



Increasing Linkages between Sexual and Reproductive Health and Substance Use Service Settings: A Toolkit for Practitioners

Partnership to Advance Integrated Referrals *(PAIR)* Project





Public Health Solutions

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healthsolutions.org

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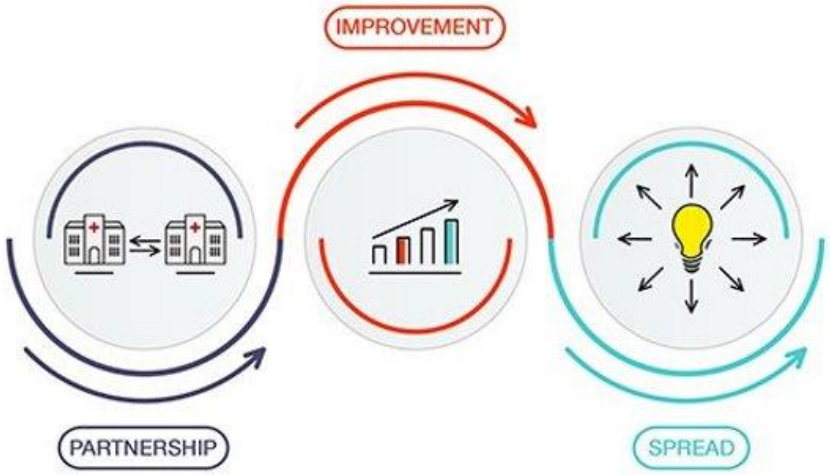
Disclaimer

- The project described was supported by Grant Number 1 FPRPA006066-01-00 from the HHS Office of Population Affairs
- Contents are solely the responsibility of the authors and do not necessarily represent the official views of the Department of Health and Human Services or the Office of Population Affairs

Objectives

- Discuss a novel approach to advance referral partnerships between sexual and reproductive health (SRH) and substance use (SU) service settings.
- Identify at least one way to use the toolkit to improve screening practices for SRH/SU needs and build partnership relationships.
- Draft a plan to initiate the first module of the toolkit (preparing for Quality Improvement work) in their clinical setting

Excite and inspire you to take concrete actions to improve gaps in healthcare and advance health equity



BACKGROUND

Public Health Solutions (PHS)

PHS Mission: To support underserved New Yorkers and their families in achieving optimal health and building pathways to reach their potential

We work directly in communities throughout the five boroughs to provide crucial services to vulnerable families that help them achieve optimal health and build pathways to reach their potential.

Neighborhood WIC
Our Neighborhood WIC Centers provide education and counseling around nutrition and physical activity, breastfeeding support, and checks to purchase nutritious foods for pregnant and nursing women and children up to age five years old. We help over 35,000 eligible pregnant and nursing women and children each year.

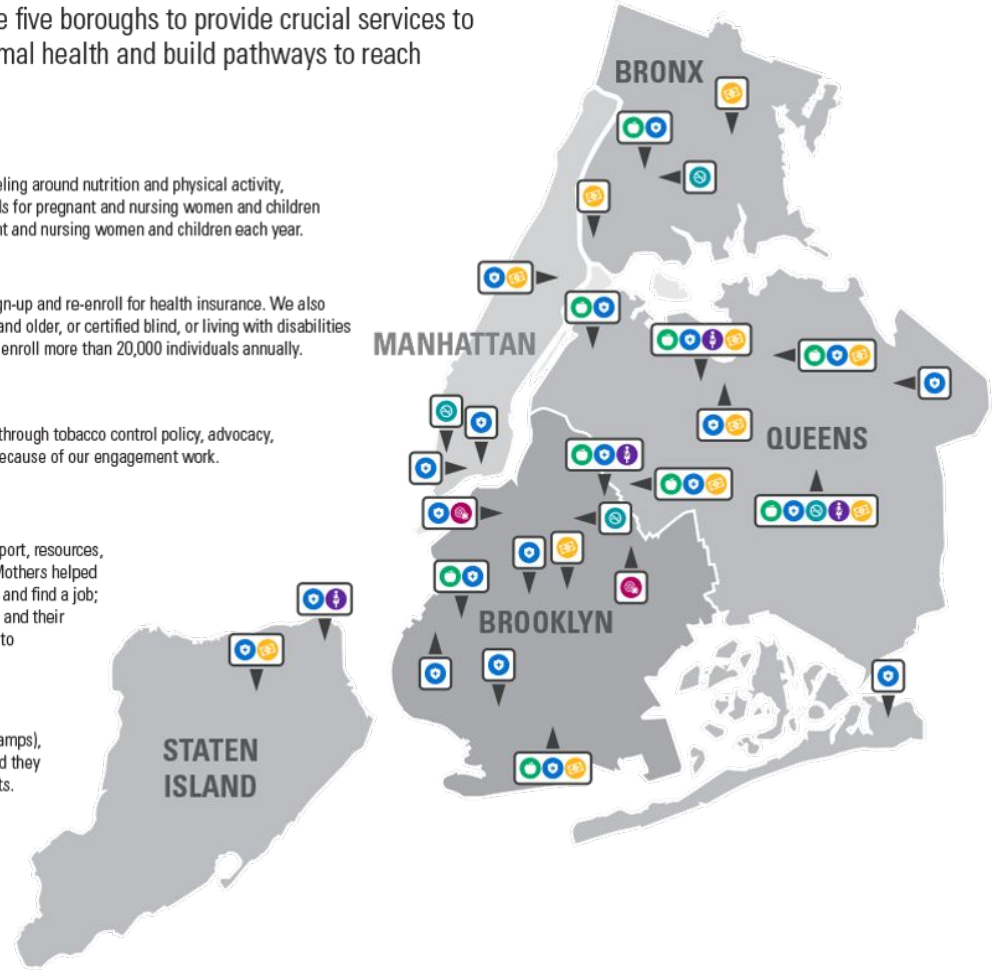
Health Insurance Enrollment
Our Health Insurance navigators help community members sign-up and re-enroll for health insurance. We also provide facilitated enrollment for individuals who are age 65 and older, or certified blind, or living with disabilities to enroll in Medicaid and the Medicare Savings Program. We enroll more than 20,000 individuals annually.

NYC Smoke-Free
NYC Smoke-Free works to protect the health of New Yorkers through tobacco control policy, advocacy, and education. Over 15,000 apartment units are smoke-free because of our engagement work.

Maternal and Child Health
Our Maternal and Child Health teams provide a variety of support, resources, and services for pregnant women and parents of newborns. Mothers helped by our home-visiting programs are more likely to finish school and find a job; less likely to have preterm or deliver a low-birth-weight baby; and their children do better in school and are more than twice as likely to participate in a gifted learning program.

SNAP Assistance
Our SNAP counselors assist clients to enroll in SNAP (food stamps), which helps eligible community members to purchase the food they need from most grocery stores and other approved food outlets.

Sexual and Reproductive Health Centers
Our Sexual and Reproductive Health Centers provide affordable, comprehensive, and confidential reproductive healthcare services to more than 4,000 women, men, and adolescents each year.

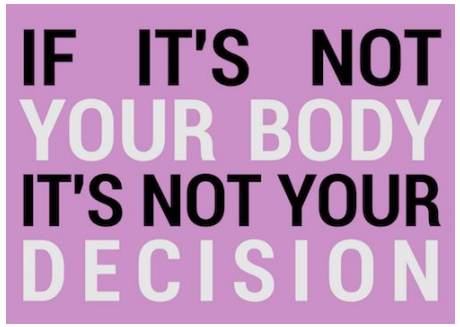


Why we do this work

Potential for Impact

- Everyone has the human right to make decisions about their lives, including decisions about childbearing and family creation- our unit's work is grounded by the Sexual and Reproductive Justic (SRJ) framework
- Access to fact-based, unbiased contraceptive counseling can support these rights by providing patients with information and, if desired, their choice of contraceptive method
- Patient/Client-centered care leads to improved health outcomes, and patients feel valued and involved in their health care
- Patients/Clients will return to providers and counselors who respect their bodily autonomy and provide high quality care and referrals to care

Disclaimer: PHS supports the use of inclusive and less stigmatizing language for people accessing SRH and SU services. However, we cite some language in its original format, so as not to change the understanding of the citation.



What is a QILC?

Quality Improvement Learning Collaborative (QILC): A collaborative approach for healthcare sites to reach a shared goal by conducting individual quality improvement, convening for learning sessions and learning from each other as well as experts in the field.

