

- Comprehensive resolution of patient medical needs that integrates MH/SA services, including groups, psychotherapy, milieu therapy, pharmacology, etc.
- 24/7 management of safe, structured environment to deter relapse and promote engagement in recovery
- Assessments and treatment plans grounded in best practices, philosophy and protocols of trauma informed care, harm reduction and universal caring
- A setting that is rooted in ***cultural humility*** and accepting of diversity

  MiYong Kim (2008)
- Comprehensive discharge planning and follow-up services in collaboration with community-based providers and services, including housing
- Outpatient services that sustain the recovery process established during the inpatient stay

Our goal is to be the employer of choice for choice employees

How could we stand out in a crowd?

We needed to *Image build* in the region so other providers would view us as the resource facility to treat the most difficult of populations.

Guiding principles in a transformation

- Establish a sense of urgency
- Form a powerful coalition
- Create a vision
- Communicate the vision
- Empower others to act on the vision
- Plan for and create short term wins
- Consolidate improvements and produce more change
- Institutionalize new approaches

"Leading Change":Kotter, (1995)

Secondary Foci of the *Change Momentum*…

- Dedicated commitment by *Leadership*
- Philosophical root to the *Vision*
- Establishing partnerships and collaboratives
- Academic partnerships
- Opportunities for research
- Image building
- Review of clinical practice issues
- Safety in the workplace environment
- Outreach and public service

Engaging partners…

All vendors and existing programs on the Campus were viewed as key to transitioning into the collective model. The umbrella group would be known as the

Addictions Collaborative:

- Department of Public Health clinical units
- DPH Ambulatory Services
- Department of Mental Health psychiatric units
- Department of Correction Unit and clinical services
- hopeFOUND Agency
- Methadone Assisted Treatment Program
- Boston PHC Needle Exchange Van Program
- Off-site collaborators and providers

Does this Focus-Driven Model work?

- Instills a sense of pride and accomplishment in the hospital
- Encourages interested clinical staff to seek out opportunities to enhance their clinical practice and related competencies.
- The hospital is a recognized ***Center of Learning*** evidenced by:

  4 Medical Schools

  9 Schools of Nursing (graduate and undergraduate)

  Psychology Program

  Social Work internships

  Counseling internships and practicums

  Rehabilitation, Occupational and Speech Therapy internships
- Strong IRB and research opportunities for academic centers
- The clinical teams provide comprehensive services to individuals that help to maximize their quality of life and economic self-sufficiency in the community

Other measures of success…

- Enhanced Addictions Clinical Consultative Team

  -from 1 SA counselor to 4 fully licensed and credentialed clinicians
- Director of AS is a PhD RN-Clinical Specialist in Public Health
- Consults to the AS are approximately 30 per month with just under 1000 clinical entries in 9 months for FY 07.
- Monthly SA conference integrated into HIV lecture series
- Collaboration with UMASS Medical School for clinical development and research
- Participation in Tufts University School of Medicine Addiction Pharmacology Course
- 2007-Chief of Medicine recruited with Addiction Medicine credentials
- Integration of SA TX into HIV and co-infection clinics
- Multiple MOU's have been developed
- Strong connection to American Society of Addiction Medicine

Continuing the Process…

- Basic competencies for staff have been established
- R.E.S.P.E.C.T. Strategic Initiative is redefining Substance Abuse Policy to address behavior rather than the *disease* state of a patient
- Partnerships in the community have been enhanced by sharing expertise
- Engaging in Symposiums on a National level
- Presentations by clinical staff on Addictive Disorders, Domestic Violence, Compassion Stress in Healthcare Professionals and Internal Motivation Intervention as well as other AD related topics
- Association memberships and presence…CASA, CCSAD, national AD memberships
- Staff have received multiple awards from various agencies within the past 5 years
- First ever annual ***Lemuel Shattuck Conference on Addictive Disorders*** appealing to all clinical disciplines-immediate success gauged by evaluations and numbers of individuals seeking registration

Tasks for the future…

A Phased Approach

Phase I → Phase II → Phase III

Where we were

Examination of our mission

Develop ideas and initiatives

Begin immediate support of committed vendors and collaborators

Where we are

- Creation of partnerships
- Strengthened, stabilized, and shifting of resources
- Competencies developed
- Embracing of work with special populations

Where we need to go

Flexibility in state regulated system

Research and promotion of evidence based clinical practice

Strong image presence in academic institutions

Strategic redistribution of funding

Keeping the momentum alive

- Continuous leadership inventory
- Challenge the process
- Inspire a shared vision
- Collective discussion and sharing of information
- Enable each other to act
- Model the way
- Encourage the heart and the passion

NEPHLI experience 2008

Freedman and White's Model

- Commitment *to all*
- Consistency *in your approach*
- Continuity of care *to individuals*
- Comprehensive *capacity*
- Communication *to staff and patients alike*
- Coordination of care *for all you serve*
- Compliance *to standards of care*
- Consolidation & *integration of services*

Based on Journal of Healthcare Management

50:2 March/April 2005

Is this *Model* applicable to other facilities?

- ***It Takes a Village…***
- Ask what meaningful benchmarks you have for self-examination for what you do and what you can do better?
- Empower your *villages* to develop a vision based on principles and standards of care.
- Assure that you achieve results and examine and retool the plan based on the results.
- Above all…recognize your patient/client base and develop your programs based on who you serve.

Improving Clinical Performance in Hospitals

Ettinger, W. (2008) Prescriptions for Excellence in Health Care

Questions?

- We appreciate your time with us today.
- We are here for a limited period of time for questions and discussion

Enjoy the remainder of the Conference!

Contact information

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