Welcome to the NYC ED MAT Quality Collaborative

- Lines will be muted during the presentation
- To ask a question, please raise your hand or type your question in the question box
- The slides and materials are available in the handout section.
- For technical difficulties, please email AVassistance@GNYHA.org
- For administrative questions (i.e. registration/handouts/etc.), please email Qsylvester@gnyha.org

NYC ED MAT QUALITY COLLABORATIVE

December 10, 2020

GREATER NEW YORK HOSPITAL ASSOCIATION
Over 100 years of helping hospitals deliver the finest patient care in the most cost-effective way.

Agenda

I. Welcome
II. Stigma is More Harmful Than the Drug Itself: A Patient Perspective
III. ED MAT Assessment Summary Data
IV. Creating Actionable Action Plans
V. Q & A
VI. Next Steps

ED MAT Collaborative Timeline

Jan 2020	Feb 25 2020	Mar - Sept 2020	Oct 15 2020	Nov 19 2020	Dec 10 2020	Jan 14 2021	Feb 2021
In-Person Meeting	Web #1	Postponed	Web #2	Web #3	Web #4		

GREATER NEW YORK HOSPITAL ASSOCIATION

How we will work together

GNYHA/DOHMH will support the Collaborative in the following ways:

Monthly webinars

- Supportive forum
- Learn and share best practices
- Troubleshoot issues around process improvement and project implementation
- Presentations from internal and external partners

Access to resources: data, research, process improvement tools

Data submission and analysis, technical support

Day-to-day support and troubleshooting

STIGMA IS MORE HARMFUL THAN THE DRUG ITSELF: A PATIENT PERSPECTIVE

Bethany Medley, LCSW
Doctoral Student, Columbia School of Social Work
Graduate Research Assistant, Social Intervention Group

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Stigma is more harmful than the drug itself: A patient perspective

December 10th, 2020

Bethany Medley, MSW

Doctoral Student, Columbia School of Social Work

Graduate Research Assistant, Social Intervention Group

My Lived Experience

- 5 years of intravenous heroin use
- 10 ‘treatment’ instances (outpatient & inpatient)
  - Only 1 supported buprenorphine
  - 9 forbid the use of bupe or methadone
  - None offered overdose prevention or other harm reduction interventions
- Went the the ED ~5x seeking treatment for opioid withdrawal
  - Never offered MOUD
  - Peers recommended I present suicide ideations to obtain ‘treatment’
- Self-medicated through non-prescribed, community-based bupe
- Found recovery through immense social support in combination with various social privileges in 2010
- Requested HCV test in 2014, positive, received treatment after appeal
- Introduced to harm reduction in 2016
- Lost countless friends to overdose due to stigma, abstinence-based ideologies, & punitive drug policies

Person-centered language

Instead of this…	Say this…
Addiction	Substance Use Disorder
Drug Addict, Abuser	A **person who** uses drugs
"Clean" or "Dirty" toxicology	Test was "Negative" or "Positive"; test was "unexpected" or "expected"
Got clean	A **person who** formerly used drugs
Junkie, Crackhead, Tweaker, etc.	A **person who** uses… (specify drug/s)
Addicted Newborn, or "Born Addicted"	Babies born with prenatal substance exposure, or, Newborn Opioid Withdrawal

Stigma & Drug Use

- There is **no** evidence that reducing stigma will encourage drug use
- Stigma worsens drug-related health consequences & denies rights
- Discrimination against people who use drugs is widespread, mostly legal, & socially acceptable
- Drug use stigma is often combined with other stigmatizing health & social conditions & other forms of discrimination
- In a recent study, only 8% of surveyed ED physicians agreed that working with patients with substance use who have pain is "satisfying" and only 10% agreed that they "enjoy giving extra time to patients like this." (Mendiola et al. 2018)

"Craving doesn't begin to describe the feeling. Heroin isn't ice cream. I craved dope the way a drowning person craves air." – David Poses

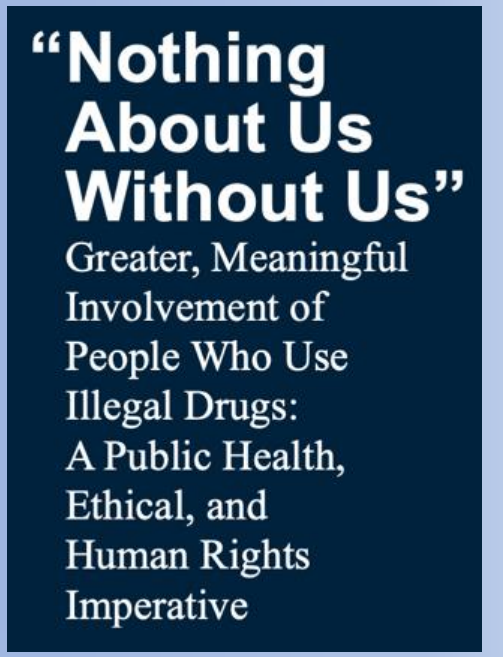
Harm Reduction in Healthcare

- A combined public health & social justice movement
  - Emphasizing harm reduction, treatment, & healthcare
  - Supports anti-prohibition & decriminalization
  - Meaningful involvement of people w lived experience
- Patient-centered goals
- Realistic – people are going to use drugs
- Non-judgmental – anti-stigma language & compassionate care
- Incremental – celebrates any positive change
  - Emphasizes positive health-related, social, & economic outcomes over quantification of drug consumption
- Non-coercive & non-punitive – backwards movement is not penalized

Anti-stigma practices

- People who use drugs are *the* "experts by experience"
  - Best practices rooted in the survival experiences of people who use drugs
- Inclusion of people with lived experience must be involved in every stage of policy & programmatic development, implementation, & evaluation process
  - Hire as professional consultants (offer competitive compensation & skill-sets)
  - Regularly request speaking engagements
  - Develop Community Advisory Board

- Offering harm reduction education & treatment are tools for empowerment – affirms the lives, worth, & value of PWUDs



Peer-driven harm reduction in the ED

- Naloxone & overdose prevention education
  - NYC's Relay Program
  - NYS 'Never Use Alone' Hotline 1-800-997-2280
- MOUD education (including non-prescribed use)
  - Review pros & cons of all 3 MOUD options
  - Informs people on how to properly use bupe (i.e. sublingually, avoid precipitated withdrawals, micro dosing options)
- HCV peer advocates
  - Helps navigate testing & treatment
- Safe injecting/drug consumption education
  - Helps build trust, delivers message of compassion

Homework Assignment

Go to a pharmacy and ask for needles and syringes OR naloxone without a prescription

Reflect on how this process made you feel

Email me your reflections & any other questions you may have

bethanycmedley@gmail.com

Thank you!