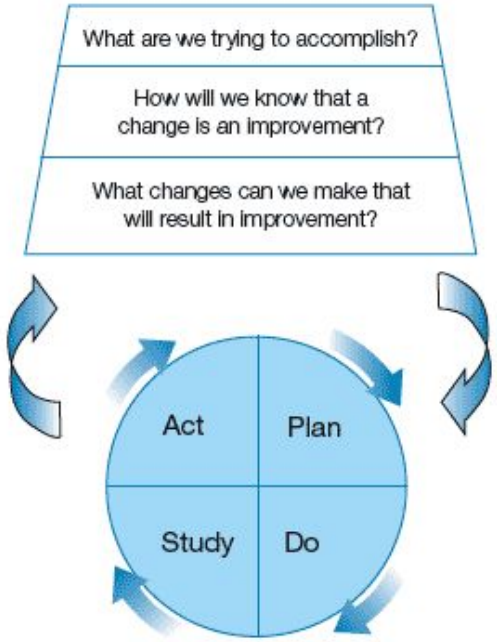
- Structure designed by the Institute for Healthcare Improvement (IHI), called the Breakthrough Series Model*
- Typically 12-24 months
- Multiple healthcare settings participate
- Sites who participate in a QILC:
  - Set improvement aims
  - Identify changes for improvement and test change ideas
  - Collect data to measure improvement
  - Meet regularly and collaborate with other sites in the QILC
  - Receive technical assistance from experts in the field

*Institute for Healthcare Improvement (IHI)'s Breakthrough Series Model: http://www.ihi.org/resources/Pages/IHIWhitePapers/TheBreakthroughSeriesIHIsCollaborativeModelforAchievingBreakthroughImprovement.aspx

IHI's Model

- **Breakthrough Series Collaborative**
  - Improvement method that relies on spread and adaptation of existing knowledge to multiple settings to accomplish a common aim.[1]

- **Model for Improvement**[2]
  - Set specific and measurable aims
  - Establish quantitative measures
  - Identify changes that might result in improvement
  - Test changes using plan-do-study-act (PDSA) cycles



1. Institute for Healthcare Improvement. *The breakthrough series: IHI's collaborative model for achieving breakthrough improvement*. Cambridge, MA: Institute for Healthcare Improvement, 2003.
2. Langley GL, Moen R, Nolan KM, et al. *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance*. 2nd Ed. San Francisco: Jossey-Bass Publishers, 2009.

Impetus for PAIR: Gaps in Care

- Limited sexual and reproductive healthcare services available for people capable of pregnancy who have a substance use disorder (SUD)
- People capable of pregnancy face challenges in accessing contraception including lack of awareness, misconceptions about method efficacy, challenges with appointment scheduling, difficulties filling birth control prescriptions, trouble getting to appointments and cost barriers[1], [2]
- Nearly half of all pregnancies in the United States are unintended, however, for those who have substance use needs, rates of unintended pregnancy are as high as 90%. [3], [4]
- **Best practices** recommend implementing **Screening, Brief intervention and Referral to Treatment (SBIRT)** in primary care. However, there is little standardization of SBIRT and challenges with implementation [5]
- No guidelines exist, to our knowledge, for the implementation of basic SRH services in substance use service settings (but these best practices exist for other healthcare settings, including primary care)

Citations:

[1] Power to Decide (2018). Access Is Power: Opioid Use Disorder and Reproductive Health. Beyond the Beltway.
Retrieved: https://powertodecide.org/system/files/resources/primary-download/Opioid%20Use%20Disorder%20and%20Reproductive%20Health%20.pdf

[2] Fischbein, Rebecca L., Bethany G. Lanese, Lynn Falletta, Kelsey Hamilton, Jennifer A. King, and Deric R. Kenne. "Pregnant or recently pregnant opioid users: contraception decisions, perceptions and preferences." *Contraception and reproductive medicine* 3, no. 1 (2018): 4.

[3] Finer, Lawrence B., and Mia R. Zolna. "Declines in unintended pregnancy in the United States, 2008–2011." *New England Journal of Medicine* 374, no. 9 (2016): 843-852.

[4] Smith, Carleigh, Elizabeth Morse, and Steven Busby. "Barriers to Reproductive Healthcare for Women With Opioid Use Disorder." *The Journal of perinatal & neonatal nursing* 33, no. 2 (2019): E3-E11.

[5] Gotham, Heather J., Katherine Wilson, Kimberley Carlson, Gabrielle Rodriguez, Araba Kuofie, Jacki Witt. Implementing Substance Use Screening in Family Planning. *The Journal for Nurse Practitioners* 15, no. 4 (2019): 306-310.

Partnership to Advance Integrated Referrals (PAIR) Project Overview

Aim: By April 2022, participating sites will improve SRH and SU services for persons capable of pregnancy by:

- Identifying and addressing unmet reproductive health needs among clients accessing substance use services
- Identifying and addressing unmet substance use service needs among patients accessing reproductive health services
- Improving linkages between SRH and SU providers

Project Phases

Year 1 (Oct 2019-Sept 2020):

Planning with Collaborative Advisory Board (CAB)

- QI and Evaluation tool development
- Training curricula development

Years 2-3 (Oct 2020 – Sept 2022):

Quality Improvement Learning Collaborative (QILC) Implementation and Evaluation

- 18-month QILC: shared learning, training and technical assistance
- Individual site QI activities using PAIR QI tools, measurement & reporting
- "Partner pairs" of SRH and SU clinical sites collaborating on QI work
- Post-QILC analysis and evaluation (6 months)

Collaborative Advisory Board (CAB)

Participating organizations

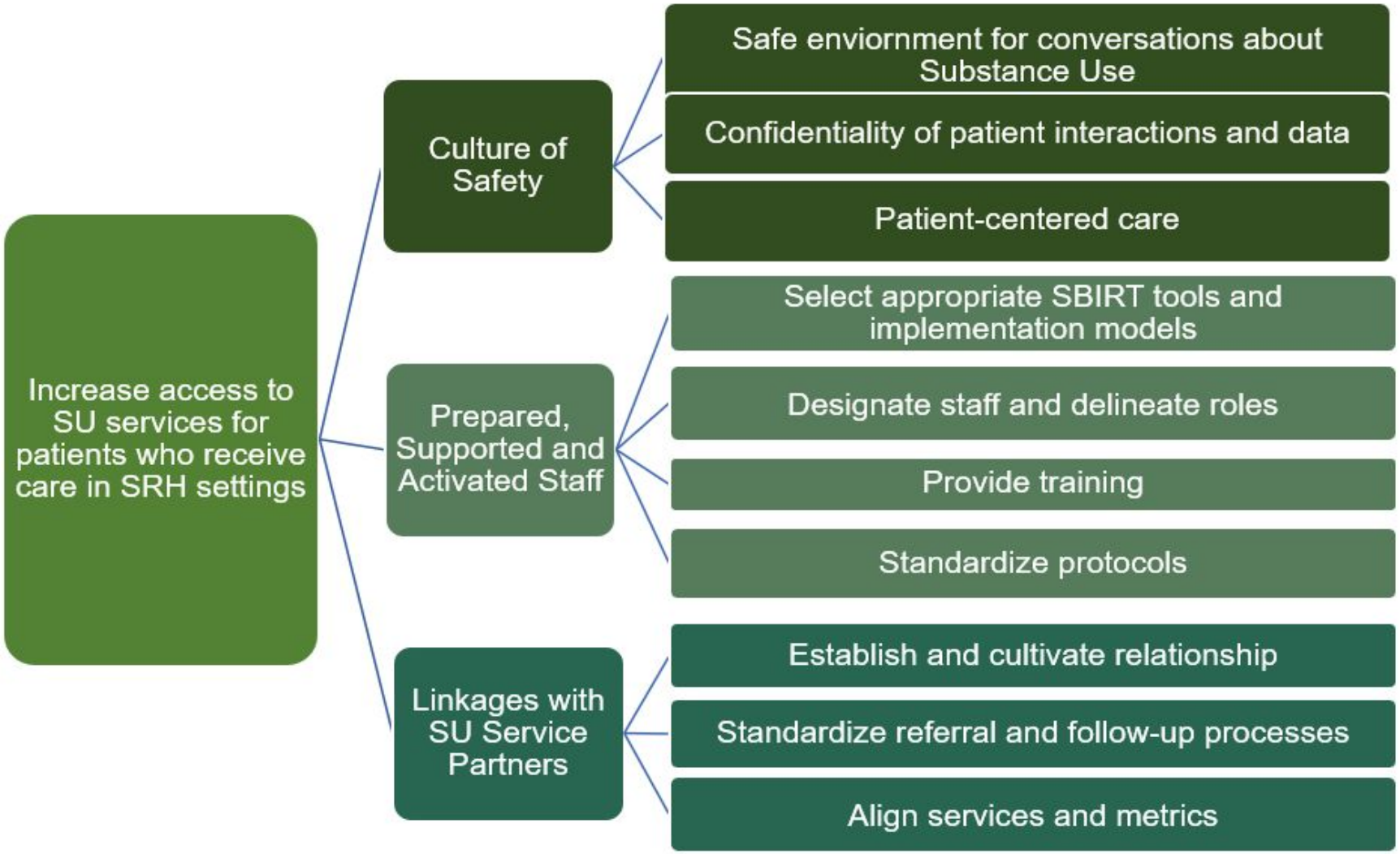
Substance Use (SU) Service Sites	Sexual and Reproductive Health (SRH) Service Sites
Arms Acres	Planned Parenthood of Greater NY
Project Hospitality	PHS SRH Centers
New Directions	Ryan Health
	The Door – A Center for Alternatives

CAB member roles included: Director of Operations and Quality, Addiction Services Coordinator, Agency Director, Quality Improvement Director, Women's Health Promotion Manager, Director of SRH Services, Director of Funding, Assistant Director of Health Education and Outreach

