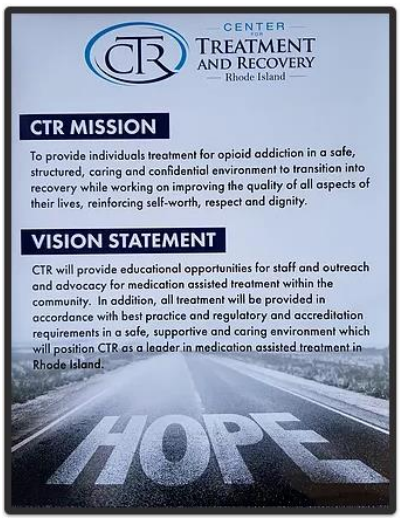
RIQI/RI-PTN TCPI Exemplary Story: **Center for Treatment and Recovery (CTR)**



At **Center for Treatment and Recovery**, we pride ourselves on our excellence in patient care and our compassionate and engaged staff. Our recently articulated Commitments, Mission, and Vision Statement are a clear reflection of our priorities

Center for Treatment and Recovery (CTR) is a Rhode Island Opioid Treatment Program (OTP) that was founded in 2003 by Wendy Looker, RN, BS (CEO) and Madeline Rosario-Almonte. We are a CARF (Commission on Accreditation of Rehabilitation Facilities) accredited Medication Assisted Treatment (MAT) facility serving all Rhode Island and Southeastern Massachusetts. As described on our website (https://www.methadoneri.com/), we are "committed to providing the safest, most effective and professional care for [our] patients struggling to overcome the disease of addiction to opiates." At our singular location, in Pawtucket, Rhode Island, we provide care for approximately 350 individuals with MAT and a Health Homes model that affords a comprehensive set of supports and services. Along with administering methadone, we offer medical exams, individual and group counseling, ongoing clinical evaluations, relapse prevention, substance use education and individual treatment planning. It is important to note that our location is in an urban center, making our facility accessible for individuals with a wide variety of socioeconomic backgrounds. As an Exemplary Practice, CTR leverages our small size and team approach to pack a big punch when it comes to joy in work, individualized success in clinical care, openness to innovation, and excellence in care coordination.

Organizational Vision and Success Garnered through a Tightknit, Team Approach

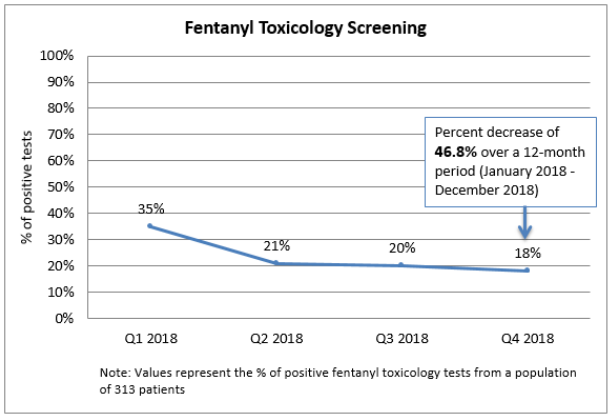
While there are many challenges when working with individuals with Opioid Use Disorder, CTR relies on our strong team work and a supportive culture to find success. As our CEO, Wendy Looker describes, "One of the things that makes us special is the fact that we are a single location based agency. We are small, and whenever we need to do something to better care for our patients, to implement new practices or make changes, we don't have a lot of red tape." We are able to leverage our size and strong team to be more agile than other practices are able to be. This approach has translated to excellent staff retention and joy in work at our organization. We have a core group of staff who have worked here for around 10 years and the majority of our staff have been with us well over 3 years. In other organizations, people at high levels can sometimes be far removed and disconnected from the staff working within a practice. In contrast, the major decision makers at CTR work directly *for and within* the agency. We have many opportunities to maintain lines of communication. For example, we hold staff meetings every other week so our team can provide regular, ongoing feedback. We have group supervision for our clinical staff that includes clinically based meetings in which they can communicate about any issues that have been identified and need to be addressed. We also have an annual

review process when feedback is provided for individuals regarding their performance. This robust communication and teamwork aids us in being particularly adaptable and agile when it comes to changes and improvements to our practice.