Q & A

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ED MAT ASSESSMENT SUMMARY DATA

Jared Bosk

Vice President, Survey and Outcomes Research

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Collaborative Measures

4 Goals of Collaborative

- Increasing ED capacity to prescribe buprenorphine
- Identifying patients for buprenorphine induction in the ED
- Increasing provision of buprenorphine in the ED
- Improving connections with community OUD providers

Measurement Strategy

- Collect data that measures progress and identifies challenges – not research!
- One to three common measures per goal
- Optional measures to enhance ability to monitor the intervention

Protocol/Process Information

- Flexibility in how to define/measure aspects of intervention
- Request for additional information on protocols, algorithms, or screening tools used
- Share definitions/algorithms with collaborative

Assessment of Hospital Practices for Providing Buprenorphine in ED

Assessment Topics

- Current practices in ED for treating OUD patients
- Status of implementation of best practices
- Barriers to implementation of best practices
- Areas where collaborative can help

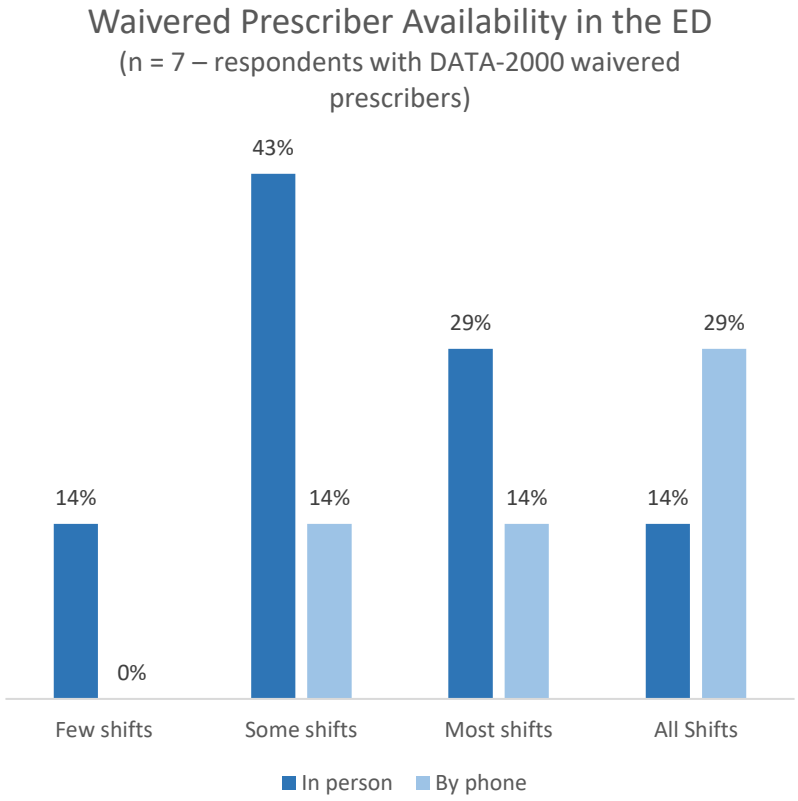
Benefits of Assessment

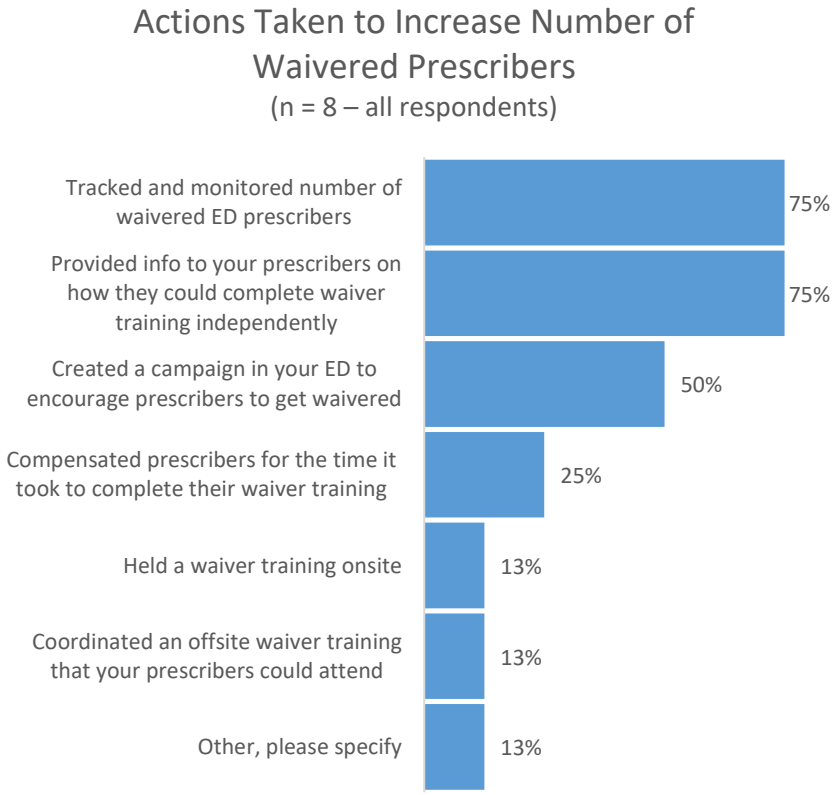
- Identify common areas to focus on
- Identify early leaders in best practices
- Demonstrate success - structural changes often happen first

Timing of Assessment

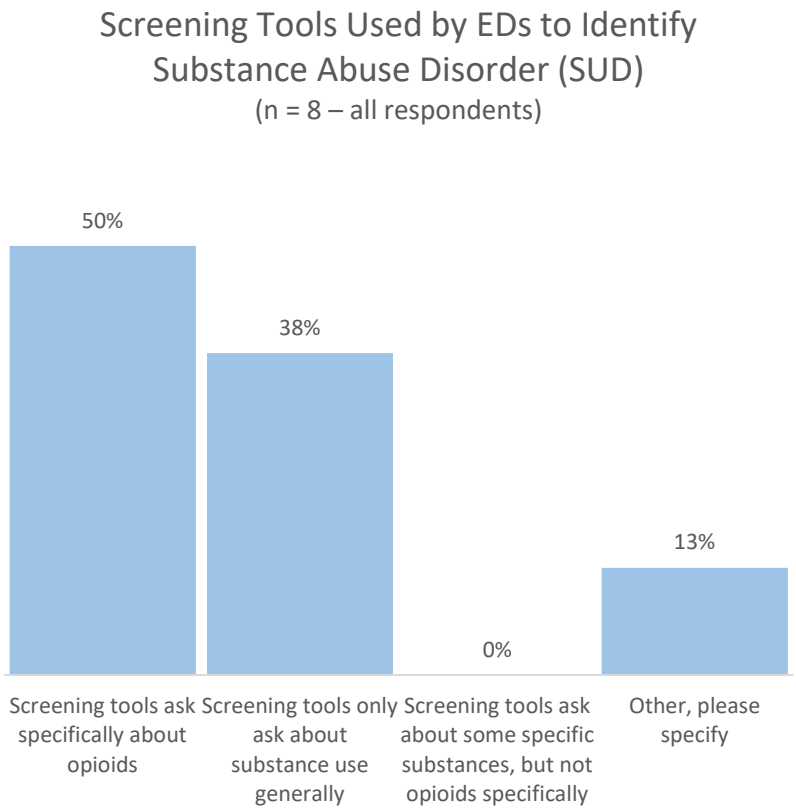
- Initial assessment in October
- In field for 6 weeks
- 8 hospitals completed the assessment

