MNO-OB Teams Call: Screening and Linkage to Care Part II: Screening, Brief Intervention, & Referral to Treatment (SBIRT)

July 23, 2018
12:30 – 1:30pm
Introductions

• Please enter for yourself and all those in the room with you viewing the webinar into the chat box your:
  • Name
  • Role
  • Institution
• If you are only on the phone line, please be sure to let us know so we can note your attendance

Please enter the name, role and institution of yourself and all those in the room viewing the webinar
Based on feedback and discussion after our trial of holding the June MNO-OB and MNO-Neo calls back to back, ILPQC decided to move back to two separate Monday calls:

- MNO-Neonatal Teams - 3rd Monday of the month from 1pm - 2pm (new call information and webinar link).
- MNO-OB Teams - 4th Monday of the Month from 12:30pm – 1:30pm (same call information and webinar link).

ILPQC has posted updated call information on our website [www.ilpqc.org](http://www.ilpqc.org), and will include call information in team newsletters.

To accommodate the important information for both the MNO-OB and MNO-Neonatal teams, ILPQC will be sending out separate monthly communications with unique information for both teams.
Overview

• Getting started
• Updates
• Resources for SBIRT
• Screening & Intervening for Perinatal Substance Use at Dartmouth-Hitchcock- Daisy Goodman, DNP, MPH, CNM (Dartmouth-Hitchcock)
• Quality Improvement Examples
• Team Talk - Tammy Fritz, MSN, RNC-OB (Advocate Condell Medical Center)
• Next Steps & Call Schedule
Getting Started

• Each team should have a scheduled monthly meeting
• Completed REDcap data access form for team members to enter or access data reports
• At least one team member attended a data training call or watch recorded video
• Reviewed data collection form and started process for baseline data collection due Aug 15
• Starting QI work with: implementation of a validated self-report screener (L&D, prenatal sites) and implementation of SBIRT protocol to counsel all screen positive women and link to MAT / addiction services
Mothers Affected by Opioids: How do We Improve Care?

Increase moms on Medication Assisted Therapy by delivery
- Hospitals implement and share with affiliated prenatal care sites a validated screening tool, implement SBIRT protocol, map local resources and create a process flow to link moms with OUD to MAT and needed services.
- Provide education to providers on stigma reduction and key protocols (screening, SBIRT, linkage to care, optimal care protocols)

Engaging moms in the non pharmacologic care of babies with NAS (breastfeeding, skin to skin, rooming in)
- Care checklist prenatally and at L&D
- Patient education (consult and standardized education materials) empowering moms their participation matters!
- Hospital level process flow / protocol changes to increase maternal participation (rooming in, breast feeding, eat-sleep-console)
MNO 6 Key Opportunities for Improvement

1. **Improve identification of pregnant women with opioid use disorder (OUD)** through standardized screening and assessment for OUD and implementation of Screening, Brief Intervention, Referral to Treatment (SBIRT) protocol (*L&D and prenatal care sites*).

2. **Improve linkage to addiction care for moms with OUD** through standardized mapping of local resources to link moms to addiction services, and improved process flow, share with inpatient OB units, ER and affiliated prenatal care sites.

3. **Optimize clinical care of pregnant women with OUD** through patient and provider education, implementation of care protocols/checklists and consultations to be completed prior to or during delivery admission (*L&D and prenatal care sites*)
4. Increase maternal participation in the care of opioid exposed newborns (rooming in, breastfeeding, swaddling/holding, eat-sleep-console) through standardized education materials and a neonatal / pediatric consult.

5. Improve outcomes for opioid exposed newborns through key interventions: standardize identification and assessment of opioid-exposed newborns, increase maternal involvement in care, optimize non-pharmacologic newborn care, standardize pharmacologic treatment, and develop standard safe discharge plans.

6. Optimize prevention of OUD through provider and patient education, provider compliance with PMP lookup state law when prescribing any narcotic, and implementation of clinical guidelines for strategies to reduce opioid over-prescribing after delivery.
MNO Key Elements Link to our Improvement Goals

Screening and Linkage to Care - Optimizing Care for Moms/Babies - Prevention
What data are you collecting to track your progress?

- **Monthly Data (by the 15th of following month)**
  - OB Teams
    - All women with OUD collect process and outcome measures
    - Random sample of 10 charts from all deliveries to collect % screened for OUD
  - Neo Teams: All opioid exposed newborns

- **Quarterly Data (every 3 months)**
  - Structure measures to track your QI work: screening tool and SBIRT implementation, patient and provider education, protocol implementation, mapping resources, process flow etc.
PROCESS & OUTCOME MEASURES:

• Improve identification of women with OUD and linkage to addiction care
  • Percent of random sample of women at delivery with documented screening for OUD (% screened prenatal, % screened delivery admission) #
  • Percent of mothers with OUD at delivery on medication assisted treatment (MAT) *

