Exemplary Professional Practice: Care Delivery System(s)

| EP5 Nurses are involved in interprofessional collaborative practice within the care delivery system to ensure care coordination and continuity of care. |

EP5b: Provide a description, with supporting evidence, of nurses’ involvement in interprofessional collaborative practice that ensures care coordination and continuity of patient care.

Introduction

Addiction is defined as a primary, chronic brain disease characterized by compulsive use despite harm. It is a disease in and of itself. This can be the hardest part for family members, clinicians, and the public to come to terms with because addiction is completely irrational. It is a disease that hijacks the part of the brain that makes rational decisions and weighs risks and benefits. So just like a person with a stroke may be unable to use language or move a part of their body, a person with addiction is literally unable to use the part of the brain that can look at negative consequences and make a rational judgment about using. It is also for many people a chronic disease, meaning that people don’t get “cured” but rather treatment allows an individual to manage their illness and minimize relapses.

The U.S. Department of Health & Human Services describes opioid abuse as a serious public health issue reaching epidemic proportions in the United States. Opioid-related deaths have been on the rise across the country, with Massachusetts surpassing the national average. At the Massachusetts General Hospital, the Emergency Department (Ellison 1/Lunder 1) feels the full impact of this patient population. The Emergency Department cares for over 9,000 substance use disorder (SUD) patients each year, seeing an average of 26 patients per day. Twenty-two percent of SUD patients are admitted to MGH as inpatients or for observation, while the other 78% are discharged by the Emergency Department.

MGH Substance Use Disorder Initiative

In 2014, Massachusetts General Hospital identified substance use disorder as a key clinical priority and designed a broad strategic initiative to improve the quality of care for these patients. MGH recognized the need for SUD care to shift from an acute, episodic approach to chronic care management and developed a new, integrated model with strong connections and linkages between inpatient, outpatient and community based services. This model leverages the clinical talents of the interprofessional team to ensure care is coordinated across the care delivery system and continuity of care is maintained, a key to therapeutic success in this population. Key components of the model include the Inpatient Addictions Consult Team, the Bridge Clinic and Recovery Coaches.
Addictions Consult Team (ACT)

The Addictions Consult Team (ACT) is an interprofessional inpatient consult team of addiction experts providing patient assessment and treatment recommendations including standardized withdrawal management and pharmacotherapy initiation. This inpatient team of internists, psychiatrists, advanced practice nurses, social workers, and recovery coach utilizes a specialized interdisciplinary approach that improves access to treatment, and facilitates transitions between inpatient, outpatient and community care. ACT collaborates with other departments, including Case Management and Pharmacy, to ensure inpatient care is comprehensive and individualized. A physician or nurse practitioner (NP) provides initial consultation and frequently a social worker consultation is indicated as well. A recovery coach is embedded with the ACT / Bridge Clinic to provide peer coaching and support to patients.

The MGH Addictions Consult Team was launched in October of 2014 (attachment EP5b.a) and has been implemented hospital-wide since Dec 2016. ACT leadership includes co-medical directors from Medicine and Psychiatry, Sarah Wakeman, MD and Mladen Nisavic, MD and a Nurse Team Leader, Christopher Shaw, PMHNP-BC, Adult Psychiatric and Mental Health Nurse Practitioner.

Other members of ACT include:
- Hasena Omanovic, MSN, PMHNP-BC (ACT/ Bridge Clinic)
- Marissa De Mirelle, Clinical Social Worker, LICSW
- Lorraine Salada, Clinical Social Worker, LICSW
- Jacqueline Bango, Clinical Social Worker, LICSW
- Nicole Bourgeois, Recovery Coach (ACT/Bridge Clinic)

In addition to the regular staff members listed, Psychiatry and Medical residents rotate on staff, spending 2-4 weeks with the team.
Bridge Clinic