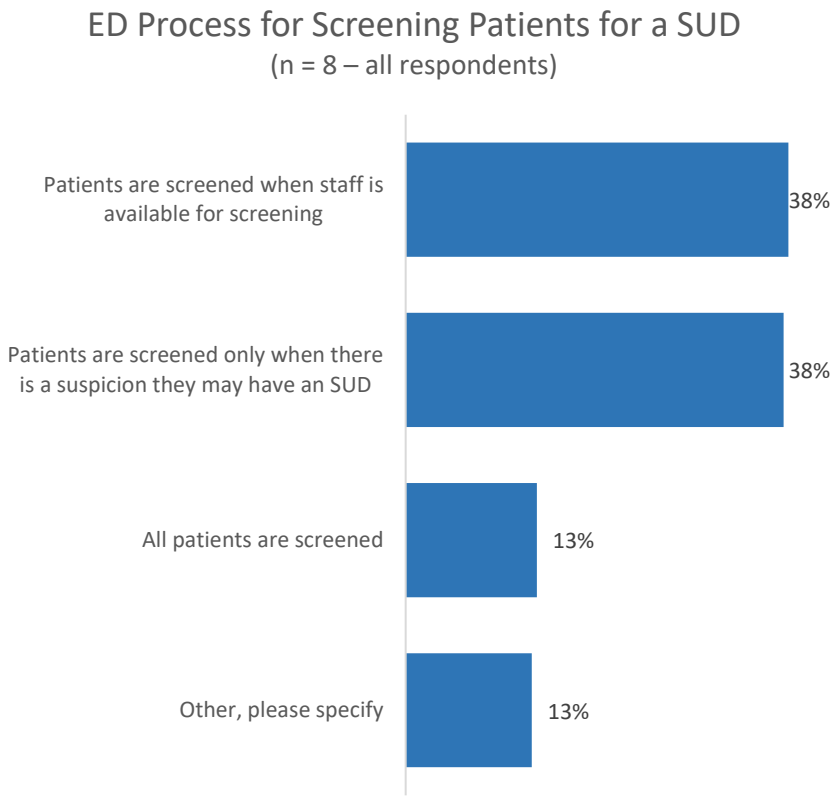
Goal 1: Increasing ED Capacity to Prescribe Buprenorphine



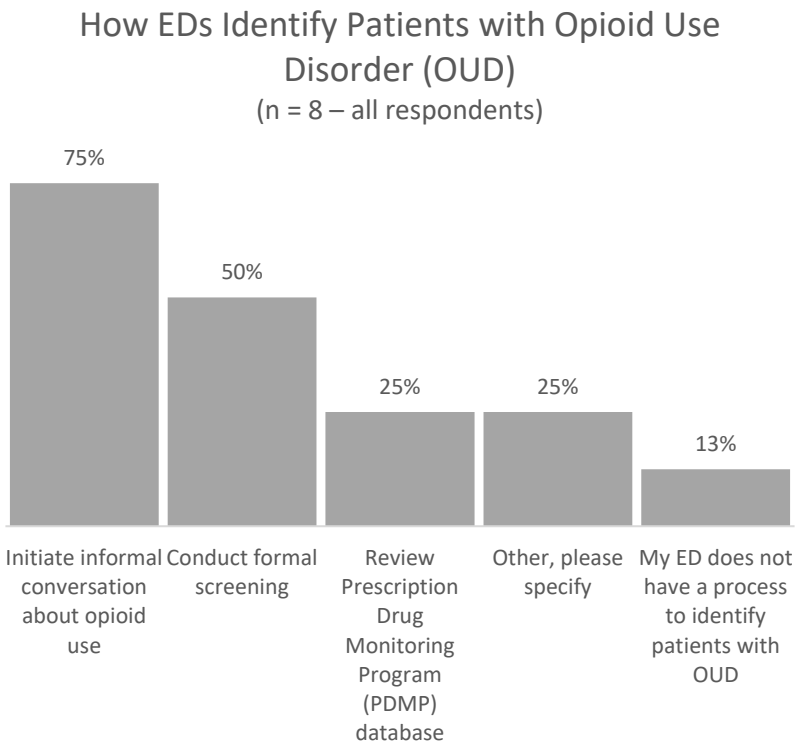


Goal 2: Identifying Patients for Buprenorphine Induction in the ED

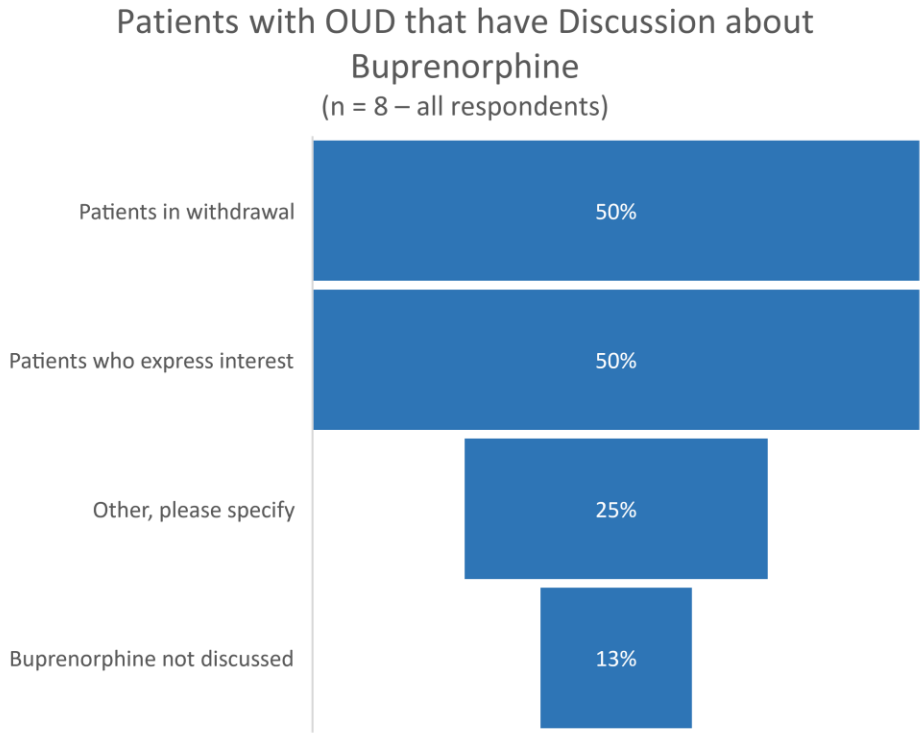




Goal 2: Identifying Patients for Buprenorphine Induction in the ED



None of the responding hospitals use practitioner/community referral, review PSYCKES for previous OUD flags, or review PSYCKES for case history when identifying patients with potential OUD

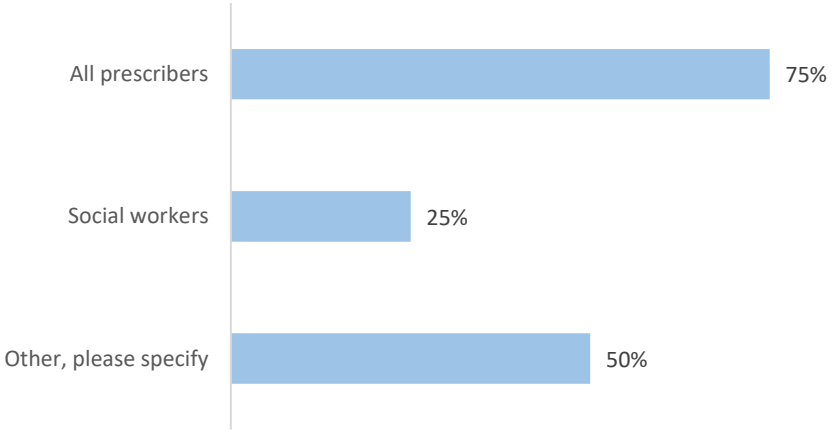


None of the responding hospitals discuss buprenorphine with all patients identified as having OUD