# random sample of 10 charts per month, will submit % with monthly data

* Outcome Measure
STRUCTURE MEASURES:

Improve identification of women with OUD and linkage to addiction care

- Percent of hospitals / prenatal care sites using validated screening tool and SBIRT protocol for opioid use in pregnancy
- Percent of hospitals and affiliated prenatal care sites with addiction care community resources mapped and linkage to care process flow implemented
Help with getting started

• Review your toolkit – updates on ILPQC website
• Read all MNO email newsletters
• We are developing an MNO Kick-Off slide set to help your team get started and will share in an email newsletter
• We are working on Grand Rounds slide set and speakers bureau, contact us to request MNO Grand Rounds for your hospital
• Email or call us with all questions!
MNO-OB Toolkit is Online!

http://ilpqc.org/MNO-OB

MNO-OB Toolkit

1. Initiative Resources
   a. 11 Steps to Getting Started with the ILPQC Mothers and Newborns affected by Opioids (MNO) – OB Initiative
   b. MNO & Key Opportunities for Improvement
   c. Mothers and Newborns affected by Opioids Aims and Measures
   d. Mothers and Newborns affected by Opioids OB Data Form
   e. Mothers and Newborns affected by Opioids OB Neo Combined Data Form
   f. Mothers and Newborns affected by Opioids Structure Measures Data Form
   g. Mothers and Newborns affected by Opioids Key Drivers Diagram
   h. Mothers and Newborns affected by Opioids OB Readiness Survey
   i. Plan-Do-Study-Act Worksheet

2. Mothers and Newborns Affected by Opioids Initiative Slide Set

3. National Guidance: AIM Bundle

4. National Guidance: ACOG Committee Opinions

5. Screening and assessment of pregnant women with OUD

6. Screening, Brief Intervention, Referral to Treatment (SBIRT) Protocols and Example Process Flow

7. Improve Linkage to Addiction Care

8. Example Protocols/Best Practice Recommendations/Checklists for Prenatal - Intrapartum - Postpartum Care of Women with OUD

9. Counseling/Prescribing Naloxone/Narcan

10. Additional Resources Optimize Care of Women with OUD

11. Education Materials for Pregnant Women with OUD

12. Patient and Provider Education

13. Clinical guidelines / strategies to reduce opioid over prescribing postpartum

14. Overview of new Illinois state law on ILPMP Lookup

*Key Resource

The following material is an example only and not meant to be prescriptive. The resources provided in this toolkit are for informational purposes only. The exclusion of a resource, program, or website does not reflect the quality of that resource, program or website. Note: websites and URLs are subject to change.
MNO REDCAP DATA SYSTEM & TRAINING CALLS UPDATES
REDCAP ACCESS

- Complete the REDCap Access Form for ALL members of your team who need REDCap access!
- Please indicate if the team member needs access to OB data, Neonatal data, or BOTH
- There is one MNO data form in REDCap with OB and Neo fields in separate subforms
ILPQC MNO-OB Data Forms

✓ MONTHLY: MNO OB/Neo Monthly Mothers with OUD and Opioid-Exposed Newborns Data Form
✓ MONTHLY: MNO-OB Monthly Sample of Documentation of OUD Screening
✓ QUARTERLY: MNO-OB Quarterly Structure Measures
MNO Neo Data Collection Timeline

• Complete the REDCap Access Form for ALL members of your team who need REDCap access

• Complete Baseline Data Collection (October – December 2017) by August 15\textsuperscript{th} for:
  – MNO OB/Neo Monthly Mothers with OUD and OEN Data Form
  – MNO-OB Monthly Sample of Documentation of OUD Screening
  – MNO-OB Quarterly Structure Measures (Quarter 4)

• Prospective MNO-OB Data Collection Begins July 2018
  – MNO OB/Neo Monthly Mothers with OUD and OEN Data Form
    • July 2018 data due August 31\textsuperscript{st}, due the 15\textsuperscript{th} of the month for future months
  – MNO-OB Monthly Sample of Documentation of OUD Screening
    • July 2018 data due August 31\textsuperscript{st}, due the 15\textsuperscript{th} of the month for future months
  – MNO-OB Quarterly Structure Measures (Quarter 2)
    • Q2 2018 due August 31\textsuperscript{st}, due the 15\textsuperscript{th} of first month of the next quarter
Recordings of MNO-OB REDCap Data Training Calls

Click this link to watch the recording of the MNO-OB REDCap data submission training:

https://northwestern.webex.com/northwestern/ldr.php?RCID=f3b7cd9387671496665ad6ef85364eb0
SCREENING, BRIEF INTERVENTION, REFERRAL TO TREATMENT (SBIRT)
Mothers Affected by Opioids: How do We Improve Care?

