Quality and Productivity Commission

30th Annual Productivity and Quality Awards Program

"Heritage of Excellence"

2016 APPLICATION

Title of Project (Limited to 50 characters, including spaces, using Arial 12 point font):

NAME OF PROJECT: ASSESSING ALCOHOL USE IN PSYCHIATRIC PATIENTS

DATE OF IMPLEMENTATION/ADOPTION: JULY 2014
(Must have been implemented at least one year - on or before July 1, 2015)

PROJECT STATUS: X Ongoing _____ One-time only

HAS YOUR DEPARTMENT PREVIOUSLY SUBMITTED THIS PROJECT? _____ Yes X No

EXECUTIVE SUMMARY: Describe the project in 15 lines or less using Arial 12 point font. State clearly and concisely what difference the project has made.

1 The goal of the Performance Improvement (PI) project was to increase compliance with
2 the Inpatient Psychiatric Facility - Substance Use (IPF-SUB) 1 Joint Commission and
3 Centers for Medicare and Medicaid Services (CMS) Core Measure compliance from 0%
4 to 90% by December 2015, instead is sustained at 100%. This involves administration
5 of a validated alcohol use screening tool for every patient within 72 hours of admission
6 to a psychiatric hospital in response to a public health concern. Unhealthy alcohol use is
7 a serious public health concern and social cost. Our effort is to identify patients at the
8 time of admission to an inpatient psychiatric hospital who can benefit from substance
9 treatment. Since substance use disorders are among the top 3 psychiatric problems in
10 the US, this is a fundamental initiative in an at-risk population. This project may lead to
11 a decrease in health complications, injury, unemployment, and impaired functioning as
12 a result of long term unhealthy alcohol use. Intervening early may reduce health care
13 and social costs associated with unhealthy alcohol use. In addition, this project's
14 success may increase CMS reimbursement and hospital scoring to LAC+USC MC and
15 the LA County system as a whole by exceeding the required compliance benchmark.

BENEFITS TO THE COUNTY

(1) ACTUAL/ESTIMATED **ANNUAL** COST AVOIDANCE	(2) ACTUAL/ESTIMATED **ANNUAL** COST SAVINGS	(3) ACTUAL/ESTIMATED **ANNUAL** REVENUE	(1) + (2) + (3) = TOTAL **ANNUAL** ACTUAL/ESTIMATED BENEFIT	SERVICE ENHANCEMENT PROJECT
$	$	$	$	☒

ANNUAL = 12 MONTHS ONLY

SUBMITTING DEPARTMENT NAME AND COMPLETE ADDRESS		**TELEPHONE NUMBER**
Department of Health Services - LAC+USC Medical Center 2051 MARENGO STREET LOS ANGELES, CA 90033		323-409-8159
PROGRAM MANAGER'S NAME Liz Budek Assistant Nursing Director, Administration Quality Improvement Advisor		**TELEPHONE NUMBER** 323-409-8159 **EMAIL** lbudek@dhs.lacounty.gov
PRODUCTIVITY MANAGER'S NAME AND SIGNATURE (PLEASE CALL (213) 893-0322 IF YOU DO NOT KNOW YOUR PRODUCTIVITY MANAGER'S NAME) Gerardo Pinedo SIGNATURE ON FILE	**DATE** 6/30-/2016	**TELEPHONE NUMBER** 213-240-8104 **EMAIL** gpinedo@dhs.lacounty.gov
DEPARTMENT HEAD'S NAME AND SIGNATURE Mitchell H. Katz, M.D. SIGNATURE ON FILE	**DATE** 6/30/2016	**TELEPHONE NUMBER** 213-240-8101

We Support Plain Language

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1st FACT SHEET – LIMITED TO 3 PAGES ONLY:

Challenges:

1. Meeting the ambitious goal: This psychiatry multidisciplinary team PI project specifically addresses improving patient care by meeting the core measure requirement to assess alcohol use in a vulnerable psychiatric population from 0% to 90% compliance which is a huge challenge in itself! Since this is a mandated requirement for inpatient psychiatric facilities, we initially faced the challenge of how to tackle the performance improvement when our baseline was at 0%.