Our recent efforts to define our strategic plan and commitments are excellent examples of the high level of engagement found in the staff at CTR. In this process, we involved our *entire staff* and worked together to define our vision, new mission statement and commitments to our patients (that are shared at the top of this story) as well as assessing our code of values and ethical conduct for our organization. To do this, we set up monthly meetings and developed specific tasks to be completed each month throughout the year. We created worksheets for each person to use for a review of our past and current vision and mission statements. As a group, we conducted a SWOT analysis (Strengths, Weaknesses, Opportunities and Threats) from which we created a matrix and focused on the top three to five elements in each category. We then created a well-defined strategic vision summary and set priorities for the next five to ten years. As a part of this, we have KPIs (Key Performance Indicators) that have been defined to provide clarity for our team regarding how we should focus our efforts and track data to measure success. Through this inclusive methodology, we now have a more formalized Quality Improvement process. We also created an improvement team that includes members from a variety of departments within our organization.

Excellence in Care, Care Coordination and Follow-up for Patients who Need it the Most

The strong working relationships we have at CTR translates to a highly tailored, personalized approach to our patient care while consistently following federal and state guidelines specific to our accreditations. We *know* our patients and work to develop a positive rapport with each individual receiving treatment. Our success in providing excellence in care can be seen through our data. For example, as seen in the adjacent run chart, in an analysis of data regarding *Fentanyl Toxicology Screening*, in 2018, we tracked a 46.8% decrease in positive tests for our patients. This success is critical as we work toward supporting our patients in their recovery. As we provide a wide range of clinical support through our Health Homes model, the Clinical Quality Measures we track also demonstrate our overall success in clinical care. For example, we are at a rate of 99% for our *Tobacco Use: Screening and Cessation Intervention* measure, which is significantly above the National MIPS Benchmark of 83%.



Through treatment at CTR, our patients demonstrate a high rate of success through an analysis of Fentanyl Toxicology Screening data. As can be seen in the above run chart, in 2018, we found a 46.8% reduction in positive Fentanyl screenings for our patients

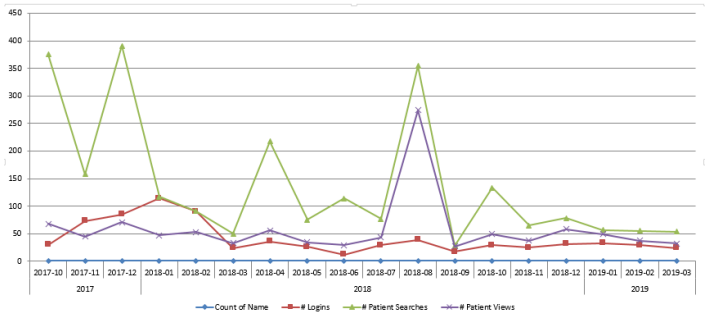
Along with our team approach, our strong success can be attributed to our patient engagement and our organization's openness to innovation. Given the nature of the population we treat, family engagement in our programming is limited, but we consistently offer family counseling when our patients provide a required release of information. Additionally, we are currently working with various groups to develop specialized peer recovery training specifically geared towards the support of individuals utilizing MAT as part of their opioid use treatment. To gain this, we are working in coordination with OTARI (the Opioid Treatment Association of Rhode Island), SUMHLC (the Substance Use and Mental Health Leadership Council), and MARC (Medication Assisted Recovery Coalition). Additionally, to enhance community engagement, we recently added an OTP Community Liaison to our staff. This individual is deeply involved in prevention efforts and attends community meetings, including the *Governor's Overdose Prevention and*