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Engaging moms in the non pharmacologic care of babies with NAS (breastfeeding, skin to skin, rooming in)

- Care checklist prenatally and at L&D
- Patient education (consult and standardized education materials) empowering moms their participation matters!
- Hospital level process flow / protocol changes to increase maternal participation (rooming in, breast feeding, eat-sleep-console)
1. Improve identification of pregnant women with opioid use disorder (OUD) through standardized screening and assessment for OUD on: admission to labor and delivery, emergency rooms, affiliated outpatient prenatal sites; and implementation of Screening, Brief Intervention, Referral to Treatment (SBIRT) protocol.

2. Improve linkage to addiction care for moms with OUD through standardized mapping of local resources to link moms to addiction services/MAT/behavioral health services in your area. Share completed local linkage to care resources document and process flow for linking moms with OUD to MAT and needed services, with inpatient OB units, ER and affiliated prenatal care sites.
What is SBIRT?

- **ALL** patients who screen positive for OUD should receive a brief intervention and referral to treatment
- Should be administered privately with open-ended discussion and without judgment
- Providers can be reimbursed for SBIRT (see ILPQC toolkit for codes)

“Providing written handouts to ALL women can reach those who are afraid to disclose use, but may be at risk/need treatment.”

*ACOG district II slide set*
What is SBIRT continued...

- Has been shown to be effective in reducing substance abuse and creating healthcare costs
- Brief (even 5 mins.) opportunistic interventions can be very powerful in helping people change risky behavior
- Does not have to be performed by a physician; any trained professional can be effective
- Can be integrated in nearly any practice

| S | Screening |
| B | Brief     |
| I | Intervention |
| R | Referral |
| T | Treatment |
Effective Brief Intervention
Includes 3 Steps

1. **Offer FEEDBACK and information about pregnancy**
   - Example: “From what I understand from your screening, you are using XX and I am concerned about your use of XX. What connection (if any) do you see between your use of XX and this pregnancy.”

2. **LISTEN and understand the patient’s motivation**
   - Example: “I hear that you use XX to deal with stress of life at home.”

3. **EXPLORE other options to address patient’s motivation for substance use and readiness for treatment**
   - Example: “Are there other ways to deal with stress in a more healthy way?”

*ACOG district II slide set*
SBIRT continued...

- Work with behavioral health/social work to help assist with the intervention component of SBIRT
- Make referrals as needed that facilitate access to treatment and related services for women with OUD
  - Make connections with treatment providers to build relationships
  - Establish clear protocol / process flow for referral for MAT / services
  - After referral follow up with MAT providers on a regular basis
    - at least once a month
- Ensure support for providers starting buprenorphine waiver training or newly trained.

*Remember*

Each setting where SBIRT is implemented is different. Adapting SBIRT to your local setting is important
MNO-OB Toolkit: SBIRT Resources

- Helping women get Treatment: Screening and diagnosis of OUD overview*
- Screening for Substance Use using an SBIRT Framework (step-by-step how to develop a screening protocol)*
- Example Process Flow Map for SBIRT at Initial OB Visit*
- Example Protocol for Women who Endorse or Screen Positive for OUD to Link to Substance Use Care Services*
- Example Algorithm/Process Flow for Substance Use Screening in Pregnancy (Prenatal and Labor and Delivery)*
- Substance Use/Disorders Screening and Management During Pregnancy: Quick Reference Guide with Example Algorithm / Process Flow for Screening and Brief Intervention (page 3-5 & page 29)
- Brief Negotiated Interview Card
Using Quality Improvement to Implement SBIRT protocol / process flow

- Use your REDcap data reports to track progress and feedback to staff.* Follow up with staff on use of SBIRT.
  - Provide data feedback to staff as a way to create culture change and sustainable use of SBIRT with every screen positive patient
- To build a sustainable SBIRT program, staff need to have the tools for adapting SBIRT to their specific setting.
  - See ILPQC toolkit for SBIRT Pocket cards / process flow examples
  - Post process flow and train staff on SBIRT protocol
- Work in small interactive steps, adapting SBIRT components into your workflow using QI techniques (ex PDSA) rather than launch one big project
  - Small, progressive changes to determine workflow

*adapted from the National Center on Addiction and Substance Abuse at Columbia University.
SCREENING & INTERVENING FOR PERINATAL SUBSTANCE USE AT DARTMOUTH-HITCHCOCK
Screening and Intervening for Perinatal Substance Use at Dartmouth-Hitchcock

Daisy Goodman, DNP, MPH, CNM
Using the “SBIRT” Approach

- **Screening**: the healthcare professional assesses a patient for risky substance use behaviors using standardized screening tools. Screening can occur in any healthcare setting.

- **Brief Intervention**: the healthcare professional engages a patient showing risky substance use behaviors in a short conversation, providing feedback and advice.

- **Referral to Treatment**: the healthcare professional provides a referral to brief therapy or additional treatment to patients who screen in need of additional services.
Tablet-based SBIRT Process in the Prenatal Clinic
OK, so we are pretty good at screening....but now what should I do?

