# The Miriam Hospital

# Community Health Needs Assessment Implementation Strategy

# October 1, 2019- September 30, 2022

As a result of the Community Health Needs Assessment (CHNA) prepared for The Miriam Hospital (TMH) as of September 30, 2019, TMH's leadership team, executive management, and other individuals critical to the organizational planning process have created an implementation strategy detailing action item plans covering the period from October 1, 2019 through September 30, 2022 to address the significant needs identified in TMH's CHNA report. Based on the complex health issues in the community, TMH has strategically planned ways to address these significant needs in order to maximize the improvement of the overall health and wellness of residents within its community. As discussed in the September 30, 2019 CHNA, available online at https://www.lifespan.org/sites/default/files/lifespan-files/documents/centers/lifespan-community-health/9-30-2019-TMH-CHNA.pdf, TMH identified the following issues as significant health needs currently facing its community:

1. Access to Care

2. Healthy Weight and Nutrition

3. Cancer

4. Community-based Education and Outreach

5. Mental and Behavioral Health

| **Significant Health Need #1** | **Access to Care** | | |
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| Actions Planned for Implementation | Resources Planned to Address Significant Health Need | Anticipated Impact on TMH Community | Outside groups collaboration |
| 1.1 "Prescribe a Bike"<br>In partnership with JUMP Bike Share, TMH will launch a "Prescribe a Bike" Program in June 2020 for 800 community members annually who will have free access to bikes for one of the following health needs or social determinant of health obstacles:<br>• Access to transportation;<br>• Hypertension;<br>• Diabetes;<br>• History of Cardiac Disease;<br>• Obesity. | 800 memberships to be dispersed at various Lifespan locations, including:<br>• TMH Center for Primary Care;<br>• Lifespan Community Health Institute (LCHI);<br>• Lifespan Cardiovascular Institute (CVI) Clinics;<br>• Ambulatory Clinics;<br>• Women's Medicine;<br>• Orthopedics Institute. | • Increased exercise;<br>• Reduced carbon footprint;<br>• Helmet distribution for safety;<br>• Increased access to reliable/free transportation. | • JUMP Bikes;<br>• American Heart Association;<br>• RI Bike Safety Group. |

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| 1.2 Lifespan affiliates' partnership with the Nonviolence Institute (NVI) will continue to serve the TMH community's access to health through the following ways:<br>• Provide nine street level workers in the Providence area who will work to mitigate the risk and incidence of physical violence, resulting in injury or death in the community;<br>• Connect directly with patients at TMH who have been victims of violence and provide them with access to victim compensation assistance and social workers;<br>• Assist hospital staff in the patient contact and assessment of victim/trauma related incidents. | • Involvement with the NVI at the board and staff level;<br>• Annual donation to the NVI to support its operational overhead. | • Mitigation of injury and death in the community from gang-related violence;<br>• Assistance for victims of such trauma which allows streetworkers to assist patients to apply for victim compensation from state and federal funding streams. | • Rhode Island Nonviolence Institute;<br>• City and State Law Enforcement. |
| 1.3 Opening of the East Greenwich Cardiac Rehabilitation (CR) satellite location to eliminate wait list at Collyer Street location and improve access to care:<br>• Target of referral to enrollment within 2 weeks;<br>• Fill a gap in a demographic area that didn't offer CR. | • Dean Ornish Intensive Cardiac Rehab Program;<br>• Rehab staff;<br>• CR Medical Director and Manager;<br>• Lifespan Design Team. | • Meet the needs of an underserved area regarding cardiac rehab. | • Lifespan Development office;<br>• The Champlin Foundation;<br>• CVI administration. |
| 1.4 In 2020 TMH, in coordination with Lifespan affiliates, will implement "Ride Roundtrip" an initiative to improve patient access to healthcare, improve internal patient navigation that will ultimately provide a better patient experience, and ultimately lead to better health outcomes.<br><br>Leveraging this digital technology is designed to decrease missed patient appointments, thereby increasing access for all patients. The program is expected to significantly reduce patient burdens or difficulties in obtaining rides for crucial appointments. | • Information technology software;<br>• Technical staff;<br>• Administrative staff. | • Program will increase patient access;<br>• Improved patient experience and health outcomes;<br>• Program will alleviate transportation as a barrier to access healthcare. | • External rideshare and transportation companies. |
| 1.5 In coordination with the hospital affiliates, the Lifespan Physician Group, Inc. (LPG) will actively recruit primary care physicians, medical specialists, and advanced practice providers to fill vacancies and match community needs. | • Internal business development staff and outside recruitment firms;<br>• Advertising;<br>• Job fairs. | • Program will increase patient access;<br>• Improved patient experience and health outcomes. | N/A |
| 1.6 In coordination with LPG, explore new models of care delivery with a focus on primary care and lowest cost. | • TMH and LPG management teams, physicians, and community at large. | • Improved patient experience and health outcomes. | N/A |