Center for Treatment and Recovery			
Quality Measure	Performance Target	Current Performance	National MIPS Benchmark
Prevention			
Tobacco Use: Screening and Cessation Intervention	26%	99%	83%

Our high rate of success in the Tobacco Use: Screening and Cessation Intervention Clinical Quality Measure is another example of our success at CTR. Our current performance of 99% is significantly above the National MPIS Benchmark of 83%

Intervention Task Force (https://preventoverdoseri.org/the-task-force/) and *Health Equity Zone* (http://www.health.ri.gov/programs/detail.php?pgm_id=1108) meetings in our state. Finally, we are the only OTP in our state that provides transportation *free of charge* for our patients to ensure they can get to treatment every day, as needed. For this, we have a van and full time drivers on staff to be available when required by our patients.

Further, our innovative approach includes the use of technology and data in a number of capacities. First, we regularly use our state's Health Information Exchange (HIE), CurrentCare, to find valuable information for care coordination. In CurrentCare, we can access details about their medications, lab results, problem lists, EMS data, and discharge documents. In conjunction with CurrentCare, we leverage RIQI Care Management Alerts and Dashboard to help us stay informed when our patients are admitted and discharged from acute care hospitals in Rhode Island. As described in greater detail in our Care Management Testimonial (available in the appendix), this tool has been extremely valuable in helping us provide timely interventions and follow-up for our Health Home patients. With Care Management tools, we receive information when our patients are admitted and are then able to follow-up with these individuals to make sure they have the care they need. As part of this, we provide education to teach them to avoid using Emergency services unnecessarily. Since we have started using this tool, we have demonstrated a savings of approximately $132,000 in avoided ED and hospital utilization. This success can be attributed to interventions we provide, such as teaching patients they can go to a walk-in clinic if it is not an emergency. We can also help get them set-up with a Primary Care Provider. Also, we have many unique situations in which we are able to outreach and provide targeted care and support. For example, we had a patient who was on a respirator and signed out of the hospital against medical advice. When we learned of his hospitalization through our Care Management Dashboard, we were able to outreach to this individual and provide the specific follow-up and care he needed. Finally, through using these tools, we have been able to obtain critical information that augments the treatment we provide. In particular, when a hospital does additional drug testing, it is very helpful for us to receive this information so it can be included in a patient's treatment plan. In one example, a hospitalized patient was asked if he smoked marijuana (which is not always tested for) and the person said 'yes.' We were able to add this to our record and take this information into account when providing care.



Use of data from CurrentCare Viewer (Rhode Island's Health Information Exchange- HIE) is valuable in helping with care coordination for our patients. The above graph provides information regarding log-ins and views of patient records in the Viewer.

Along with CurrentCare and the Care Management Dashboard, CTR also participated in the RIQI PTN Pilot of HealthCoach for Me. Our Case Mangers used this tool to engage patients who could benefit from an on-line resource to support positive behavior change regarding their health. At CTR, we facilitated the enrollment of 20 patients who had access to the tobacco cessation, weight loss and healthy eating programming available through this platform.

