Peer Insights on Industry Trends in Behavioral Health and Human Services and value of Joint Commission Accreditation

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The Joint Commission

In Conversation with a Peer Leader and Industry Expert

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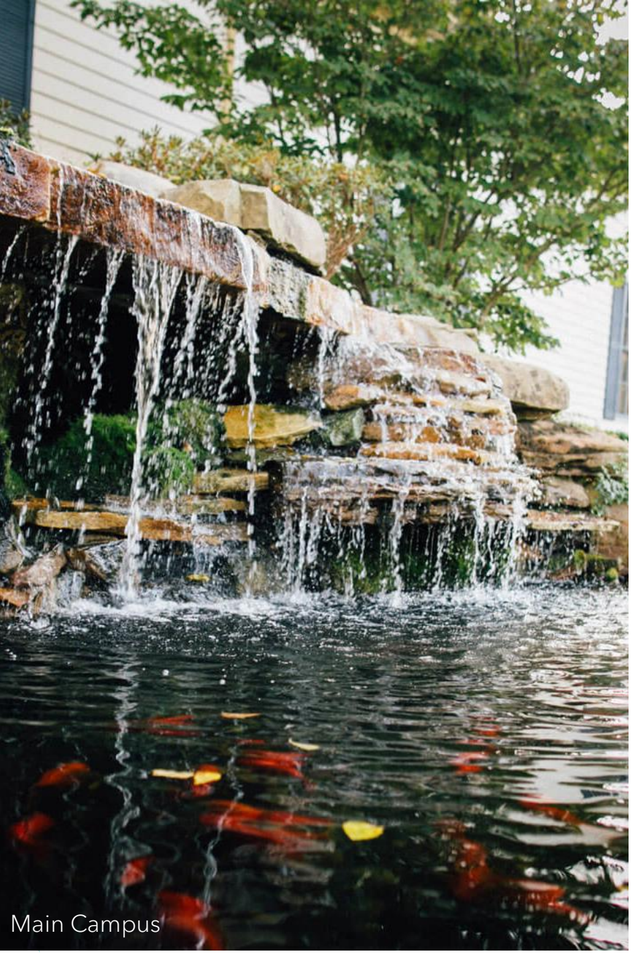
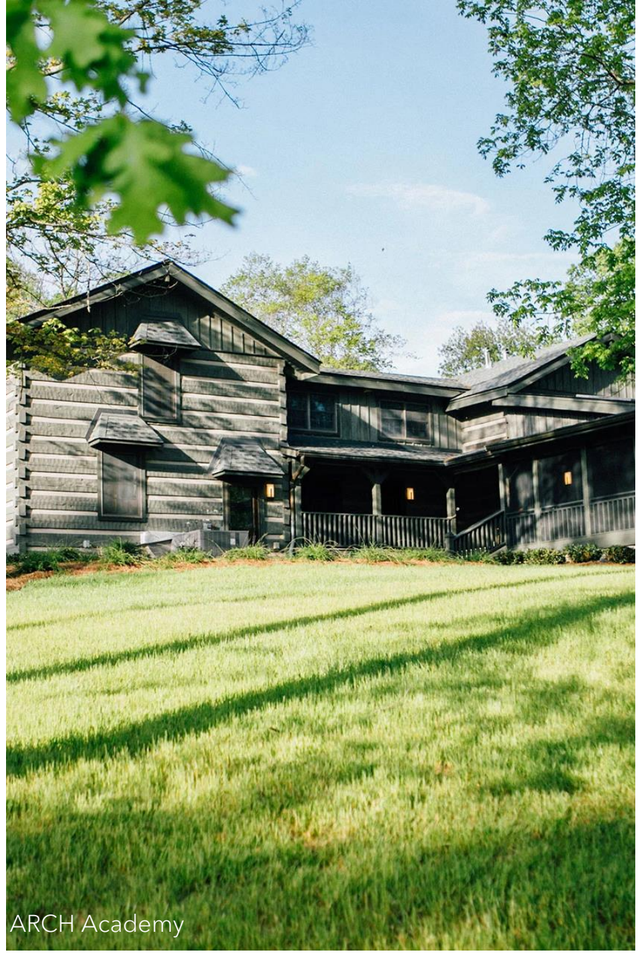
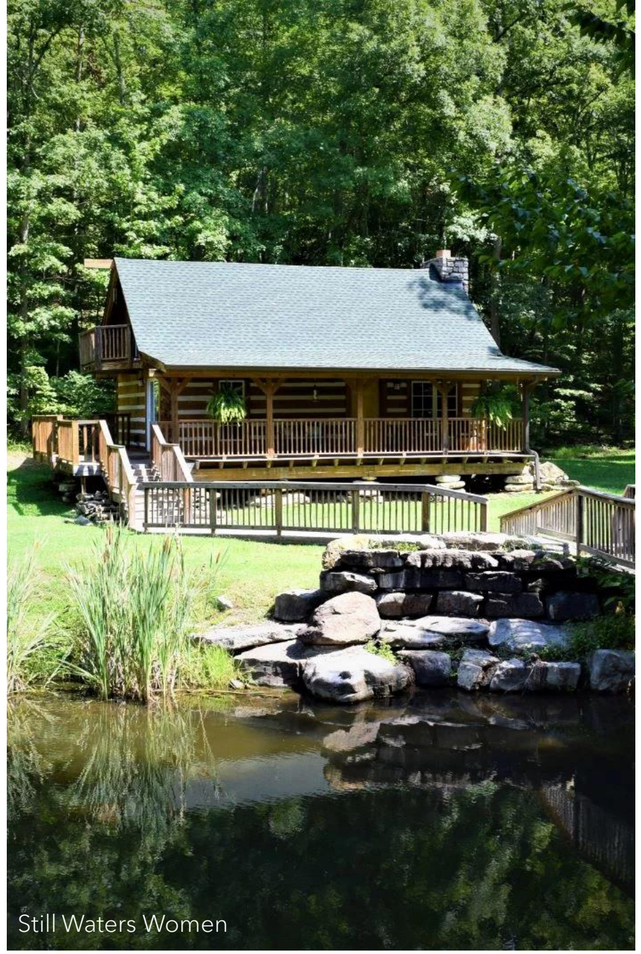