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| 1.7 LPG intends to open six Urgent Care locations within Rhode Island and Southeastern Massachusetts during fiscal years 2020-2021. | • Facility space;<br>• Capital expenditures and operating funding;<br>• Professional and administrative staff. | • Reduce barriers to access for patients without primary care physicians;<br>• Expand community points of access;<br>• Urgent care services improve health information and limit number of medical records, improving continuity of care. | N/A |
| 1.8 Under management of LPG, expand access to specialty care, including neurosurgery, rheumatology, cardiology, gastroenterology, and ophthalmology. In addition, both spine and pain management services are expected to grow during the next three years. | • Facility space;<br>• Capital expenditures and operating funding;<br>• Professional and administrative staff. | • Improve access to medical and surgical specialties;<br>• Reduce incidence of stroke and improve stroke care. | N/A |
| 1.9 LPG will continue to lead the integration of behavioral health services into primary care practices. | • Professional and administrative staff;<br>• Psychologists. | • Improved access to behavioral health services. | N/A |
| 1.10 Implementation and expansion of technology in interpreter services, including "Interpreter on Wheels". Where appropriate, interpreter services will be made available using laptops and other electronic devices. | • Capital investment | • Improved access to interpreter services, reducing barriers to care. | N/A |
| 1.11 In coordination with the Lifespan accountable care organization (ACO), work collaboratively to transform healthcare delivery through contracting relationships which reward our collective efforts to deliver highly efficient care at the highest level of quality to the satisfaction of not only the patients but also the providers. Part of that effort includes the assignment of care managers to our most complex patients to manage chronic medical conditions as well as address many social determinants that may impact wellness. | • Administrative staff;<br>• Professional staff. | • Improved access to care by improving coordination and integration of services within the medical community. | N/A |
| 1.12 TMH and its Lifespan affiliates have formed a "Patient Access – Strategic Focus" working group whose mission is to improve patient access to services.<br>• Focus areas include reducing barriers to access, system-wide scheduling, reducing patient cancellations, referral guidance, and patient tracking.<br>• "Patient Access – Strategic Focus" working group leads a telehealth initiative which represents the interactive electronic exchange of information for the purpose of diagnosis, intervention, or ongoing care management between a patient and/or health care provider situated remotely. | • Administrative staff;<br>• Professional staff;<br>• Capital investment and operating funding. | • Improved access to care by reducing barriers, improving coordination, and reducing cancellations;<br>• Provide the community with real-time virtual visits, remote patient monitoring, and real-time secure confidential messaging. | N/A |

