Site Plan-Do-Study-Act (PDSA) Example

Change, Test, Repeat: Using NIATx to implement SBIRT

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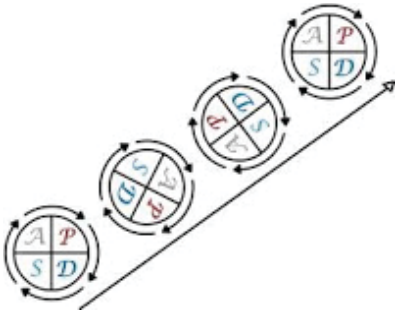
Introducing a new practice like SBIRT can be a challenge in any setting. In the Dartmouth Hitchcock Medical Center (DHMC) Perinatal Addiction Treatment Program (PATP) we faced the added challenge of implementing a new practice across three departments and two institutions.

That's where my previous experience with the NIATx model came into play. I was fortunate to be a part of a NIATx STAR-SI grant in Maine while working for Crossroads for Women (Crossroadsme.org). Over three years beginning in late 2006, the ten state-provider partnerships used the NIATx diffusion model to accomplish four goals: build state capacity to improve access and retention; build payer/provider partnerships that drive the improvement process; implement payer improvement strategies; and implement performance monitoring and feedback systems.



The incremental and iterative approach that NIATx teaches was key to the success in our SBIRT integration project. We used rapid-cycle testing or PDSA Cycles so our change teams could try out a change to make sure it was working and that it was an actual improvement.

Visit the NIATx website to learn How to conduct a PDSA Cycle.

As I wrote in my last blog post, Integrating Care and Improving Birth Outcomes with SBIRT, we launched the PATP in fall 2013. By September 30, 2014, SBIRT was fully implemented across all three OB/Gyn divisions at the Dartmouth Hitchcock Medical Center.

Here are some lessons that have emerged from the four Plan-Do-Study-Act (PDSA) cycles we ran to get SBIRT in place:

Cycle 1: Confidential screening in Maternal Fetal Medicine (MFM) Team
Perceived barrier: Patient reluctance to separate from family members for screening
Change tested: Nurses' perceptions that patients would not want to be seen alone

Data: Before: Patients were screened for drug/alcohol use with their family members present, unless they came alone.
After: Only five of the first 386 patients declined to be seen alone (and therefore were not screened.)

Results or lessons learned: Sequestering patients is much easier than anticipated, and provided unexpected opportunities for disclosure of a number of important issues, both substance-related and not.

Appendix C

Cycle 2: SBIRT pilot in Maternal Fetal Medicine (MFM) Team
Perceived barrier: Fitting SBIRT into nursing workflow will be difficult and make visits longer.
Change tested: Nurse training in screening techniques and BI/Implementation
Data (Qualitative from nursing): Nurse workflow was not adversely affected and communication about prenatal substance use was enhanced, improving the care delivered.

Results or lessons learned: Nurses report "We are finally starting to deal with this issue in a practical way. SBIRT provides a framework for making this happen!"

Cycle 3: SBIRT implemented in Certified Nurse Midwife (CNM) Team
Perceived barrier: Provider discomfort with providing brief intervention (BI)
Change tested: Provider training in BI
Data: (Qualitative) CNMs are able to manage BI and referral process to PATP; and patients with SUD are no longer required to transfer care to the MFM team.

Results or lesson learned: Provider training can increase comfort level in caring for pregnant women with SUD.

Cycle 4: SBIRT implemented in General OB/GYN Division
Perceived barrier: Nurses' discomfort with process
Change tested: Nurse and provider training; followed by additional training session (Grand Rounds) six months after implementation
Data: Not available from all nurses or providers; APRN staff has adopted SBIRT as standard practice and feels comfortable with BI and referral process.

Results or lesson learned: Need to be able to collect department/division level data to assess whether program goal of evidence-based screening for SUD for all PN patients has been met.

What else did we learn from these change cycles? For one thing, developing a timeline and planning out cycles strategically is key. What we wish we'd known at the onset was how difficult it would be to access data to measure process and outcomes. Electronic implementation of screening (available soon, with the implementation of mobile tablets) should improve data capture.

Our next PDSA cycle will be used to implement electronic record-keeping. The OB departments have not had sufficient staffing to assess what proportion of new OB patients are actually getting screened. With the help from The New Hampshire Charitable Organization, the OB/GYN Department was able to purchase mobile tablets that will be used to make the switch from pen and paper screening to electronic screening. Once electronic screening is operationalized, we

will be able to compare the number of patients screened to the number of new OB visits scheduled. Electronic screening will allow for better data collection, outcomes tracking, and consistent billing practices. Adding an electronic best practice alert for positive screens will be included with the electronic roll-out, and this will prompt providers to enter the correct charges.

Appendix C

What has become clear to us is that this partnership of integrated care is benefiting all involved. As we continue to share our experience, new champions come forward, and our vision becomes clearer and more comprehensive, despite the perceived barriers.

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- See more at: http://attcniatx.blogspot.com/2015/08/change-test-repeat-using-niatx-to.html#sthash.8Yt2JFjz.dpuf