Main Campus


ARCH Academy


Still Waters Women


Still Waters Men

PEER PERSPECTIVES: JOINT COMMISSION ACCREDITATION IN IMPROVING PATIENT SAFETY AND OUTCOMES

Jennifer Sujdak, MHA, Director of Quality Management

cumberland heights | ARCH ACADEMY ADOLESCENT RECOVERY | Still Waters | Research Institute Cumberland Heights

OBJECTIVES

- Discuss trends impacting the industry
- How Joint Commission accreditation affects continuous quality improvement and compliance
- Tips for managing multiple locations

CUMBERLAND HEIGHTS AT A GLANCE

MISSION To transform lives, giving hope and healing to those affected by alcohol and drug addiction.

EMPLOYEES Approximately 350 employees.

PATIENTS On average, 2500 individuals served per year.

LOCATIONS Twenty (20) locations throughout Tennessee.

TREATMENTS Detox, Residential (Adults & Adolescents, Extended Care, Intensive Outpatient, Outpatient (In Person/Tele), MAT, Family Care, and more

The Joint Commission

Key Trends Impacting the Industry & Your experience with Joint Commission Accreditation for Behavioral Health and Human Services

TRENDS IMPACTING THE INDUSTRY

QUALITY INITIATIVES

What does Quality Improvement look like in Substance Use Disorder?

Cumberland Heights measures QI by reporting on compliance with policies procedures in addition to patient outcomes and changes in symptomology:

- **Treatment Access** (wait times)
- **Treatment Completion**
- **Treatment Dosage** (length of stay and care transitions
- **Measurement Based Care** results (PHQ-9, GAD-7, Impulsivity, etc.)
- **Patient Satisfaction**

RISK MANAGEMENT

Managing risks with data-decision making

As part of risk management strategies, Cumberland Heights has an Incident Report Dashboard, which trends incidents and allows filtering by program, incident type, date, time of day, and other demographic data.

NPSG: SUICIDE RISK MANAGEMENT

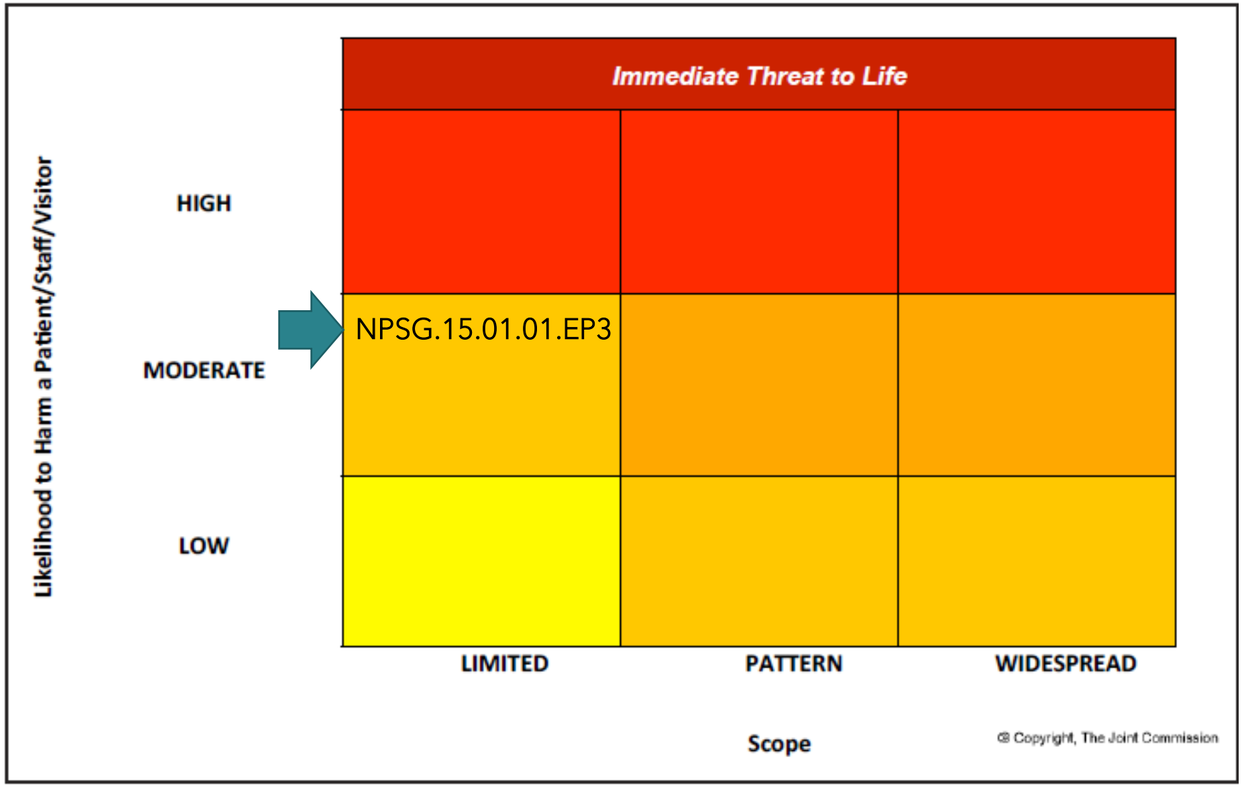
Mitigating the risk of suicide with stratification and continuous monitoring