| **Significant Health Need #2** | **Healthy Weight and Nutrition** | | |
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| Actions Planned for Implementation | Resources Planned to Address Significant Health Need | Anticipated Impact on TMH Community | Outside groups collaboration |
| 2.1 Program Orientation Sessions:<br>• Attendance at a free orientation session is required prior to enrollment. Efforts are made to increase access to the TMH Weight Management Program by making it easy to attend orientation.<br>• Orientation sessions are held at least weekly in Providence and as needed in East Greenwich.<br>• The program's health educator meets one-on-one with any patient requiring an interpreter and is also available to meet with any patient who cannot attend any of the scheduled sessions.<br>• For patient convenience, there is also an on-line orientation session that averages ten participants per month. | • Professional staff;<br>• Clinical staff;<br>• Administrative support;<br>• Physical space. | • Program patients will improve their health outcomes through improved weight management. | • Collaboration and professional partnerships with primary care physicians and other specialists. |
| 2.2 Program offerings and anticipated expansion at both Providence and East Greenwich locations of the Center for Weight & Wellness (CWW):<br>• Yoga sessions and fitness classes are currently offered to current and past Center for Weight & Wellness (CWW) patients.<br>• Expansion of community participation anticipated with a formalized primary care provider clearance process.<br>• CWW expects to expand the health and wellness education options for patients by piloting the Weight and Wellness Academy - offering four-week supplemental courses on a variety of health and wellness topics. This experience has also influenced some new approaches for FY '20.<br>• For FY '20, increased emphasis on improving wellness is now reflected through available wellness programs such as "Your Choice, Your Weight!" and Stress Management.<br>• Also for FY 20, TMH has introduced "Hypnosis for Weight Loss", a new approach aimed at helping patients in overcoming barriers to adopting healthy habits and achieving a healthy weight. | • Professional staff;<br>• Clinical staff;<br>• Administrative support;<br>• Physical space. | • Program patients will improve their health outcomes through improved weight management. | • Collaboration and professional partnerships with primary care physicians and other specialists. |

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| East Greenwich:<br>• In FY '19, the East Greenwich CWW location piloted a teen weight and wellness program (ages 14-18).<br>• The program has been successful, but with a small number of patients.<br>• As of 1/1/2020, the program has expanded to the Providence location.<br>• Currently, the physician leader and other team members are meeting with community pediatricians, Hasbro Children's Hospital clinicians and others to promote the program and clarify the referral process.<br><br>Corporate Weight and Wellness:<br>• In FY '19 and into FY '20, the CWW team is delivering an on-site weight and wellness program to employees at a small company in Jamestown, RI. Sixteen employees are participating in the weight management or wellness programs being offered.<br>• Efforts to promote this option to other businesses are on-going.<br><br>Community Education/Collaboration:<br>• TMH plans to continue an annual *Simple Seven* (health fair) at the Providence location to provide information and educate current and former patients, Lifespan employees, and community members. The session offers brief lectures on nutrition, weight control, stress management, and fitness. Brief yoga and fitness classes will be offered during the event, as well as blood pressure screenings, weight/body fat analysis.<br>• In Spring 2020, CWW plans a *"Know Your Numbers*" community event to emphasize the importance of monitoring blood pressure, cholesterol, BMI, body fat, waist circumference, weight, etc. Educational materials and sessions will be offered, as well as several stations offering on-the-spot screenings. This event will be held in our Providence location.<br>• CWW continues to collaborate with the Center for Bariatric Surgery and offers a post-bariatric support group on a monthly basis.<br>• When a CWW patient is a candidate for bariatric surgery, CWW medical providers explore that option with him/her and when there is interest, makes a referral to the Center for Bariatric Surgery. | | | |