Proportion of Obstetric Patients Screened at the First Prenatal Visit

State benchmark **OB % Screened**

<table>
<thead>
<tr>
<th>% OBGYN Screened</th>
<th>Target</th>
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<td>14.9% 9.5% 26.5% 32.0% 53.8% 76.3% 80.4% 86.4% 85.1% 89.0% 84.8% 91.5% 94.6% 90.4% 91.2% 91.5% 75.7% 75.7% 93.0%</td>
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Evaluating SBIRT

• # of patients screened/# attending NOB appt
• # of positive screens (AUDIT-C + NIDA)/# screened
• Breakdown of positive NIDA screen by score

AUDIT-C = 3 pre-screening questions about prior year alcohol use
NIDA = 1 pre-screening question about frequency of drug use in past year
That's a lot of positive screens... what does this mean?
Everyone who screens in the “at risk” category needs a Brief Intervention.
Q1 Please describe your prior experience and/or training in Motivational Interviewing (MI) or SBIRT (Screening, Brief Intervention, Referral for Treatment).

Answered: 34    Skipped: 0

No experience
Have heard of MI or SBIRT ...
Formal training in MI in...
Formal training in...
Provider Counseling at Baseline: Illicit Drug Use

Q4 What percentage of your pregnant patients do you counsel about illicit drug use?

Answered: 20  Skipped: 14
Provider Counseling at Baseline: Alcohol Use

Q5 Do you counsel every pregnant patient about the risks of alcohol use in pregnancy?

Answered: 32  Skipped: 2

Yes

No
Ask women whether they have used drugs or alcohol in the past year

Ask women about the quantity and frequency of use

Use a validated screening tool as directed

Assess a woman’s readiness to change

Q7 How confident are you in your ability to:

Answered: 31  Skipped: 3
Advise a woman to change due to risk to herself or pregnancy

Refer a woman for treatment

Document use and your discussion in the record

Q7 How confident are you in your ability to:

- Advise a woman to change due to risk to herself or pregnancy
- Refer a woman for treatment
- Document use and your discussion in the record

*Not at all confident* | *Barely confident* | *Neutral* | *Somewhat confident* | *Very confident*
Brief Negotiated Interview (BNI)

- Validated approach developed for fast-paced healthcare environments at Boston University
- Utilizes motivational interviewing techniques
  - Enhance autonomy
  - Increase motivation for change
  - Develop discrepancy
**A Brief Negotiated Interview**

| 1) **Build Rapport & Bring it Up** | • One health issue we discuss with all pregnant patients is alcohol and drug use. Having an honest conversation about these behaviors helps us provide you and your baby the best possible care.  
  • You don’t have to answer any questions if you feel uncomfortable. Would it be okay to talk for a minute about alcohol/drugs? |
|----------------------------------|--------------------------------------------------------------------------------------------------|
| 2) **Pros and Cons** Summarize   | • People use alcohol and drugs for lots of reasons  
  • Help me understand, through your eyes, what do you like about using [X]?  
  • What do you like less about using [X]?  
  • So, on the one hand [PROS], and on the other hand [CONS]. |
| 3) **Information & Feedback**     | • I have some information on risks of drinking and drug use during pregnancy. Would you mind if I shared them with you?  
  (Refer to appropriate handouts/cards as needed)  
  • **There is no known amount of alcohol that is safe to drink during pregnancy or when trying to get pregnant.** Drinking anything containing alcohol during pregnancy can cause Fetal Alcohol Spectrum Disorders (“FASDs”), which include physical problems, intellectual and behavioral disabilities.  
  • Use of drugs during pregnancy can also increase the risk for other pregnancy complications and health problems for your baby and behavioral and developmental problems in childhood.  
  • Use of drugs and alcohol while breastfeeding can also have negative effects on your baby.  
  • What are your thoughts on any of that? |
| 4) **Readiness Ruler** Reinforce positives Ask about lower numbers | • This Readiness Ruler is like the Pain Scale we use in the hospital.  
  • On a scale from 1-10, with 1 being not ready at all and 10 being completely ready, how ready are you to make any kind of changes in your [X] use?  
  • You marked ___. That’s great. That means you are ___ % ready to make a change.  
  • Why did you choose that number and not a lower one like a 1 or a 2? |
| 5) **Action Plan** Affirm ideas Write down steps | • What are some steps you could take to reduce the things you don’t like about using [X]? What ideas do you have to keep you and your baby healthy and safe?  
  • Those are great ideas! Is it okay for me to write down your plan, your own prescription for change, to keep with you as a reminder?  
  • What should I write down on here? |
### Standard Drink