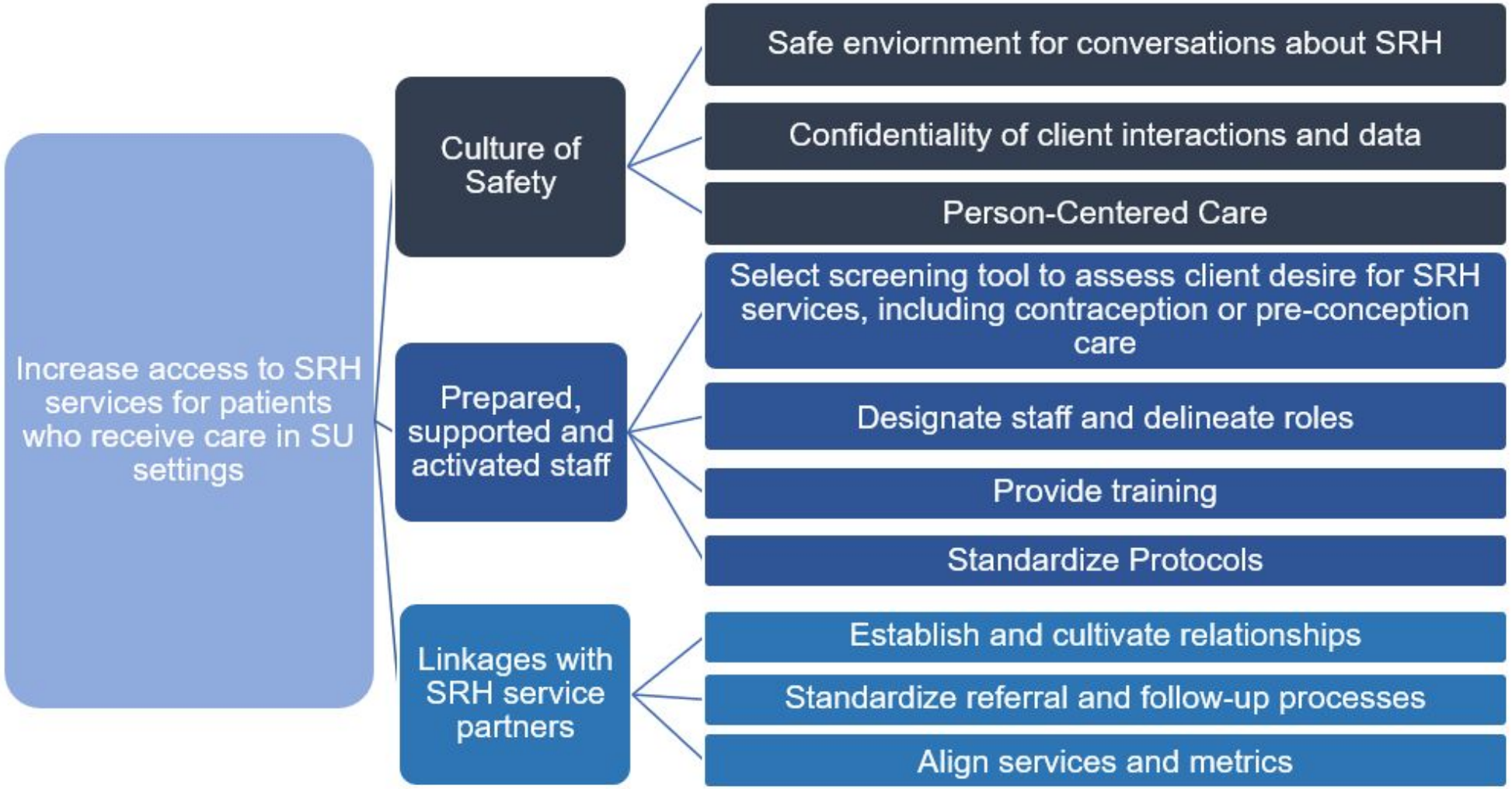
- **CAB Operations**
  - Met monthly (in person, then virtually, separate and collectively)
  - Set Partnership Principles
  - Independently reviewed materials
  - Discussed and addressed anticipated implementation challenges

- **CAB Deliverables Used in QILC**
  - **QI Tools**-change packages, clinical self-assessments, improvement plan templates, clinical measures
  - **Evaluation Tools**- patient experience surveys, staff Knowledge, Attitude, and Practice survey, QILC team survey, learning session evaluations
  - **Training Content-**Implementing SRH Screening and Brief Conversations in SU settings (using the PATH model), Implementing Screening, Brief Intervention and Referral to Treatment (SBIRT) in SRH settings

SRH Setting Driver Diagram



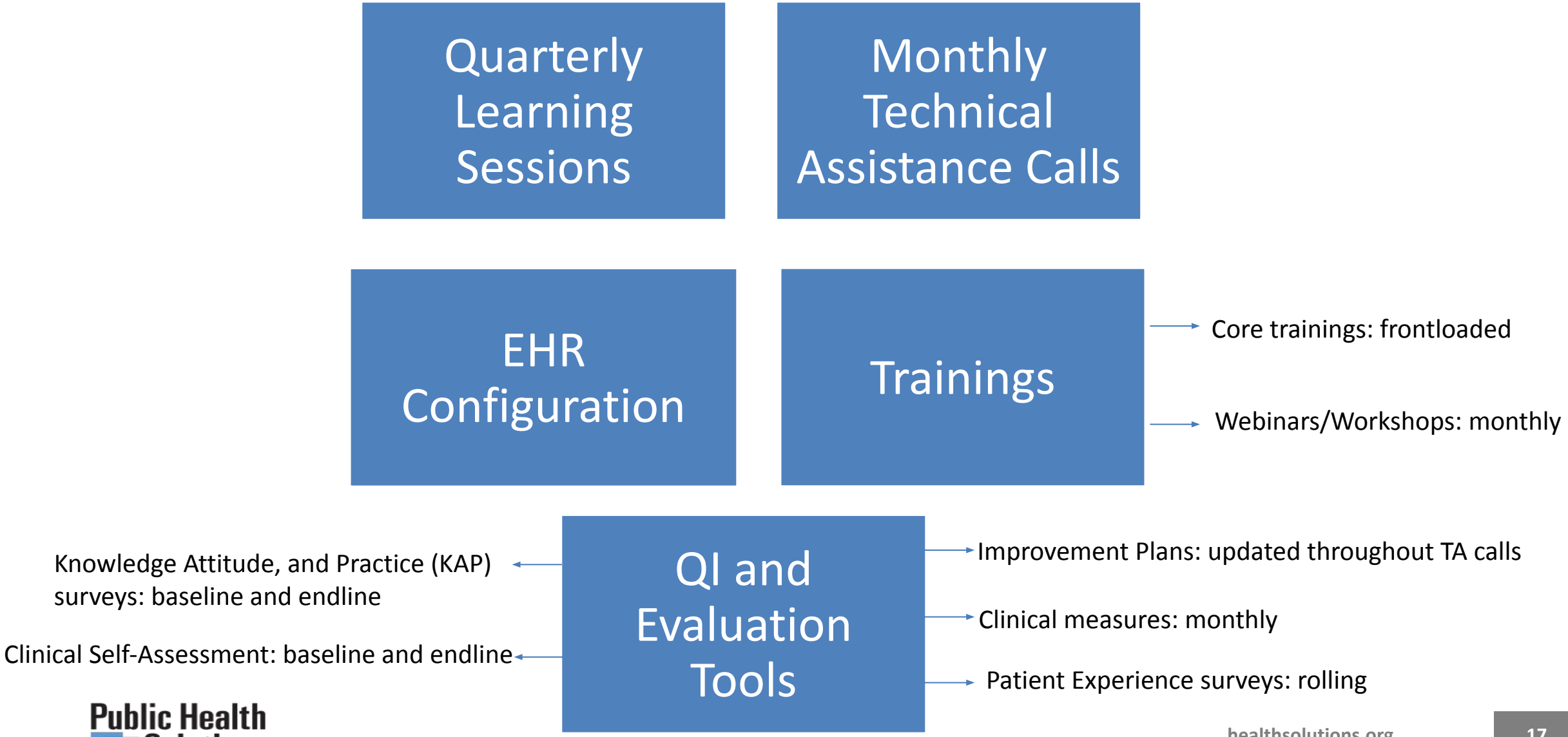
SU Setting Driver Diagram



PAIR QILC Sites

Partner Pairs		
SRH Service Sites	**SU Service Sites**	**Location**
Livingston Reproductive Health Center	CASA - Trinity	Livingston, NY
Family Planning of Syracuse	Crouse Health Hospital	Syracuse, NY
PHS SRH Centers	Bridging Access to Care	Brooklyn, NY
Arms Acres	The Door- A Center for Alternatives	Queens and Manhattan, NY
Harlem United		Manhattan, NY

QILC Structure (October '20 – May '22)



PAIR QILC RESULTS

Measurement for PAIR QILC

How you will know if changes are leading to improvement:

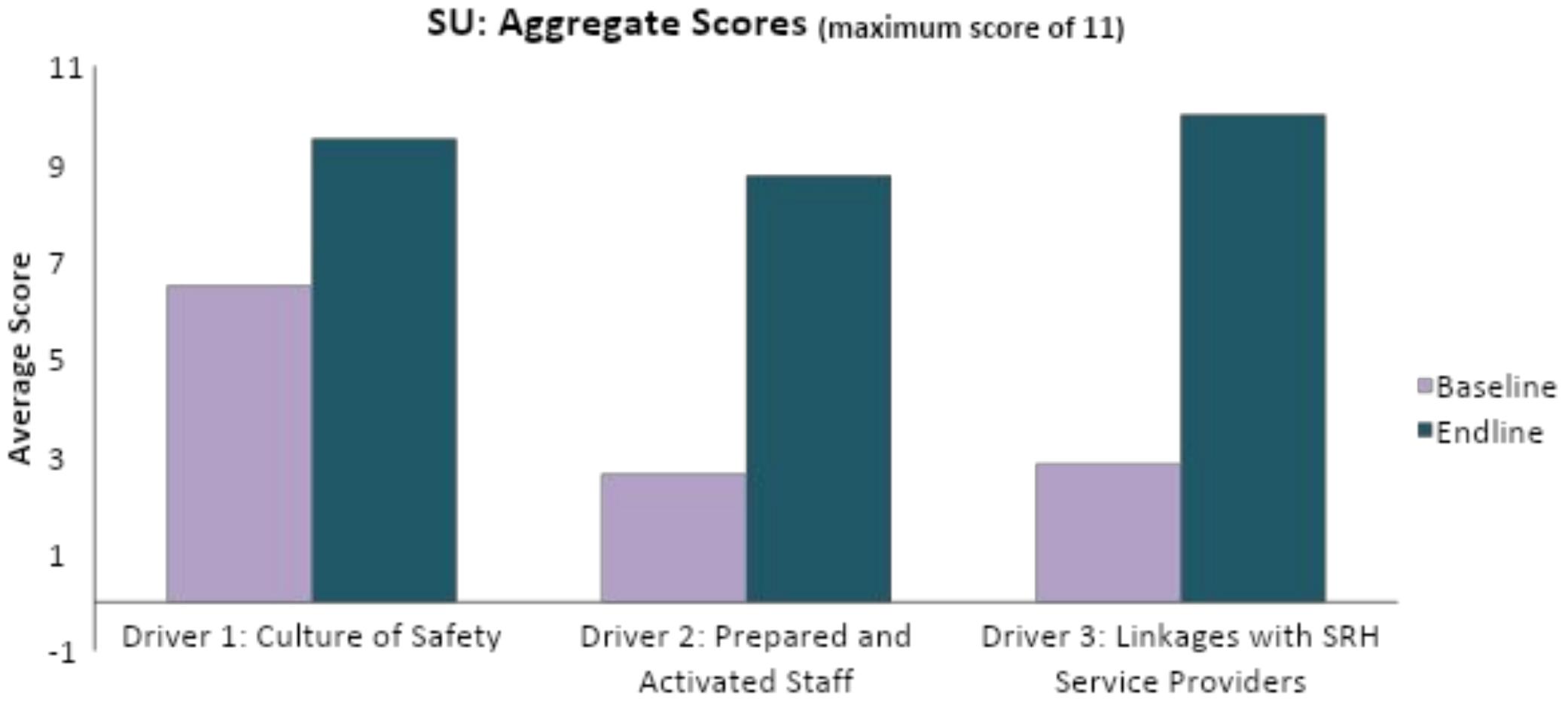
Evaluation Tools	Purpose	Frequency
Organizational Self-assessment	Identify organizational capacities/needs.	Baseline, end line
Knowledge, Attitude, Practice (KAP) Survey	Identify knowledge and attitudes of staff and QI team. Additional sections for QI team members including needs, successes, and challenges of QI process.	Baseline, end line
Post-Learning Session Evaluation	Identify strengths and areas for improvement as well as needs to be addressed in future learning sessions.	After every learning session
Clinical Measures	Track rates of screening, brief intervention, and referrals.	Monthly
Client Experience Survey (CES)	Identify strengths and areas for improvement of SU/SRH services delivered.	Ongoing
QI Team Interviews	Identify successes and challenges in the QI process.	End line

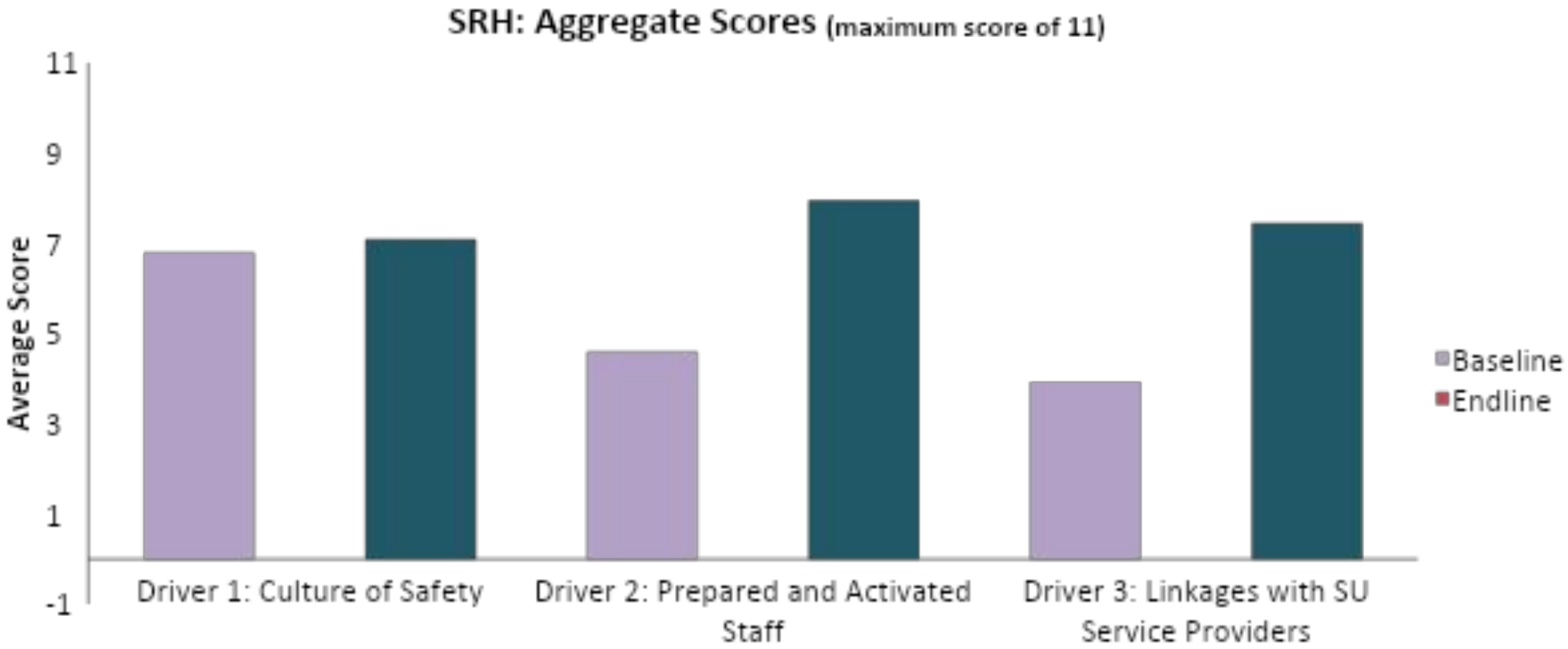
SELF-ASSESSMENTS

Clinical Self-Assessments: *Example questions*

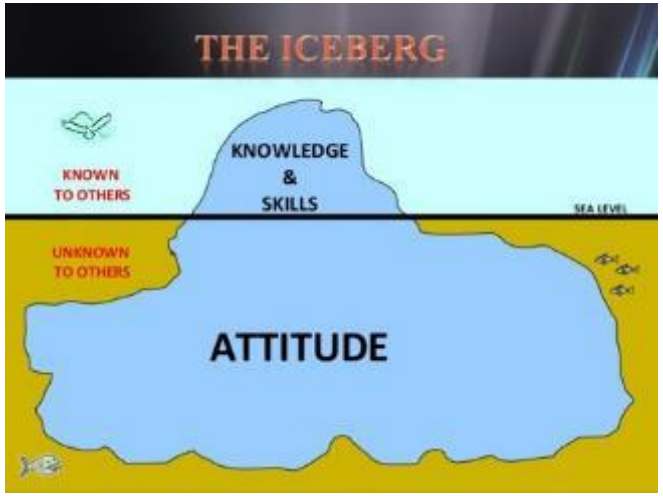
Driver 3: Linkages with Substance Use (SU) Service Partners

Components	Level D	Level C	Level B	Level A
1. Established Relationship	Our clinic has **no** established partnership with a program that provides SU services.	Our clinic has considered a partnership with a SU program, but a partnership has not yet been implemented formally.	Our clinic has a formal partnership with one or more SU programs. There is an established administrative liaison at the partner agency (agencies). When there are problems the staff meets with the partner agency to discuss data and shared goals.	Our clinic has a formal partnership with one or more SU programs, and actively seeks out additional partnerships. There are established liaisons at each partnering agency. Clinical staff **regularly** meets with the partner agency to monitor data and share resources.
Select Score	0 1 2	3 4 5	6 7 8	9 10 11
2. Referral Processes	There is no established referral process. Warm handoffs are **never** implemented.	There is no formalized referral process**,** but staff **occasionally** makes warm handoffs to SU programs. Staff **sometimes** documents referrals in the EHR but there is no structured field.	There is a **formalized** referral process. Staff **consistently** uses warm hand-offs when patients express interest in referrals. There is a system in place to monitor referrals, but it's not regularly reviewed.	Our clinic has a shared approach for referrals with its partnering agencies. The referral process is **regularly** reviewed to assess for necessary changes. Staff consistently enters information about referrals into the EHR.
Select Score	0 1 2	3 4 5	6 7 8	9 10 11
3. Shared Accountability	There are no joint goals across our clinic and partnering SU agencies	Our clinic has some goals established with partner agencies, but they are outdated. There are no regular review processes in place to evaluate goals and set realistic targets.	Our clinic has established goals with partner agencies. There are occasional review processes to evaluate successes and challenges.	Our clinic is guided by a set of shared goals established with partner agencies that have an aligned mission. There are regularly scheduled meetings to evaluate progress towards goals and amend targets as needed.
Select Score	0 1 2	3 4 5	6 7 8	9 10 11


SU: Aggregate Scores (maximum score of 11)
Average Score
11
9
7
5
3
1
-1
Driver 1: Culture of Safety
Driver 2: Prepared and Activated Staff
Driver 3: Linkages with SRH Service Providers
Baseline
Endline


SRH: Aggregate Scores (maximum score of 11)
Average Score
11
9
7
5
3
1
-1
Driver 1: Culture of Safety
Driver 2: Prepared and Activated Staff
Driver 3: Linkages with SU Service Providers
Baseline
Endline

Knowledge, Attitude, Practice (KAP) Survey



Partnership to Advance Integrated Referral: PAIR Learning Collaborative

Public Health Solutions

KNOWLEDGE, ATTITUDE, PRACTICE (KAP) SURVEY

(For review only. Actual survey to be administered online.)