Cumberland Heights has a protocol for screening and assessing individuals for risk of suicide, and a risk-stratification criteria for monitoring and following up with patients who are identified as "at risk".

CH has leveraged technology to assist counselors with automatic reminders, reassessment need alerts, and effectiveness reports.

SAFER MATRIX

SAFER™ Matrix



Placement of RFI on SAFER™ Matrix and Follow-Up Activity

SAFER™ Matrix Placement

SAFER Matrix™ Placement	Required Follow-Up Activity
HIGH/LIMITED, HIGH/PATTERN, HIGH/WIDESPREAD	• 60 day Evidence of Standards Compliance (ESC) • ESC will also include two additional areas surrounding Leadership Involvement and Preventive Analysis • Finding will be highlighted for potential review by surveyors on subsequent onsite surveys up to and including the next full survey or review
MODERATE / PATTERN, MODERATE/ WIDESPREAD	
MODERATE / LIMITED, LOW / PATTERN, LOW / WIDESPREAD	• 60 day Evidence of Standards Compliance (ESC)
LOW/LIMITED	

SUICIDE RISK ASSESSMENT PROTOCOL (SRA)

Screening, Assessment, and Risk Stratification

THE COLUMBIA LIGHTHOUSE PROJECT
IDENTIFY RISK. PREVENT SUICIDE.

The C-SSRS Screening Tool

Always ask questions 1 and 2.	Past Month	
1) Have you wished you were dead or wished you could go to sleep and not wake up?	Low Risk	
2) Have you actually had any thoughts about killing yourself?	Low Risk	
If **YES** to 2, ask questions 3, 4, 5, and 6. If **NO** to 2, skip to question 6.		
3) Have you been thinking about how you might do this?	Moderate Risk	
4) Have you had these thoughts and had some intention of acting on them?	High Risk	
5) Have you started to work out the details of how to kill yourself? Did you intend to carry out this plan?	High Risk	
Always ask question 6.	Lifetime	Past 3 Months
6) Have you done anything, started to do anything, or prepared to do anything to end your life? Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, held a gun but changed your mind, cut yourself, tried to hang yourself, etc.	Mod Risk	High Risk

Lifetime Assessment

MIN RISK

If the patient endorses "NO" on all questions, they are considered **Minimal Risk**. Continue to monitor and assess as clinically indicated.

LOW RISK

If the patient endorses SI **without** method, plan, or intent within their lifetime, they are considered **Low Risk.** Patient will be reassessed as clinically indicated and before discharge. Crisis plan and resources reviewed.

MOD RISK

If the patient endorses SI **within the past month**, or a **suicide attempt within their lifetime**, the patient is considered **Moderate Risk.** Patient will be reassessed the next day, as clinically indicated, and before discharge. Crisis plan and resources reviewed.

HIGH RISK

If the patient endorses SI **with** method, plan, or intent **within the past moth**, or an **attempt within the past three months**, the patient is considered **High Risk**. MD and Program Director notified. MD will determine 1:1, admission or referral to higher level of care, psychiatric eval. Patient will be reassessed next day, as clinically indicated, before discharge, and receive a wellness call. Crisis plan and resources reviewed.

ADDITIONAL ASSESSMENTS

Measurement Based Care: Using validated tools for screening and assessment

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

1	Little interest or pleasure in doing things
2	Feeling down, depressed, or hopeless
3	Trouble falling or staying asleep, or sleeping too much
4	Feeling tired or having little energy
5	Poor appetite or overeating
6	Feeling bad about yourself - or that you are a failure or have let yourself or your family down
7	Trouble concentrating on things, such as reading the newspaper or watching television
8	Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual
9	Thoughts that you would be better off dead, or of hurting yourself

GENERAL ANXITY DISORDER (GAD-7)

1	Feeling nervous, anxious, or on edge
2	Not being able to stop or control anything
3	Worrying too much about different things
4	Trouble relaxing
5	Being so restless that it is hard to sit still
6	Becoming easily annoyed or irritable
7	Feeling afraid as if something awful might happen

TIMELINE: RESIDENTIAL TREATMENT

C-SSRS (Since Last Contact):
If the patient indicated any risk while in treatment (low, moderate, high) they will receive a C-SSRS upon discharge.
If patients indicate High Risk at discharge, MD is NOTIFIED.
Patients will receive a 48-hour wellness call from a clinician to follow up.

BPSS:
BPSS completed by intake assessor.
Lifetime C-SSRS assessment completed if not done by nursing.
ALERT: An email is triggered if moderate/high risk to remind clinician of needed reassessment.