1 drink = 12oz beer  
5oz wine

**Liquor** (80 proof = 40% alc/vol)  
*Increase # drinks if liquor is 100 proof (50% alc/vol).

- **Shot**  
  1.5oz = 1

- **Nip**  
  2oz = 1.6

- **Pint**  
  16oz = 11

- **Fifth**  
  26oz = 17

- **Liter/Quart**  
  32oz = 21

**Mixed Drink**  
Rum & cola = 1  
Margarita = 1.5  
Martini = 2  
LI Ice Tea = 4-5

**Beer** (5% alc)  
12oz = 1  
16oz = 1.5

**Alcopop/Wine Cooler** (5% alc)  
12oz = 1

**Malt Beverage/Liquor**  
16oz (6-8% alc) = 2-3  
16oz (12% alc) = 4  
24oz (12% alc) = 5

**Wine** (12% alc/vol)  
*Increase # drinks if >12% alc/vol.

- **Glass**

- **Bottle**

- **Magnum**  
  ~ 2 reg. wine bottles

- **Jug/Cask**  
  3-5L = 24-40

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### READINESS RULER

How ready are you to make a change?

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Documenting SBIRT

Counseling for drug and alcohol use
When SBIRT screening is positive for either drug use or moderate to heavy alcohol use (even prior to pregnancy), brief intervention is a billable service. Documentation should include time spent counseling along with details of the interaction:

- Face-to-face interaction with the patient
- Assessing readiness for change
- Advising the patient about risks
- Suggesting treatment(s) for the patient

Example language
“I met with ________ to discuss her positive (AUDIT/DAST) screening. We discussed the risks of alcohol and drug use during pregnancy, and explored options for supporting abstinence from alcohol and illicit drugs. We reviewed patient information about DHMC policies about prenatal substance use and state-specific reporting requirements.  Referral to Behavioral Health was offered. She accepted/declined ________. Time spent in counselling was (<15/15-30) minutes.”
...and don’t forget Tobacco Counselling!

Documentation
Should include time spent counseling and details of the interaction. Requirements for reporting smoking cessation counseling include:

– Face-to-face interaction with the patient
– Assessing readiness for change
– Advising the patient to quit
– Suggesting treatment(s) for the patient, which can be as simple as supplying them with the phone number of the ‘quit line’ (800-QUIT NOW)

CPT codes

• **99406** – smoking & tobacco cessation counseling visit; intermediate, greater than 3 minutes & up to 10 minutes
• **99407** – smoking & tobacco cessation counseling visit; intensive, greater than 10 minutes.

Sample diagnostic code

• **F17.200** Nicotine dependence, unspecified, uncomplicated
Getting Paid for SBIRT

CPT codes

- **99408** Alcohol and/or substance (other than tobacco) abuse, structured screening (eg, AUDIT, DAST), and brief intervention (SBI) service; 15 to 30 minutes
- **99409** Alcohol and/or substance (other than tobacco) abuse, structured screening and brief intervention (SBI) service, greater than 30 minutes

Sample Diagnostic Codes:

- **O99.320** Substance abuse affecting pregnancy, antepartum
- **F11.20** Opioid use disorder, moderate, dependence*
- **F12.10** Marijuana use

*There are many codes to choose from for OUD, indicating level and duration of treatment participation*
Questions?

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Daisy.J.Goodman@hitchcock.org
QI EXAMPLES
Applying the IHI model and PDSA Cycle to Improve Identification of OENs

PDSA Worksheet

**AIM**
What are we trying to accomplish?

**MEASURES**
How will we know that a change is an improvement?

**CHANGES**
What changes can we make that will result in improvement?

*available for review on ilpqc.org*
Applying the IHI Model and PDSA Cycles continued

1. Do initial PDSAs on smallest scale possible
   – A “cycle of one” usually best: one patient, one doctor, one day
   – “Failed” cycles are good learning opportunities, particularly when small

2. Test under as many conditions as possible
   – Think about factors that could lead to breakdowns, supports needed, “naysayers”

3. Always identify the prediction/hypothesis before testing the change
   – Allows improved learning from “failures” and refinement of your theory

4. Use a “study measure” specific to the PDSA
   – Usually not one of the project measures
   – Is a measure specific to the small test of change
   – Qualitative results are very valuable in early PDSAs
PDSA: Plan

The Power of “ONE”

Conduct your test with...

• ONE day
• ONE physician
• ONE patient
Aim - Discover preferred screening tool

Results - IHRI Screening tool was preferred

Aim - Does IHRI + BNI-ART = sBIRT for providers.

Results - IHRI + BNI-ART = SBIRT

Aim - Discover how “–BIRT” with IHRI

Results - IHRI + Process flow ≠ sBIRT
PDSA: Plan

2. Plan

3. Do

PDSA WORKSHEET

Team Name: Collaboration Health
Date of test: July 30, 2018
Test Completion Date: August 2, 2018

Overall team/project aim: Improve identification of pregnant women with opioid use disorder through standardized screening and assessment for OUD

What is the objective of the test? To implement standardized screening, assessment and a brief intervention for OUD on admission to labor and delivery

PLAN: After discussing how our hospital currently manages OB process flow and use screening and brief intervention on admission to L&D, we performed two PDSA cycles. Those cycles showed that our providers preferred the Institute for Health Recovery Integrated (IHR) Screening tool, but needed another tool in order to feel confident in performing a brief intervention and referral to treatment (BIRT). Our next step is to determine the workflow for implementing the Brief Negotiated Interview and Active Referral to Treatment Algorithm (BNI-ART) for patients who screen positive for OUD.

