Edith Baker Integrated Healthcare Fellowship
Behavioral Health Workforce Education and Training Program
University of Pittsburgh School of Social Work
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2019-20 Student Research Projects
PURPOSE OF THE BEHAVIORAL HEALTH WORKFORCE EDUCATION AND TRAINING (BHWET),

EDITH M. BAKER INTEGRATED HEALTHCARE FELLOWSHIP

University of Pittsburgh School of Social Work was awarded a grant from the Health Resources and Services Administration (HRSA) through the Behavioral Health Workforce Education and Training (BHWET) Program to fund the Edith Baker Integrated Healthcare Fellowship. The Edith M. Baker Integrated Healthcare Fellowship is designed to prepare social workers to meet the needs of individuals in integrated health care settings in rural and metropolitan medically underserved areas. A special emphasis is placed on expanding field placements in behavioral health. Interdisciplinary training is provided for students, faculty, and field instructors to assure quality behavioral health services to communities in need. The fellowship connects the School of Social Work, the University of Pittsburgh School of Medicine, Division of Family Medicine, and major providers of primary care in the region to provide training for social work students in sites that offer behavioral/mental health services. This training grant will provide funding to 112 advanced standing and second-year Master of Social Work students over four years.

The Baker Integrated Healthcare Fellowship provides students with specialized coursework that addresses treatment models, policy and social work practice for integrated health care. Appropriate coursework is integrated with experiential learning in their field placement training opportunities. In addition, the students participate in career development workshops, a regional summit, poster presentation event, biweekly seminars, weeklong interdisciplinary Medical School course, two medical forums sponsored by the Working Group on Interprofessional Education, and our annual co-sponsored training event with the University of Pittsburgh, Children’s Hospital Leadership Education in Neurodevelopmental and Related Disabilities (LEND) Program.

Newly created and expanded field placement opportunities have been developed in rural and medically underserved areas, surrounding Allegheny County. Most of the organizations are Federally Qualified Health Centers (FQHC) where integrated behavioral health training in psychiatry, behavioral pediatrics, psychiatric nursing, substance use disorder prevention and treatment, marriage and family therapy, and occupational therapy is occurring.
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An Examination of Secondary Traumatic Stress
UPMC Presbyterian-Shadyside
Melanie Di Bello, Amanda Harris, and Hayley Sweitzer

Background
Social workers, regardless of specialization, are often called to bear witness to the trauma of others and face a high rate of professional contact with traumatized persons. Secondary traumatic stress (STS) is the sequelae of continued, close contact with victims of trauma and is believed to be one cause of social workers’ departure from the field prematurely. The symptoms of STS mirror the symptoms of posttraumatic stress disorder (PTSD) in individuals with direct trauma exposure, e.g. avoidance, arousal, and intrusion. Furthermore, PTSD is directly related to poor physical and emotional health outcomes. These long-term adverse outcomes are believed to extend to those who experience high levels of STS.

Literature on STS focuses on the experience of social workers who hear the retelling of their clients’ trauma in a post hoc therapeutic setting. Hospital social workers experience an individual’s trauma in a different way; they interact with individuals in the critical hours after the traumatic event. Therefore, they not only hear the retelling of a client’s story, but bear witness to the client’s physical injuries and resulting terror. These experiences are unique to social workers in a hospital setting and their impact has not been systematically explored in trauma research. The present study hopes to fill this research gap by investigating the prevalence of STS in hospital social workers. A literature review of mediating factors revealed that an individual’s trauma history, level of social support, and years of experience in the social work field are related to STS. Since it has been observed that many of the UPMC social workers have spent decades in a traumatic environment, the authors of the current study chose to investigate the relationship between years of experience in the field and the experience of STS.

Methods and Results
An anonymous electronic survey was sent to approximately 50 social workers employed by UPMC Presbyterian-Shadyside with a response rate of 60 percent (n=30). The survey included basic demographic questions, length of time in the social work field, and the Secondary Traumatic Stress Scale. The STS scale is a 17-item Likert style self-report instrument which has demonstrated both validity and internal consistency. A Pearson’s r data analysis for years in the social work field (M=8.16, SD=8.27) and secondary traumatic stress score (M=39.76, SD=10.02) revealed a weak to moderate negative correlation, r=-0.36. Individuals who worked longer in the field experienced less secondary traumatic stress.

The results of the independent sample t-test indicated there was a significant effect between STS score and years in the field, t (29)=-11.23, p<0.05.

Discussion and Implications for Social Work
The purpose of this study was to investigate the prevalence of STS in a sample of UPMC social workers and the relationship between the experience of STS and years working in the social work field. Figure 1 shows the distribution of STS scores. More than half of the sample, 63 percent, had STS scores of moderate or higher. Figure 2 displays the negative correlation between years in the field and STS score where the more time spent in the field led to lower experiences of STS. This study not only shows that the majority of social workers display moderate to high levels of STS but also indicates that new social workers experience STS at a higher rate than seasoned social workers.

A possible explanation for this occurrence is that seasoned social workers possess more refined coping mechanisms to protect them from the potentially devastating effects of working in a traumatic environment. A multitude of mediators are most likely at work in this relationship making it crucial that the social work profession work to mitigate the impact of secondary exposure to trauma, especially for those most vulnerable to its effects.

Limitations
There are possible limitations for this study. First, a larger sample size would have allowed for more precise statistical analysis. Another possible limitation is the fact that more than half of respondents had worked in the field for less than 10 years which may have skewed the results. Lastly, our survey did not include questions regarding the participants’ trauma history and adverse childhood events, possible confounding variables, due to concerns about approval from management. To better understand the mediators of STS in social workers, future studies should explore how trauma history affects the experience of STS.
An Examination of Secondary Traumatic Stress
Authors: Melanie Di Bello, Amanda Harris, and Hayley Sweitzer
Edith M. Baker Integrated Healthcare Fellowship

Background
Social workers, regardless of specialization, are often called to bear witness to the trauma of others and face a high rate of professional contact with traumatized persons. Secondary traumatic stress (STS) is the sequelae of continued, close contact with victims of trauma and is believed to be a cause of social workers’ departure from the field prematurely.1 The symptoms of STS mirror the symptoms of posttraumatic stress disorder (PTSD) in individuals with direct trauma exposure e.g. avoidance, arousal, and intrusion. Furthermore, PTSD is directly related to poor physical health outcomes, interpersonal problems, substance misuse, and other mental health disorders such as anxiety and depression.2 These long-term adverse outcomes are believed to extend to those who experience high levels of STS.1,2

Relevance and Research Question
Literature on STS focuses on the experience of social workers who hear the retelling of their clients’ trauma in a post hoc therapeutic setting. Hospital social workers experience an individual’s trauma in a different way; they interact with individuals in the critical hours after the traumatic event. Therefore, they not only hear the retelling of a client’s rape but bear witness to the client’s physical injuries and resulting terror. They see persons who are badly maimed, and they are present with parents in the moment they are told their child has died. These experiences are unique to social workers in a hospital setting and their impact has not been systematically explored in trauma research. The present study hopes to fill this research gap by investigating the prevalence of STS in hospital social workers. A literature review of mediating factors revealed that an individual’s trauma history, level of social support, and years of experience in the social work field are related to STS.3 Since it has been observed that many of the UPMC social workers have spent decades in a traumatogenic environment, the authors of the current study chose to investigate the relationship between years of experience in the field and the experience of STS.

Methods
The current study utilized a cross-sectional survey design to gather data using an anonymous electronic survey that was sent to approximately 50 social workers employed by UPMC Presbyterian-Shadyside with a response rate of 60 percent (n=30). The survey included basic demographic questions, length of time in the social work field, and the Secondary Traumatic Stress Scale. The STS scale is a 17-item likert style self-report instrument which has demonstrated both validity and internal consistency.1

Results and Discussion
A Pearson’s r analysis for years in the social work field (M=8.16, SD=8.27) and secondary traumatic stress score (M=39.76, SD=10.02) revealed a weak to moderate negative correlation, r = -0.36. Individuals who worked longer in the field experienced less secondary traumatic stress. The results of the independent sample t-test indicated there was a significant effect between STS score and years in the field, t(29) = -1.23, p < 0.05.

The purpose of this study was to investigate the prevalence of STS in a sample of UPMC social workers and the relationship between the experience of STS and years working in the social work field. Figure 1 shows the distribution of STS scores. More than half of the sample, 63 percent, had STS scores of moderate or higher. Figure 2 displays the negative correlation between years in the field and STS score where the more time spent in the field led to lower experiences of STS. This study not only shows that the majority of social workers display moderate to high levels of STS but also indicates that new social workers experience STS at a higher rate than seasoned social workers.

Implications for Social Work: A possible explanation for this occurrence is that seasoned social workers possess more refined coping mechanisms to protect them from the potentially devastating effects of working in a traumatogenic environment. A multitude of mediators are most likely at work in this relationship making it crucial that the social work field work to mitigate the impact of secondary exposure to trauma, especially for those most vulnerable to its effects.

References

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Assessing CMS Standards of Discharge Planning
UPMC Magee-Womens Hospital
Haley Martin and Audrey Wrobel

Background
Readmission rates and patient length of stay are two significant concerns for hospitals. These events accumulate thousands of dollars in unnecessary costs. Research concludes that appropriate discharge coordination significantly decreases the patient’s length of stay as well as reduces readmission rates. In 2012, the Center for Medicare and Medicaid Services (CMS) implemented a standard of discharge guidelines and further reduced reimbursement rates to hospitals with excessive readmissions. As a result of these implementations, healthcare facilities must prioritize timely and effective discharge plans to foster successful patient outcomes.

Research Questions
As of November 29, 2019, the CMS updated their discharge planning regulations for acute care hospitals. One criterion states the patient’s evaluation must be made on a timely basis in order to avoid delays in discharge and to ensure appropriate post-hospital arrangements. At Magee, social workers as well as care managers conduct patient psychosocial interviews to develop discharge plans with the patient’s goals in mind. As related to timelines of interventions, the evaluation sought to conclude if social workers and care managers at UPMC Magee were conducting initial patient interviews in a timely manner; furthermore, is timeliness of the interview related to patient length of stay in the hospital?