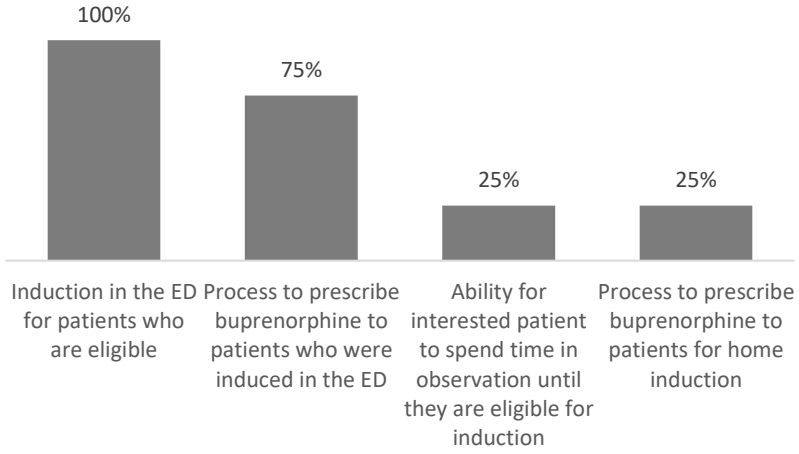
Goal 3: Increasing Provision of Buprenorphine in the ED

Only 50% of responding hospitals have a buprenorphine protocol

Staff Types Trained on Buprenorphine Protocol
(n = 4 – respondents with a buprenorphine protocol for OUD patients)



Part of Buprenorphine Protocol
(n = 4 – respondents with a buprenorphine protocol for OUD patients)



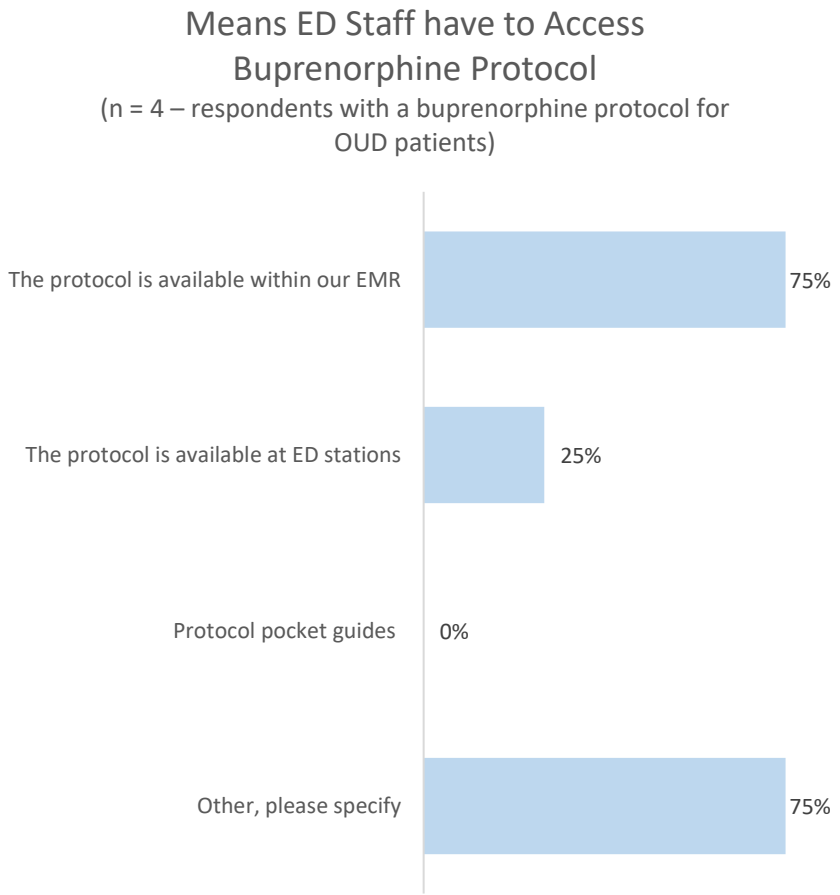
Staff Types not Trained on Buprenorphine Protocol

- Prescribers with their DATA-2000 waiver only
- Nurses
- Clerks
- Discharge Planners

Not Part of Buprenorphine Protocol

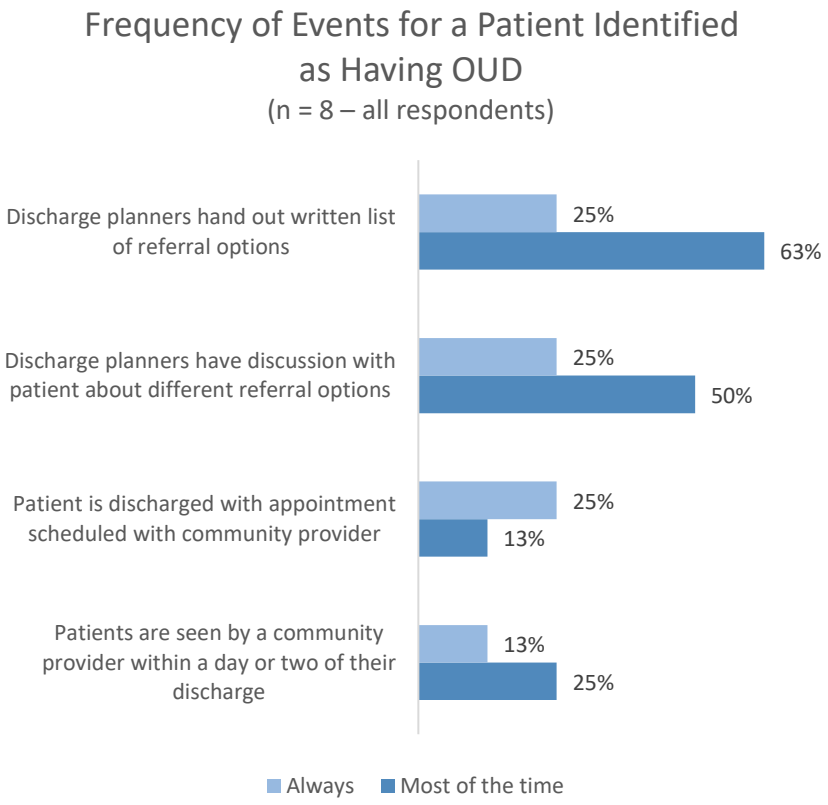
- Provision of buprenorphine “home pack” to allow for home induction
- Process to induce patients who came into the ED because of an opioid overdose or overdose reversal

Goal 3: Increasing Provision of Buprenorphine in the ED



- Most EDs do not proactively make patients aware of the availability of buprenorphine
- The following were not done by any of the responding hospitals:
  - Signs in the waiting area and rooms mention availability of buprenorphine
  - Signs in the waiting area and rooms encourage patients to discuss treatment options for opioid use
  - Pamphlets provided to patients make them aware of buprenorphine availability
  - Information provided (formal and informal) to community-based providers