Briefly describe the test: Test the BNI-ART for best fit for implementation as standardized intervention for patients who screen positive for OUD.

How will you know that the change is an improvement? Feedback from provider if the implementation of BNI-ART provided confidence when performing a BIRT after use for one patient.

What driver in the initiative key driver diagram does the change impact? “Early screening of all women”

What do you predict will happen? We predict the provider champion will discover that using the BNI-ART Algorithm will assist in feeling prepared and confident when performing a BIRT.
PDSA: Plan

**Plan**

1. Prepare paper copies of the screening tool for Dr. Delivery and BNI ART algorithm.
   - Person responsible: Autumn
   - When: Aug 3
   - Where: L&D

2. Meet with Dr. Delivery to review tool and process flow.
   - Person responsible: Autumn
   - When: Aug 4
   - Where: Dr. Delivery Office

3. Test the screening tool once with the first patient admitted to L&D.
   - Person responsible: Dr. Delivery
   - When: Aug 5
   - Where: L&D

4. Debrief with QI team to discuss feedback.
   - Person responsible: Autumn, Beth, Dr. Delivery
   - When: Aug 6
   - Where: Staff meeting room

5. Develop subsequent PDSA cycle/other action.

Plan for collection of data: Notes from screening tool administration on 1 patient each and qualitative discussion of experience using screening tool.
PDSA: Do

DO: Test the changes.

Was the cycle carried out as planned? X Yes □ No

Record data and observations. Dr. Delivery tested the IHRI screening tool accompanied with the BNI-ART with one patient who screened positive for OUD in L&D. Dr. Delivery reported feeling more prepared during the intervention unlike the prior PDSA cycle.

What did you observe that was not part of our plan?
We didn’t expect the provider to request more education and simulation to feel better equipped and confident during the -BIRT.
PDSA: Study

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

Compare the result of your test to your previous performance:
First test: Identified IHRI Screening Tool as the preferred method for screening all patients.
Second test: The process flow map diagram used was not enough for the providers to feel confident or equipped to properly implement - BIRT.
Third test: BNI-ART assisted the provider in feeling more prepared. Need to repeat screening tool with BNI-ART with more patients to determine need and areas for education.

What did you learn?
Preparedness and confidence is valued by providers when performing a brief intervention and referral to treatment for a patient who has screened positive for OUD.
**PDSA:** Act

**ACT:** Decide to Adopt, Adapt, or Abandon.

- **Adapt:** Improve the change and continue testing plan. Plans/changes for next test: Test the IHR! Screening tool and BNI-ART Algorithm on L&D with 5 patients who screen positive during 1 day on L&D to receive feedback and assist in identifying potential areas of education and possible training needs.

- **Adapt:** 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
Sample OUD Screening Process Flow Diagram

1. Screening tool used with existing RN admission process
   - Positive
   - Brief Intervention using BNI-ART privately
     - Willingness to accept treatment?
       - Yes: Initiate treatment and referral process for inpatient stabilization.
       - No: Signs of withdrawal?
         - Yes: Unclear if physiologic dependence
           - No: Initiate referral process for outpatient stabilization including social work and close provider follow-up.
         - No: Signs of withdrawal?
           - Yes: Initiate Positive OUD Refusal for treatment process
           - No: Initiate referral process for outpatient stabilization including social work and close provider follow-up.

2. Delivery on this admission?
   - Yes: Follow L&D delivery process
   - No: Re-screen at next admission

3. Provide information about perinatal risks.
4. Assess/address psychiatric co-morbidities.
5. Assess/address social risks including domestic violence and homelessness.
6. Close follow-up with social worker and out-patient provider.

adapted from www.doh.wa.gov
MNO-OB TEAM TALK
ILPQC MNO 30/60/90 Plan
Tammy Fritz MSN, RNC
Nina Budhwani BSN, RNC

July 23, 2018
● Located in Lake County, IL.
● Population of 703,462 residents
● Level 2+ Special Care Nursery
● Highest level nursery for Lake County
● 34 Labor and Delivery Nurses
● 25 Special Care Nurses
● 1827 deliveries in 2017
● 11 of these infants were exposed to drugs in utero
● As of July 2018, 6 cases of IUDE identified and treated in our special care nursery
Team Members ILPQC OB MNO