PATIENT IS ADMITTED

DAY 1 | DAY 2/3 | Follow up assessments (C-SSRS Since Last Contact) may occur if indicated by Lifetime, f/u assessments or clinical indication | DAY 7 | DAY 14 | DAY 21 | DAY 28 | DISCHARGE

NURSING SCREEN & ASSESSMENT:
C-SSRS Screen completed, if high risk a full C-SSRS (Lifetime) assessment is completed.
ALERT: Email is triggered if moderate/high risk to remind clinician of needed reassessment.

SCREENERS:
Patient completes screeners at each week of treatment.
ALERT: Screener alert triggered (text and email) if patient answers "more than half the days" or "nearly every day" to question #7 on the GAD-7 and/or question #9 on the PHQ-9.

MBC SCREENERS:
Patient arrival. First set of screener assessments completed before patient is admitted (PHQ-9, GAD-7).

Admission Date	Name	SRA
8/21	Derrick Henry	
8/22	Ryan Tannehill	1
8/28	Ryan Stonehouse	
9/2	DeaAndre Hopkins	2
9/6	Kevin Byard	2
9/7	Jeff Simmons	3
9/8	Harold Landry III	1
9/11	Treylon Burks	2
9/16	Kristian Fulton	0

PATIENT ROSTER:

SRA (Suicide Risk Assessment) Status
Shows patient risk (if applicable) and follow up criteria needed
KEY:
(0): Lifetime C-SSRS needed
(1): Moderate/High Risk with Next Day C-SSRS needed
(2): Moderate Risk with C-SSRS needed before Discharge
(3): High Risk with C-SSRS needed before discharge and follow up wellness call

JOINT COMMISSION: CONTINUOUS COMPLIANCE

Measuring compliance of protocols, effectiveness of quality initiatives, and patient outcomes

Female Demographic Information

Sample Size: n=494
Avg. Age: 42

Average Length of Stay:
36 days

Male Demographic Information

Sample Size: n=1336
Avg. Age: 37

Average Length of Stay:
38 days

Female Marital Status

- Married 43%
- Widowed 3%
- Single 36%
- Separated 2%
- Divorced 14%
- Cohabitating 2%

Female Primary SUD Diagnosis

- Alcohol 71%
- Cannabis 2%
- Opioid 19%
- Sedative 1%
- Stimulant 8%
- Hallucinogen <1%

Male Marital Status

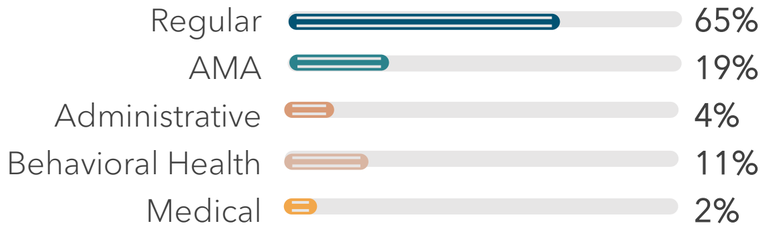
- Single 54%
- Cohabitating 2%
- Married 33%
- Separated 2%
- Divorced 8%
- Other 1%

Male Primary SUD Diagnosis

- Alcohol 63%
- Cannabis 8%
- Opioid 16%
- Sedative 2%
- Stimulant 9%
- Other Psychoactive 1%