Method
Chart audits utilizing Cerner EMR were conducted on 60 randomly selected patients who were admitted to UPMC Magee’s medical-surgical units between November 1, 2019 to January 1, 2020. Patient charts were evaluated for patient length of stay and timeliness of social work and care manager intervention. Timeliness of intervention was defined as the time between the patient’s admission versus initial social work/care management documentation.

Results
Timeliness of social work and care management documentations were compared to the patient’s length of stay and charted on a scatter plot. Results indicate the timeliness of social work intervention is positively related to the patient’s length of stay; as the time between patient admission and initial social work documentation increased, the patient’s length of stay increased. In regards to timeliness of care management intervention, there seemed to be a small effect of intervention time and patient length of stay.

Implications for Social Work
Timely and effective discharge planning is an essential role of social work in the hospital setting. Delays in discharge planning can result in increased patient length of stay, which accumulates thousands of dollars in hospital costs, as well as poor care coordination, which can lead to hospital readmissions. The CMS guidelines for discharge planning ensure personnel are adhering to safe discharge practice, which ultimately improves patient outcomes. Through evaluations of UPMC Magee’s current discharge process, results communicate the importance of timely interventions by the social work staff.
Assessing CMS Standards of Discharge Planning
Haley Martin and Audrey Wrobel, Edith Baker Integrated Healthcare Fellowship

Background
Readmission rates and patient length of stay are two significant concerns for hospitals, as these events accumulate thousands of dollars of unnecessary costs. Research concludes appropriate discharge coordination significantly decreases the patient’s length of stay as well as reduces readmission rates. In 2012, the Center for Medicare and Medicaid Services (CMS) implemented a standard of discharge guidelines and furthermore reduced reimbursement rates to hospitals with excessive readmissions. As a result of these implementations, healthcare facilities must prioritize timely and effective discharge plans to foster successful patient outcomes.

Method and Results
Method:
Chart audits utilizing Cerner EMR were conducted on 60 randomly selected patients. Patients were admitted to Magee’s medical-surgical units from November 1, 2019 to January 1, 2020. Charts were evaluated for:
- Timeliness of social work intervention
- Timeliness of care manager intervention
- Patient length of stay

Results:
Results of the audits concluded timely social work interventions were associated with shorter patient length of stays. Results also indicated that timeliness of care management documentation seemed to have a smaller effect on patient length of stay.

IHC Competencies
Interpersonal Communication: The ability to establish rapport and communicate effectively with patients, their family members, and other providers.
- Discharge plans are patient-driven, and the social worker must be able to communicate effectively to explore preferences and potential barriers.
Collaboration and teamwork: The ability to function effectively as a member of an interprofessional team.
- At UPMC Magee, social workers and care managers facilitate the discharge process, which can require extensive collaboration with the entire medical team.
Practice-Based Learning/Quality Improvement: The ability to assess and continually improve the services delivered as an individual provider and as an interprofessional team.
- The results of the evaluation assess UPMC Magee’s current processes as it abides to CMS standards.

Research Questions
As of November 29, 2019, the CMS updated their discharge planning regulations for acute care hospitals. One criterion states the patient’s evaluation must be made on a timely basis in order to avoid delays in discharge and to ensure appropriate post-hospital arrangements. At Magee, social workers and care managers conduct patient psychosocial interviews to develop discharge plans with the patient’s goals in mind.
- Are social workers and care managers conditioning evaluations in a timely manner?
- Is timeliness of evaluation related to patient length of stay in the hospital?

Implications for Social Work
Timely and effective discharge planning is an essential role of social work in the hospital setting. Delays in discharge planning can result in increased patient length of stay as well as poor care coordination. The CMS guidelines for discharge planning ensures personnel are adhering to safe discharge practice, which ultimately improves patient outcomes. The evaluation of UPMC Magee’s current discharge process communicates the importance of timely interventions by the social work staff.

Acknowledgements
This fellowship is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number, MO1HP33767. Behavioral Health Workforce Education and Training (BHET) Program. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.
Assessment of Compassion Fatigue and The Code Lavender Initiative Among Oncology Medical Staff

UPMC Shadyside Hospital
Megan Van Doren

Oncology hospital systems face institutional stress daily through patient and employee trauma. The role of vicarious trauma in health disparities among medical staff members has been vastly overlooked, which can lead to compassion fatigue. The 2018 Medscape National Physician Burnout and Depression Report discovered a burnout rate of 39% among surveyed oncologists in the USA (Burki, 2018). Their symptoms of burnout included vicarious trauma, emotional exhaustion, reduced interest in work, and diminished feelings of personal accomplishment. Caring for cancer patients can drain an entire multidisciplinary cancer care team physically, intellectually, and emotionally if proper interventions are not discussed and utilized.

Within UPMC Shadyside Hospital, outpatient holistic resources are readily available for cancer patients; however, due to the mental health stigma among medical professionals (i.e., physicians, nurses, care management), or lack of awareness of such programs, many staff members are unwilling to seek help for their compassion fatigue symptoms. To reduce vicarious trauma and compassion fatigue among oncology professionals, the Cleveland Clinic created The Code Lavender Initiative (2009). The Holistic Rapid Response effort has gained momentum among hospitals nationwide including Allegheny Health Network in Pittsburgh. Implementing Code Lavender among UPMC Shadyside Hospital can reduce the mental health stigma and bring awareness of work-place trauma experienced by oncology caregivers.

The evaluation was conducted using Qualtrics software. Qualtrics is a web-based survey tool (Qualtrics, Provo, UT). The online survey incorporated two trauma-informed scales (ProQOL and the STS) to address the current mental health needs of those who experience work-place trauma (i.e., physicians, nurses, care managers, and social workers at Shadyside hospital). This survey assessed how severe the risk of compassion fatigue was among medical staff, if a current outpatient intervention was being utilized, and if there was a general interest for a more effective intervention: The Code Lavender Initiative. There were 50 participants (10 men, 37 women, and 3 who indicated "other" for their gender). Their ethnic identification included (90.48%) Caucasian, (4.76%) African-American, (2.38%), Asian-American, and (2.38%) Other.

The exploratory analysis indicated that the staff who participated averaged a moderate risk of compassion fatigue: ProQOL (N= 50, M= 3.4, S.D.= 0.85) and a mild risk for vicarious trauma: STS (N=50, M=1.9, S.D.=1). Seventeen participants (34%) indicated the Outpatient Center for Integrative Medicine, CISM training, and Life Solutions were some of the interventions they were currently using. Additionally, the methods participants use for self-care included, “being with children/pets”, “working out”, “meditation/mindfulness”, “socialization with friends outside of work”, “reducing work hours”, “music”, “maintaining professional boundaries”, “consuming alcohol”, and “having a faith community”. The individuals who had a higher risk of compassion fatigue indicated they do not recognize a way to cope due to work/life conflicts and not utilizing mental health days (i.e., preserving PTO). Interestingly, 87% of the participants indicated that more resources should be available to staff members. Also, when asked if participants would use the Code Lavender Initiative, 52% said they would call a code for their coworker, 15% would call a code for themselves, and 33% were unsure.

This project is relevant to health care social workers because we have a responsibility to maintain self-care in order to best serve the needs of our clients. By advocating to reduce the mental health stigma among oncology hospital staff, social workers can help medical providers address their work-place trauma in healthy ways, make effective medically informed decisions, reduce institutional stress, and prevent patient harm. With this project, it was my hope to advocate for more efficient mental health resources for oncology staff members. Since its implementation at UPMC Presbyterian/Shadyside hospitals (March 2020), Code Lavender has been an effective intervention for staff members especially during the COVID-19 pandemic with a significant increase in usage (a month after the survey was distributed) among onsite faculty.
Assessment of Compassion Fatigue and The Code Lavender Initiative Among UPMC Oncology Medical Staff
Megan Lynn Van Doren
Edith Baker Integrated Healthcare Fellowship

Background
In 2009, a partnership between holistic nurses and chaplains at Cleveland Clinic led to the first Code Lavender initiative (Holistic Rapid Response). Code Lavender is available to all patients, families, and healthcare providers at Cleveland Clinic, though nearly all of the codes have been called to support staff members. The team responds to an average of three to four Code Lavender events monthly, with triggers varying from the unexpected death of a fellow staff member to the emotional aftereffects of experiencing second-hand trauma from patients (e.g., a Code Blue event). In 2012, Cleveland's team executed its largest Code Lavender event. Following shootings at Chardon High School in Northeast Ohio, the team provided an enterprise wide Code Lavender for the entire staff of Cleveland Clinic’s Hillcrest Hospital. Several victims of the shooting were transported to Hillcrest, and many staff there had children enrolled at Chardon High.

The team served more than 500 employees in a 72-hour period. Nurses and chaplains are summoned when the staff member who experiences the mental health crisis or coworker calls the code. The staff member receives a lavender wristband to designate to other healthcare professionals that they are trauma care and need time to recover. Then the team of holistic nurses and chaplains offers care in the moment, and then partners with their Employee Assistance Program/Wellness Center to provide long-term assistance. Various holistic approaches depending on the hospital are used to reduce the mental health crisis including Manual Therapies (reflexive brushing, light massage, reflexology), Energy-based Tools (Reiki, Healing Touch), Expressive Arts (playing recorded music, singing, self-driven art, journaling, storytelling), and Mind-Body Tools (guided imagery, meditation, movement and breathing exercises, acupressure, holistic coaching). Needs specific to UPMC Shadyside Hospital would be assessed through the staff survey.

References

Issue/Objective
Oncology hospital systems face institutional stress daily through patient and employee trauma. The role of vicarious trauma in health disparities among medical staff members has been vastly overlooked which can lead to compassion fatigue. The 2018 Medscape National Physician Burnout and Depression Report discovered a burnout rate of 39% among surveyed oncologists in the USA. Their symptoms of burnout included vicarious trauma, emotional exhaustion, reduced interest in work, and diminished feelings of personal accomplishment. Caring for cancer patients can drain an entire multidisciplinary cancer care team physically, intellectually, and emotionally if proper interventions are not discussed/used.