Your organization is participating in a Sexual and Reproductive Health and Substance Use Quality Improvement (QI) Learning Collaborative. Your organization's QI Team would like your input on the new services being planned. Your feedback will help ensure that their work will be effective in improving the quality of services being provided by your organization.

This survey is being collected **anonymously**. Responses from all surveys will be gathered together and only shared in aggregate (all together). This is to protect your privacy and we hope it will help you to feel comfortable being honest.

1. Please indicate which category best describes your role at your organization (check all that apply):
   - ☐ Administrative (e.g., leadership, quality improvement, front desk, finance, IT, clerical, etc.)
   - ☐ Medical Provider (e.g., MD, NP, PA)
   - ☐ Care Team Member (e.g., counselor, peer counselor, social worker, health educator, etc.)

2. How many years have you been serving in this type of role (including at your current organization and/or others)?
   - ☐ Less than 2 years
   - ☐ Between 2 and 5 years
   - ☐ More than 5 years

3. Is the primary focus of the current services you provide:
   - ☐ Sexual and Reproductive Health (SRH)
   - ☐ Substance Use (SU)

4. The following question asks about your attitude towards substance use. **There are no right or wrong answers**. Please answer as honestly as possible.

Do you agree or disagree with the following statements:	*Strongly Disagree*	*Disagree*	*Agree*	*Strongly Agree*
a. If I were under treatment for substance use, I would not disclose this to any of my friends. [1]	1	2	3	4
b. I tend to think that patients who use substances do not share the same values as me. [2]	1	2	3	4
c. I often think patients who use substances have caused their own health problems. [3]	1	2	3	4
d. Patients who use substances overutilize our resources and take time from my other responsibilities. [4]	1	2	3	4

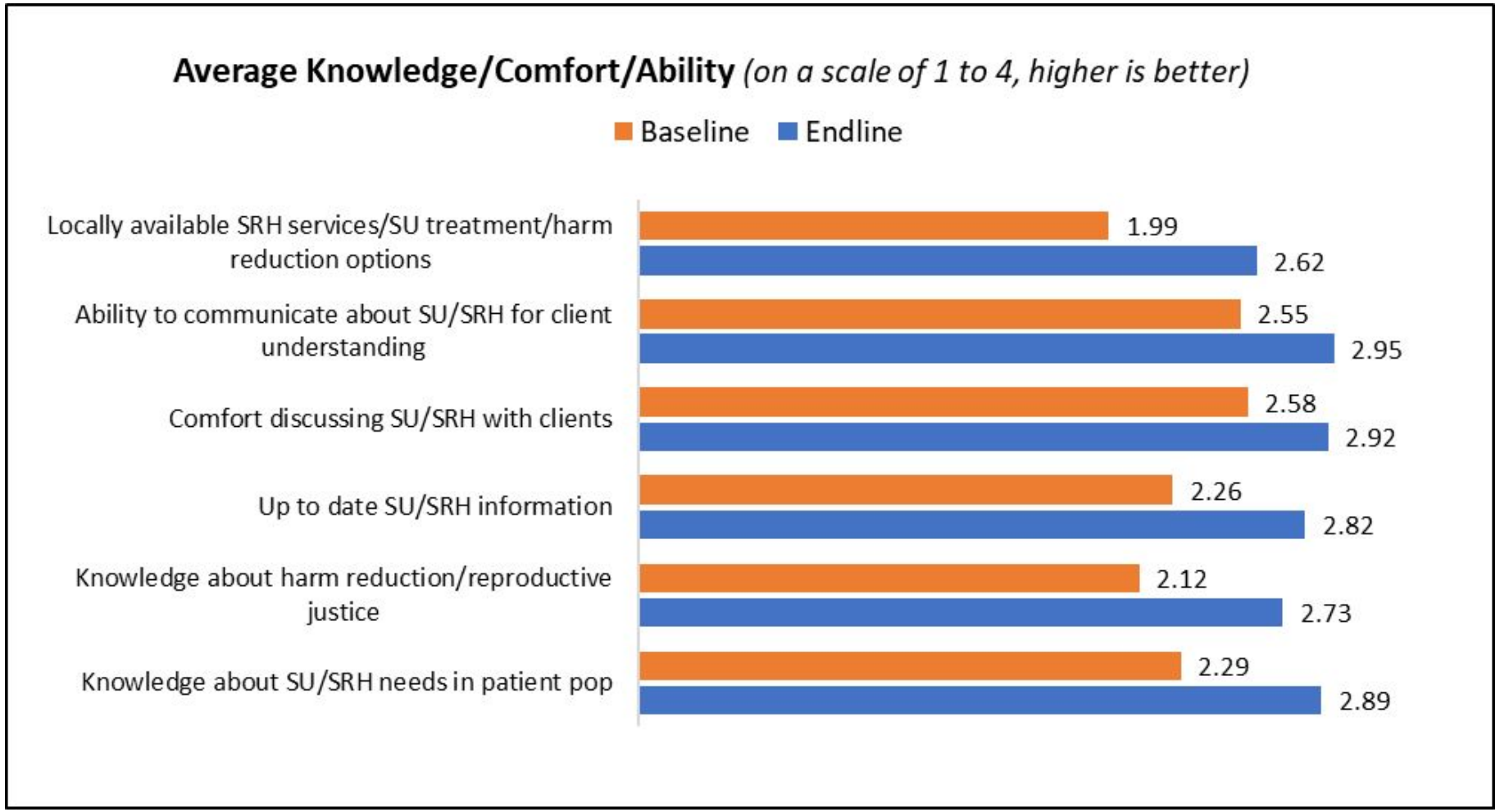
5. The following question asks about your knowledge and comfort with the **new substance use screening, brief intervention, and referral to treatment (SBIRT) services** your organization plans to implement.

How would you rate yourself in the following areas?	*Poor*	*Fair*	*Very Good*	*Excellent*
a. Overall knowledge about substance use in your patient population.	1	2	3	4
b. Knowledge about the harm reduction approach to substance use.	1	2	3	4
c. Ability to stay up to date on information about substance use and substance use services.	1	2	3	4
d. Comfort discussing substance use with patients.	1	2	3	4
e. Your ability to communicate substance use information in a way that patients understand.	1	2	3	4
f. Your knowledge of a range of locally available substance use treatment services including self-help (AA/NA), faith-based, and in-patient or out-patient support services.	1	2	3	4
g. Your knowledge of locally available harm reduction options.	1	2	3	4

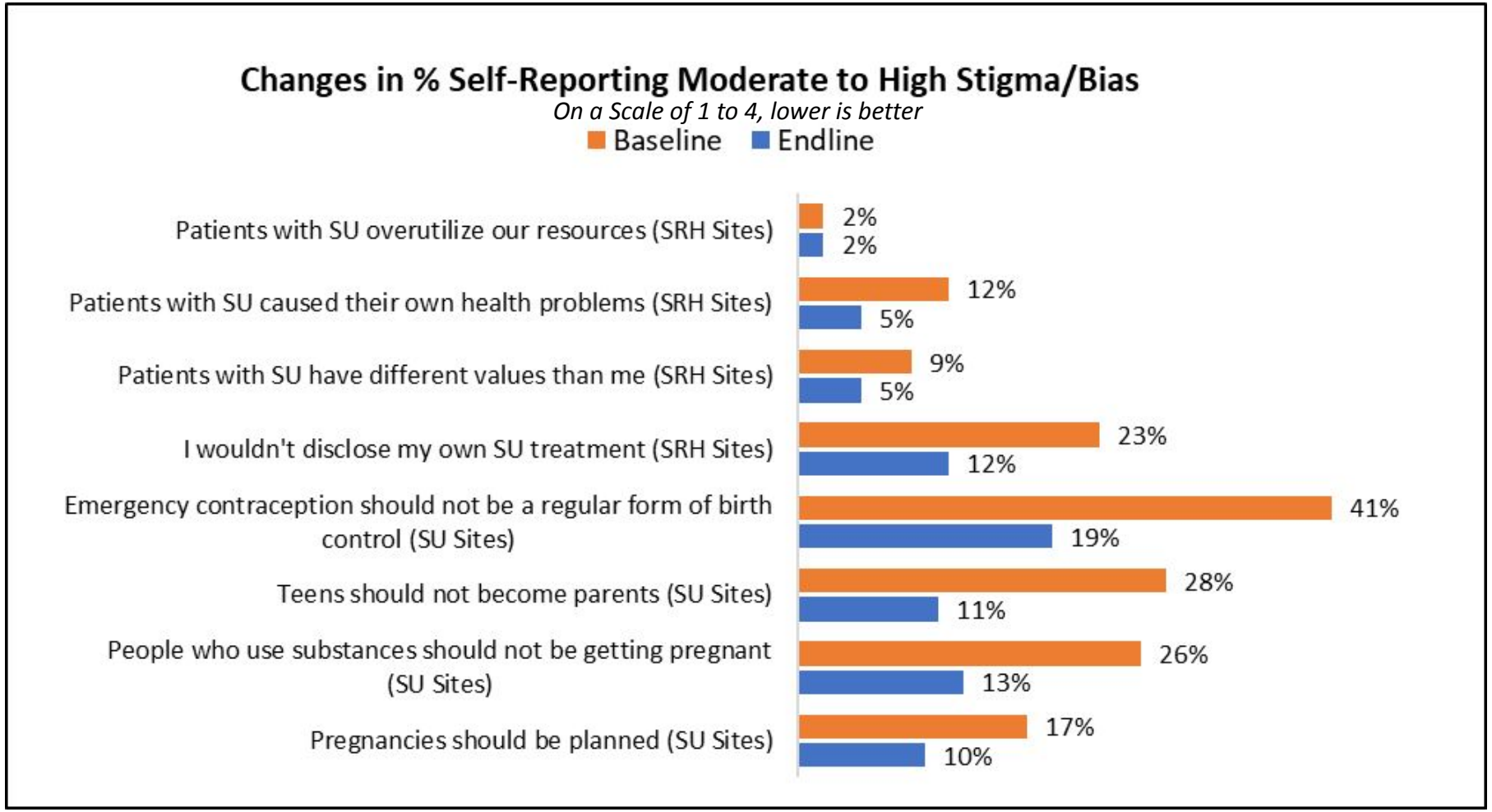
6. **How would you rate your ORGANIZATION in the following areas?**