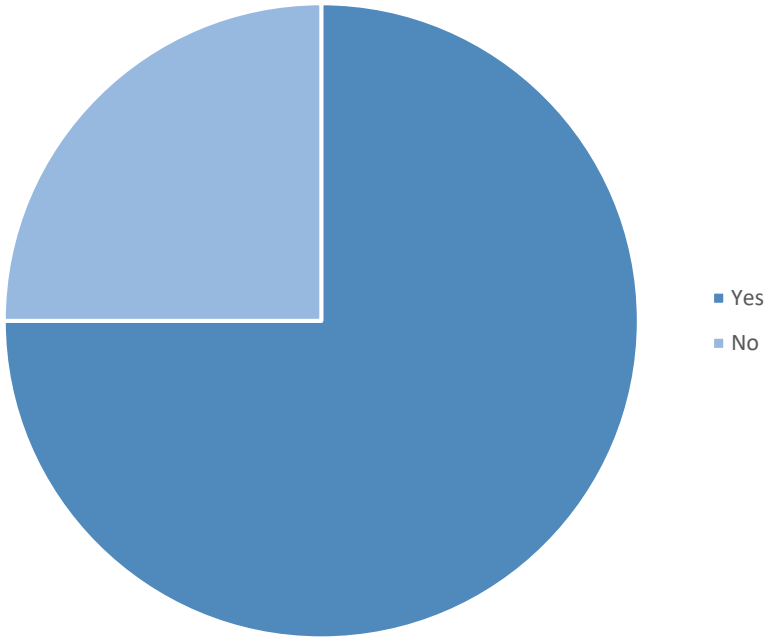
Goal 4: Improving Connections with Community OUD Providers



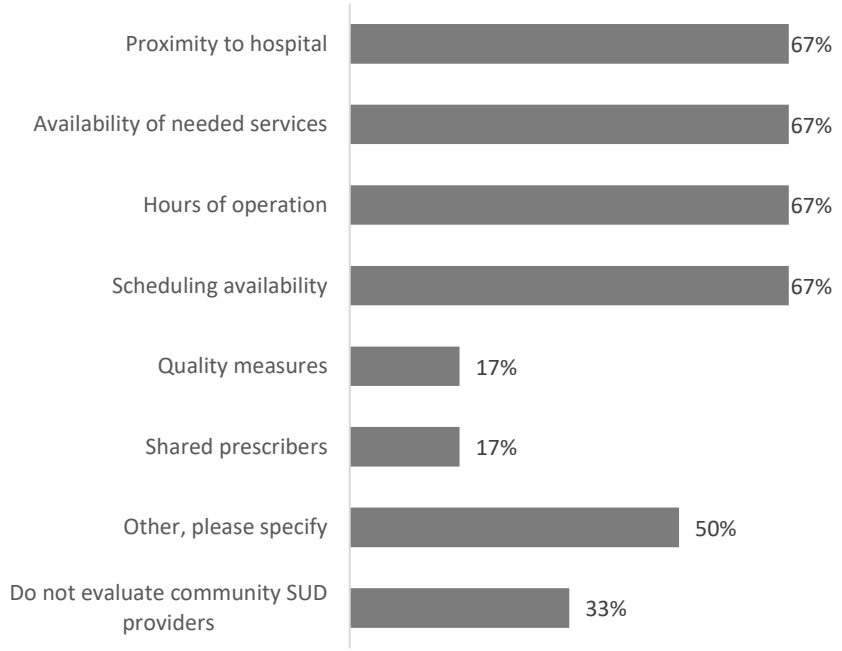
- No responding hospitals had the following events occur "Always" or "Most of the time" when a patient is identified as having an OUD:
  - Community Providers provide information back to ED on whether patient has shown up to appointment
  - Community providers provide information back to ED on whether patient remains in treatment

Goal 4: Improving Connections with Community OUD Providers

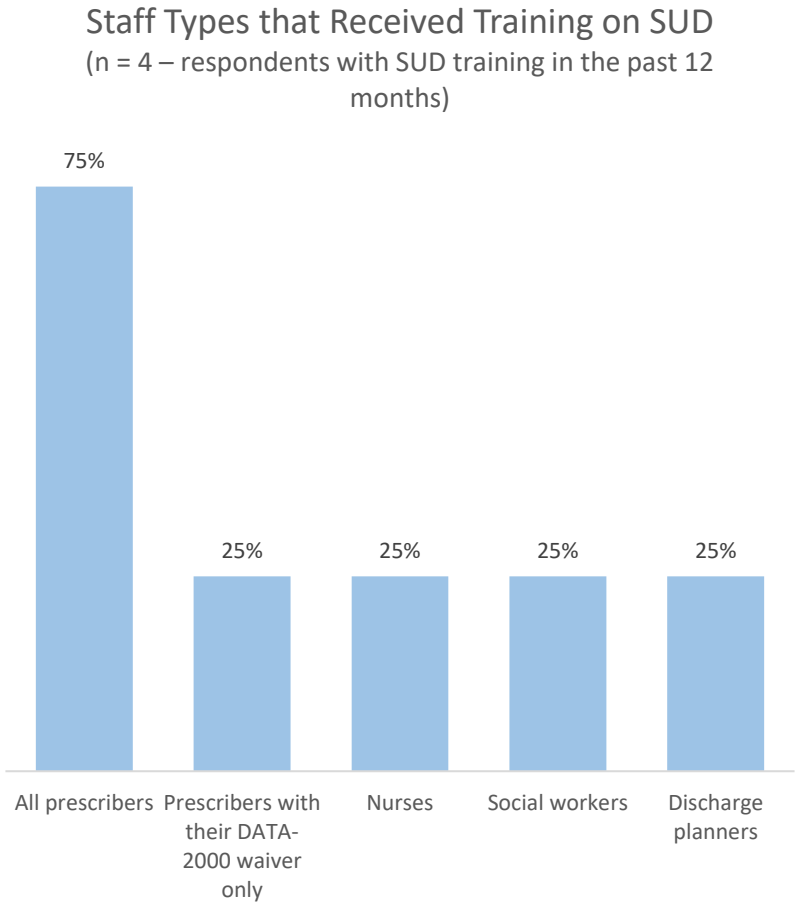
Hospital Has Preferred List of Community SUD Providers
(n = 8 – all respondents)



Evaluation of Community SUD Providers
(n = 6 – respondents with a preferred list of community SUD providers)