Within UPMC Shadyside hospital, outpatient holistic resources are readily available for cancer patients; however, due to the social mental health stigma among medical professionals (i.e., physicians, nurses, care management), lack of awareness of such programs, many staff members are unwilling to seek help for their compassion fatigue symptoms. To reduce vicarious trauma and compassion fatigue among oncology professionals, the Cleveland Clinic created the Code Lavender Initiative. The Holistic Rapid Response effort has gained momentum among hospitals nationwide including Allegheny Health Network in Pittsburgh. Implementing Code Lavender among UPMC Shadyside Hospital can reduce the mental health stigma and bring awareness of work-place trauma experienced by oncology caregivers.

Methods
The analysis was conducted using Qualtrics software. Qualtrics is a web-based survey tool (Qualtrics, Provo, UT). The online survey incorporated two trauma-informed scales (ProQOL and the STS) to address the current mental health needs of medical staff who experience work-place trauma (i.e., physicians, nurses, care managers, and social workers at Shadyside hospital). This survey assessed how severe the risk of compassion fatigue was among medical staff, if a current outpatient intervention was being utilized, and if there was a general interest for a more effective intervention: The Code Lavender Initiative. There were 50 participants (10 men, 37 women, and 3 who indicated “other” for their gender). Their ethnic identification included (90.48%) Caucasian, (4.76%) African-American, (2.38%) Asian-American, and (2.38%) Other.

Results
The exploratory analysis indicated that the staff who participated averaged a moderate risk of compassion fatigue. The team found (N=50, M=3.4, S.D.=0.85) and a mild risk for vicarious trauma: STS (N=50, M=1.9, S.D=1). Seventeen participants (34%) indicated that the Outpatient Center for Integrative Medicine, CISM training, and Life Solutions were some interventions they were currently using. Interestingly, 87% indicated that more resources should be available. Also, when asked if participants would use the Code Lavender Initiative, 52% said they would call a code for their colleagues, 12% would call a code for themselves, and 33% were unsure.

How would you use The Code Lavender Initiative?
- Call a code for a coworker
- Call a code for yourself
- Unsure if I would use this service

Implications
This project is relevant to the social work profession because it is our responsibility as social work professionals to maintain self-care in order to best serve the needs of our clients. By advocating to reduce the mental health stigma among oncology hospital staff, social workers can help medical professionals address their work-place trauma in healthy ways, make effective medically informed decisions, reduce institutional stress, and prevent patient harm. With this project, it was my hope to advocate for more efficient mental health resources for oncology staff members. Since its implementation at UPMC Presbyterian/Shadyside hospitals, it has been an effective intervention for staff members especially during the COVID-19 pandemic with a significant increase in usage among onsite faculty.

NASW Core Competencies
- Screening & Assessment
- Collaboration & Teamwork
- Practice based Learning & Quality Improvement

Acknowledgements
This fellowship is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number M01HP31376, Behavioral Health Workforce and Education and Training (BHWE/T) Program. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS, or the U.S. Government.
This study was carried out to better understand the gaps in follow-up patient care during addiction recovery. A major aim of the study was simultaneously carried out as the authors were informed, through surveys, of the barriers to treatment and patient follow-up care. The authors found follow-up care and barriers to treatment inextricably linked. Through this study, the authors were able to address both. The data collected from interviews resulted in an approach to best practice. According to the research, it is important to address barriers to care and follow up treatment for patients in recovery. This study was carried out with patients with substance withdrawal in the UPMC McKeesport Addiction Medicine Program. To carry out the research, the authors used descriptive research and survey methods to collect data on this population group. Data collected from the surveys was used to ascertain the nature of aftercare for participating patients. The authors created a survey on Google forms, which comprised 6 questions, as part of their caseload in working with patients at UPMC McKeesport Hospital. The study included detox patients instead of rehabilitation patients because the authors believed their answers would be even more informative.

After gathering the data from the surveys, the authors organized the data into a Google form database, which was then used to extrapolate commonalities and differences in collected responses. Thus, the data pointed to common barriers and challenges patients faced in relation to their follow-up with treatment and overall recovery. The authors then used these answers to address the research questions to understand overarching similarities and commonalities in patient responses. After administering the interviews to patients, the authors did in fact see results which were telling and informative. One of the questions from the survey asked the patients “what was their longest time out of treatment before coming to the unit?” The answer choices ranged from 0-3 years. Overall, the authors found that the most consistent time, regardless of clean time was 1-3 months. We found this to imply, upon leaving treatment, 0-3 months is the most sensitive period for patients who are vulnerable and at high risk for relapse. We also found the number one barrier mentioned by patients was “not ready”, which contributes to their vulnerability and high risk. Furthermore, because out-patient treatment is optional, patients who are not ready for discharge may be less likely to follow through with outpatient treatment options. In-patient treatment has more structure and oversight, or MAT which patients may feel is necessary for their physical and mental health. Survey results showed a correlation between barriers to treatment, as it relates to the “sensitive period” being 1-3 months, and outpatient treatment; both put patients “at-risk” upon discharge. The authors gained additional knowledge of the gaps in aftercare planning as it relates to rates of success for this population.

The gaps in addiction recovery are complicated. However, in our brief study, we did find contributing factors in need of further study in patient recovery. This study will contribute additional understanding regarding the role of follow-up patient care in substance abuse withdrawal treatment. The ultimate goal is to, if possible, provide additional treatment services to facilitate patient success during post-discharge recovery.
Data shows that patients are being **most** recommended the treatment they are **least** likely to be successful with.

The above displays the treatment recommendations participants received as they left treatment. Vocabulary: IP, inpatient; OP, outpatient; MAT, Medication Assisted Treatment.

The above shows the recommendations specifically for those who did not complete their recommendations. Outpatient as the leading recommendation. Vocabulary: F/U; follow up.

What would you say are the barriers to your recovery? 41 responses

The above are barriers identified by participants. Leading reported barrier: "Not ready/motivated."

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**References and Acknowledgements**

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Barriers to Skilled Nursing Discharge Planning for Patients with Opioid Dependency

UPMC St. Margaret Hospital
Kyle Terrill

The Department of Care Management at UPMC St. Margaret includes a number of hospital professionals, mostly consisting of care managers and social workers. Together, one of their main roles is to facilitate safe and successful discharges for every patient leaving the hospital. Upon discharge, many patients require a higher level of care that may not necessarily be feasible from the comfort of their own home. Skilled nursing facilities (SNFs) assist with providing a number of medical services including intravenous (IV) antibiotic continuation and physical, occupational, and speech therapies. Throughout the course of the opioid epidemic, many individuals living with opioid addiction have found solace in medication assisted treatment (MAT), which includes prescription drugs that help alleviate symptoms of opioid withdrawal, and ultimately help curb addiction. Though other MAT drugs exist, the most popularly prescribed are methadone, Suboxone (buprenorphine and naloxone), and Subutex (buprenorphine). Individuals with an opioid dependency, or those who are on a MAT regimen that require a higher level of medical attention at the time of hospital discharge face a number of barriers, including discharge to SNFs to receive quality inpatient health care. The objective of this qualitative study is to identify the barriers that patients with opioid dependency experience when being discharged to SNFs and suggest how the healthcare system can improve its practices.

In order to identify specific barriers, three methods of data collection were implemented. Chart reviews (n=30) of both current and previous patients with a co-occurring skilled need and opioid dependency that had difficulty being admitted to an SNF or limited SNF options upon discharge were conducted to determine discharge barriers. Interviews with SNF admissions staff and hospital liaisons (n=4) were conducted to identify reasons for acceptance or denial of patients with skilled needs and opioid dependency. Interviews with geriatricians and SNF physicians (n=5) were conducted to discuss the needs of their patients, particular MAT licensure processes, and their opinions of practicing MAT. Using these three methods, identified barriers for admission to SNFs included the facility’s inability to provide transportation, high cost of IV antibiotics, lack of physicians with appropriate MAT licensure, staff inability to care for these patients, fear of compromising the facility’s reputation, and an overwhelming stigma of individuals who use/have previously used opioids. Social work notes in each patient’s electronic health record indicated that patients with a skilled need, as well as an opioid dependency, being discharged to a SNF experienced one or more of these barriers, which limited their options for admitting facilities. SNF employees, both admissions staff and liaisons who visit patients in the hospital, identified reasons why their facilities were unable to accept patients with a skilled need and opioid dependency. Physicians who practice in the field of long-term care identified that patients in SNFs who require MAT experience a major barrier because physicians must be licensed to prescribe MAT drugs. Many physicians do not obtain licensure because they feel it is unnecessary for their practice and do not want their practice to be associated with MAT and patients with opioid dependency.

Health care social workers with inpatient health care settings experience difficulty planning safe discharge for patients with opioid dependency who require a skilled level of care, because many facilities are unwilling to accept them. Transportation, IV antibiotics, physician/staff capability, facility reputation, and overall stigma often stand in the way of vulnerable patients receiving the medical attention they need after a hospital admission. As social workers, it is important to understand these barriers when planning safe discharges for our patients and advocate for health care practice and policy changes.
Barriers to Skilled Nursing Discharge Planning for Patients with Opioid Dependency

Kyle Terrill, Edith Baker Integrated Healthcare Fellowship
University of Pittsburgh School of Social Work, Pittsburgh, PA, Department of Care Management, UPMC St. Margaret

### Background
- UPMC St. Margaret is a 250-bed teaching hospital that serves approximately 250,000 residents from northern Allegheny County and the Alle-Kiski Valley, many of whom are geriatric patients.
- Social workers at UPMC St. Margaret work within the Department of Care Management to address patients' social needs and help plan safe and successful discharges. Many patients require a skilled nursing facility (SNF) for ongoing needs including intravenous (IV) antibiotic continuation or physical/occupational/speech therapy, along with medication assisted treatment (MAT) with methadone, Suboxone, or buprenorphine.
- These needed skills are medically necessary and should be delivered in the minimally restrictive and intrusive environment that skilled nursing facilities offer.

### Research Objective
This study aims to identify the barriers to discharge to skilled nursing facilities that patients with opioid dependency experience and suggests how the health care system can improve its practices.