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| • CWW continues to take referrals from the Center for Bariatric surgery for pre- and post-bariatric surgery weight loss.<br>• CWW offers quarterly newsletters that educate and spotlight the success of patients in the program. About 2,500 copies of these newsletters are delivered to local primary care and specialist offices for use with their patients | | | |
| 2.3 Offer a variety of weight loss strategies available to Cardiac, Pulmonary, Vascular Rehab, and Health for Life Participants<br>• Enrollment for multiple Weight Loss studies;<br>• Enrollment for Weight Loss track;<br>• One-on-one consult with nutritionist. | • CR nutritionist;<br>• Staff behavioral therapist. | • Participants are learning effective weight loss strategies and are exposed to plant-based and Mediterranean diets to improve weight loss outcomes. | N/A |
| 2.4 Relationship with Johnson Wales University<br>• 40 hours-a-week culinary intern offers Supermarket Tours and Cooking demonstrations for patients with cardiac, pulmonary, and vascular disease. | • Johnson & Wales University student intern. | • Enhances everyone's knowledge to shop, purchase, and cook in a heart-healthy fashion, resulting in better lipid and weight loss outcomes. | • Local grocery market;<br>• Johnson & Wales University. |
| 2.5 Organize "Food is Medicine" in hospital, community, and school settings.<br>• This free, four-week class teaches participants how to prepare affordable and nutritious meals in order to improve their health, all on a limited budget. The Miriam Hospital plans to offer the "Food is Medicine" series in its service area in each of fiscal years 2020-2022. | • Professional staff;<br>• Administrative staff;<br>• Cooking and dietary supplies;<br>• Facility space. | • Participants will learn how to decrease their risk of obesity and related chronic diseases, as well as practice cooking healthy meals. | N/A |
| 2.6 Offer the CDC-recognized Diabetes Prevention Program<br>• The Diabetes Prevention Program (DPP) is a lifestyle change program targeting people at risk of developing Type 2 diabetes, helping to prevent or delay the onset of this chronic disease. Currently available in English and Spanish, the program consists of weekly one-hour sessions for the first six months that taper off to bi-weekly, then monthly sessions for the next six months. The program is free and participants, who must be at least 18 years old to join, receive free program materials. The program will offer a free cohort of the year-long DPP in each of fiscal years 2020-2022. | • Professional staff;<br>• Administrative staff;<br>• Cooking and dietary supplies;<br>• Facility space. | • Taught by a trained Lifestyle Coach, the program will provide information, support, and accountability for participants to maintain healthy lifestyle changes. Program goals include weight loss and increased physical activity | |

| **Significant Health Need #3** | **Cancer** | | |
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| Actions Planned for Implementation | Resources Planned to Address Significant Health Need | Anticipated Impact on TMH Community | Outside groups collaboration |
| 3.1 Recruitment of physicians for growth of the cancer research program that will allow the TMH community access to state-of-the-art research care and expertise. | • Brown Medicine and Lifespan recruitments. | • Expansion of the research protocols being offered to our community offers options for patients to be treated by the care teams known to them and closer to home and family. | |
| 3.2 Addition of navigation support, both clinical and non-clinical, to assist patients through the cancer experience as well as supporting community health events. | • TMH financial support. | • Navigation helps to support interprofessional practice among caregivers in the community as well as providing advocates at community events throughout the state. | • Gloria Gemma Foundation. |
| 3.3 Implementation of a colorectal multidisciplinary clinic at TMH. | • Physical space on campus;<br>• MD/Radiation/Surgical support. | • Patient-centered care at TMH that allows patients to have one visit that includes all the disciplines for a plan of care. | |
| **Significant Health Need #4** | **Community-based Education and Outreach** | | |
| Actions Planned for Implementation | Resources Planned to Address Significant Health Need | Anticipated Impact on TMH Community | Outside groups collaboration |
| 4.1 Cancer Care<br>• Organize the annual Rise Above Cancer 5K Event (last held on 7/20/2019);<br>• Continue Skin Cancer screenings and detection;<br>• Continue smoking cessation program called “Tar Wars”;<br>• Lunch and Learn Series based at TMH for patients and caregivers. | • Financial support from TMH as well as Lifespan staff support throughout the system;<br>• All the noted events bring healthcare prevention/screening, as well as awareness, into the community;<br>• Community partners for the events. | • Participants will improve their health outcomes through improved education, awareness, healthy living, and health screening. | N/A |