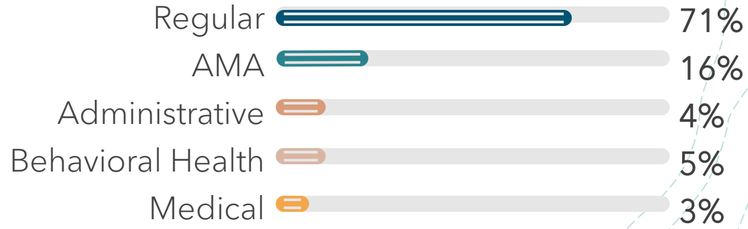
Female Co-Occurring Diagnosis

Female Discharge Type

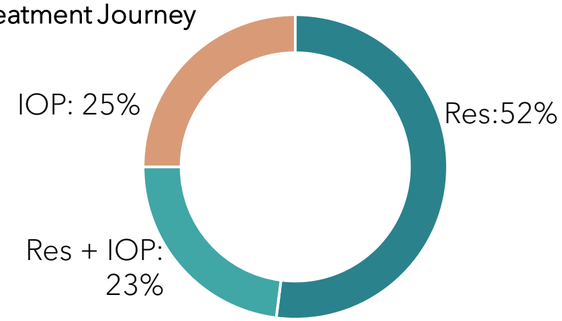


Male Co-Occurring Diagnosis

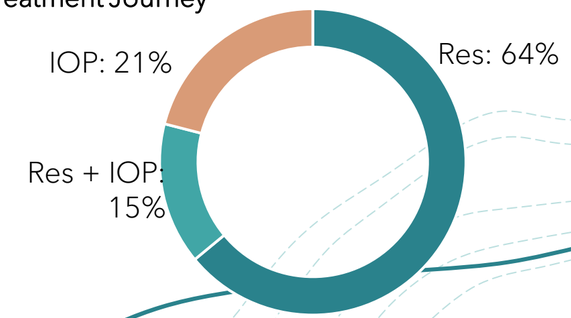
Male Discharge Type



Female Treatment Journey



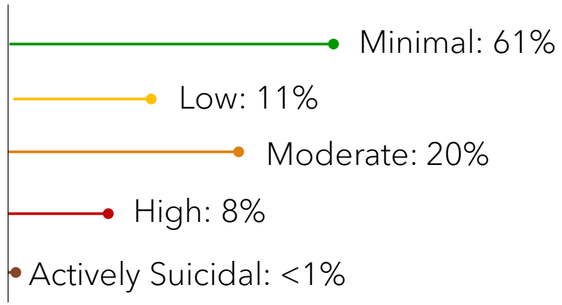
Male Treatment Journey



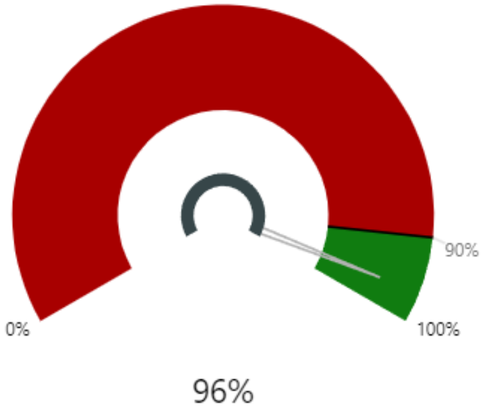
JOINT COMMISSION: CONTINUOUS COMPLIANCE

Measuring compliance of protocols, effectiveness of quality initiatives, and patient outcomes

Risk Status: Lifetime C-SSRS (Residential Patients)



Patients identified as moderate or high risk are reassessed for suicide within 36 hours as part of the SRA protocol.
Cumberland Heights has a goal of ensuring ≥90% patients are reassessed for risk of suicide with a C-SSRS Since Last Contact within the expected time frame.

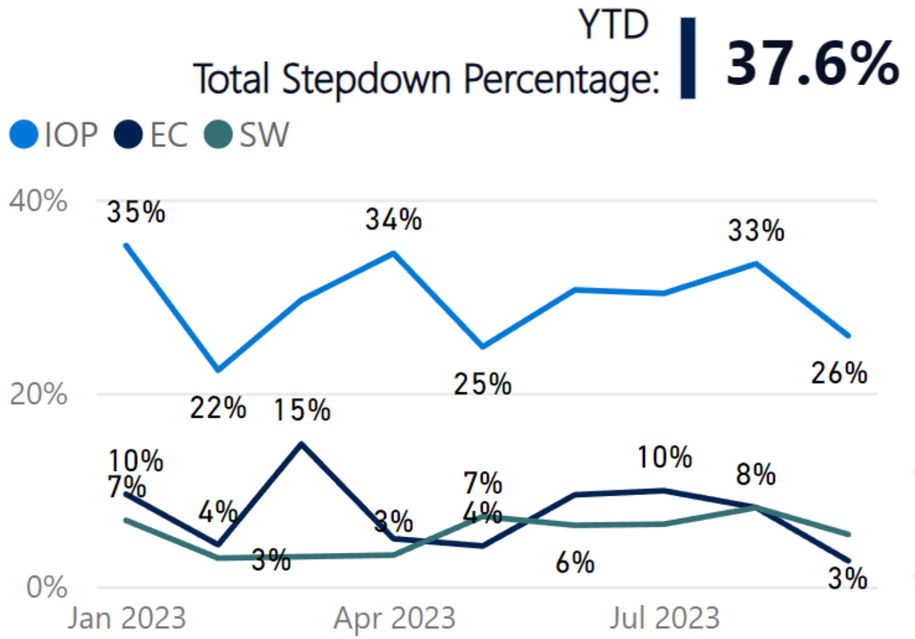


SUICIDE RISK AND MENTAL HEALTH

- A person is **300 times more likely to die by suicide in the first week after discharge** (Chung et. al, 2019).
- 30% of patients do not attend an outpatient appointment in the first 30 days (NCQA, 2021).
- Tennessee's suicide rate was 29% higher than the national average rate in the last published report (TN.gov., 2021).
- Recommendations for best practices encourage a transition from inpatient to outpatient care for individuals with a history of suicide risk (SAMHSA, 2023).

JOINT COMMISSION: CONTINUOUS COMPLIANCE

Measuring compliance of protocols, effectiveness of quality initiatives, and patient outcomes