### Research Design and Methods
- In-depth chart reviews (n=30) of identified current and previous patients with a co-occurring skill and opioid dependency that had difficulty being admitted to a SNF or had limited SNF options upon discharge were conducted to determine discharge barriers.
- Interviews (n=4) with SNF admissions staff and hospital liaisons were conducted to discuss day-to-day operations and identify reasons for acceptance/denial of patients with opioid dependencies.
- Interviews (n=5) with geriatricians and physicians who care for patients at skilled nursing facilities were conducted to discuss care needs for their patients and medication assisted treatment licensure process and their opinions regarding MAT licensure.

### Identified Barriers for Admission to Skilled Nursing Facilities

<table>
<thead>
<tr>
<th>Barrier</th>
<th>Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transportation</td>
<td>Frequent travel to methadone clinics, Limited/costly resources for patient transport</td>
</tr>
<tr>
<td>IV Antibiotics</td>
<td>High cost of medication, Significant financial loss for SNF</td>
</tr>
<tr>
<td>Physician Licensure</td>
<td>No interest or incentive to gain credentials, Geriatricians not used to opioid dependency</td>
</tr>
<tr>
<td>Staff Capability</td>
<td>Nurse to patient ratio, Limited capability</td>
</tr>
<tr>
<td>Reputation</td>
<td>Security Concerns, Negative impact on future referrals</td>
</tr>
<tr>
<td>Stigma</td>
<td>Patient Demographics, Preference of other patients and families</td>
</tr>
</tbody>
</table>

### Discussion
- Social work notes within each patient’s electronic health record indicated that patients with opioid use disorder being discharged with a skilled need experienced barriers to discharge that limited their options for admitting skilled facilities.
- SNF employees identified reasons why facilities are unable to accept patients who have a skilled need at time of discharge from the hospital who have an opioid dependency.
- Physicians practicing in the field of long-term care do not see the need to be licensed to prescribe MAT drugs due to the health concerns of their patients and often do not want their practice to be associated with MAT.

### Conclusions
- As social workers have difficulty planning safe discharge plans for patients with an opioid dependency as well as a skilled need, patients themselves experience several obstacles when being discharged from the hospital.
- Many skilled nursing facilities are unable to accept these patients due to staff/physician capabilities, inability to provide transportation to MAT clinics, high prices for certain antibiotics, concerns for safety, and stigma. These are all areas where policies can, and ought to be altered in order to provide optimal healthcare.
- It is important for social workers to be aware of these barriers when facilitating discharges and advocate for changes in policy and practice.

### Acknowledgements
This fellowship is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number, M1HP31376, Behavioral Health Workforce Education and Training (BHWCET) Program. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS, or the U.S. Government.

I extend thanks to the University of Pittsburgh School of Social Work, the Edith Baker Integrated Healthcare Fellowship, faculty members, and UPMC St. Margaret Department of Care Management.
Education and Utilization of Advance Directives in AGH Patient Population
Allegheny General Hospital
Ke’Amber Moses

Background

The education and exposure a patient and their family receive regarding end of life treatment and advance directives can directly impact their experience of quality care planning and care coordination. By completing an advance directive and having a plan for end of life care, patients can effectively communicate their wants, desires, and preferences regarding the level of care and treatment provided.

While interning at Allegheny General Hospital (AGH), I have noticed a variation in the number of patients who do and do not have advance directives and have witnessed several patients and their families refuse supportive care services, such as palliative care, due to a lack of understanding of the role and purpose of the services offered.

Purpose

This descriptive research study was conducted to describe the education and utilization of advance directives at Allegheny General Hospital among patients and professionals. During the study, various observations of practitioner-patient interactions were recorded, and information was gathered by way of focus groups and interviews involving oncology and palliative care healthcare providers.

Findings

Findings from the study indicate that there is a gap in advance directive education and awareness among AGH’s patient populations as well as some professional populations within AGH.

Implications

This study is relevant because medical social workers attempting to ensure patient’s needs are addressed and education provided to patients is inclusive, relevant, and relatable across various cultures, populations, and disciplines. Assessing the utilization and education of advance directives improves the competence and awareness of healthcare professionals while also enhancing the patient process of care and care planning.
Education and Utilization of Advance Directives in AGH Patient Population

Ke’Amber Moses, Edith Baker Integrated Healthcare Fellowship

Research Design & Method

Research Design

Descriptive with the intent to assess the type and use of education provided to patients at Allegheny General Hospital as it pertains to advance directives.

Sampling

- Purposive sampling
- One population including specialty healthcare professionals in the field of oncology and palliative care
- Diverse demographics in regard to levels of education/certification, SES, and age

Data Collection

- Observations of oncology practitioner-patient interactions were conducted for 7 months 3 days a week for 8 hours, regarding goal planning and advance directives
- Observations of palliative care practitioner-patient interactions were conducted for 8 weeks 1 day a week for 4-6 hours, regarding end of life conversations and advance directives
- Focus groups and interviews of palliative care and oncology staff were conducted to discuss current education provided to patients and other hospital staff regarding advance directives

Instrumentation

- Recording patient responses to advance directive education (PA Act 169)
- Reviewing current resources used for advance care planning (i.e. advance directives)
- Assessing hospital education around advance directives

Conclusion

Findings show there is a gap in advance directive education and awareness among AGH’s patient populations as well as some professional populations within AGH. As witnessed through observation, some patients showed interest in completing an advance directive while others questioned the relevance and/or importance of completing one. Furthermore, patients and healthcare professionals not properly trained and/or educated on advance directives and advance care planning have common misconceptions about the two.

There are several negative stigmas around preparing advance directives due to minimal conversations concerning planning for death, unlike the discussion of funeral preparation. The observed professionals agree that it is important for all healthcare professionals to know how and when to initiate end of life conversations so that patients do not associate advance directives or advance care planning with “quitting”. Advance care planning is supportive care and the completion of advance directives allow patients and patient’s families to discuss goals of care early on with comfort in mind.

Background

- Advance directives are commonly used in advance and end of life care planning
- Patients decline completing an advance directive due to a lack of understanding and knowledge on the document and its relevance
- Unit social workers typically explain the importance of advance directives to patients who express interest

Significance

This study is relevant because medical social workers are to ensure patient’s needs are addressed and that education provided to clients is inclusive, relevant, and relatable across various cultures, populations, and disciplines. Assessing the utilization and education of advance directives improves the competence and awareness of healthcare professionals, while also enhancing the patient process of care and care planning.

Acknowledgements

This fellowship is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services under grant number M01IP02796, Behavioral Health Workforce Education and Training Program. The information presented is that of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred from HRSA, HHS, or the U.S. government.
Effectiveness of Center of Excellence Behavioral Health Interventions Based on Show Rate Data
Western Psychiatric Institute and Clinic: Center of Excellence Addiction Medicine Services
Gabriel Becker

The purpose of this study was to record show rates of clinical engagement sessions (i.e. behavioral and mental health counseling) and interventions used in those sessions. I recorded show rates monthly, for six months, starting in September 2019 and ending in February 2020. I found that in the warmer months (i.e. the first three months of the study) more patients were scheduling appointments and the show rate was consistently higher than the last three months of the study.

From the 57% show rate from September 2019 to November 2019, the show rate steadily increased by each month, peaking at 63% in November. From the 63% show rate in November the show rate steadily decreased to a 49% show rate in February 2020. The number of scheduled sessions remained over 100 scheduled sessions through the first three months with October having the most scheduled sessions (163). With regards to the last three months of the study, none of the months reached 100 scheduled sessions, with December having the fewest amount of scheduled sessions (73). In conclusion, the data indicate the effectiveness of COE engagement cannot be determined solely based on show rate data as there are many factors to consider. Factors such as changes in seasons (possible increase in depression and motivation to seek out OUD treatment), holidays such as Christmas and New Year’s Eve in December affecting the number of appointments scheduled, the ability for patients to show for their appointments due to the nature of the OUD recovery (i.e. relapsing and getting sick) and other barriers such as a lack of transportation and scheduling conflicts.

This conclusion is imperative to explaining show rate fluctuation, particularly when considering funding for behavioral health clinics such as the Center of Excellence. Funders use show rate data to indicate the amount of funding for clinics such as the Center of Excellence. In many cases, funders do not consider the aforementioned factors such as inclement weather, holidays, or even patients recovering from a relapse. The Center of Excellence OUD recovery population also has barriers such as a lack of transportation that need to be a funding consideration.

When considering funding and the effectiveness of the Center of Excellence clinical interventions, I recommend a mixed-methods approach regarding research. The optimal approach would be to amalgamate this quantitative approach with a qualitative phenomenological interviewing component of the Center of Excellence patients. Since performing qualitative interviewing takes a lot of time and resources it would be difficult to make the interviewing generalizable to the entire Center of Excellence patient population. I suggest offering a supplementary survey for the Center of Excellence patients to fill out to study more generalizable effectiveness and satisfaction of the Center of Excellence clinical engagements and interventions. Both the qualitative phenomenological interviewing and patient satisfaction survey provide a patient’s subjective quality of effectiveness regarding the Center of Excellence’s clinical engagement and interventions.
Effectiveness of Center of Excellence Behavioral Health Interventions Based on Show Rate Data
Western Psychiatric Institute and Clinic: Center of Excellence

Introduction
The Center of Excellence (COE) at the University of Pittsburgh Medical Center (UPMC) is a behavioral-mental health clinic which serves the opioid use disorder population through harm reduction interventions and medicated assisted treatment (MAT) (i.e. buprenorphine and naltrexone). The COE is integrated with the UPMC Center of Psychiatric and Chemical Dependency Services (CPCDS) which is an out patient clinic under the UPMC Western Psychiatric Institute and Clinic (WPIC). The primary clinical behavioral health intervention used at the COE is motivational interviewing (MI) which is supplemented by other modalities such as cognitive behavioral therapy (CBT) and acceptance commitment therapy (ACT). The COE also is staffed with peer navigators (PN). PNs are staff members that are in recovery of addiction that assist COE patients with case management and support needs.