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| 4.2 Congestive Heart Failure (CHF Clinic and outreach)<br>• Post-hospitalization follow up visit within 5-7 days;<br>• Continuity of care through better coordination of services and communication with internal and external multidisciplinary teams;<br>• Expanded guidelines re: directed medical therapy to optimize quality of care in the ambulatory setting;<br>• Improved patient education to better support transition from one care setting to the next;<br>• Increased utilization of palliative care to better align with patient needs. | • Professional staff;<br>• Clinical staff;<br>• Administrative support;<br>• Financial support;<br>• Outpatient pharmacy;<br>• Visiting nurse services;<br>• Telehealth capabilities;<br>• Hotline. | • Provides education and professional support to the community, which will improve the care for patients with chronic illness | • Collaboration and professional partnerships with primary care, visiting nurse agencies, infusion centers, physicians, and other healthcare specialists. |
| 4.3 Increase referrals to Cardiac Rehab (CR) through the implementation of:<br>• BPA for CVI physicians in the ambulatory office setting;<br>• Workflow modifications to allow APP's to refer to CR;<br>• Additional access to the CR referral from inpatient setting prior to hospital discharge;<br>• Patient consults at the bedside. | • EPIC team;<br>• NP's, PA's;<br>• CVI Physicians;<br>• CVI Quality Council;<br>• CR Medical Director and Manager;<br>• Rehab clinicians. | • Reach a wider population of eligible candidates with cardiac disease;<br>• Improve enrollment and participation in CR, resulting in improved clinical and psychosocial outcomes and positive impact on morbidity and mortality. | N/A |
| 4.4 Improve education and awareness to health care providers regarding benefits of CR for the purpose of secondary prevention through:<br>• Grand rounds;<br>• Departmental in-services;<br>• Presentations at faculty meetings. | • CR Medical Director and Manager. | • An increase in referral and utilization of CR provides a positive outcome on the management of heart disease in the community. | N/A |
| 4.5 Improve education and awareness to community members regarding cardiac disease management through presentations:<br>• On Spanish radio channel;<br>• At Mended Heart meetings;<br>• Lifespan Community lecture series;<br>• Wellness and Health fairs;<br>• Channel 10 Health Check;<br>• Family Nights (an evening of education for family members);<br>• LVAD & HF support group for individuals and family members. | • CR Medical Director and Manager;<br>• CR staff. | Education provided to community members to better understand:<br>• Available education, resources, and services for cardiac disease management;<br>• Benefits of risk factor management regarding disease progression. | Collaboration with:<br>• Lifespan Marketing and Communications;<br>• Lifespan community wellness;<br>• Mended Hearts;<br>• CVI MD's. |
| 4.6 Offer Outpatient Diabetes Management<br>• Offer 6-week workshops for individuals with diabetes and their family members – 2 hours a week for 6 weeks. | • Diabetes nurse educator;<br>• Dietician;<br>• Pharmacist. | • Improve the management and outcomes for diabetic individuals in the community. | N/A |

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| 4.7 Offer Tobacco Consultant Program- offered to individuals who currently use tobacco products or who have quit in the past 6 months. | • Tobacco consultant. | • Improve outcomes associated with smoking cessation for individual with cardiac or pulmonary disease. | N/A |
| 4.8 Offer Pulmonary Disease Management for patients with COPD and respiratory problems. | • Pulmonary Rehab clinical staff, medical director, and respiratory therapist;<br>• Liquid Oxygen system. | • Improve quality of life for individuals with pulmonary disease. | N/A |
| 4.9 Offer Health for Life Cardiac Risk Reduction Program – Offer exercise, behavior modification, and risk reduction class for the purpose of primary prevention. | • CR staff;<br>• Nutritionist;<br>• Behavioral therapist;<br>• Tobacco specialist;<br>• Diabetes Nurse. | • Reduce risk for MI through risk reduction strategies. | N/A |
| 4.10 Charity fundraising- Annual participation in the American Heart Association Heart Walk. | • CR staff and patients. | • Raise awareness and funds to support AHA in reducing heart disease through research. | • American Heart Association. |
| 4.11 Offer small group Heart Failure education classes. | • Cardiac fellow. | • Provides education to improve symptom management, medication compliance, and adherence to sodium restrictions to help reduce heart failure readmission rates and improve quality of life. | N/A |
| 4.12 In coordination with Lifespan affiliates, continue to provide community-based education programs like Avenues of Healing, tobacco cessation programs, and Cancer Survivors Day events.<br><br>Avenues of Healing is an annual breast cancer educational conference designed for breast cancer survivors and their families, friends, caregivers, and other support groups. This free program attracts hundreds of participants every year who come to learn about the latest in treatment, research, and healthy survivorship. Delivered by the Lifespan Community Health Institute (LCHI) in partnership with the Lifespan Cancer Institute and American Cancer Society, each year's conference includes a keynote speaker, panel presentations, a resource fair, and a hot and healthy brunch menu. Lifespan expects to serve at least 150 women in each of fiscal years 2020-2022 with a breast cancer education program and will work to engage additional partners to reach a diverse audience. | • Financial support from TMH as well as Lifespan staff support throughout the system;<br>• All the events bring healthcare prevention/screening as well as awareness into the community;<br>• Community partners for the events. | • Participants will improve their health outcomes through improved education, awareness, healthy living and health screening. | • American Cancer Society. |