	Poor	*Fair*	*Very Good*	*Excellent*
a. Treating all patients with courtesy and respect.	1	2	3	4
b. Taking the time to answer patients' questions.	1	2	3	4
c. Giving patients information in ways that they can understand.	1	2	3	4
d. Providing patients with options.	1	2	3	4

KAP Surveys


Average Knowledge/Comfort/Ability (on a scale of 1 to 4, higher is better)
Baseline
Endline
Locally available SRH services/SU treatment/harm reduction options
1.99
2.62
Ability to communicate about SU/SRH for client understanding
2.55
2.95
Comfort discussing SU/SRH with clients
2.58
2.92
Up to date SU/SRH information
2.26
2.82
Knowledge about harm reduction/reproductive justice
2.12
2.73
Knowledge about SU/SRH needs in patient pop
2.29
2.89

KAP Surveys


Changes in % Self-Reporting Moderate to High Stigma/Bias
On a Scale of 1 to 4, lower is better
Baseline
Endline
Patients with SU overutilize our resources (SRH Sites)
2%
2%
Patients with SU caused their own health problems (SRH Sites)
12%
5%
Patients with SU have different values than me (SRH Sites)
9%
5%
I wouldn't disclose my own SU treatment (SRH Sites)
23%
12%
Emergency contraception should not be a regular form of birth control (SU Sites)
41%
19%
Teens should not become parents (SU Sites)
28%
11%
People who use substances should not be getting pregnant (SU Sites)
26%
13%
Pregnancies should be planned (SU Sites)
17%
10%

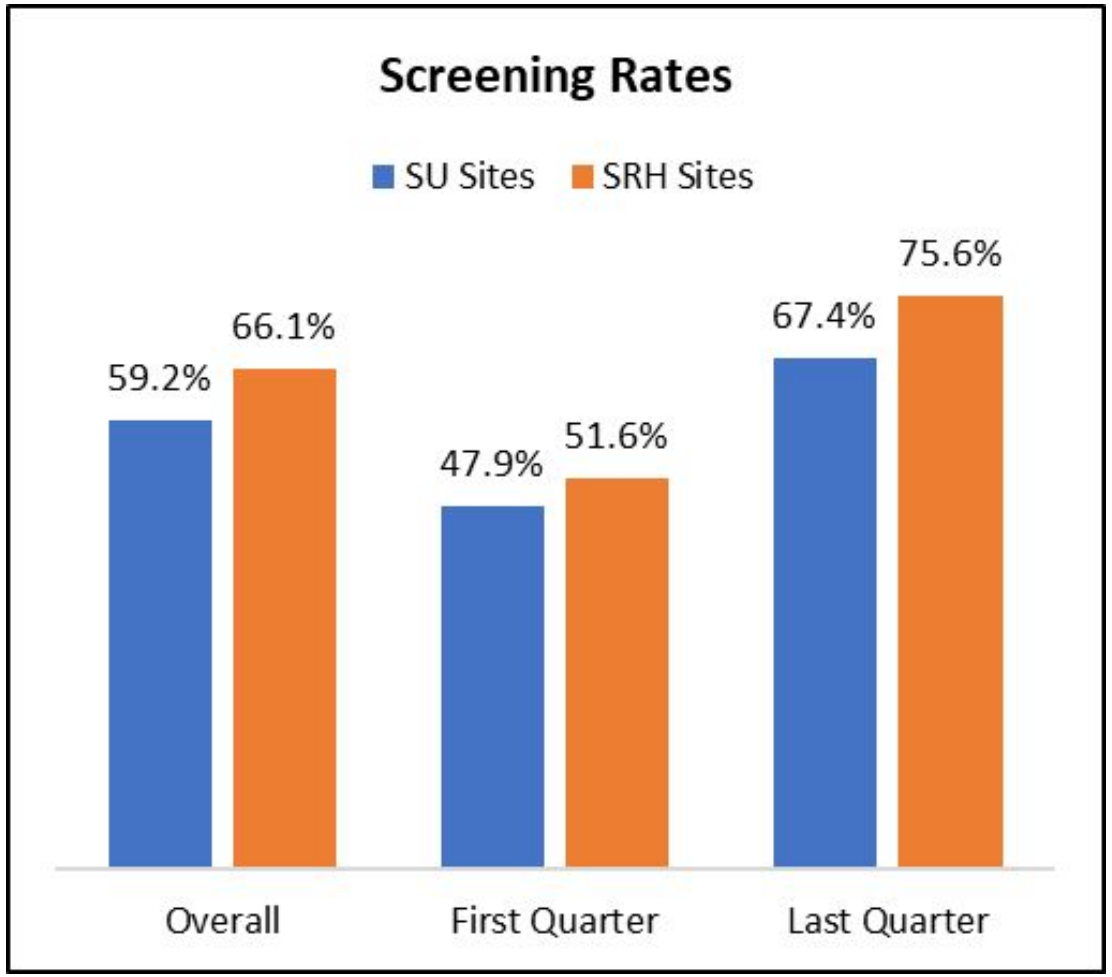
Clinical Measures

Measures for Sexual and Reproductive Health (SRH) Service Settings *Sites will report data MONTHLY. Each cell in the table below refers to the % or # during the specific reporting month.*			
Measure	**Percent**	**Numerator**	**Denominator**
Substance Use (SU) Pre-Screening [5]	% of persons capable of pregnancy [6] who are pre-screened for SU	# of persons capable of pregnancy who are pre-screened for SU	# of persons capable of pregnancy who complete a new patient or annual visit at the SRH service site
SU Full Screening	% of persons capable of pregnancy who complete a full screening for SU	# of persons capable of pregnancy who complete a full screening for SU	# of persons capable of pregnancy who screen positive (or above tool threshold) on the pre-screen
SU Brief Intervention	% of persons capable of pregnancy who receive an SU brief intervention	# of persons capable of pregnancy who receive an SU brief intervention	# of persons capable of pregnancy who screen positive (or above tool threshold) on the full screening
SU Referrals Given [7]	% of persons capable of pregnancy who receive a referral to an SU service site (designated partner agency/other)	# of persons capable of pregnancy who receive a referral to an SU service site (referrals given will be reported separately for designated partner agencies and other agencies)	# of persons capable of pregnancy who receive an SU brief intervention
Referral Outcomes [8]	% of persons capable of pregnancy who have each of the following referral outcomes: 1) Completed [9], 2) Not completed, 3) Unable to verify. Outcomes will be reported separately for designated partner agencies and other agencies.	# of persons capable of pregnancy who have each of the following referral outcomes: 1) Completed, 2) Not completed, 3) Unable to verify. Outcomes will be reported separately for designated partner agencies and other agencies.	# of persons capable of pregnancy who receive a referral to an SU service site (referrals given will be reported separately for designated partner agencies and other agencies)