**Team Lead/Clinical Educator**
Tammy Fritz MSN, RN, RNC

**Clinical Nurse Manager**
Sara Marcy MSN, RN, RNC

**Director of Nursing**
Kathy Voss MSN, RN, RNC

**Quality Leads**
Nina Budhwani, BSN, RN, RNC
Janet Dobbertin BSN, RN, RNC

**Physician Lead**
Dr. Robert Rosenberg

**Pharmacy**
Jennifer Aguado

**Emergency Department**
Cassie Kohl BSN, RN

**Social Work**
Amy Case
Current Process

• **Admission** – basic 3 question alcohol/substance abuse questionnaire

• **Protocol Intrauterine Drug Exposure Testing Guideline**
  – Consistently identifies and tests both mom and baby per listed risk factors
    • Ex: Maternal risk factors- inadequate prenatal care, poor maternal weight gain, placental abruption, previous positive toxicology screen for illicit or prescribed medications (Opioids).
    • Neonatal risk factors- IUGR, S&S of NAS, unexplained preterm delivery <35 weeks
  – Collection process for umbilical cord drug testing
The 5Ps is an effective tool of engagement for use with pregnant women who may use alcohol or drugs. This screening tool poses questions related to substance use by women’s parents, peers, partner, during her pregnancy and in her post. These are non-confrontational questions that elicit genuine responses which can be useful in evaluating the need for a more complete assessment and possible treatment for substance abuse.

- Advise the client responses are confidential.
- A single “YES” to any of these questions indicates further assessment is needed.

1. Did any of your Parents have problems with alcohol or drug use?
   ___ No ___ Yes

2. Do any of your friends (Peers) have problems with alcohol or drug use?
   ___ No ___ Yes

3. Does your Partner have a problem with alcohol or drug use?
   ___ No ___ Yes

4. Before you were pregnant did you have problems with alcohol or drug use? (Past)
   ___ No ___ Yes

5. In the past month, did you drink beer, wine or liquor, or use other drugs? (Pregnancy)
   ___ No ___ Yes
## 30-60-90 day plan

### 30 days
- Interdisciplinary Team meeting
- Identify Team Members
- Review MNO toolkit/resources
- Identify access and review access and forms for data entry
- Review potential goals/outcomes

### 60 days
- Interdisciplinary Team meeting
- Identify goals/outcomes
- Identify validated screening tool to trial-5ps
- Education on Stigma
- PDSA cycle
- Enter preliminary REDCap data
- Process flow diagram

### 90 days
- Interdisciplinary Team meeting
- Education
- Develop Protocols
- Implement practice change
- Collect data/Begin PI measures to evaluate process
Barriers

- Patients presenting to the ED
- RN comfort level with addressing opioid misuse with patient and family
- RN/MD comfort level with caring for a neonate affected by opioids rooming in with mother
- Encouraging breastfeeding for moms who have a positive drug screen/currently taking
- Insurance and access to community resources
Strategies

- Provide continued education to staff
- Provide education to ED and ancillary departments related to MNO initiative/best practice
- Collaborate with team members
- Develop a protocol to allow neonates that meet specific criteria to room in as much as possible with mother during stay
- Using alternative non-opioid medication to treat patient pain
- Limit opioid prescription upon discharge
- Utilize opioid prescription registry before opioid prescription by MD
**Process Flow Diagram**

1. Pregnant patient presents to ER or OB

   - Gateway (maternal permission)
   - Referral to outpatient resources and treatment

2. All patients assessed with a validated screening tool

   - Maternal screening positive for OUD
   - Notify primary physician & SCN RN *
   - Social service consult
   - Referral to outpatient resources and treatment
   - Opioid misuse education upon discharge/follow-up calls

3. Routine care, Opioids ordered per recommended guidelines

4. Opioid misuse education upon discharge for all pregnant/PP patients

5. Develop a multidisciplinary collaborative plan of care with pt/family before D/C (MD/RN/LC/psych/Chaplin)

   - YES

   - NO
PDSA

- Identify a validated screening tool
- Testing screening tool in LD
- Educate and incorporate tool in LD and expand to OB physician office
- Evaluate screening tool - Adapt/Adopt/Abandon
THANK YOU
MONTHLY CALLS, UPCOMING TRAININGS AND MOC PART IV OPPORTUNITIES
NEXT MNO-OB TEAMS CALL