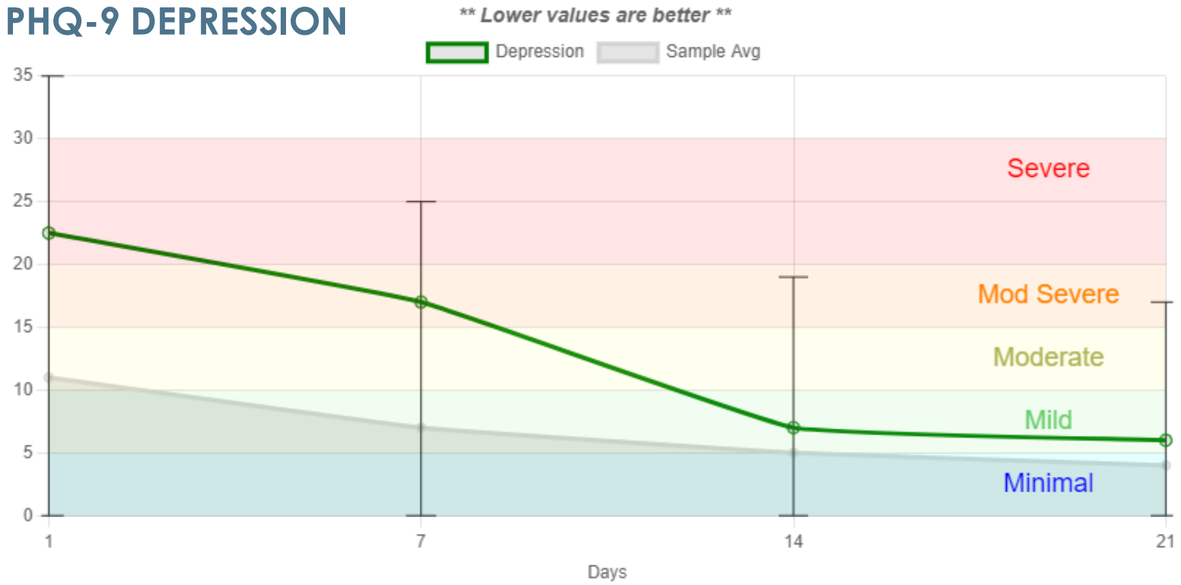


- Stepdown transitions report shows percentage of residential patients who successfully transitioned to a stepdown level of care in Cumberland Heights' system.
- This visual is filtered by patients who live in the state of TN.

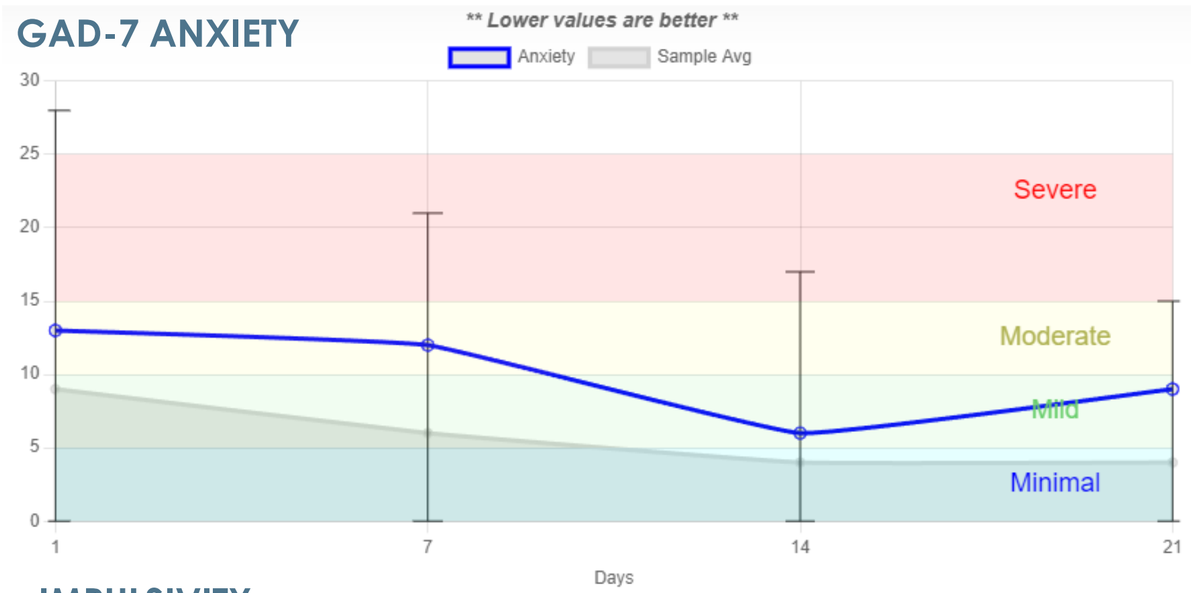
JOINT COMMISSION: CONTINUOUS COMPLIANCE

Measuring compliance of protocols, effectiveness of quality initiatives, and patient outcomes