2. How to become educated about the definition and requirement: In late 2013, the Augustus F. Hawkins inpatient psychiatric hospital team was informed about new patient assessments that were required within the first 72 hours of admission, one being the IPF-SUB 1 core measure. However, our response was slow in starting the project as there was an identified knowledge deficit in understanding the expected requirement, which could possibly be attributed to poor communication and paucity of quality improvement personnel, particularly the lack of an identified Quality Improvement (QI) team. Augustus F. Hawkins is a 62 bed, inpatient psychiatric hospital that provides treatment for underserved patients. It is a challenge to determine how to best educate so many providers who are already busy with the demands of attending to and caring for the acute needs of psychiatric inpatients.

3. How to organize a dedicated multidisciplinary QI leadership team and plan: Due to conflicting schedules, lack of awareness regarding the requirement and lack of psych QI leadership, it took a few months for the QI advisor to organize a multidisciplinary team consisting of a LAC+USC Medical Center QI Psychiatric Inpatient director, psychiatry medical director, quality improvement advisor, and nursing leadership.

4. How to select a validated alcohol use screening tool: The first initiative was to quickly respond to the IPF-SUB 1 for the lack of a validated alcohol screening tool and identify one that is user friendly and CMS approved. Since there are a number of such tools, our team needed to research and meet to consider the pros and cons of each, in addition to obtain information about which would be time efficient as well as most widely used in psychiatry.

5. How to educate providers and disseminate the screening tool: Psychiatric residents and on-call MDs, who are on rotating schedules, perform the admission assessment. It is a constant challenge to communicate and educate these providers regarding emerging and/or changing requirements.

6. How to monitor the documentation to provide timely feedback: It became clear that we needed to determine a mechanism for close monitoring of admission documentation to catch deficiencies within the 72 hour time frame while maintaining compliance with the vast county and federal mandates.

7. How to eliminate missing, misplaced or lost AUDIT forms: Since the AUDIT tool was copied and left at the nursing stations for providers to complete then placed into the patient paper chart, we discovered the forms were often completed but lost or placed into various sections of the chart

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Solutions and Benefits:

In October 2014, the QI director developed a vision to utilize the QI model based upon rapid cycle small tests of change: PDSA-Plan, Do, Study, Act. The initial objectives were to organize the multidisciplinary QI team to begin a process of study to determine the problem areas, devise a plan of action, design interventions, further study and action, analyze the gaps, re-visit action plans and interventions in iterative cycles. The consumers are the psychiatric inpatients. We had to move swiftly, thoughtfully and creatively at every step along the way.

After researching options, the team decided upon the AUDIT-10 (Alcohol Use Disorders Identification Test -10 items), developed and validated by the World Health Organization as a clinician administered simple method for screening excessive drinking including anchor points to guide intervention recommendations. We immediately made copies of the AUDIT-10 available on the 6 inpatient wards, the resident library, sent mass emails and held mandatory in-service education sessions, primarily to the medicine service who were responsible for completing the AUDIT-10 upon admission or within 72 hours of admission. Aside from email and phone contact, the QI team has embedded didactic in-service training on AUDIT-10 documentation in the LAC+USC psychiatry residency lecture series for all 4 years of residency.

To address the problem of providers stating they completed the assessment but the paper form was not found, the following was done: the AUDIT-10 was attached to the existing admission packets; worked with the LAC+USC forms committee to integrate the AUDIT-10 into the printed admissions packet with expedited printing; and revised the electronic health record (EHR) MD admission template to embed items that required the provider to indicate the AUDIT-10 score and interpretation of the score reflecting a suggested intervention.

To monitor documentation, the QI director took on the task of reviewing the charts of every patient admitted to Hawkins every day then provided feedback to ward chiefs as well as to the admitting doctor to ensure completion within 72 hours of admission. Over 40 charts were reviewed in November 2014 and this was effective. Not only were providers beginning to incorporate the AUDIT-10 screen into their routine admission assessment, within a month of our PI initiative, compliance with assessing our patients for unhealthy alcohol use upon admission rose from 0% to 98%! We went beyond the CMS requirements by adding suggested interventions in our "plan" section of the admission note, ordered books on alcohol and substance use in English and Spanish that could be distributed to patients requiring further education during their hospital stay. .By the end of May 2015, the Medical Center implemented an EHR system called ORCHID. The PI QI team worked in tandem with the behavioral health ORCHID workgroup as the new workflow for assessing unhealthy alcohol use changed from the physician provider to nursing upon admission. The Audit-10 was replaced by the AUDIT-C (a 3- item validated version) which eventually became a mandatory field that nursing completed at the time of admission assessment.