Monday, August 27th, 12:30-1:30pm

MNO-OB Teams Call

Linkage to Care: Community Mapping of Resources
<table>
<thead>
<tr>
<th>MNO Data Collection</th>
<th>Monthly Data Patient-Level</th>
<th>Monthly Data Sample</th>
<th>Quarterly Data Structure Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data Collection Form(s) Name</td>
<td>MNO OB/Neo Monthly Mothers with OUD and Opioid-Exposed Newborns Data Form</td>
<td>MNO OB Monthly Sample of Documentation of OUD Screening</td>
<td>MNO OB Quarterly Structure Measures</td>
</tr>
<tr>
<td>Baseline Time Period</td>
<td>October – December 2017</td>
<td>October-December 2017 (Quarter 4)</td>
<td></td>
</tr>
<tr>
<td>Baseline Due Date</td>
<td>August 15</td>
<td>August 15</td>
<td></td>
</tr>
<tr>
<td>Prospective Data Collection Start</td>
<td>July 2018</td>
<td>Q2 2018</td>
<td></td>
</tr>
<tr>
<td>Prospective Data Due Date</td>
<td>July 2018 due August 31st, 15th of the month for future months</td>
<td>Q2 2018 due August 31st 15th of first month of the next quarter (i.e. Q3 data due Oct 15)</td>
<td></td>
</tr>
<tr>
<td>Who/what are we collecting data on?</td>
<td>All women with OUD / Opioid exposed newborns collect process and outcome measures</td>
<td>Random sample of 10 charts from all deliveries to collect % screened for OUD</td>
<td>Track your QI work: patient and provider education, protocol implementation, mapping resources, process flow etc.</td>
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## UPDATED BASELINE DATA COLLECTION GUIDANCE

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### Baseline Time Period
- October – December 2017
- October-December 2017 (Quarter 4)

### Baseline Due Date
- August 15
- August 15

### Who/what are we collecting data on?
- All women with OUD / Opioid exposed newborns collect process and outcome measures
- Random sample of 10 charts from all deliveries to collect % screened for OUD
- Track your QI work: patient and provider education, protocol implementation, mapping resources, process flow etc.

Some teams may have only a small # across 3 months:
- 3 months (Oct-Dec 2017 baseline data)
- **If less than 5 moms, go one month earlier until 5 cases are identified for baseline (can go back into 2016 as needed)**
OB & Neonatal MOC Part IV Opportunities

Obstetric Teams- NEW ACOG MSPP (OB-Gyns and Multi-Specialty Physicians)-DUE NOV 1st, 2018

• Step 1: Participating physicians complete Physician Attestation Survey
• Step 2: On-site project leads complete Project Lead Attestation Survey
• MNO-OB AND/OR Severe Maternal Hypertension will BOTH qualify!

• EMAIL INFO@ILPQC.ORG with any questions!
REGISTRATION OPEN: ACOG/ASAM Buprenorphine Training

• 4 hour online course + 4 hour in-person led by an addiction medicine specialist & OB/GYN for physicians
  – MOC Part IV credits
  – CME for 8 hours credit (via ASAM)
• 4 hours in-person + 20 hours of online-training for NPs and APNs
  – Contact hours (via ASAM)
• Working with ACOG to host 2 in-person maternal-focused Buprenorphine Trainings for physicians, nurse practitioners and APNs in Illinois
• Initiates buprenorphine waiver process

Register for the Friday, September 14th (8:00am – 12:30pm) training HSHS St. John’s Hospital, Springfield:
https://elearning.asam.org/p/obgyn_IL1

Register for the Monday, October 22nd (8:00am – 12:00pm) training Prentice Women’s Hospital, Northwestern, Chicago, IL:
https://elearning.asam.org/p/obgyn_IL2
SAVE THE DATE
ILPQC 6th Annual Conference
Monday, November 5, 2018
Westin Lombard
Contact

• Email info@ilpqc.org
• Visit us at www.ilpqc.org
THANKS TO OUR SPONSORS

IDPH
Illinois Department of Public Health

CDC
Centers for Disease Control and Prevention

DHS
Illinois Department of Human Services

JB & MK PRITZKER
Family Foundation
Who to collect data on

*Monthly Data: Patient-Level

- All women with OUD / opioid exposed newborns process & outcome measures

All women with Opioid-Use Disorder delivering at your hospital including:

- Positive self-report screen assessed to have OUD;
- Positive opioid toxicology test during pregnancy or reporting opioid use disorder;
- Using any non-prescribed opioids during pregnancy;
- Using prescribed opioids chronically longer than a month in the third trimester.
- In addition, include mothers if newborn (viable pregnancy ≥24 weeks, 0 days) has an unanticipated positive neonatal cord, urine, or meconium screen for opioids.
Definition of Screening

- Definition of screening includes: standardized use of a self-reported validated screening tool for substance use / opioid use disorder (see MNO toolkit for examples of validated screening tools).

Example screening tools:
- Validated self-report screening tool (see MNO toolkit for examples, http://ilpqc.org/MNO-OB)
- Non-validated screening question (single item screening question- “Any illicit drug use in this pregnancy?”)
- Urine toxicology screen/test is a separate option and should not be recorded as “Validated self-report screening tool” or “Non-validated screening question”
Who to collect data on

- Monthly Data: Sample
  - Random sample of 10 charts from all deliveries to collect % screened for OUD
- For 10 randomly sampled charts from all deliveries per month, report if OUD screening was documented in the patient’s prenatal and L&D medical record with the following options:
  - Yes
  - If Yes, screened with (check all that apply):
    - Validated self-report screening tool
    - Non-validated screening question
    - Urine toxicology screen/test
    - Other: ________________
  - No
  - Not screened, OUD previously identified