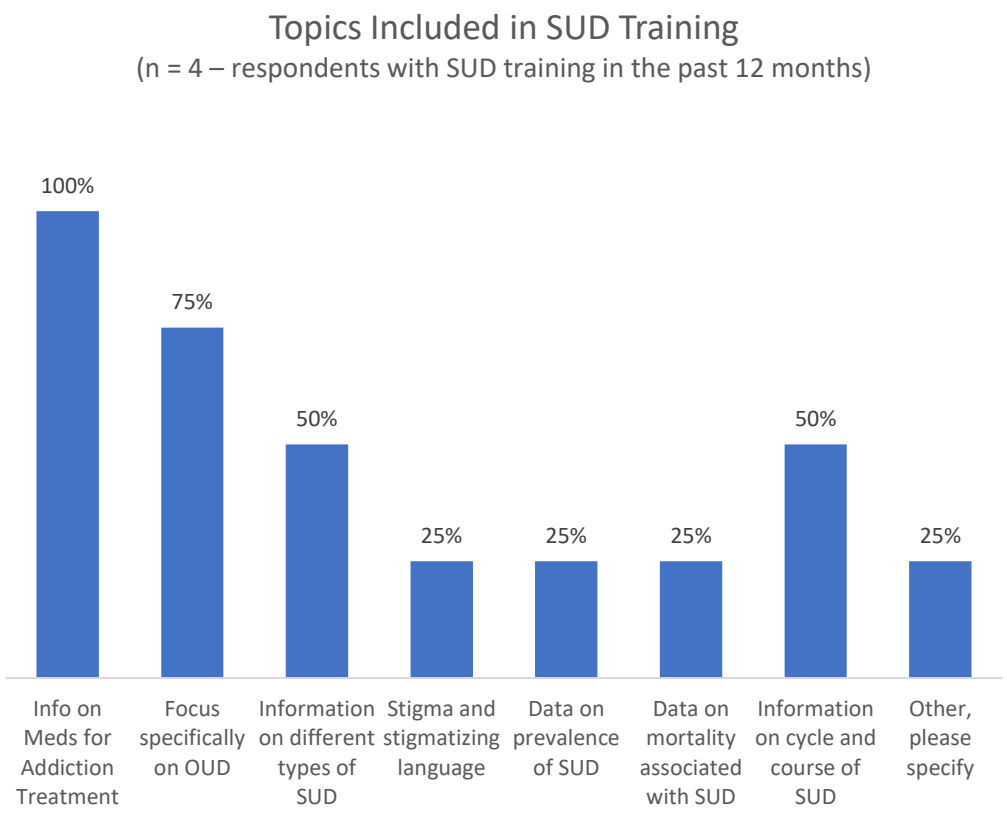


Training



- Only 50% of responding hospitals had conducted any training in Substance Use Disorder in the past 12 months

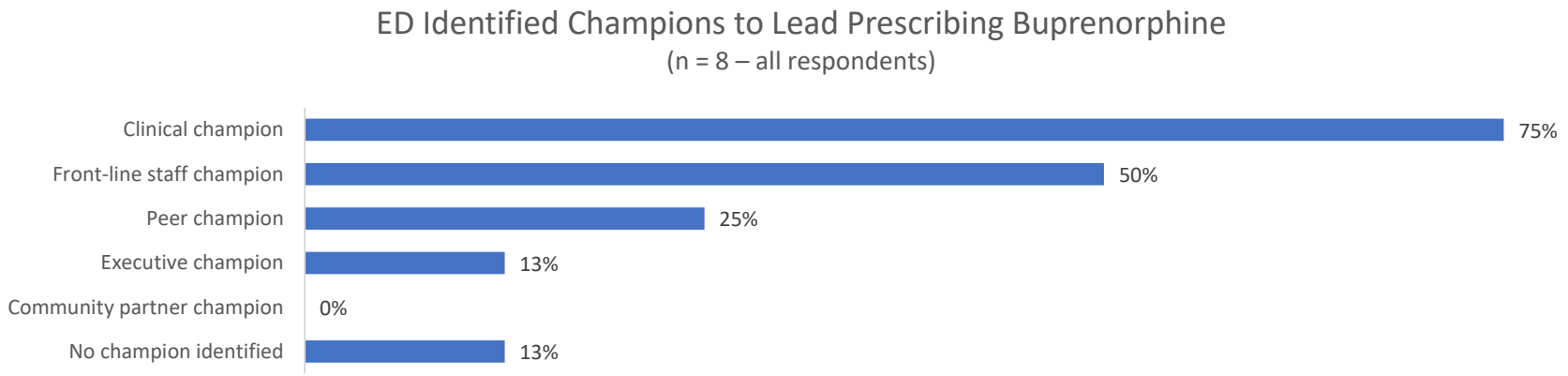
Training



- All responding hospitals said that SUD training conducted by hospital staff
- No responding hospitals had SUD training conducted by public health department, community providers, or an outside training group

Needs

Barriers to Providing Buprenorphine in the ED (1 = most challenging, 6 = least challenging)	Average Rank	1	2	3	4	5	6
Time and resources to complete induction in ED	2.375	25%	38%	13%	25%	0%	0%
Prescriber buy-in	2.75	25%	38%	0%	13%	25%	0%
Availability of community OUD providers to refer patients to	3.25	38%	0%	13%	13%	25%	13%
Identifying eligible OUD patients	3.75	13%	13%	25%	13%	13%	25%
Lack of waivered prescribers	4.375	0%	0%	25%	25%	38%	13%
Stigma surrounding opioid addiction	4.5	0%	13%	25%	13%	0%	50%



CREATING ACTIONABLE ACTION PLANS

Wing Lee, MBBS, MPH, CQFP
Director, Quality, Patient Safety and Clinical Programming