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| 4.13 In partnership with TMH's Lifespan affiliates, organize with schools, employers, and churches to offer educational workshops/programs at their locations.<br>• The programs will deliver primary and secondary prevention information. The LCHI will track the number of organizations with which it partners and will formalize its partnerships with large agencies as measured by signed partnership agreements.<br>• Continue to offer a health literacy course that includes guidance on how patients should interact with their providers and appropriate emergency department utilization. Healthwise is a free, 1.5-hour course designed to help participants make informed decisions about their health, prepare for a medical visit, and learn the essential questions to ask their provider. The LCHI plans to deliver quarterly Healthwise classes, serving at least 50 adults in each of fiscal years 2020-2022. | • Professional staff;<br>• Administrative staff;<br>• Operational funding. | • Participants will improve their health outcomes through improved education, awareness, healthy living, and health screening. | • Providence school system;<br>• Community employees and religious organizations. |
| **Significant Health Need #5** | **Mental and Behavioral Health** | | |
| Actions Planned for Implementation | Resources Planned to Address Significant Health Need | Anticipated Impact on TMH Community | Outside groups collaboration |
| 5.1 In response to the opioid epidemic in Rhode Island, Governor Gina Raimondo assembled an Overdose Prevention and Intervention Task Force to develop a strategic plan for addressing this public health crisis. The initial action plan emphasized the strategic pillars of prevention, rescue, treatment, and recovery. In 2019, this action plan was updated to build upon past accomplishments and progress made. This revised plan proposes five additional cross-cutting principles that aim to guide future initiatives, including: integrating data to inform crisis response; meeting, engaging, and serving diverse communities; changing negative public attitudes on addiction and recovery; universal incorporation of harm-reduction; and confronting the social determinants of health.<br><br>The Lifespan system is uniquely positioned to participate in these state initiatives to have a significant impact on the opioid epidemic. This mission can be achieved by leveraging expertise across the system and improving access to and awareness of lifesaving behavioral health services. | • Professional staff;<br>• Clinical staff;<br>• Administrative support. | • Existing and prospective patients will have greater access to evidence-based treatment for substance use disorders, therefore minimizing negative consequences associated with the untreated disorder. | • Collaboration with state agencies and community-based organizations. |

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| 5.2 In fiscal year 2020, Lifespan will build upon existing capabilities to ensure that patients meeting criteria for a substance disorder are appropriately assessed and linked to treatment. In clinical settings across the system, patients presenting with a substance use disorder will be systematically identified through validated screening measures as part of the standardized initial admission assessment. Comprehensive evaluations will provide treatment recommendations and linkage to community care in a timely manner. Assessment and treatment initiation will continue to occur at various entry points, to meet patients where they are at, and enhance the likelihood of treatment access/retention.<br><br>Lifespan Clinical Settings – Lifespan Recovery Center (LRC):<br>• The LRC provides multidisciplinary, recovery-oriented services and emphasizes rapid access to treatment. The LRC specializes in addressing substance use and common co-occurring psychiatric conditions through counseling and pharmacology. Over the next year, the LRC will continue to focus on partnering with key stakeholders to meet the needs of the community and educate regarding available services. For example, clinicians at the LRC are collaborating with Newport Hospital and the "No Wrong Door" initiative to participate in ARISE trainings to develop family- and community-based strategies for supporting individuals with substance use disorder. The LRC is also working toward establishing a "low-threshold" model of addiction treatment that emphasizes engagement and harm reduction to reduce barriers to care. Features of this model include performing unobserved (home) medication inductions and offering walk-in services that do not require adhering to a formal appointment. | • Professional staff;<br>• Clinical staff;<br>• Administrative support;<br>• Electronic medical records;<br>• Physical space;<br>• Harm-reduction materials (e.g., naloxone, fentanyl test strips). | • Improved access to treatment;<br>• Increased treatment engagement and retention rates;<br>• Greater access to rescue/harm-reduction materials;<br>• Enhanced patient experience by addressing psychosocial aspects of care (e.g., medical/psychiatric comorbidities; social determinants of health);<br>• Decreases the negative impact of substance use disorders. | • Collaboration with state agencies (e.g., Department of Corrections, No Wrong Door initiative); collaboration across Lifespan system; collaboration with community-based organizations. |