Background
The continuance and adherence of OUD patient behavioral counseling within evidence based practices such as MI is integral to optimal OUD recovery (Coffin et al., 2017). Behavioral health interventions supplemented with harm reduction philosophy and MAT medication such as methadone and the various forms of buprenorphine (i.e. suboxone) have been clinically proven to reduce opioid relapse and prevent opioid overdose (Hser et al., 2013; Hsu, Marstellar, Kacher, & Fingerhood, 2019; Makarenko et al., 2016). Hsu and colleagues (2019) suggest that the most effective MAT delivery environment is at a PCP site that has integrated behavioral healthcare. This research design attempts to infer effectiveness of clinical behavioral health engagement based on show rate correlation.

Research Question
How effective is COE behavioral health clinical engagement based on patient show rate correlation?

Methods
Patient clinical engagement show rates data was extracted from COE PsychConsult and Epic patient databases. For this study, show rate data was gathered from patients seen by two COE behavioral health therapists between September 2nd, 2019 and February 29th, 2020. The design breaks down clinical session show rate data for both therapist’s patients. Only established patients were included in the analysis. Established patients are patients that were current in the program at some point during the month or were enrolled into the program (completed intake assessment and found appropriate for COE). Phone calls, Peer support, and group show rates were not included in the data analysis. Rescheduled clinical appointments were not counted as a no show but canceled appointments were. An exploratory research design was used for this study.

Results
COE Show Rates by Month

<table>
<thead>
<tr>
<th>Month</th>
<th>Show Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sept. 2019</td>
<td>71</td>
</tr>
<tr>
<td>Oct. 2019</td>
<td>94</td>
</tr>
<tr>
<td>Nov. 2019</td>
<td>81</td>
</tr>
<tr>
<td>Dec. 2019</td>
<td>44</td>
</tr>
<tr>
<td>Jan. 2020</td>
<td>52</td>
</tr>
<tr>
<td>Feb. 2020</td>
<td>45</td>
</tr>
</tbody>
</table>

Amount of Schedule Sessions and Shows by Month

- September 2019: 71 showed out of 124 scheduled
- October 2019: 94 showed out of 163 scheduled
- November 2019: 81 showed out of 129 scheduled
- December 2019: 44 showed out of 73 scheduled
- January 2020: 52 showed out of 93 scheduled
- February 2020: 45 showed out of 91 scheduled

Research Question
How effective is COE behavioral health clinical engagement based on patient show rate correlation?

IHC Competencies
Interpersonal Communication, Screening and Assessment, Care Planning and Care Coordination, Interventions, & Informatics.

Social Work Implications
This data analysis is relevant to social work because it implies the efficacy of patient clinical engagement as it relates to patient clinical show rates in the program and exposes other factors when considering show rates of patients (i.e. barriers). Patients participation in counseling sessions is a crucial part towards the road to recovery for OUD patients. Measuring engagement via patient show rate can inform modifications towards approaches for patient outreach, therapeutic modality, and the referral process. The ultimate goal for measuring engagement efficacy is optimal patient recovery and health outcome for OUD patients.

Conclusion and Limitations
Initially, the goal of this research project was to obtain effectiveness of COE clinical engagement interventions through recording show rates of clinical engagement sessions (i.e. behavioral and mental health counseling). As I recorded the data I found that many no show appointments were consequential to COE patients relapsing, having to seek emergency services, holidays, lack of transportation, and bad weather. In the warmer months, the COE had more scheduled appointments (i.e. September, October, and November). December had the fewest amount of appointments due to staff taking holidays off and patients going out of town for the holidays. Also I deduce that the decrease in temperature and harsh weather conditions prevented many COE patient from showing to their appointments and even from scheduling them. In order to optimally record valid effectiveness of engagement interventions I suggest surveys COE patients on a scalable measure and conducting qualitative interviews. These two suggestions would record effectiveness of interventions from the patient subjective standpoint, which would be a more valid approach to study the effectiveness of COE interventions.

Acknowledgements
This fellowship is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number, M01HP31376, Behavioral Health Workforce Education and Training (BHWET) Program. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government. This study was made possible by participating UPMC COE staff members.

References
Examining Health Professionals’ Understanding and Utilization of POLST (Pennsylvania Orders for Life-Sustaining Treatment)  
Forbes Regional Hospital  
Jessi Smirga

Issue/Research Question:

The Pennsylvania Orders for Life-Sustaining Treatment (POLST) is a physician order that provides a patient, who has an advanced or irreversible or terminal illness, wishes for advance care planning. The POLST is a document used to help patients avoid unwanted hospitalizations, protects their right to choose the treatments they want, respects personal autonomy, avoids medical errors, and can potentially improve end of life care. The POLST should be sent with the patient’s health care file/record every time they are transferred from one level of care to another. It is meant to be useful in emergency medical situations, providing a snapshot of a patient’s advanced directives. The POLST can be filled out by a Physician, RN, NP, PA, Social Worker, or admissions staff person.

In an acute care setting, such as a hospital, there are challenges with initiating the POLST process and ensuring that a POLST is followed during an emergent medical situation. This research examined: (1) what each health care professional specialty knows about the POLST; (2) health care professionals’ comfort with having POLST conversations; and (3) if health care professionals understand how to use the POLST. From these answers, there was a determination on whether health care professionals are comfortable with their role as POLST facilitators and whether or not healthcare networks are providing adequate education to their employees. There is a noticeable disconnect between what a patient states their wishes are and what occurs when that patient is no longer able to speak for themselves, and this research examined health care professionals’ role with this disconnect.

Summary:

The cross-sectional questionnaire had seven basic demographic questions and twelve general questions that were designed to capture a full understanding of what the POLST is, comfort level with the POLST, and how to use it. The questionnaire consisted of multiple-choice questions with predefined answers offering respondents the possibility to choose and rank among several options. Possibilities included to grade on a “not knowledgeable” to “extremely knowledgeable” scale, and a “not comfortable” to “extremely comfortable” scale. Respondents were given two True/False questions to determine knowledge of POLST policies. Respondents were also given an image choice question that allowed respondents to select one or more image answers from a set of specific questions about how to correctly complete a POLST. Responses were received (171). Of these 171 respondents, 46 were physicians, 42 were master level clinicians (MSW, PA, NP), and 83 were nurses. Of all the participants, 55% recorded that they have had an hour or less of training on the POLST. 66% answered that they would find it beneficial to have more training on the POLST.

Conclusion:

Physician responses indicated that 56% have moderate or lower knowledge on what the POLST is, and 46% stated that they are moderately comfortable or less in having these conversations with patients. Of the master level clinicians, 57% answered that they have moderate or lower knowledge on what the POLST is, and 55% were moderately comfortable or less with having these conversations. Nurse responses indicated that 61% have moderate or lower knowledge on what the POLST is, and 59% were moderately comfortable or less with having these conversations.

Only 25% of respondents answered correctly that a social worker or case manager can have the ability to initiate a POLST. 30% of physicians responded incorrectly to the case scenario question on how to correctly fill out the POLST.
Examining Health Professionals’ Understanding and Utilization of POLST (Pennsylvania Orders for Life-Sustaining Treatment)

Jessi Smirga
Edith M. Baker Integrated Healthcare Fellowship

Forbes Regional Hospital

Forbes Hospital primarily serves the communities of eastern Allegheny and Westmoreland counties. Forbes is a 349-bed facility with 15,000 inpatient admissions, 12,000 surgeries and nearly 50,000 emergency department visits annually. In addition, it offers a complete spectrum of specialty services such as cardiology, orthopedics, neurosurgery, oncology, stroke care, endocrinology, behavioral health, inpatient rehabilitation, and obstetrics. Forbes is also a certified Level 2 Trauma Center.

Research Question

This survey research examined (1) What each health care professional specialty knows about the POLST; (2) Health care professionals' comfort with having POLST conversations; and (3) If health care professionals understand how to use the POLST.

What is a POLST?

The Pennsylvania Orders for Life-Sustaining Treatment (POLST) is a physician order that provides a patient who has an advanced or irreversible or terminal illness, wishes for advance care planning. The POLST is a document used to help patients avoid unwanted hospitalizations, protect their right to choose the treatments they want, respect personal autonomy, avoid medical errors, and can potentially improve end of life care. The POLST should be sent with the patient’s health care file/record every time they are transferred from one level of care to another. It is meant to be useful in emergency medical situations, providing a snapshot of a patient’s advanced directives. The POLST can be initiated by a Physician, RN, NP, PA, Social Worker, or admissions staff.

What is your knowledge of POLST?

What is your comfort level with having end-of-life/POLST conversations with a patient?

Discussion of Results

171 responses were received. Of these 171, 46 were physicians, 42 were masters level clinicians (MSW, PA, NP), and 83 were nurses. Of all the participants, 55% recorded that they have had an hour or less of training on the POLST. 66% answered that they would find it beneficial to have more training on the POLST. 56% of physicians answered that they have moderate or lower knowledge on what the POLST is, and 46% stated that they are moderately comfortable or less in having these conversations with patients. Of the master level clinicians, 57% answered that they have moderate or lower knowledge on what the POLST is, and 55% were moderately comfortable or less with having these conversations. Nurse responses indicated that 61% have moderate or lower knowledge on what the POLST is, and 59% were moderately comfortable or less with having these conversations.

Only 25% of respondents answered that a social worker or case manager can have the ability to initiate a POLST, which is true. 30% of physicians responded incorrectly to the case scenario question on how to correctly fill-out the POLST.

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References and Acknowledgements

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How Does Behavioral Intervention Impact High-Complexity Patients’ Physical and Mental Health?
UPMC Total Care IBD Program
Ryan Young

Background & Purpose
This research took place at UPMC Total Care’s Inflammatory Bowel Disease Medical Home Program (IBDMH). The IBDMH uses a model of care designed to provide preventative, integrated, and holistic services to patients. Patients who are part of this medical home program generally have an IBD diagnosis—Crohn’s Disease (CD) or Ulcerative Colitis (UC). To support the holistic model of care, the care team is multidisciplinary and includes: 2 gastroenterologists, a psychiatrist, 2 social workers, 2 nurses, and a dietician. Altogether, they work collaboratively managing medical and mental health concerns with these patients. Additionally, most patients who are part of the medical home program have a variety of needs and—because of the nature of their chronic illness—can be at risk for a behavioral or medical crisis. To best intervene to prevent negative financial or health-related consequences, it is important for staff to understand which patients need close follow-up or have complex needs in multiples areas of their health. This project utilizes a measure of complex patient needs—Complexity Scores—that allow for a quick quantitative summary of patients’ historical and present challenges. This project aims to improve the quality of services by understanding how behavioral therapy is impacting higher-complexity patients in the IBDMH.

