Building Blocks for Successful Care: Activation and Implementation

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Agenda

- Who the grantees are
- Building community partnerships:
- Practices to support implementation
  - SBIRT: Pam Pietruszewski
  - A menu of options: peer support, group support
  - The role of data in managing change
  - Building a communication plan
- The role of the implementation team and managing change
- Work plan key elements
- Team and stakeholder reflection and planning

The nature of the change: Key building blocks: concepts, practices, context

Communication

Collaboration with tribes or UIHC

Sustainability

Clinical team

Community team/ community needs

Recovery oriented, trauma informed, wellness approaches (conceptual and culture change)

Building the comprehensive team: outside

Building community partnerships: chickens and green beans

Essential Components of Partnerships

- Continuous leadership involvement and/or commitment of staff
- Shared interpretation of partnership goals.
- Consistent focus on and commitment to the vision / values.
- Data indicating outcomes / benefit.
- Everyone doing what was agreed upon.
- Ability to share information (Business Associates Agreement)
- Shared communication to the community.

Cooperation and collaboration

"**Cooperation** is the process of working together to the same end, usually for the betterment of the community."

- Community meetings
- Task force / committees
- Alliances / membership
- Idea-oriented

"**Collaboration** is a purposeful relationship in which all parties strategically choose to cooperate to achieve shared or overlapping objectives."

- **Voluntary**
- Built on the strength of the relationship between leaders and members
- No financial benefit (initially)
- Action-oriented

Partnership – Doing the Work

"**Partnership** is a collaborative relationship between two or more parties based on trust, equality and mutual understanding for the achievement of a specified goal."

- **Equality** is a key feature of the relationship.
- There is a shared goal / objective.
- Involves risks as well as benefits.
  - Financial dependencies
  - Outcome dependencies
- Shared accountability

What else makes a community partnership/coalition work?

The nature of the change: Key building blocks: concepts, practices, context

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Communication in many directions:

- Internal practice staff
- Patients and their families
- Larger hospital staff
- Other community resources
- Larger community as a whole

8 times 8 ways….

Communicate, overcommunicate, overcommunicate

Sustainability

- Financing tip sheets: support for coding and documentation
- Developing other perinatal specific financing resource
- Consultation on regular coaching calls

Grantee profiles: Providence (St Pat's)

A collaborative approach to screen and treat perinatal drug use at Providence St. Patrick hospital

The Collaborative Approach to Screen and Treat Perinatal Drug Use at Providence St. Patrick Hospital (SPH) is focused on improving the continuity of care for pregnant women with substance use disorder, in Missoula and the surrounding areas, throughout their journeys from prenatal care, delivery, and outpatient treatment and services. The overarching goal is to provide holistic, non-judgmental care empowering women with skills and resources to successfully care for their newborns, especially those with neonatal abstinence syndrome (NAS). The Family Maternity Center will partner with Western Montana Clinic's Obstetrics and Gynecology providers and Providence SPH Neurobehavioral Health to establish and implement a clinical care team inclusive of licensed behavioral health clinicians. At the community-level, partnerships will be maintained with the Missoula City-County Health Department, the NAS Workgroup, Child Protective Services, and other appropriate agencies. Providence SPH and Community Medical Center will work collaboratively on educational and outreach efforts for staff and the community-at-large regarding the critical importance of addressing the impact of perinatal drug and alcohol use in Missoula. A central focus is provider education regarding the need for universal drug screening for all pregnant women in Missoula and the surrounding areas to improve health outcomes for mothers and their newborns.

Grantee Profile: Community Medical Center

A collaborative approach to improving screening and treatment for perinatal drug use in Missoula

Community Medical Center (CMC) will improve the quality of care for pregnant women and infants affected by substance use disorders in Missoula County. In collaboration with Partnership Health Center, St. Patrick's Hospital, and community groups serving pregnant women, we aim to reduce the stigma that prevents many women with substance use disorders (SUD) from seeking help and remove barriers to effective treatment and recovery. Obstetric offices will standardize screening and care for women with SUD, and partner with community organizations to provide referrals to addiction support services. Assisted by licensed addiction counselors and nurse coordinators, CMC's two Maternal-Fetal Medicine specialist physicians and Partnership Health Care staff will develop capacity to provide effective, integrated treatment of SUD to pregnant women. In addition, CMC's Mother-Baby unit will institute a program to engage parents as partners in the treatment of Neonatal Abstinence Syndrome (NAS) after birth. This approach will use train parents to use evidence-based, non-pharmacologic methods to soothe withdrawal symptoms in babies. The goal of this approach is to improve mother-infant bonding, strengthen families, decrease pharmacologic treatment and long hospital stays for NAS, and decrease foster care placements in Missoula County.