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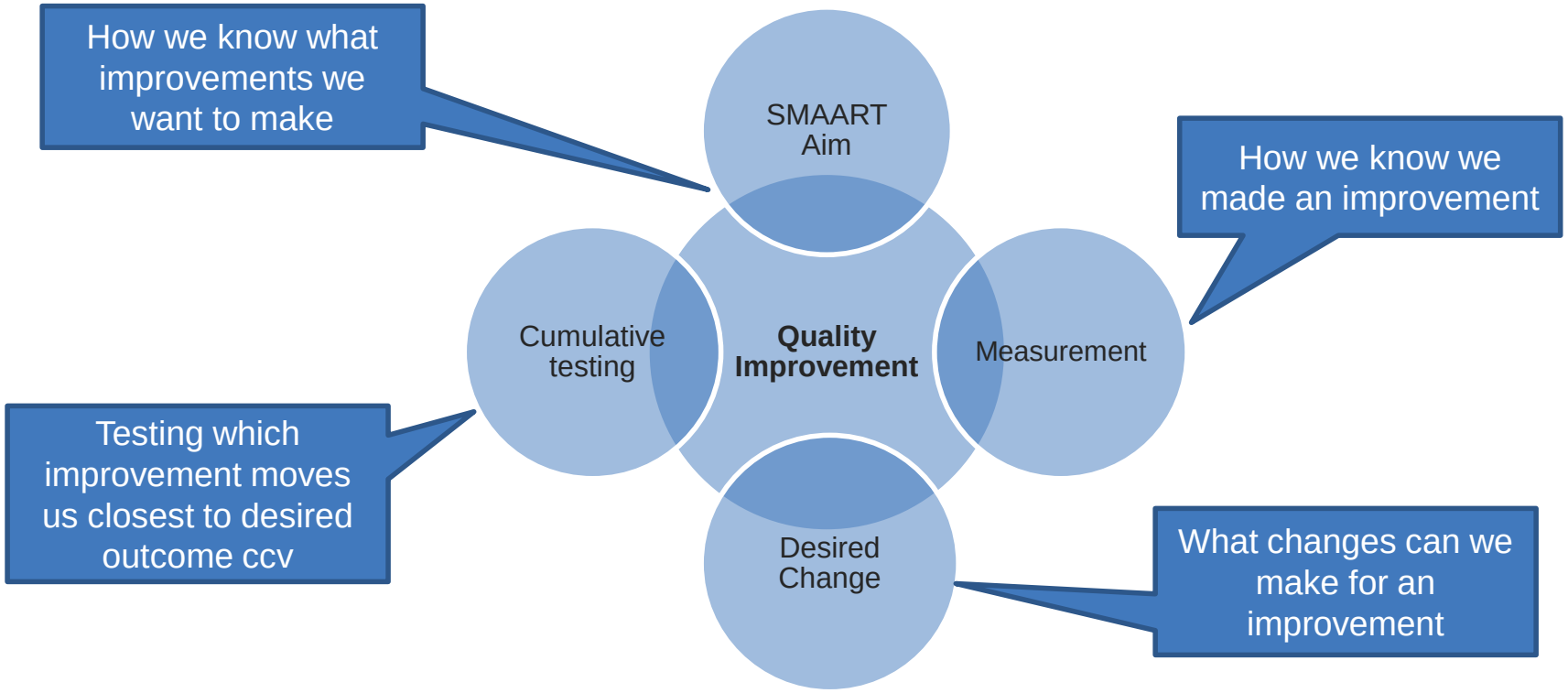
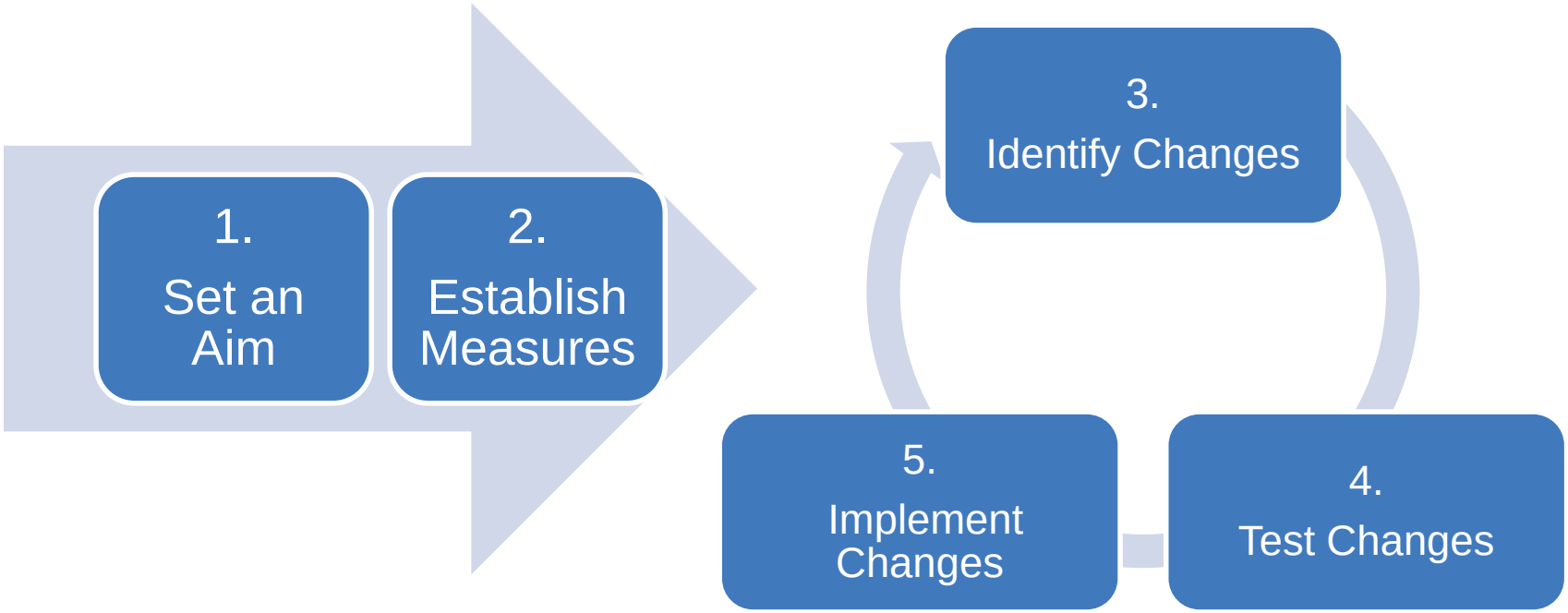
Reminder of QI Principles



Real QI Project Flow



Pre-Assessment Opportunities Identified

Screening	13% screen all patients for SUD in the ED
Buprenorphine protocol	50% have a protocol in place to provide patients with OUD with buprenorphine
	Of those with protocol: 75% have protocol in EMR 25% protocol is available at ED stations
	75% of EDs do not proactively make patients aware of buprenorphine availability
Team Composition	25% have a clinical champion
	13% have a executive champion
	25% have a peer champion
	0% have a community partner champion

Checklist to Set Up Your Project Up For Success

- **Clearly identified goals and aims**
  - Achievable
  - Realistic
- **Identify a team with key stakeholders**
  - Involve the “right” staff – including front line staff
- **How will you identify opportunities for improvement?**
  - Gap Analysis
  - Process Map
  - Driver Diagram
  - Cause and Effect Diagrams
  - Pareto Charts
  - Staff Interviews
  - Evidence Based Best Practices

- **Select measures**
  - Outcome, process and balancing measures
  - How will data be collected
  - How to share data
- **Plan for spread from the beginning**
- **Plan to overcome potential barriers to success**

Sample SMART Aim for ED MAT Project

- By March 31, 2021 we will screen 90%* of all ED Patients for SUD using a validated assessment with results of the assessment documented** in the medical record

- *based on weekly sampling of charts – where the entire assessment needs to be completed to be counted.
- ** if only screening is completed and result is not documented, assessment is considered incomplete

Specific –
Measurable –
Actionable
Achievable
Realistic/Relevant to Stakeholders and Organization
Timely

Your ED MAT Project Team Members

Executive Leadership

- CNO
- CMO
- CQO

Technical Expertise

- IT/ EMR
- Data Analyst
- Pharmacy

Day to day Leadership

- Staff
- RN
- MD
- Social Work

Clinical Leadership

- Chair of ED
- Director of Nursing Quality
- Chair of Bx Health/Psych
- Director of Addiction Services

ED-based Leaders

- Nurse Manager
- Nurse-MD Dyad

Front Line Staff

- RN
- MD, PA, NP
- Resident
- Social worker
- Counselors
- Unit clerk

Identifying the "Right Team"

- **Who do we want on the team?**
  - **Staff who:**
    - Know the process well
    - Have an interest in participating in the project
    - Can influence the success or failure of your project
    - Have their workflow changed/impacted as a result of your team's interventions

Sample Action Plan

Aim: By March 31, 2021 we will screen 90%* of all ED Patients for SUD using a validated assessment with results of the assessment documented in the medical record**

Action Description	*Who is responsible?*	*Time frame*	*How do we know it was successful?*	*Hazard Forecast/ potential roadblocks*	*Outcome*
Identify suitable SUD assessment	ED * Behavioral health chairs	1 week	Clinicians	Clinicians unfamiliar with new screening test – test with clinicians for ease of use/buy-in – use PDSA	

Sample PDSA Worksheet

PDSA WORKSHEET

Hospital Name:	Date of test:	Test Completion Date:
What is the question the test will answer? What is the objective of the test?		