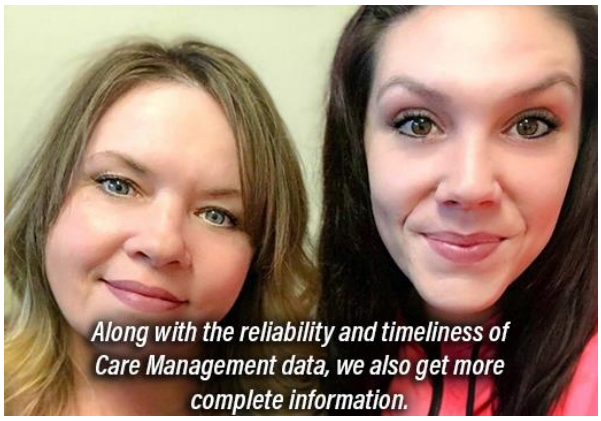
Conclusion

Our success at CTR is built on a solid team approach that is inclusive of staff at every level. The positive impact of our shared vision and openness to improvement and innovation is felt by our patients through the exceptional, individually tailored care we provide. Through the use of data and technology, we have made notable advances in care coordination and are able to provide support and timely follow-up for our patients when they need us the most. Most importantly, we know first-hand, that our approach truly makes a difference for each of our patients. One example of patient success at CTR can be seen in an individual who had a psychotic episode in our waiting room. At the time this person was taking illicit benzodiazepines, was not following through with her referrals and appointments, and needed to be admitted for inpatient treatment. But,

in our care, we worked quickly to arrange an appointment with a mental health provider. Our nursing staff used CurrentCare to find important information to help her get on-track with her medications. With continuous follow-up by our staff, including providing support with her medications and transportation, she was able to move towards compliance and better health. When we see our patients' lives improving in this way we know we are making a difference, one patient at a time.

Appendix

Care Management Alerts and Dashboard Testimonial:
https://riqi.org/how-we-help/care-management-testimonials



Brittany Fiola, Medical Assistant, Melissa Souza, RN, Director or Nursing and Vance Velletri, LPN, Dosing Nurse

How did things take place before Care Management Services?
Before we had Care Management Services at the Center for Treatment and Recovery (CTR), we depended on the hospitals to communicate to us and send us discharge information for our patients. Typically, upon admission of one of our patients, hospital staff will call CTR to confirm dosing information with our nurses. But, when staff from the hospitals didn't call to confirm dosing, we would have to rely on patients' self-reporting to us that they had been to a facility. If the patient didn't inform us, sometimes we would never know that they had gone to a hospital. In some cases, if a patient hadn't been in to our clinic for two to three days, we would call their emergency contact and learn that our patient was hospitalized. Additionally, there would be times when we wouldn't know about a hospitalization until we were informed much later from their insurance company.

"We discuss information from our Care Management tools in our staff meetings on a regular basis to determine appropriate treatment, including interventions by our counselors and to decide if a patient should have more intensive follow-up with the provider."

Along with issues around being reliably informed about hospitalizations, there were a number of other significant challenges that we were experiencing. For example, planning for our patients' discharges was difficult because we were not typically informed when this was happening. Once we did learn of a discharge, we would call the hospital to get a record of our patient's last medication dosage level, but hospital staff often wouldn't provide any further information about the hospitalization or the reason for the admission. We would then either need to call or fax a release to the hospital in order to get the needed discharge summary. When we did this we would not always hear back from the hospitals right away after faxing the release, so we would have to wait until we received this data. Once we receive the paperwork, it would sometimes have a minimal amount of information, such as bloodwork

and a current medication list. In some cases, even their record of the patient's last administration of medication was missing. We spent a lot of time submitting releases in order to get needed discharge paperwork and tying together the information we required.
There were a number of risks involved when hospitals did not communicate with us: In some situations, hospitalized patients were at risk of not getting correctly medicated if the most recent dosing information was not obtained from us. Also, when we were not informed about a hospitalization, we could be unaware of a new diagnosis and or newly prescribed medications that might possibly interact with their Methadone treatment. Given these factors, we spent a great deal of time working to get the critical information we need.

How do things take place with Care Management tools?
Now that we have our Care Management Alerts and Dashboards, we receive an Alert as soon as our patient has been admitted to an acute care hospital or Emergency Room in Rhode Island. We are also informed when they are discharged. We are not 'out of the loop' like we had been previously: we don't have to rely on the hospitals calling us or the patients self-reporting when they have an admission. This makes it much easier for CTR to coordinate care with the hospitals and our patients. Our whole process is more organized and it doesn't take as much time because everything is all right there. We do not have to go back and forth requesting information from the hospitals, like we used to.

"[With Care Management tools], we are not 'out of the loop' like we had been previously: we don't have to rely on the hospitals calling us or the patients self-reporting when they have an admission. This makes it much easier for CTR to coordinate care with the hospitals and our patients."