Methods & Measurements
To be included in this project, a patient had to have at least two (2) appointments at the IBDMH in 2019. This was done to establish two time points (i.e. pre and post). Patients also had to have a total complexity score of at least 21 (moderate or above).

There were four measures used to evaluate changes in patients’ medical and mental health from their first appointment in 2019 to their second. Patients completed questionnaires measuring GI symptoms (HBI) and well-being in the context of their CD or UC (SIBDQ). These were used as measures of patients’ medical or GI health. Note that it represents a good outcome if the HBI is low (measures symptoms) and if the SIBDQ is high (measure of well-being). Patients complete questionnaires measuring anxiety (GAD-7) and depression (PHQ-9) symptoms. These were used to measure mental health symptoms. Note that lower scores represent a good outcome for both GAD-7 and PHQ-9 because they measure symptoms. Patients were divided into two groups—those who received behavioral therapy (defined as at least 2 sessions with a social worker) at the IBDMH in 2019 and those who did not. These two groups were compared based on the four measures listed above (HBI, SIBDQ, GAD-7, PHQ-9) to understand if behavioral interventions impact this group of higher complexity patients’ medical or mental health.

Findings, Conclusions, & Limitations
Ultimately by using a paired-sample t-test to compare patients’ first and second appointments in 2019, results showed that patients who received behavioral intervention recorded a significant reduction in anxiety symptoms and a non-significant reduction in depression symptoms. Patients who did not receive behavioral health intervention at the IBDMH showed no change in their anxiety or depression symptoms. Both groups showed a reduction in GI symptoms (HBI) and an increase in quality of life measures (SIBDQ). These findings suggest that behavioral intervention at the IBDMH has a significant impact on patients’ anxiety symptoms. One possible explanation for the non-significant change in depression symptoms could imply patients with chronic illnesses like CD and UC often experience chronic fatigue and other symptoms that may be picked up on the PHQ-9. There are several limitations to this investigation: (1) it is not known how many patients are receiving therapy in the community; (2) involvement with a psychiatrist was not included; (3) several patients had missing data; (4) Total N under 100; (5) it is unlikely that this data is generalizable given the specificity of the sample and the specialization of the IBDMH.
Introduction

- The Inflammatory Bowel Disease Medical Home (IBDMH) provides preventative and integrated services.
- Patients have IBD – Crohn’s Disease or Ulcerative Colitis.
- Staff include: 2 gastroenterologists, 1 psychiatrist, 2 social workers, 2 nurses, and a dietician.
- It is important to identify patients who are at risk of a crisis and intervene to prevent negative financial or health-related consequences.
- This project aims to improve the quality of services by understanding how behavioral health therapy impacts higher-complexity patients.

Methods

- Patients complete measures of GI symptoms (HBI) & well-being (SIBDQ): (1) Harvey Bradshaw Index (HBI) ; (2) Short inflammatory bowel disease questionnaire (SIBDQ)
- Patients complete measures of anxiety/depression symptoms: (1) GAD-7 for anxiety ; (2) PHQ-9 for depression.
- At each visit, providers assess functioning and assign a complexity score.
- Patient Inclusion Criteria: (1) Total complexity score of at least 21 (moderate range cut-off) (2) At least 2 visits to IBDMH in 2019.
- Patients who received behavioral therapy (defined as at least 2 sessions) at the IBDMH are compared to patients who did not have behavioral therapy on the measures of their GI and mental health.

Results

| Table 2 Pre-post t-test of Active behavioral therapy vs No behavioral therapy |
|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|
|                 | Visit 1 (SD)    | Visit 2 (SD)    | Mean change    | t-score (df) by visit | Sig             |
| SIBDQ n=28      | 37.43 (11.08)   | 41.96 (13.84)   | 4.54           | 2.36 (27)         | 0.026           |
| HBI n=31        | 6.16 (5.51)     | 4.45 (3.29)     | -1.71          | -2.16 (30)        | 0.039           |
| GAD-7 n=35      | 11.63 (6.00)    | 8.97 (4.91)     | -2.66          | -3.10 (34)        | 0.004           |
| PHQ-9 n=34      | 11.59 (6.12)    | 10.03 (6.21)    | -1.56          | -1.41 (33)        | 0.168           |
| No BH n=37      | 38.22 (11.45)   | 44.11 (12.67)   | 5.89           | 3.23 (36)         | 0.003           |
| HBI n=43        | 7.77 (7.68)     | 5.84 (4.75)     | -1.93          | -2.06 (42)        | 0.046           |
| GAD-7 n=45      | 8.93 (6.02)     | 9.00 (7.29)     | 0.07           | 0.09 (44)         | 0.928           |
| PHQ-9 n=45      | 8.24 (5.11)     | 8.58 (6.44)     | 0.33           | 0.46 (44)         | 0.647           |

Key Findings

- Patients who received behavioral therapy showed: *a significant decrease in anxiety symptoms.
- Patients who did not receive behavioral therapy showed: *no change in their anxiety symptoms.
- Both groups showed: *a significant reduction in GI symptoms (HBI).

Conclusion

- Depression measures may show a lack of change because of the high rates of chronic fatigue or sleep disruptions among this population of patients.
- Limitations: unknown number of patients receiving therapy privately; involvement with psychiatrist was not included; missing data.
Immediate and Long-Term Food Assistance Programs, A Quality Improvement Assessment
UPMC UPP Matilda Theiss Health Center
Courtney L Watsula

UPMC Matilda Theiss Health Center is a University of Pittsburgh Physicians Family Medicine clinic located in Pittsburgh’s Hill District. Since the 1960’s, Matilda Theiss has provided healthcare to individuals of all ages. Recently, the Matilda Thiess Health Center has partnered with the Greater Pittsburgh Community Food Bank to address food insecurity for the center’s patients.

The Greater Pittsburgh Community Food Bank (GPCFB) opened its doors in Pittsburgh’s Hill District in June of 1980. Today, they work through a network of partner agencies and Partner Distribution Organizations (PDOs) who support additional agencies throughout the service area.

To determine food insecurity, a Hunger Vital Screening survey was administered to 165 patients at Matilda Theiss Health Center as a part of their patients’ yearly well care visits. The survey consisted of six questions pertaining to food insecurity developed by the GPCFB. If patients scored 5/6 or higher on the Hunger Vital Screen, they were offered immediate relief through a Hunger Thrive Box kept onsite with a variety of nonperishable food items. Each box contained a recipe card, local Food Bank schedule, cereal (2), oatmeal (2), shelf stable milk (2), canned vegetables (5), canned fruit (3), canned tuna/chicken (2), peanut butter, and beans.

Based on survey scores, 53 patients received the Thrive Box. A follow-up survey was conducted with 30 of the 53 recipients to assess the impact and quality of the Thrive Box on the overall food insecurity of their household. In addition, the follow-up survey inquired if additional services were needed to support the individual and/or the household’s nutritional needs. At follow-up, participants were provided information about the 412 Food Rescue and Green Grocer. The 412 Food Rescue delivers to Matilda Theiss Health Center once a month, free of cost to clinic patients. The 412 Food Rescue program provides meat, canned foods, bread, snack items, fresh and/or frozen vegetables, and fruits from Gordon Food Services (GFS). The Green Grocer is a weekly mobile farmer’s market truck selling fresh fruits, vegetables, meat and dry goods, located at Matilda Theiss Health Center every Tuesday from 10-11am.

Data collection from the Hunger Vital Screening survey determined that 100% of the recipients of the Food Bank Hunger Thrive Box used all the items within the box. Impact of the box scored a 6 of 10, and quality of the box rated a 6 of 10. Additional comments from the recipients were 1) more canned foods; 2) more milk; 3) more canned fruit; 4) different cereal; and 5) easier to carry packaging. The second stage of the study was to determine if patients who were given additional supplemental food resources participated in the 412 Food Rescue program. Sixty-six percent (66%) of patients who were provided information about the 412 Food Rescue participated in the program. Data collected from stage 2 of the study indicated that 100% of items selected by patients attending the 412 Food Rescue program were used. Impact of the 412 Food Rescue scored a 7 of 10, and quality rated an 8 of 10. Additional comments from the recipients regarding the 412 Food Rescue program were 1) more fruits/vegetables; 2) more variety of meats; 3) smaller cans; and 4) modified distribution times. It was not surprising that the quality rating of the Food Rescue program was higher that the Hunger Thrive Box because patients had the opportunity to select their own food choices when participating in the Food Rescue program.

This two-stage assessment of the food assistance programs contributed toward determining whether current programs are successful in aiding the target population with hunger and food insecurity. The study will continue to be conducted by the integrated health care team at UPMC Matilda Theiss to determine the most beneficial option to aid patients who are identified as experiencing hunger/food insecurity. Recommendations based on this study include: 1) surveys be integrated into all yearly well screenings; 2) responsibility of survey distribution be established and consistent; 3) data be shared with integrated healthcare team; and 4) data be shared with program stakeholders from the GPCFB and 412 Food Rescue.
Immediate and Long-Term Food Assistance Programs, A Quality Improvement Assessment
Courtney L Watsula, Edith M. Baker Integrated Healthcare Fellowship 2019-20

Background

UPMC Matilda Theiss Health center is a University of Pittsburgh Physicians Family Medicine primary care clinic located in Pittsburgh's Hill District. Since the 1960's Matilda Theiss has provided health care to individuals of all ages.