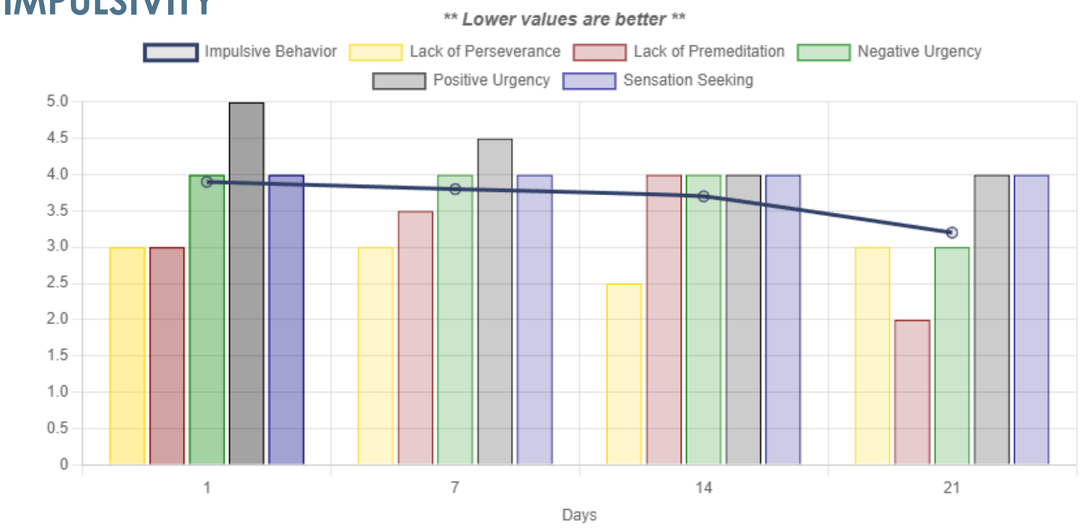
PHQ-9 DEPRESSION



GAD-7 ANXIETY



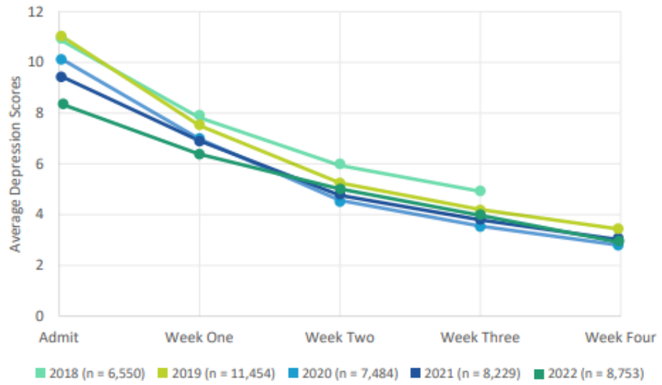
IMPULSIVITY



Patient's depression and anxiety symptoms decreased over time while in treatment. Impulsivity has also decreased while in treatment. Patient has learned skills to cope with triggers and symptoms.

HOW DO OUR PATIENTS RESPOND TO TREATMENT?

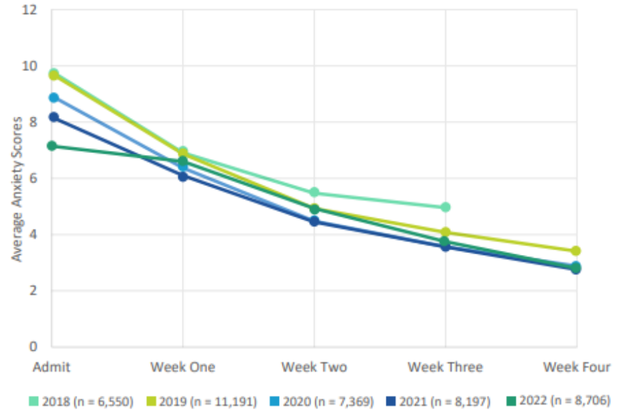
OBSERVED REDUCTION IN DEPRESSION SYMPTOMS



67%

Decrease in Depression Symptoms that contribute to Substance Use Disorder (2018-2022)

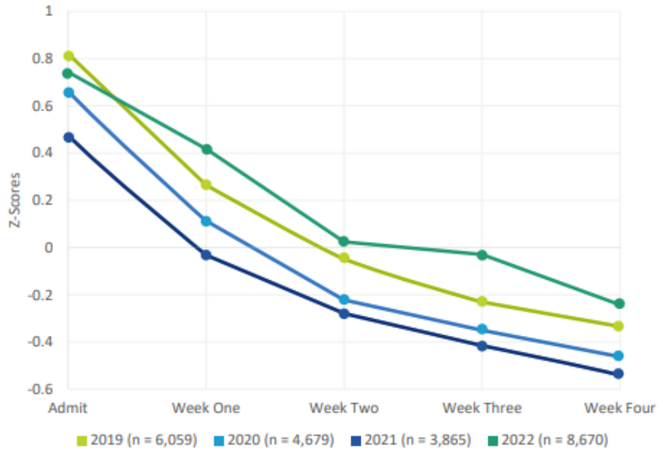
OBSERVED REDUCTION IN ANXIETY SYMPTOMS



63%

Decrease in Anxiety Symptoms that contribute to Substance Use Disorder (2018-2022)

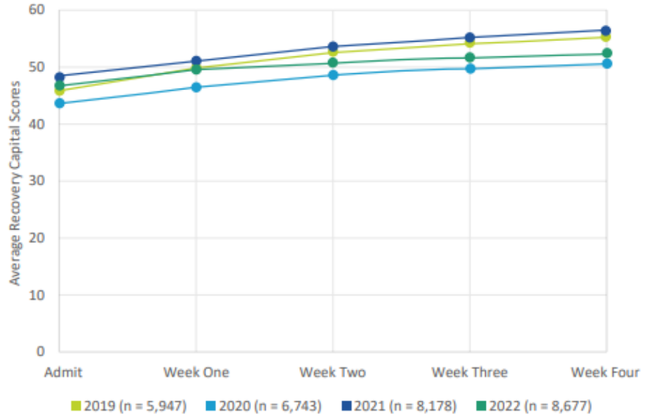
OBSERVED REDUCTION IN CRAVING SYMPTOMS



88%

Decrease in Craving Symptoms that contribute to Substance Use Disorder (2018-2022)