With our current process, when we receive an Alert, the nurse is notified of the event. They can check our records to see if the hospital has already called for dosing information. Then, we can monitor the Care Management Dashboards for the discharge and be prepared for the patient to return to our care. We are able to use the discharge disposition codes included in the Dashboards to help us know where our patients are and what follow-up is needed. Also, we discuss information from our Care Management tools in our staff meetings on a regular basis to determine appropriate treatment, including interventions by our counselors and to decide if a patient should have more intensive follow-up with the provider.
There have been many instances when Care Management tools have been uniquely helpful. For example, when hospitals don't call and confirm dosing, we can be prepared for when the patient is discharged and will return to our care. Sometimes, after a hospitalization, a patient may not be on Methadone anymore. In one situation, we had a patient who was discharged but did not return to our care. We were able to reach out to confirm the person's status and make sure they were all right. For patients who frequently go in and out of the hospital, we have observed that staff at the hospitals sometimes use dosage information on file from the previous hospitalization. As dosing can change with some regularity, it is really important for them to communicate with us each time the patient is newly admitted to their facility. There is definitely space for improvement for communication with hospitals, and Care Management tools are helping with this.
Along with the reliability and timeliness of Care Management data, we also get more complete information. We are no longer limited by our patients' self-report or the minimal

information we used to receive from the discharge paperwork we receive from the hospitals. With Care Management Alerts, we receive a copy of the Lifespan Discharge Continuity of Care (CoC) document (when a patient goes to a Lifespan facility). This CoC document is more detailed and helpful than the paperwork we would otherwise receive from patients when they remembered to bring us this information. Particularly when the patient is not enrolled in CurrentCare, this document can be key to getting the information we need.
Having the Care Management Dashboards helps us in other ways. For example, we are now better able to track the number of Emergency Room visits and admissions our patients have. We need this data for our Health Home reports. Additionally, sometimes we are able to get updated and correct demographic information, such as telephone numbers (which can change with some frequency) so we are able to contact our patients, when needed.
Since we started using the Care Management Dashboards, we have also benefitted from knowing when our patient is enrolled in CurrentCare. With CurrentCare we can get additional information that helps support the care we provide. For example, in CurrentCare, we can find lists of diagnoses and medications. When we have this data, it is easier for us to determine if there is a health concern that takes priority and needs to be worked on more than other issues. For example, one of our patients had an issue with alcohol but we had not previously been informed about this piece of this individual's history. Through knowing this, we are better able provide care that is safe and best meets the unique needs of our patients.
How does that impact your life/work?

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The impact of having Care Management Alerts and Dashboards is that we now have better knowledge about the all-around care of our patients. This data helps us be aware of issues that could impact a patient's treatment episode negatively here at the clinic. It's a very helpful tool for coordinating care and facilitates us to be organized and provide the best care for our patients. This obviously affects patients in a positive way.
We have a small group of staff here at CTR and we work together closely. Many of our patients are good at calling and we develop relationships with them. But, before we had our Care Management tools, we didn't realize how many different hospitalizations we didn't know about. If patients didn't inform us and bring us their paper work, we simply didn't know. Now we know *every single time*. A patient could have been in a hospital overnight and then come to us the next morning. Now we can always be sure to be aware when this happens so we can verify that the dosing is correct and safe. When our patients are in the hospital for a more extended time, nurses can monitor and keep track so we can be better prepared when they return. It's helpful that our staff can be aware of a discharge so they can ask the patient how they made out at the hospital and support this communication.
When there is information that we can't find in the Dashboards, we can often find what we need in the CurrentCare Viewer. Using CurrentCare makes it easier to find important information regarding bloodwork and medications. CurrentCare also helps improve data collection for state reports for our Health Home population. We need to complete a quarterly

report in which we track blood pressure, BMI, glucose levels and admissions. These tools really help pulling this data together.