Grantee profile: Benefis Hospital

Addressing Perinatal SUD and Prevention of NAS in Cascade County and Montana's Northern Tribes

Benefis Hospitals together with community agencies, IHS, and Montana's northern tribes will work to reduce the adverse outcomes of perinatal drug and alcohol use for newborns and their families through supportive, team based care and better coordination between health care providers and social service agencies. Beginning in Great Falls/Cascade County and on the Blackfeet Reservation, we will develop and implement the program in year one and work toward expanding it to Rocky Boy, Fort Belknap, and Fort Peck in year two.

Grantee Profile: St. James Hospital

A Relational Model for Reducing Perinatal Substance Use Disorders in Southwest Montana

St. James Healthcare (SJH), in partnership with a network of community partners, seeks to both prevent perinatal substance abuse and improve care and access for pregnant women struggling with substance use in Southwest Montana. The multidisciplinary community team includes SJH, Montana Chemical Dependency Center, Southwest Montana Community Health Center, Butte-Silver Bow Health Department, the Southwest Region Child & Family Services, and the Butte Community Action Team. Our program emphasizes the critical importance of the first 1000 days of life (from conception through the initial two years of life) as foundational to health. It is during the first 1000 days a child's brain is developing most rapidly and is most affected by perinatal substance abuse. Our program emphasizes a relational model of care and education inclusive of behavioral health, consistent prenatal care, and care coordination to address social factors impeding treatment. As a key component, our program engages the father or significant partner within the sphere of care, treatment and social support. The program seeks to reduce occurrences of substance use in pregnancy, and specifically encourages a path to long term recovery through early detection and intervention, accessible treatment, and increasing community awareness in Southwest Montana.

How will we measure success?

The role of data in change

- Benign observer: numbers, registries, focused goals that can change over time
  - Drives possible short term change projects
- Informant toward contextual changes: cost/outcomes, barriers
- Setting for cross program learning
- Drives small practice changes (registry)

Examples: how many people are screened?
how many people are screening positive?
no show rates

Quantitative Data

Current Perinatal Data Outcomes					
		grantee 1	grantee 2	grantee 3	grantee 4
	How many years of data are you reporting on?	2.5	2	2	2
	The average number of deliveries at the	484	1158	269	1400
Outcome #1: Infant Drug Screen Data	Number of infants screened for drug exposure:	0	93	24	167
	The number of drug positive newborns:	0	60	21	121
	neonatal drug screen:	0.0%	5.2%	8.0%	8.6%
	Average length of stay for drug positive newborns, in days:	4	15	5	10.74
Outcome #2: Neonatal Abstinence Syndrome	Percent of newborns diagnosed with NAS:	0%	4%	4%	7%
	Number of newborns diagnosed with NAS:	0	50	10	97
	diagnosed with NAS, if treated in your hospital, in days (If you refer all NAS infants to another facility, enter "0"):	0	16	5	27
	level of care for NAS:	0	0	2	0
Outcome #3: Prenatal Care	hospital who received adequate prenatal care (defined as prenatal care begun by the 4th month of pregnancy, and >80% of recommended visits received):	0%	48%	83%	10%
Outcome #4: SBIRT	Percent of prenatal patients receiving	0%	0%	0%	0%
Outcome #5: Child Protective Services	to your facility who are removed by child protective services:	0%	2%	1%	5%

Quantitative Data

- Clarify definitions
- Discuss collection on kickoff call: state data base, other methods
- Identify other quantitative data that you consider important