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| • Pawtucket Counseling Services (PACS): The PACS program, offered through Gateway Healthcare, Inc., a Lifespan affiliate, is a frequent touch-point for individuals with legal involvement secondary to substance use disorders. Through its role in providing court-ordered substance use counseling, PACS serves the critical role of identifying and referring individuals who may benefit from medications for substance use disorders. | | • Through state grant funding, this program is working to address the needs of vulnerable populations such as those with criminal justice involvement. For example, the Corrections to Community program provides substance use assessments and appropriate referrals to inmates preparing for community reentry. | |
| • Medical Inpatient Services: The Substance Use Consult Service takes a multidisciplinary approach to identifying substance use disorders, initiating medication when appropriate, and providing timely discharge planning to community-based care in collaboration with internal medicine physicians. This approach emphasizes initiating substance use treatment while patients are medically admitted, to capitalize on readiness to change and provide stabilization. | | • Increases treatment engagement/retention in the community following discharge. | |
| • TMH Emergency Department (ED): Lifespan provides routine trainings to educate physicians about the nature and treatment of substance use in order to promote opportunities for intervention in the ED. Significant efforts are underway to increase the number of Drug Addiction Treatment Act (DATA) waivered physicians who are capable of initiating buprenorphine in this setting. | • Lifespan is currently in the process of creating "buprenorphine kits" that providers can order to minimize barriers to prescribing buprenorphine. It is anticipated that the kit will include medication, dosing instructions, and harm reduction materials (e.g., naloxone, fentanyl test strips, etc.). | • Implementation of this program will facilitate an increase in the number of patients initiated on buprenorphine in the ED, as well as providing post-discharge access to rescue materials. | |

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| Other Initiatives:<br><br>• Lifespan Psychiatry and Behavioral Health Access Center (The Access Center): The Access Center provides a streamlined way for patients to make an appointment or be referred to the appropriate resource for adult psychiatry outpatient programs. | • In fiscal year 2020, Lifespan will work toward establishing an Access Center that specializes in triaging calls specific to substance use disorders to link patients to the appropriate treatment setting. | • Creating a centralized intake center for this population will allow for seamless access to treatment "on demand" and will improve integration across the system. | |
| • Education and Culture Change: Lifespan will continue to provide educational opportunities within the internal hospital community and the larger medical and psychiatric community, as well as the broader public, to strengthen understanding of substance use disorders and reduce negative attitudes. | • The David C. Lewis, MD, Fellowship in Addiction Medicine at TMH will continue to provide critical training to internal medicine physicians to increase the number of providers specializing in evidence-based addiction treatment. | | |
| • Research: Lifespan remains committed to supporting lifesaving research aimed at better understanding and addressing substance use disorders, particularly opioid use disorder. Researchers across the system continue to apply for and receive funding from a variety of external funding sources to improve evidence-based practice. | • Recently received an $11.8 million federal grant to create the Center of Biomedical Research Excellence (COBRE) on Opioids and Overdose. | • The intent of the COBRE grant is to establish leadership and mentorship by experienced researchers, overseeing and supporting the work of three to five junior investigators in thematic, multidisciplinary centers, until those researchers establish a body of work to enable them to secure their own independent funding. Over the possible 15-year span of COBRE's three phases, this will build capacity and expertise in a critical area such as opioid use disorder. | |