This process is also closely monitored. Our outcome fills a gap in availability and existing services by providing alcohol use assessment to 100% of our patient population as well as brief intervention and education.

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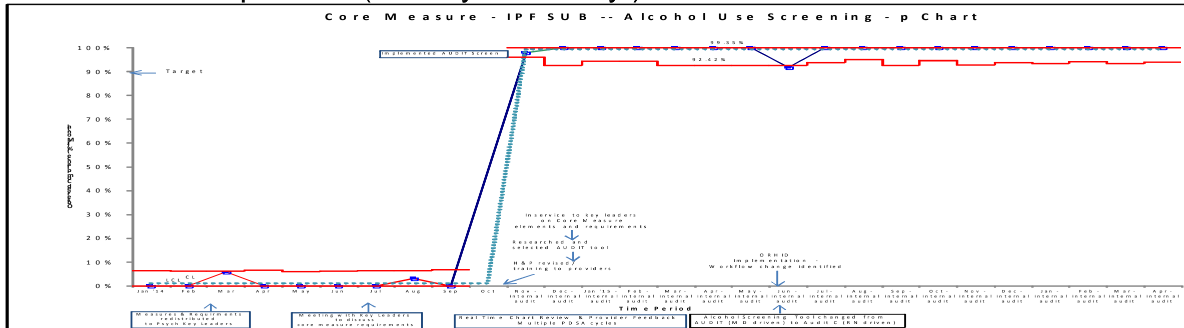
The project results have exceeded the benchmark and have been sustained for 6 consecutive quarters. The next planned step in response to this public health concern is to work with DHS to identify a substance use counselor to increase access to substance use treatment on-site and invite Alcoholics Anonymous (AA) to run group sessions for our patients (already underway!).



LINKAGE TO THE COUNTY STRATEGIC PLAN (DETAIL IS REQUIRED FOR COUNTY DEPARTMENTS): Use Arial 12 point font

This public health based initiative to improving IPF-SUB 1 core measure compliance is included in the Department of Psychiatry balanced score card (BSC) aligned with LAC+USC Medical Center's strategic map, quality goals, vision and mission and the DHS and County strategic plan. This project has linkage to both County Strategic Goal #1 and Goal #3.

Linkage to Goal #1 - This project's success has delivered customer oriented care/services while it has shown to have maximized effectiveness of existing processes, changed current structure to improve operations of essential services by agreeing upon a standardized tool and then making it available to the service providers to ensure those patients in need of additional resources are properly identified. It maintained fiscal management by using its existing resources, including subsequent incorporation of the newly implemented EHR, and by not requiring or needing additional staff or fiscal resources to complete the project. The success of teamwork and communication, successful reduction in patient harm by swiftly assessing and addressing patient risk factors that could be missed, with potentially deleterious effects on individuals and society. We are continuing to provide on-going education, consider other need for intervention and closely monitor this public health based initiative that cuts across cultural, ethnic and racial groups.

Linkage to Goal #3 –This project has integrated its service delivery to a subset of our mental health population, the inpatient psychiatric patients, as it refined the team member's roles and responsibilities to not only strive to meet compliance, but to incorporate the importance of the results to this huge public health concern. The outcome of this project goes beyond compliance as it continues to strive to improve coordination of substance use treatment services for our patients while hospitalized and with linkages upon discharge to the community or our community partners.

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COST AVOIDANCE, COST SAVINGS, AND REVENUE GENERATED (ESTIMATED BENEFITS TO THE COUNTY): If you are claiming cost benefits, include a calculation on this page. You must include an explanation of the County cost savings, cost avoidance or new revenue that matches the numbers in the box. Remember to keep your supporting documentation. Use Arial 12 point font

Cost Avoidance: Costs that are eliminated or not incurred as a result of program outcomes.

Cost Savings: A reduction or lessening of expenditures as a result of program outcomes.

Revenue: Increases in existing revenue streams or new revenue sources to the County as a result of program outcomes.

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