OBSERVED INCREASE IN RECOVERY CAPITAL RESOURCES



12%

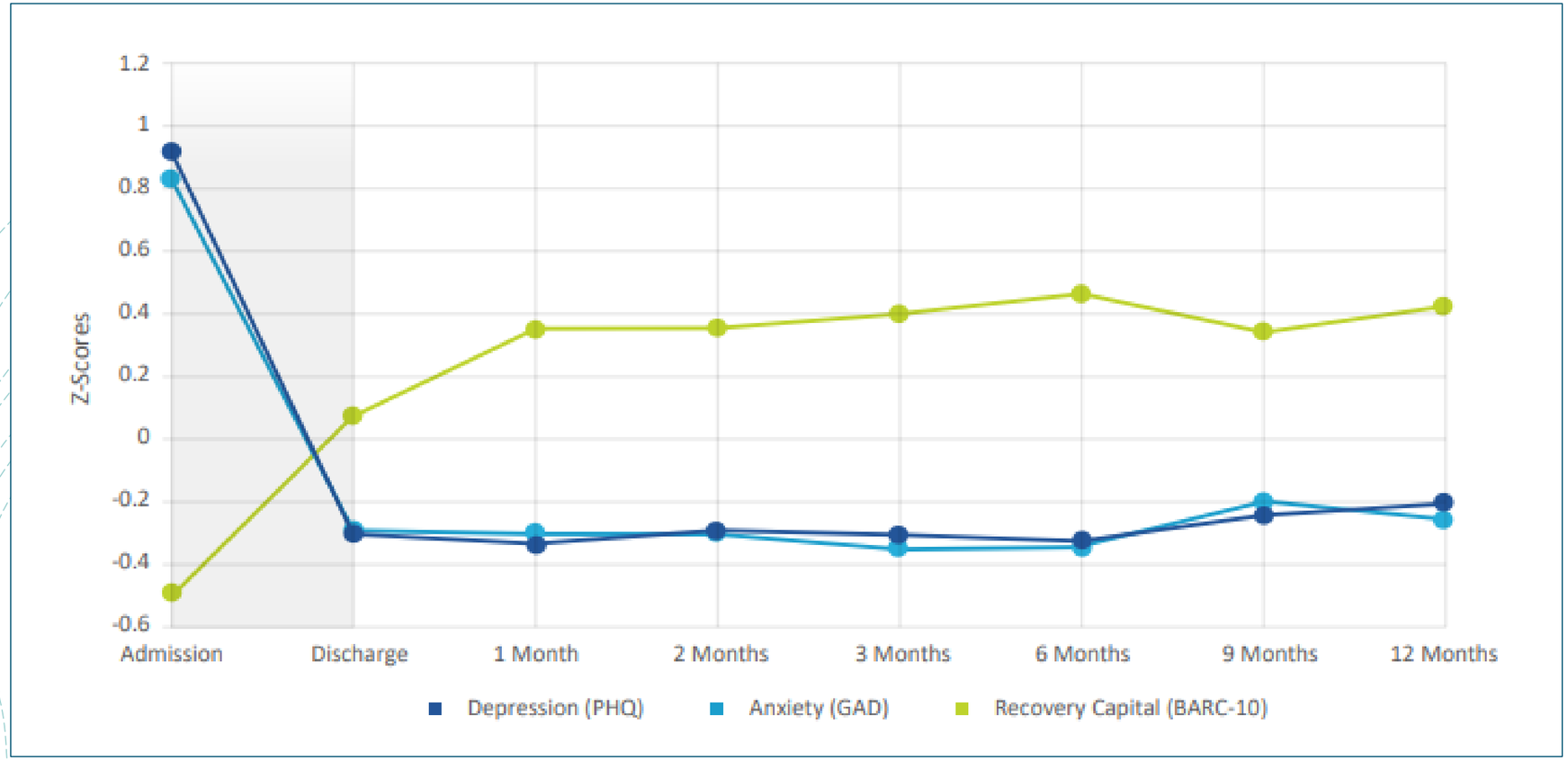
Increase in recovery capital resources that can support sustained recovery (2018-2022)

POST DISCHARGE RESULTS
THREE YEAR REVIEW

<u>Longitudinal Symptom Reduction.</u>
Patient reported symptomology sustained significant reductions through the first year-post discharge after treatment services.

<u>Decreased Readmission.</u>
Increased treatment dosage was associated with better post discharge outcomes (i.e., lower use days, higher recovery participation, and lower readmission rates).

<u>Increased Abstinence.</u>
Patients who successfully completed our programs were more likely to report sustained recovery.



2022 Annual Outcomes Report

MANAGING MULTIPLE LOCATIONS: LEVERAGING TECHNOLOGY

Cumberland Heights Critical Alerts and Continuous Monitoring: Alerting providers in real time of the need for additional screening or assessment, following up, and tracking protocol compliance and outcomes.

Email Alert	If a patient is **Moderate** or **High Risk** and requires a follow up assessment, the Primary Counselor, Program Director, and Clinical Leadership will receive an email the day the assessment is needed.
Text/Email Alert	If a patient endorses an answer that causes concern while completed a PHQ-9 or GAD-7 screener assessment, the primary counselor and program director will receive a text alert to address with the patient and assess for risk of suicide.
Daily Roster	Daily patient program roster shows patient risk stratification and follow up status. Kept on the Staff Portal for access across all departments.
Graph App	Displays patient depression and anxiety scores against the aggregate and trends changes in symptomology over time.
QM Reports	Tracks outcomes, displays aggregate MBC trends, ensures compliance with protocol; allows filtering by program/time/demographic data. Kept on Staff Portal for stakeholders to access in real time.

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QUESTIONS

Thank you!

When you become part of *Joint Commission and earn our Gold Seal*, you are recognized as having the highest standard in Quality and Safety.