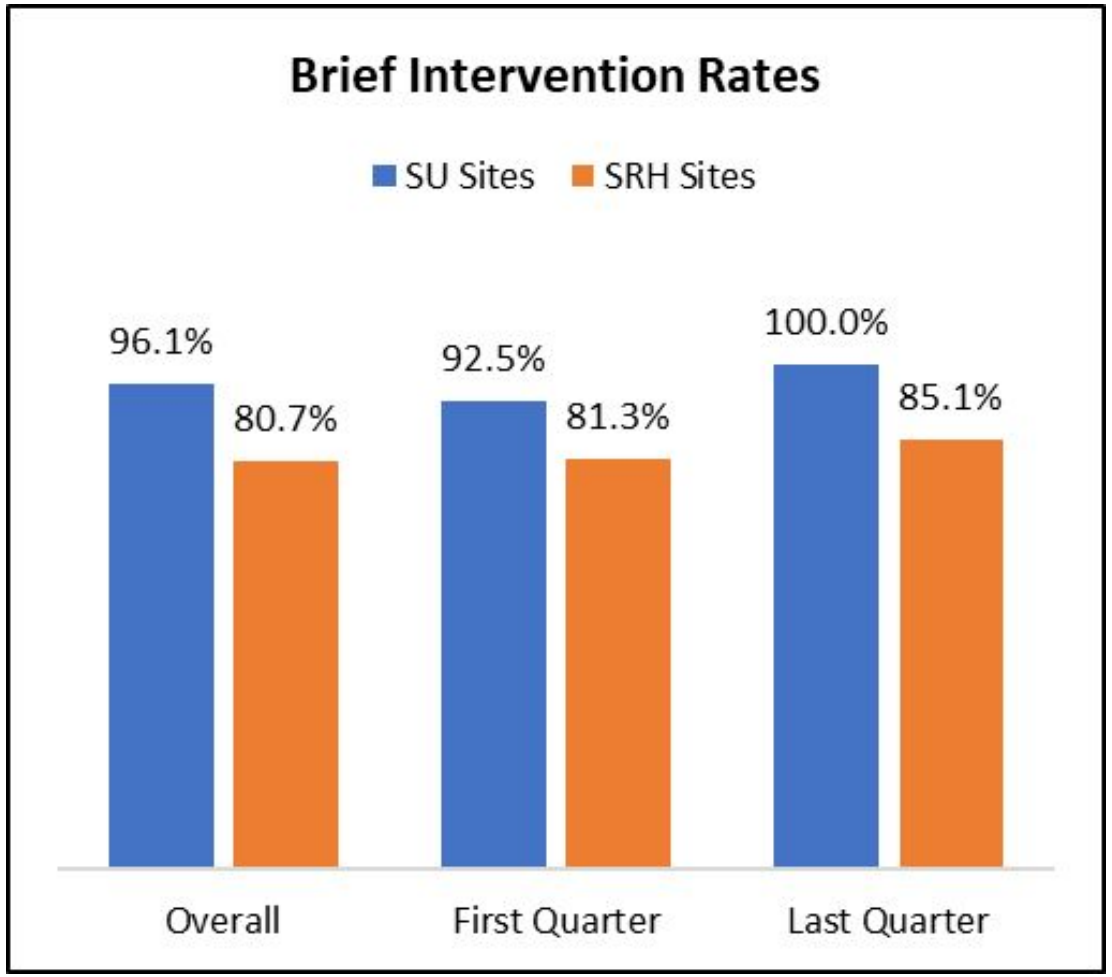
Clinical Measures

	SU Sites	SRH Sites
Screening	59.2% (N=824)	66.1% (N=4537)
Brief Intervention	96.1% (N=363)	80.7% (N=579)
Referral	9.6% (N=282)	6.3% (N=399)

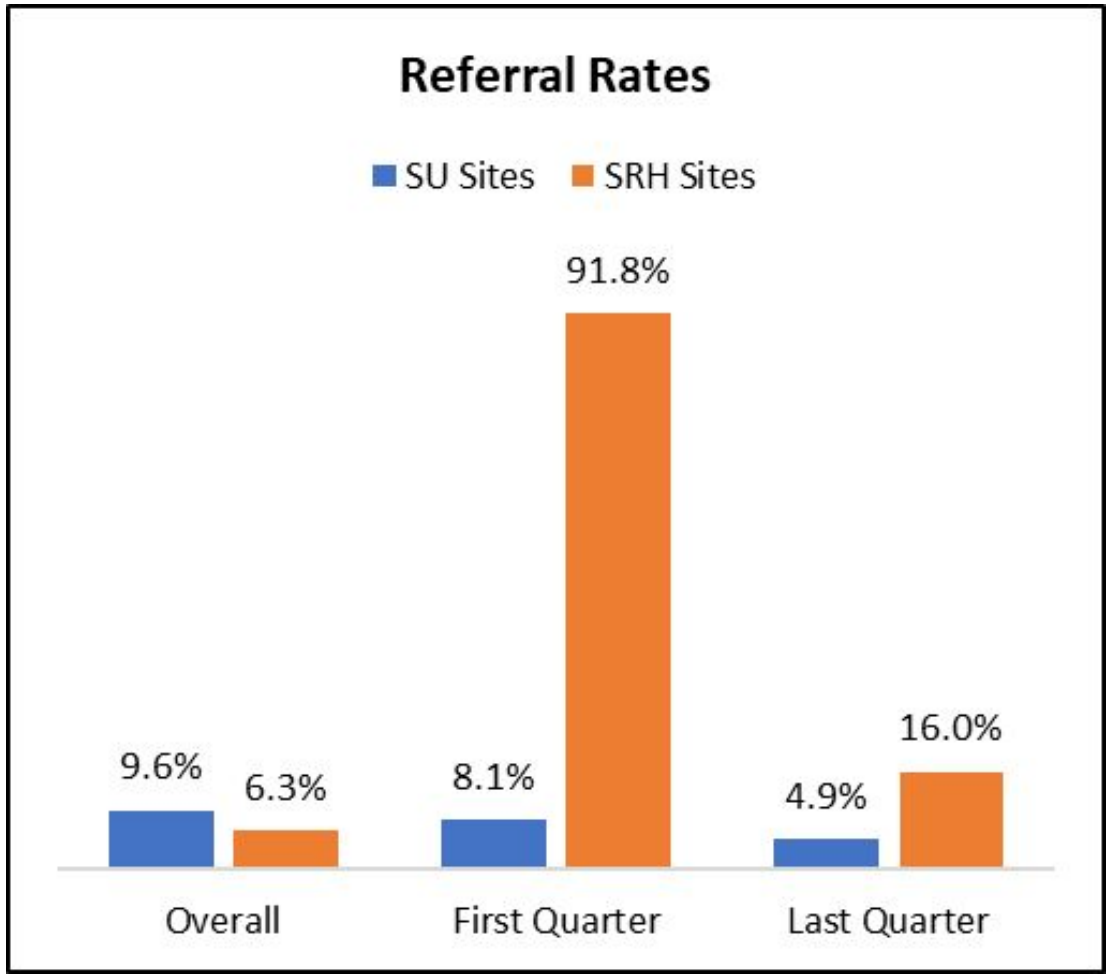
Clinical Measures



Clinical Measures



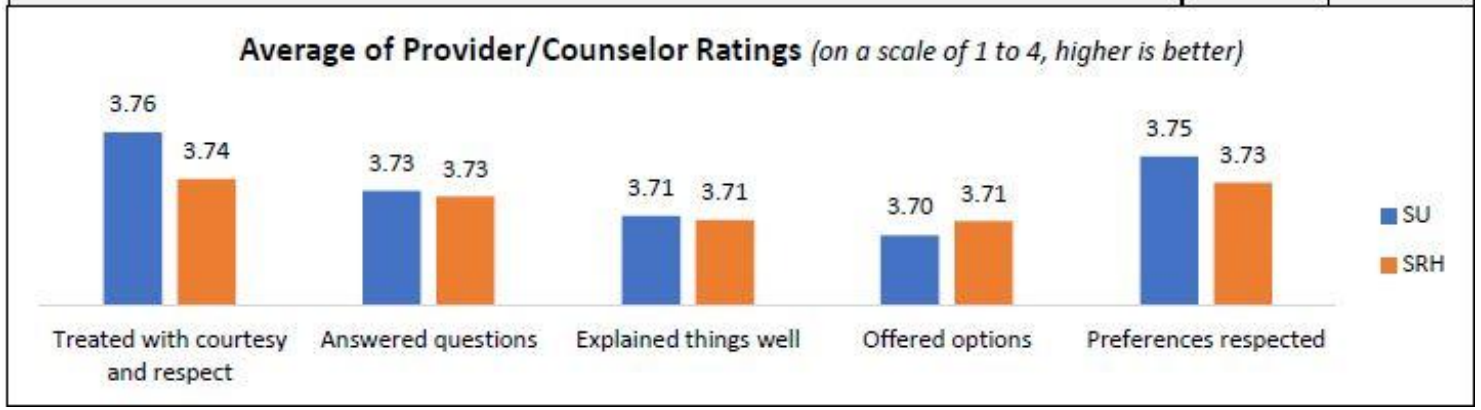
Clinical Measures



Client Experience Survey

Client Experience Surveys

Provider/Counselor Rating Questions (for person providing SRH/SU services) *Rated on a scale of 1 (strongly disagree) to 4 (agree)*	*SU Mean (higher is better)*	*SRH Mean (higher is better)*
The provider/counselor treated me with courtesy and respect.	3.76	3.74
The provider/counselor took time to answer my questions.	3.73	3.73
The provider/counselor explained things in a way I could understand.	3.71	3.71
The provider/counselor offered me options.	3.70	3.71
The provider/counselor respected my preferences.	3.75	3.73
Overall Provider/Counselor Rating. Ideal score > 3.	3.73	3.72



Challenges that impacted implementation:

- **COVID**
  - Closure of in-person services
- **Understaffing**
- **Economic pressures**

THE TOOLKIT

INCREASING LINKAGES BETWEEN SEXUAL AND REPRODUCTIVE HEALTH AND SUBSTANCE USE SERVICE SETTINGS

A Toolkit for Practitioners

Public Health Solutions

Toolkit Overview

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APPENDICES: Appendices can be found in a separate document, which accompanies the main text of the toolkit.	


Someone who wants to lead a QILC
SRH and SU service settings
Who should use this toolkit?
QI specialists
Administrators, medical directors, and head nurses

NAVIGATING AND USING THE TOOLKIT

Icons used to differentiate toolkit elements

Denotes a practical tip, in an orange box.

TIPS FOR SUCCESS

Select more than one QI champion to lead your team.

Your team cannot anticipate all the challenges that may come your way throughout the course of the project. Therefore, we strongly suggest identifying an additional project champion who can lead your team should your primary champion resign or transition to another project.