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| 5.3 Implementation Strategy for 2021 and 2022:<br>In fiscal years 2020 and 2021, Lifespan's goal is to continue to strengthen existing capabilities and promote integration across the system, facilitate rapid access to treatment through the development of innovative clinical models, and provide patient-centered care that meets a range of needs by creating other levels of care. These initiatives will include the establishment of:<br>A. A low-threshold transitional clinic for the treatment of substance use disorders. Drawing from existing models of care in other large hospital systems, there is evidence to support the utility of offering a "bridge" clinic to patients that are not yet established in outpatient addiction care. These types of programs emphasize treatment on demand by offering walk-in services seven days per week. The goal of this program is to engage patients in treatment, stabilize, and eventually refer to a long-term outpatient setting. Data derived from the Massachusetts General Hospital "Bridge Clinic" reported that over 800 patients had attended at least one treatment visit since it's opening. Of these 800 clinic visits, approximately 50% of those visits were not scheduled in advance. This highlights the importance of lowering the requirements for treatment entry to promote easy access when patients are ready to seek help.<br>B. Other levels of care to support the varied clinical needs of patients. While outpatient treatment is generally safe and effective for many individuals, there is a growing need to offer more intensive services to those who are struggling to stabilize. Further, TMH continues to witness higher rates of polysubstance use across its community (e.g., opioid and cocaine use). This clinical presentation may benefit from alternative intervention strategies, particularly since there are no current pharmacological treatment options to address cocaine use disorder.<br>C. Specialized programs to address vulnerable/under-represented populations. Significant strides have been made to increase access to evidence-based treatment for opioid use disorder, however, the focus of these efforts have primarily been on adult populations. Current addiction treatment models are generally ill-equipped to manage the needs of adolescents and young adults. Further, many physicians are reluctant to provide | | • Establishes a range of levels of care, such as outpatient, IOP, and PHP, and will thus ensure that the needs of TMH's patients are being fully met.<br><br>• Leverages the expertise of EIH providers/resources at Hasbro Children's Hospital and Emma Pendleton Bradley Hospital, thus Lifespan will be able to fill an important gap in the continuum of care for this vulnerable | |

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| medications for opioid use disorder to this age group. Recent reports suggest that <25% of adolescents and young adults diagnosed with opioid use disorder are prescribed medication; among those younger than 18 years of age, <2% receive medication. These statistics are especially disheartening considering the abundance of research supporting the efficacy of medication in addressing opioid use and preventing future incidence of overdose. The American Academy of Pediatrics has called on pediatricians to play a vital role in the assessment and treatment of substance use disorder among adolescents and young adults. Using an integrated primary care – behavioral health approach, pediatric practices are uniquely positioned to increase access to lifesaving addiction treatment. | | population that traditionally has been excluded from evidence-based treatment. | |
| 5.4 Offer behavioral therapy counseling for behavioral change strategies pertaining to risk reduction for patients with cardiac and pulmonary disease;<br>Offer psychology intervention for psychosocial counseling pertaining to depression, anxiety, and adjustment to illness for individuals with cardiac and pulmonary disease. | • Behavioral psychologist | • To improve the overall emotional wellbeing of individuals with cardiac or pulmonary disease;<br>• To improve the individual's cardiac risk through the implementation of behavior modification strategies. | N/A |

# Conclusion

The Miriam Hospital Implementation Strategy report was authorized and approved by The Miriam Hospital Board of Trustees on February 11, 2020.

TMH will document progress on the implementation strategies presented as part of its commitment to the community it serves each year in its Form 990 tax return filings as required by the IRS. TMH appreciates the continued support of its partners, recognized below, which help it meet the health care needs of Rhode Islanders. Questions or comments on the TMH CHNA or Implementation Plan may be submitted to:

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