Work Plan Elements

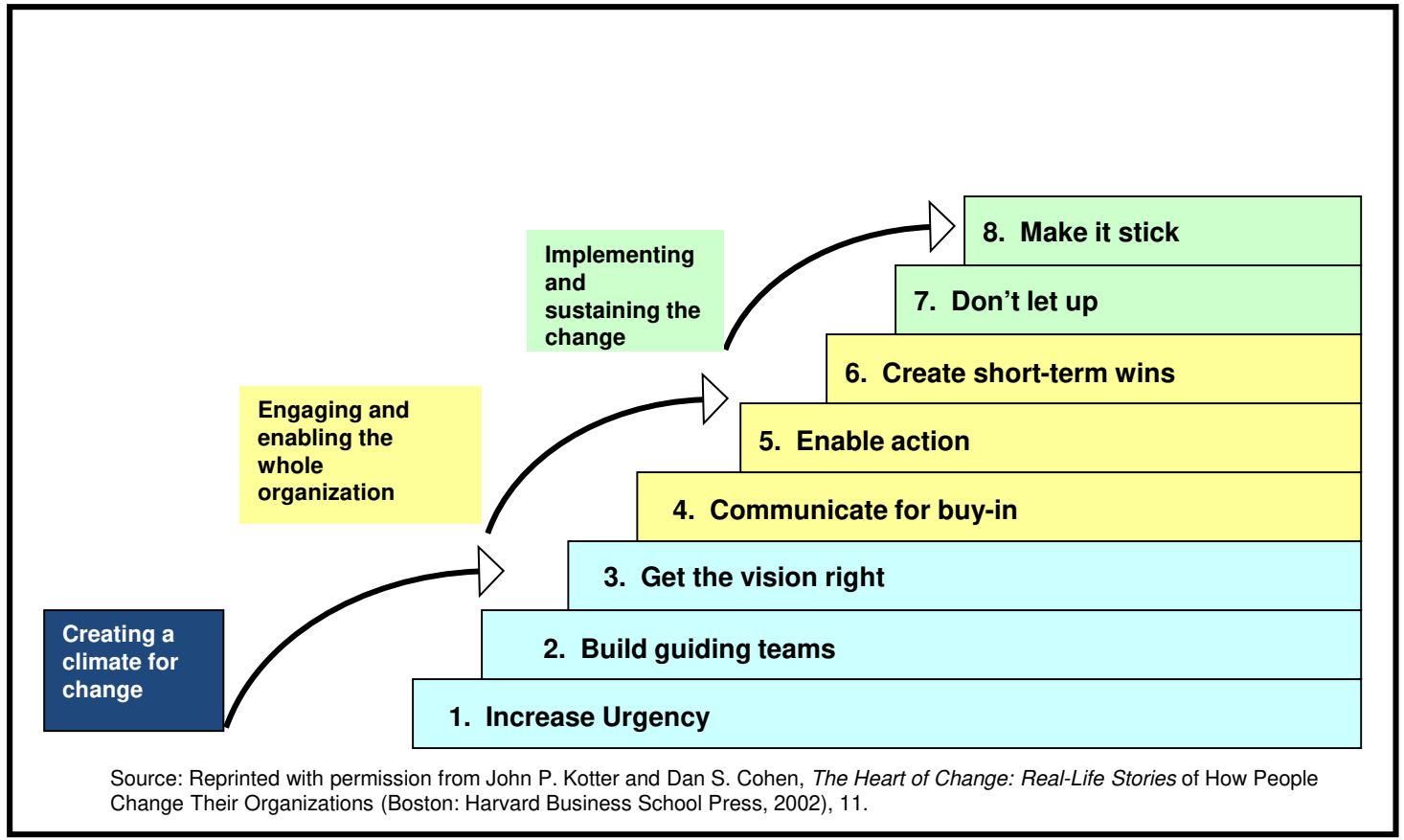
- Begin offering an integrated, team based model of clinical care for pregnant and post-partum women with SUD
- Implementation of SBIRT as a routine part of prenatal care for a majority of patients in the community
- Establish specific treatment targets and manage outcomes using disease registries
- Begin meetings of the community team which will effectively collaborate to manage the care of women with perinatal SUD
- Implement a scope of practice and care pathways that clearly define when to treat, when to consult, when to refer individuals to higher levels of SUD treatment
- Develop a system of care coordination and other measures to effectively address the unmet social needs of pregnant women with SUD
- Complete a sustainability plan for transitioning the program to stable, non-grant funding sources by the conclusion of the MHCF funding (must be completed by month 18)

Work plan elements → tracker

- Begin offering an integrated, team based model of clinical care for pregnant and post-partum women with SUD
  - Hire BH clinician
  - Hire care coordinator
  - Identify team members
  - Clear plan for team communication
  - What about peer support staff?
- Implementation of SBIRT as a routine part of prenatal care for a majority of patients in the community
  - Choose standardized screening tool
  - Establish baseline and time based target goals
  - Educate all staff
  - Develop tracking mechanism