Methodology

A Hunger Vital Screening survey was administered to 165 patients at Matilda Theiss health center as a part of their yearly well visit. The survey was a set of six questions pertaining to food insecurity developed by The Community Food Bank. If patient scored 5 or higher on hunger vital screen, they were offered immediate relief through a Hunger Thrive Box kept onsite with a variety of nonperishable food items. Next, a follow-up survey was conducted with 30 of the 53 recipients to assess the impact and quality of the Thrive Box on the overall food insecurity of their household. The second stage of the study was to determine if patients who were given additional supplemental food resources participated in the 412 Food Rescue program. The same follow-up survey was administered a second time and the impact and quality of The 412 Food Rescue were assessed.

Food Resources at Matilda Theiss

The Community Food Bank hunger thrive boxes- an assortment of nonperishable goods offered to patients scoring 5 or higher on Hunger Vital screen assessment.

The Green Grocer- at Matilda Theiss Health Center every Tuesday.

UPMC UPP Matilda Theiss Health Center

Findings

100% of surveyed recipients reported they used all the food items provided by the Hunger Thrive boxes and 412 Food Rescue.

Hunger Thrive Boxes:
Impact rating 6 out of 10
Quality rating 6 out of 10

The 412 Food Rescue:
Impact rating 7 out of 10
Quality rating 8 out of 10

Demographics

Female: 127 patients
Male: 25
Unidentified: 6

Follow-Up Data

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Social Work Implications

Following data collection, the assessment of food assistance programs has contributed toward determining whether current programs are successful in aiding the targeted population with hunger and food insecurity. This project is being used by the integrated health care team at UPMC Matilda Theiss to determine the most beneficial option to aid patients who are identified as experiencing hunger/food insecurity.

Competencies

Cultural Competence and Adaptation: The ability to provide services that are relevant to the culture of the consumer and their family.
System Oriented Practice: The ability to function effectively within the organizational and financial structures of the local system of health care.
Practice-Based Learning and Quality Improvement: The ability to assess and continually improve the services delivered as an individual provider and as an interprofessional team.

References and Acknowledgements

This fellowship is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number M01HP031376, Behavioral Health Workforce Education and Training (BHWEET) Program. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred from HRSA, HHS or the U.S. Government.
Implementation of Caregiver Check-In Calls at
UPMC St. Margaret Geriatric Care Center
Bailey Nichols

This study utilized an ABA design to determine whether there would be differences in daily self-rated stress levels and daily self-rated life satisfaction levels (see poster) for caregivers of patients with dementia throughout different phases of the study. Daily self-rated stress levels and self-rated life satisfaction scores were collected for each past week during the check-in phone calls. Likewise, the Kingston Caregiver Stress Scale, Modified Caregiver Strain Index, and Caregiver Self-Assessment Questionnaire were administered at the beginning of study (initial A phase), after the intervention (B phase), and after the withdrawal period (second A phase or “follow-up”). These three scores were combined and averaged to create their “Stress Screen Score.” It was hypothesized that there would be a decrease in both stress levels and stress screen scores and an increase in life satisfaction levels in the intervention phase as caregivers were encouraged to increase self-care behaviors as a result of the intervention. By implementing a one-month withdrawal period (Phase A2), the researcher could determine whether the effects of the motivational interviewing intervention resulted in sustained decreases in self-rated stress levels and stress screen scores and increases in life satisfaction. The baseline data (Phase A1) varied from single data points to up to three weeks of data due to the variance in recruitment and availability of subjects. To implement the intervention phase, the researcher created a topical guide for each check-in call that included motivational interviewing skills. Furthermore, the guide was approved by the researcher’s LCSW supervisor to ensure the appropriate incorporation of motivational interviewing techniques. The intervention phase ranged from two sessions to seven sessions; the withdrawal phase occurred during the month of February with a follow-up phone call the first week of March to collect self-rated stress levels, self-rated life satisfaction levels and to administer the three stress screens.

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*Times are rounded to the nearest 15 seconds
**Subject 10 had many of her conversations in person after meeting with the LCSW. Associate measurements were not taken.

Findings and Ideas for Future Research:
Because this is a single-subject study, results cannot be generalized to a larger population of caregivers. Subjects varied considerably in their stress levels and life satisfaction levels throughout the study and had different degrees of variance in day-to-day ratings within each week. Based on the qualitative data, subjects directly attributed stress levels each week to external events, such as issues with their employment (two subjects), their own physical health concerns (two subjects), the decline in the physical or mental health of the patient (four subjects), the stress of the holidays (three subjects) and anxiety regarding advanced care plans (two subjects). Therefore, more research would be helpful to explore the interaction between external events and self-care behaviors on stress levels. Throughout the study, four subjects mentioned at least one urgent situation with their loved one which prevented them from engaging in self-care behaviors (for example, subject 8 dropped out due to the severe decline and hospitalization of the patient). Because several subjects mentioned crisis situations with the patient, it would be interesting to explore whether a telephonic intervention introducing grounding and mindfulness techniques would lead to greater improvements in self-reported stress levels and life satisfaction levels when compared with the motivational interviewing approach. Nevertheless, all five of the participants found the intervention to be helpful, thus, this study can be utilized to shape social work practice and improve the lives of family caregivers.
Implementing caregiver check-in calls

UPMC St. Margaret Geriatric Care Center
- Patient centered medical home for adults over the age of 60 on the campuses of St. Margaret Hospital and Presbyterian Senior Care Oakmont
- Integrated team includes: doctors, nurses, social workers, pharmacists, psychiatrists and a neuropsychologist
- Provides a variety of supports for clients including case management, counseling, assessments and specialized care for neurocognitive disorders

The Problem
Caregivers of patients with dementia are likely to experience additional stress and emotional health concerns as they care for loved ones:
- 83% of caregivers for older adults are considered “informal” or unpaid.
- A 2018 Alzheimer’s Association Study noted that caregivers of people living with dementia engage in an average of 23.9 hours of care per week.
- 59% of caregivers of patients with dementia rank their emotional stress as “high” or “very high.”
- 72% of caregivers indicated that they were either “somewhat concerned” or “very concerned” about the trajectory of their own physical health while caregiving.
- 49% noted that providing care for people living with dementia is “highly stressful.”
- Caregivers of people living with dementia are “significantly more likely” to encounter anxiety or depression compared with those who are not caregivers.

Motivational Interviewing
A meta-analysis of Motivational Interviewing (MI) techniques indicates that MI can be an effective intervention to address the variety of client behaviors and to further evoke client self-change, from the data included in the analysis, the researchers concluded that MI has substantial positive results to support the integration of the intervention in various settings (Lundahl et al., 2010). Through MI, practitioners develop an empathetic relationship, allow the client to discuss their resistance to change by validating and supporting their hesitations about the changes, highlight the areas where the client’s values are not in alignment with their behavior and build client confidence regarding their capacity to change (Lundahl et al., 2010).

Integrated Health Competencies
Interpersonal Communication
- Provided therapeutic interventions to subjects via telephone screening & assessment as part of the care process.
- Staffed in the geriatric care center, participants were contacted to determine whether they would be interested in participating in the care program.

Cultural Competence & Adaptation
- modified intervention to include caregivers of patients with dementia.

Practice-Based Learning & Quality Improvement
- enhanced intervention to determine whether it would be beneficial to include as part of the work for UPMC.

Methods
- Single-subject multiple-baseline study completed for five participants; each participant dropped out due to severe decline of patient and sixth participant did not complete final measurements.
- ABA design
- Multiple baseline caregiver stress measures collected, completed intervention of supportive counseling and motivational interviewing (between two and seven sessions), then one month of withdrawal (no phone calls initiated, participants invited to call if needed)
- Mixed methods
- Qualitative - topical themes identified throughout intervention
- Quantitative - Daily self-rated stress and satisfaction measures recorded weekly
- Kingston Caregiver Stress Scale, Modified Caregiver Strain Index, Caregiver Self-Assessment Questionnaire administered at beginning of study (initial A Phase), after intervention (B phase), and follow-up (second A phase); scores combined and averaged as “Stress Screen”

Results: Common themes
- Self-Rated Stress
  - For most subjects, self-rated stress decreased throughout the course of the study. However, subjects related to stressful events, including work-related pressures, their own stress at the scales of the relative to dementia, rather than the stress of using care for their loved one.

Daily Life Satisfaction
- Self-Rated Satisfaction scores increased for two of the participants throughout the study, decreased for two participants, and remained stable for the fifth participant. Because of these highly variable results, none research is a larger sample of participants. This information determined the stress of using care for their loved one.

Variations in Daily Self-Rated Stress and Satisfaction Scores
- Variations between scores were calculated to conclude that highest weekly self-assessment score from lower weekly self-assessment score within each week. The “range” was found to be difference. The average score of the two highest scores is the average score and the score of the two lowest scores is the range score. Subjects’ stress and overall higher range in the daily life satisfaction scores.

Stress Screen Scores
- Interpersonal Communication
- The difference in scores was calculated by subtracting the highest weekly self-assessment score from the lower weekly self-assessment score within each week. The “range” was found to be the difference. The average score of the two highest scores is the average score and the score of the two lowest scores is the range score. Subjects’ stress and overall higher range in the daily life satisfaction scores.

Survey Results:
- While receiving care checks: 1) 51% of subjects reported increase of self-care, the most of these subjects had some level of support or care from another; 2) 56% of subjects reported that taking time for self-care behaviors made them truly feel better; 3) 25% of subjects reported that taking time for self-care behaviors made them feel more anxious; 4) 23% of subjects that report that they felt their quality of life improved since receiving care checks.

Implications for Social Work Practice
- The social work profession provides a holistic approach to client care, understanding that environmental, social, spiritual and emotional health are interconnected.
- The study suggests that when caregivers report that their quality of life improved since receiving care checks, the social work profession seeks to recognize these changes in addition to addressing the presenting problem to increase overall wellness.
- The study also suggests that when caregivers report that their quality of life improved since receiving care checks, the social work profession seeks to recognize these changes in addition to addressing the presenting problem to increase overall wellness.