The MGH Bridge Clinic does just that, bridging the treatment gap by providing care to patients who need addiction care, but lack community based providers. This includes inpatients on discharge as well as patients from the ED and primary care clinics. The clinic provides medication management, peer support services, stabilization and linkages /referral to outpatient treatment services. Physicians and Nurse Practitioners provide pharmacotherapy and referrals to outside treatment services/providers, while Recovery Coaches provide peer support services. At a patient’s first Bridge Clinic meeting, the MD or NP, Clinical Social Worker, Recovery Coach and Resource Specialist develop a plan of care with the patient. Recovery Coaches provide peer support services to patients and the Resource Specialist helps with referrals to outpatient/residential programs and seeks out providers in the community able to provide ongoing support to patients once discharged from the Bridge Clinic. Typically patients are supported by the Bridge Clinic for 2-6 months.

Bridge Clinic staff include:
- Dr. Laura Kehoe, MD, Medical Director
- Hasena Omanovic, MSN, PMHNP-BC
- Sophia Volcy, Resource Specialist
- Samantha Ciarocco, LICSW, Clinical Social Worker
- Nicole Bourgeois, Recovery Coach
- Jasmine Webb, Administrative Coordinator

Recovery Coaches

Recovery Coaches provide peer support services to patients. They have all previously struggled with addiction themselves and have proven to be a valuable resource to patients and their families. These Recovery Coaches/community health workers receive formal training and supervision and like the ACT/Bridge Clinic Recovery Coach, are embedded in the Outpatient/Community setting.
- MGH Internal Medicine Associates (IMA): Erin White
- MGH Charlestown: Efran Lozada
- MGH Chelsea: Raina McMahon
- MGH Revere: Michael Phillips
- MGH Bulfinch Medical Group (BMG): Stephen Keizer

Care Coordination and Continuity

An example of the comprehensive approach to care of a SUD patient at the MGH is illustrated with the following example of patient MQ.

On October 1, 2016 MQ, a 29-year old male, was admitted to the Medical Intensive Care Unit (Blake 7) with a severe drug overdose, requiring intubation and mechanical
ventilation. On October 3, 2016, he was transferred to the General Medicine Unit (Ellison 16) and a referral was placed for ACT. Hasena Omanovic, MSN, PMHNP-BC, conducted an initial consultation that same day. She noted that MQ was not interested in any addiction services, but he agreed to accept community resources that might help him on discharge. The following day, October 4, 2016, Marisa De Mirelle, Clinical Social Worker, LICSW, met with MQ and began aftercare planning support (attachment EP5b.b). MQ was identified as a suicide risk by Psychiatry and the decision was made to transfer MQ to an inpatient psychiatric unit. The MGH Psychiatry Unit (Blake 11) was full so Kristen Mohan, RN, BSN, Case Manager coordinated his transfer to McLean Hospital in Belmont, MA, on October 5, 2016. Her note informed the team that MQ would be transferred to McLean Hospital via ambulance at 5:30pm (attachment EP5b.c). On October 31, 2016, following his discharge from McLean, MQ met with Dr. Mary Zeng, M.D. Outpatient Psychiatry. MQ was no longer denying his problematic substance abuse and agreed to Dr. Zeng’s aftercare treatment plan, which included a referral to the Bridge Clinic. MQ had his initial Bridge Clinic visit on November 2, 2016 and continued with the clinic until the end of March 2017. The Bridge Clinic notes written by Omanovic detail that MQ received Suboxone medication, peer coaching and participated in group therapy. On March 8, 2017, Omanovic and MQ reviewed the plan for MQ to transition from the Bridge Clinic to a community based provider at the end of March, 2017 (attachment EP5b.d). Dr. Daniel M Horn, a PCP with Internal Medicine Associates (IMA) assumed primary care for MQ and they met on March 30, 2017. Horn’s note detailed the ongoing plan for suboxone treatment, and monthly visits (attachment EP5b.e).

MQ’s journey demonstrates how a committed interprofessional team collaborates to coordinate care and ensure continuity of care across the care delivery system. The continuity of care provided by Omanovic highlights the key role nurses play in collaborative practice and the ongoing support provided to patients struggling with addiction.