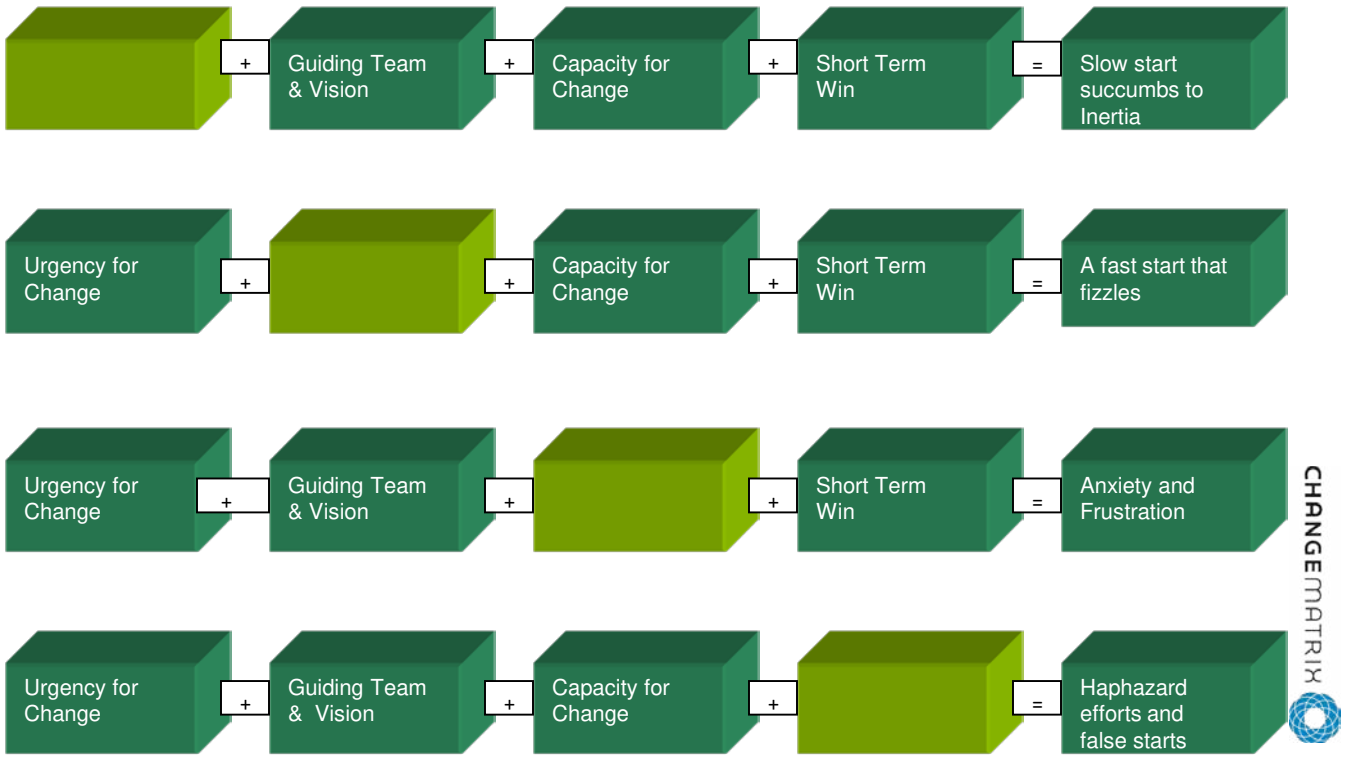
Managing the process

Eight-Step Process for Leading Successful Change



Source: Reprinted with permission from John P. Kotter and Dan S. Cohen, *The Heart of Change: Real-Life Stories* of How People Change Their Organizations (Boston: Harvard Business School Press, 2002), 11.

When Leading Change…Every Step Matters



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Create an implementation workgroup

- Executive participation or sponsorship is a must
- The Implementation workgroup Committee is the keeper of the vision
- Create a timeframe that is realistic, not reactive
- Build a team of “do-ers”
  - Executives are not day to day “do-ers”
- Give the “do-ers” the time and responsibility to get it done
- Remove barriers
- Stay involved with monitoring the timeframes / outcomes
- Start up is different than ongoing, membership may shift
- Subgroups and tiger teams.

National Council Technical Assistance

- Kickoff call: Schedule time
- Site visit: Fall 2018: agenda developed together
- Regular coaching calls with individual organizations
- Quarterly group calls
- Resources

Workspace:

- Each grantee team and their community partners gather at designated tables and identify:
  - 3 most important take aways for your teams as you get started.
  - 2 concrete action steps you will take in the next 30-60 days based on what you have heard over the past two days. These need to be written down and give Joan one copy of your action steps.
- For those of you who are not from grantee teams or communities:
  - DPPHS and other state stakeholders: Identify potential areas that require your planning/attention based on the past two days
  - Others: share around a table what your key take aways are

Workspace: report out

- Hear from each of 4 grantees
- Other comments/questions/discussion

Concluding comments and next steps