Denotes a real-world example from the Collaborative, in a green box

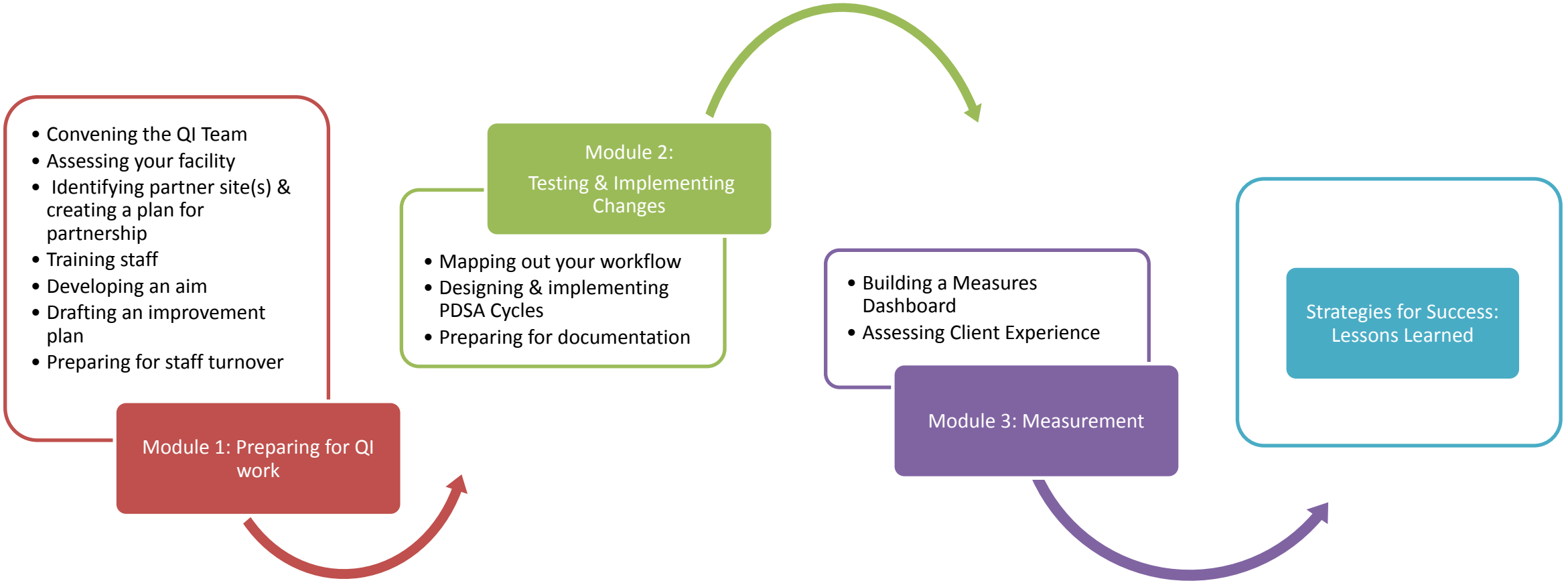
NOTES FROM THE FIELD:

Example AIM Statements

Over the next 12 months, we will

- SU: Assess all clients for SRH needs and increase access to SRH services for persons capable of pregnancy who receive care at our SU site, so that 100% of persons expressing SRH needs are supported in accessing services.
- SRH: Increase access to SRH services for persons capable of pregnancy who receive care at our SU partner site by fast tracking referrals and ensuring that these client's appointments take place within 72 hours (3 days) of referral or sooner.

Toolkit Contents



Module 1: Preparing for QI Work

TIPS FOR SUCCESS

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Your team cannot anticipate all the challenges that may come your way throughout the course of the project. Therefore, we strongly suggest identifying an additional project champion who can lead your team should your primary champion resign or transition to another project.

- Convening the QI Team
- Assessing the Service Site
- Identifying Partner Site(s) & Creating A Plan For Partnership
- Training Staff
- Developing an Aim
- Developing an Improvement Plan
- Preparing For Staff Turnover

NOTES FROM THE FIELD:

Care Provider Buy-In Is Very Important

Having a provider (or multiple) involved in every step of the process is critical to success. You should have at least one provider on board before agreeing to undertake the project.

NOTES FROM THE FIELD:

PAIR QILX sites used Self-Assessment findings to identify elements of improvement and guide AIM statement development.

TIPS FOR SUCCESS

Let staff know they are not expected to become experts in SU/SRH care. They need to know enough to start a conversation.

NOTES FROM THE FIELD:

One PAIR QILC site created a binder with all the project documents for new staff to review during onboarding.

Step 1: Build your team

An effective QI team includes individuals who fulfill the following roles:

1. **Senior leader/project champion**, such as a medical director or executive director, who can advocate for the improvement project within your organization and communicate with the Board of Directors and external organizations, such as grant makers or regulators, about your work. Senior leaders do not need to attend all meetings or participate in all QI activities.[8]

NOTES FROM THE FIELD:

Care Provider Buy-In Is Very Important

Having a provider (or multiple) involved in every step of the process is critical to success. You should have at least one provider onboard before agreeing to undertake the project.

TIPS FOR SUCCESS

Select more than one QI champion to lead your team.

Your team cannot anticipate all the challenges that may come your way throughout the course of the project. Therefore, we strongly suggest identifying an additional project champion who can lead your team should your primary champion resign or transition to another project.

2. **Healthcare provider/clinical champion**, such as a physician or nurse practitioner, who holds authority within the service setting, and can understand the clinical implications of implementing a change in service provision.

3. **Care team member**, such as a nurse, patient care assistant (PCA), clerk, health educator, peer counselor, or Credentialed Alcoholism or Substance Abuse Counselor (CASAC), who is likely to engage with clients during their visit.

4. An **Information Technology (IT)** team member, who has the capacity to configure the EHR or other electronic system to report on key measures such as screening, brief intervention/conversation, and referrals, and pull other data as needed.[9]

5. **Administrative and QI staff**, who can support and lead QI activities, such as the PDSA cycles, data collection, and data analysis. Your team should seek outside support/TA if there is not internal administrative and/or QI staff support with this portion of the project.

Module 2: Testing & Implementing Changes

NOTES FROM THE FIELD:

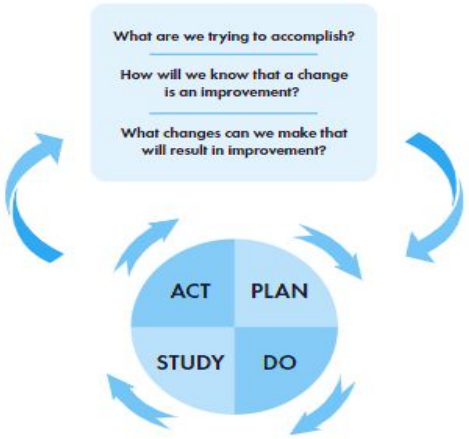
SU Site 1 Workflow: NPs implement screening, provide intervention, and refer clients. Manager of Outpatient Care follows-up on referrals made and received. When testing this new workflow, the Director, QI Analyst, Clinical Supervisor and Manager met periodically to review data, identify gaps, and work with NPs to address areas needing improvement.

- Mapping Out Your Workflow
- Designing & Implementing PDSA Cycles
- Preparing For Documentation

TIPS FOR SUCCESS

Make sure to obtain appropriate patient consent forms so you can communicate with your partner without violating HIPAA.

Figure ii. The Model for Improvement[8]



NOTES FROM THE FIELD:

Changes in EHR formatting take time to implement successfully. Ensure that all EHR systems is ready for documentation prior to the start of the project or that it is the first task completed in the QI improvement project. This will ensure that data on care provided is documented and that the data collected is accurate and easy to access for measuring improvement.

Module 3: Measurement

LIST OF MEASURES

Monthly SRH Dashboard Measures:

- SU Pre-Screening(optional)
- SU Full Screening
- SU Brief Intervention
- SU Referrals Given
- Referral Outcomes

Monthly SU Dashboard Measures

SRH Screening
SRH Brief Conversation
SRH Referrals Given
Referral Outcomes

- Building a Measures Dashboard
- Assessing Client Experience

NOTES FROM THE FIELD:

For SU sites, implementation was conducted with outpatient programs only.

For SRH sites, implementation was conducted with patients at their annual/new visits.

NOTES FROM THE FIELD:

PAIR QILC sites administered PES via paper or via online platforms. Plan to review PES data quarterly or annually depending on service site needs.

TIPS FOR SUCCESS

Remember that if you find that in one month you did not have any new clients to screen, your run charts may appear to show a sharp decline in improvement, but that may simply be due to the number of clients eligible for screening. For other measures, months of work may be required before you see any changes in your data – for example: verification of referrals.

Strategies for Success: Lessons Learned

Developing and Nurturing the QI Team

Selecting and working with partner service setting(s)

Training Staff

Measuring Success

Appendices

- KAP Surveys
- Self-Assessment Templates
- Change Package
- Building Strong Partnerships Worksheet
- Aim Statement Worksheet
- Screening Workflow Planning Worksheet
- PDSA Form
- Measures
- Patient Experience Survey

Publication Pending

Improving Linkages Between Sexual and Reproductive Health and Substance Use Providers: the Partnership to Advance Integrated Referrals

to be published in the...

Quality Management in Health Care Journal

MOVING TO ACTION:
PLANNING FOR IMPROVEMENT WORK AT YOUR SITE

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Public Health Solutions

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  - *The Door – A Center for Alternatives*