PLAN:
Briefly describe the test:

How will you know that the change is an improvement?

What driver does the change impact?

What do you predict will happen?

PLAN

List the tasks necessary to complete this test (what)	Person responsible (who)	When	Where
1.			
2.			
3.			
4.			
5.			
Plan for collection of data:			

DO: Test the changes.

Was the cycle carried out as planned? ☐ Yes ☐ No

Record data and observations.

What did you observe that was not part of our plan?

STUDY:
Did the results match your predictions? ☐ Yes ☐ No

Compare the result of your test to your previous performance:

What did you learn?

ACT: Decide to Adopt, Adapt, or Abandon.

☐ Adapt: Improve the change and continue testing plan.
Plans/changes for next test:

☐ Adopt: Select changes to implement on a larger scale and develop an implementation plan and plan for sustainability

☐ Abandon: Discard this change idea and try a different one

Poll:

- Would you be interested in participating in Quality Improvement Office Hours?
  - Yes
  - No

Poll:

- Tell us your preferred format for the Quality Improvement Office Hours:
  - One-on-one office hours
  - Office hours with hospitals in the Collaborative w/in my health system
  - Office hours with other health systems in the Collaborative
  - No strong preference

Project Planning and QI Support

- If you are interested in receiving further support in developing your ED MAT Action Plan or in need of Quality Improvement support outside of QI Office Hours, please contact Alison Bur aburke@gnyha.org.

Questions

Reminder on Data Collection Requirements

ED MAT Collaborative Assessment

- 8/13 hospitals have completed

- Survey Monkey: https://www.surveymonkey.com/r/NYCEDMAT

Reminder on Data Collection Requirements

Assign Data Contact and Submit Requested Information for Stipend

- 4/13 submitted
- Jared Bosk and Courtney Zyla will reach out to the hospital's designated data contact to provide instructions on how to submit monthly Collaborative Measures using a secure portal

Collaborative Measures – Data Submissions

- November data due 12/30/20
- Incomplete data is better than no data at all
- Data will always be due at the end of the following month

To Those Who Have Not: Please Submit Requested Information for Data Contact and Stipend

- Please fill-out the requested information below and send to Cat Caneda, ccaneda@gnyha.org, and Jared Bosk, jbosk@gnyha.org, using **"NYC ED MAT - Data Collection and Stipend"** in the email subject line.

Health System and Facility
Name of Health System:
Name of Hospital Facility:
Data Contact
Name:
Job Title:
Phone #:
Email:
Payable Check Designee
Name:
Address:
Phone #:
If you are required to notify a specific department to receive this stipend, please provide their information:

Save the Date: January 14, 2020 – 12 p.m. – 1 p.m.

Eric Morley, MD, MHA, MS
Clinical Director, Dept. of Emergency Medicine
Deputy Chief Medical Information Officer
Stony Brook University Hospital

Susan Wilner, LCSW
Assistant Director of Behavioral Health Services Operations
Stony Brook University Hospital

On this webinar, Stony Brook University Hospital will share how it implemented its MAT protocol in the emergency department. They will also discuss ED MAT services provided throughout the COVID-19 pandemic.

Please click here to register

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Next Steps

- ✓Use Planning Worksheet to guide your team's activities over the next month
- ✓Establish clear roles and identify team leader
- ✓Establish regular team meeting schedule (and stick to it)
- ✓Commit at least one team member to attend each webinar
- ✓Complete Assessment if you have not already done so
- ✓Prepare to report on your team's progress

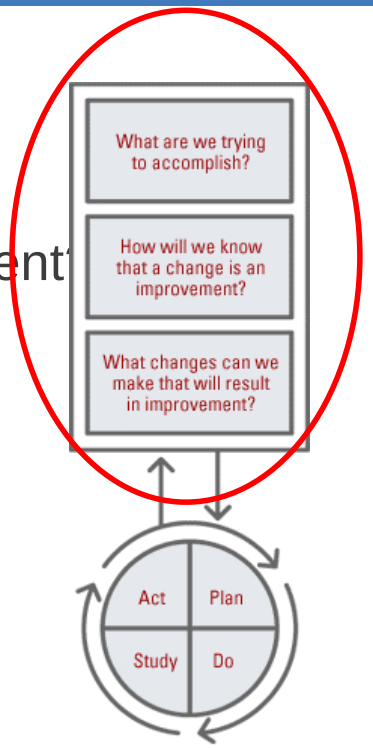
TEAM ACTION PLANNING WORKSHEET

Name of Hospital: _____ Name of Key Contact: _____

SUGGESTED ED MAT STRATEGY	CURRENT STATE? *(Indicate if fully implemented or not fully implemented, and share current state)*	ACTION PLAN? *(If not yet fully implemented, indicate action plan)*	LEAD?	STARTING WHEN? *(If not yet fully implemented, indicate when to implement action plan)*	MEASURE OF SUCCESS?
Create an ED MAT project team within your hospital with appropriate staff representation					
Develop a communication strategy or educational sessions to educate clinicians and ED staff about your ED MAT project					
Support Waiver Training as needed. Identify waivered prescribers within your emergency department and identify gaps in staffing coverage of waivered clinicians					
Identify any resources needed for successful implementation (staffing, educational materials, referral sources, IT support, financial, etc.)					
Ensure that Screening and Assessment for OUD process and personnel is in place within the ED					
Create or adopt Algorithm for Buprenorphine Induction Appropriateness and Treatment Guidelines					
Conduct needs assessment regarding referral process and warm hand-off to providers for post-ED treatment					
Identify a data plan for collection, use, and distribution of common metrics					
Identify champions among staff i.e. physicians, nurses, pharmacists, behavioral health staff, or administrators within the ED that can help ED staff adapt to changes					

The Model for Improvement

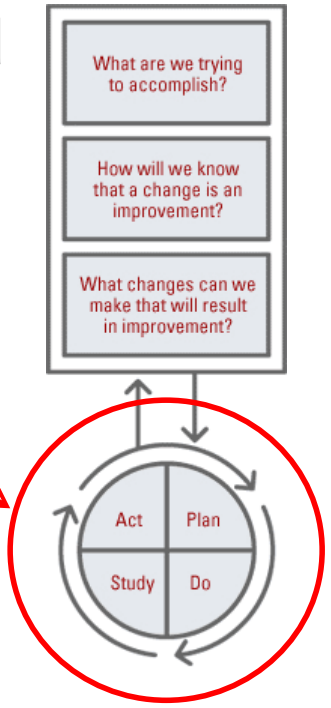
- What are we trying to accomplish?
  - *Team Aims*
- How will we know that the change is an improvement?
  - *Measurement*
- What changes can we make that will result in an improvement?
  - *Identify potential Changes/Interventions*



Source: www.ihi.org

PDSA Cycles

- Making small changes over a short period of time to test if the change works
- PDSA=Plan, Do, Study, Act
  - **Plan:** identify the change you want to make
  - **Do:** make the change
  - **Study:** it for a pre-set period of time
  - **Act**: on the change, keep it, refine it, or drop it
- Onto the next change or step



Source: www.ihi.org

Questions or Comments?

Contact Information

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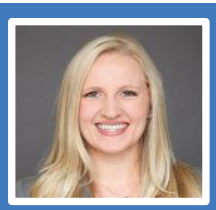

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