

Samaritan Hospital – Our Journey with Co-occurring Disorders



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Scope of Services



Mental Health

- **Samaritan Hospital**
- ***Crisis Unit***
- ***Inpatient***
- 30 bed Adult Psychiatry
- 20 bed Geropsychiatry
- 13 bed Mentally Ill Chemical Abuser (MICA)
- ***Outpatient***
- Outpatient Mental Health Clinic (on site)
- Day Treatment (off site)
- Satellite (off Site)
- ***Other***
- Employee Assistance Program (EAP)
- Primary Care Integration
- Medical-surgical consult liaison program
- Sexual Assault and Crime Victims Program
- Healthy Families Program
- **St. Mary's**
- Medical-surgical consult liaison
- Social Worker/counseling at Seton Women's Health
- **St. Peter's**
- Medical-surgical consult liaison
- Outpatient Psychiatry and Consultation office

Substance Abuse

- **St. Mary's Hospital**
- ***Inpatient***
- 10 Bed Detox
- 20 Bed Rehab
- **St. Peter's Addiction Recovery Center (SPARC)**
- ***Inpatient***
- 18 Bed Detox - at St. Peter's Hospital
- 40 Bed Rehab - at Mercy Care Lane, Guilderland
- ***Outpatient***
- Central Avenue
- Clinic
- Men's Community Residence
- Morton Street Shelter
- 2nd Avenue
- Rotterdam
- Cohoes
- Saratoga
- Latham
- ***Other***
- Youth Assistance Program
- Drinking and Driving Program (DDP)
- Admissions Review Team (ART)

Our History with Dual Diagnosis



Early Adopters

- Day Treatment Program
- Focus on Philosophy of Care – multi-dimensional
- Clients as our teachers
- Focus on relationship development
- Stages of Change

Continuum

- Development of Dual Diagnosis Inpatient Unit (MICA)
- Collaboration – warm hand-off
- Treatment trials (longitudinal perspective on readmissions)
- Medication philosophies and practices – **Consistency**
- Complimentary programming

Evolution

- Move from program specific to department wide philosophy/ approach
- Bolster outpatient/ inpatient coordination
- Partner for readmission reductions efforts
- Case management
- Health Home development

Co-occurring Disorders and the Philosophy of Care



Keys to Philosophy of Care:

- Relationship/ Engagement
 - Stages of Change – matching interventions
 - Treatment Trials – longitudinal perspective on care
 - Multidimensional
 - Re-entry planning
 - Learn from the people we serve
 - Treatment as a shared responsibility
- * This requires culture change and takes place over time

The Journey - Interventions



- Case management
- Relationship as an intervention
- Multidisciplinary meetings
- Group programming – multidimensional
- Skill building
- Celebration of successes, use of peers for motivation
- “Community”
- Collaboration, collaboration, collaboration
- Re-entry planning
- Learning environment for staff (Education, Supervision, and continuous professional development)

Readmission Reduction “Bundle”



- No magic to prevention of readmissions
- Cumulative interventions that reduce likelihood:
 - Discharge planning begins at admissions
 - Family/collateral meetings
 - Collaboration with primary care physician
 - Post discharge follow-up phone calls
 - Aftercare appointment within 3 business days
 - Home visits for identified at risk patients
 - Weekly Length of Stay Rounds – Outpatient and Inpatient
 - Readmission interview and modifications to treatment plans
 - Emergency Department intervention by discharging team

Readmission Data and Successes



- 2012 all payor rate of 30 day readmissions = 8.77%
- 36 % reduction from prior year
- Rate for individuals with post discharge home visit = 4.5% !!!!!
- The stories the numbers don't tell...
 - True partnership between inpatient and outpatient
 - Looked to as a model within our community
 - Patient participation in the process (“The hospital is not my home”)
 - Family involvement