Acknowledgement
The research is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number: U29 42022 19. Information at this website is not official U.S. HHS information and does not necessarily represent the views of the U.S. Government.
Improving Care & Collaboration Among Neurological Surgery Care Management
UPMC Presbyterian Department of Neurological Surgery
Courtney Laughlin

Problem
The Department of Neurological Surgery provides care in their outpatient and inpatient settings. The majority of surgeries are scheduled, and the patients are seen during outpatient clinic hours. Currently, clinical staff is composed of PA-C, MDs, RNs, PhD and 21 attending neurosurgeons. These providers are primarily responsible for addressing the medical needs of patients. This means there is a gap in addressing bio-psycho-social needs presented by patients and greater difficulty identifying these needs. Care management staff within neurosurgery inpatient units report a lack of communication & collaboration between providers, and this adversely impacts the quality of care being provided.

Research Questions
- Will the utilization of a social work position in the outpatient Neurological Surgery setting improve communication/collaboration among inpatient care management staff?
- Will an improvement in perceived collaboration & communication between outpatient to inpatient Neurological surgery service impact care-management’s quality of care?

Intervention Method
For the purpose of this research, an assisted care caseload was assigned for follow-up care. This consisted of 2 skull base surgeons and 1 spine-based surgeon. The intervention consisted of two primary interventions lasting 2 months.

1. Creation of Preoperative Screening Assessments
   a. A total of 35 Cranial Patients and 45 Spinal patients were assessed. (Number not recorded)
   b. An assessment tool was created and administered to identify basic demographics, medical decision makers, advance directives, social support, living arrangements, transportation, mental health concerns and Insurance coverage.
   c. For patients screening positive for bio-psycho-social barriers, their needs were to be addressed prior to admission.

2. Neurological Surgery Care Management Inpatient Morning Rounds
   a. Provide care management staff insight into identified bio-psycho-social barriers to successful treatment/discharge
   b. Inpatient care-management will be informed of screens completed and screens not completed
   c. Care-Management staff provides referrals for outpatient follow-up, to social work interns, to examine any bio-psycho-social barriers addressed and/or

An 8-question mixed method survey was administered electronically to care management staff for Neurosurgery Spine & Criminal Unit at pre- and post-intervention. Findings were divided among units based on the unique needs of the patient population. The sample consisted of 3 social workers and 3 care managers. The survey was organized into 3 sections to measure communication, collaboration & quality of care provided.

Findings
Improving Care Through Collaboration & Communication Among Neurological Surgery Care-Management

Author: Courtney Laughlin

Edith Baker Integrated Health Care Fellowship

Intervention

For the Purpose of this research an assisted care load to follow was assigned. This consisted of 2 skull base surgeons and 1 spine based surgeon. The intervention consisted of 2 primary interventions lasting 2 months.

1. Creation of Preoperative Screening Assessments
   a. A total of 35 of Cranial Patients and 45 of Spinal patients were assessed. (Number not recorded)
   b. An assessment tool was created and administered to identify basic demographics, medical decision makers, Advance directives, social support, living arrangements, transportation, Mental health concerns and Insurance coverage.
   c. For patients screening positive for bio-psycho-social barriers they begin to be addressed prior to admission.

2. Neurological Surgery Care Management: Inpatient Morning Rounds
   a. Provide care management staff insight into identified bio-psycho-social barriers to successful treatment/discharge
   b. Inpatient Care-management will be informed what has been completed and/or what still needs to be addressed
   c. Care-Management staff provides referrals for outpatient social work interns to follow-up about any bio-psycho-social barriers unable to be addressed and/or completely

Results

Spine Unit Findings

![Graph showing Spine Unit Findings]

Crannal Unit Findings

![Graph showing Crannal Unit Findings]

Research Methods

A 8 question mixed method survey was administered electronically to care management staff for Neurosurgery Spine & Critical Unit at a pre and post-intervention interval. Findings were divided among units due to unique needs of patient population. The sample consisted of 3 social workers and 3 care managers. This survey utilized 8 likert scale of 0-3

6-Not applicable
1-Could be better
2-Average
3-Frequently Amazing

The survey was broken into 3 sections to measure communication, collaboration & quality of care provided.

Communication
- How often are biopsychosocial needs being communicated to the unit?
- Satisfied are you with the response time of outpatient neurosurgery clinic staff, when needed to discuss biopsychosocial concerns?

Collaboration
- How satisfied are you with outpatient staff support in helping to provide effective care to patient once the pt is on your unit?
- Do you feel both inpatient and outpatient has similar goals to ensure a patient has a successful recovery from surgery?

Quality of Care
- How has the collaboration/communication between outpatient & inpatient neurosurgery providers adversely impacted your work? Provide an example, if applicable.
- How has the collaboration/communication between outpatient & inpatient neurosurgery providers positively impacted your work? Provide an example, if applicable.

The 7th question allowed respondents to add additional comments.
- No participants provided additional comments

Integrated Health Care Competencies
- Collaboration and Teamwork
- Practice-Based Learning and Quality Improvement
- Care Planning and Care Coordination

Implications for Social Work

Findings showed the presence of social work improved care management. These results highlight the need for social workers in a wide array of medical settings to assist in providing effective care but also effect. To improved the delivery of health care systems social workers need to continue investing in similar research studies to re-enforce and advocate to
Increasing Drug and Alcohol Screening and Assessment in a Primary Care Setting

St. Margaret’s Family Health Centers
Hannah Gallagher, Jordan Pollard, and Cassandra Stoyanoff

Background: Risky and harmful use of drugs and alcohol should be screened for in primary care settings just as any other chronic illness. Primary care settings are frontline in early detection for risky and/or harmful substance use. The National Institute on Alcohol Abuse and Alcoholism defines risky use as consuming more than four drinks on any one day or 14 drinks per week for men; more than three drinks a day or seven drinks per week for women. In a survey from the National Center on Addiction and Substance Abuse, 88% of physicians said they ask new outpatients whether they drink alcohol, but only 13% used a formal screening tool. The St. Margaret’s Family Health Centers currently use the AUDIT and DAST to screen for drug and alcohol use, respectively, but not consistently. By educating the family health center staff on the importance of screening for drug and alcohol use, we propose there will be an increase in the use of these screenings. By improving the rates of drug and alcohol screenings, PCPs and behavioral health providers will be able to work together to achieve downstream outcomes effectively. Like other disease models, early detection can lead to better outcomes for the patient. The goal of this project is to increase awareness and use of drug and alcohol screening in the primary care setting.

Competencies: Collaboration and Teamwork, Screening and Assessment, Practice-Based Learning and Quality Improvement

Methodology: This quality improvement project used a pre-post design with an educational intervention and no control group. For our baseline data, we used screening data from April 2019 gathered by resident physicians. After we implemented our intervention, we then gathered data from the charts of patients who had their first visit or annual physical exam in February 2020. According to the protocol at the family health centers, patients should be screened for drug and alcohol use once per year.

Intervention: Social work students collaborated with nurse managers, medical assistants, and residents in their monthly interdisciplinary team meetings. In this meeting, social work students educated medical professionals on the significance of drug and alcohol screenings. Social workers and medical professionals set goals and objectives to increase AUDIT and DAST screening rates.

Results: Due to COVID-19, our internships ended early, and we were unable to finish our data collection. There was an issue in how the screenings were implemented at the Lawrenceville location, and we were unable to use that data. Therefore, the research is inconclusive. Out of the 350 patients, we completed chart reviews for 60. Out of the 60 chart reviews, only 18 patients were eligible for AUDIT/DAST screening (ineligible patients had an appointment for reasons other than their first or annual exam). At the Bloomfield/Garfield location, 13 patients were eligible, and nine were screened. At the New Kensington location, five patients were eligible, and four were screened. Out of these 18 patients, 7 screened positive for drug and alcohol use. These numbers shed light on the importance of screenings because they show patients are struggling with drug and alcohol use, and the primary care setting is an ideal place to begin possible interventions.

Conclusion: More research needs to be conducted to investigate whether staff education can increase screening rates for drug and alcohol use. Some strengths in the study are the importance of the subject matter and the need for improvement in the primary care setting. There were several weaknesses in this study: We were unable to finish data collection due to COVID-19-related restrictions, screening protocol at the Lawrenceville clinic was not consistent with that of the other two locations due to unclear direction, and workflows at the family health centers may have changed between April 2019 (when the baseline data was gathered) and when we implemented the intervention. We encourage future Baker Fellows at St. Margaret’s Family Health Centers to research how to implement a cohesive workflow for drug and alcohol screenings and interventions.
Increasing Drug and Alcohol Screening and Assessment in a Primary Care Setting

Hannah Gallagher, Jordan Pollard, and Cassandra Stoyanoff

Method
1. Analyze baseline screening rates of AUDIT/DAST using data gathered in April 2019.

2. Social work students perform intervention of educating staff on the importance of drug and alcohol screening.


Intervention
Social workers collaborated with nurse managers, medical assistants, and residents in their monthly interdisciplinary team meeting. In this meeting, the social work students educated the other staff members on the significance of drug and alcohol screenings. Social workers and medical professionals set goals and objectives to increase AUDIT and DAST screening rates.

Implications for Social Work Practice
- Raise awareness about the impact of addiction and help and stigmatization in health care setting
- Identify disease and help individual seek treatment
- Promote preventive care and have early discussions with those engaging in risky drinking behaviors
- Provide counseling to those who test positive on the screening tools
- Improve workflow between nurses, doctors, and social workers to best meet the need of the patient

Competencies
- Collaboration and Teamwork: working as an integrated healthcare team to accomplish goal of increased screenings
- Screening and Assessment: improving screening rates for drug and alcohol use across the Family Health Centers
- Practice Based Learning and Quality Improvement: Improving the staff members knowledge of screening tools and furthering the use

Results/Conclusions
Due to COVID-19, we lost access to patient charts before data collection was complete. We only reviewed 60 charts and only 18 of those met the qualifications to receive the AUDIT/DAST. Of those 18, 14 received the AUDIT/DAST. The post-intervention data is inconclusive based on the small sample size.

Conclusion: More research needs to be conducted to investigate whether staff education would increase the use of the AUDIT/DAST in the primary care setting. We encourage the next cohort of Baker Fellows to research how to implement a cohesive workflow for drug and alcohol screenings and interventions.

References & Acknowledgements

This fellowship is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number, M01HP31378, Behavioral Health Workforce Education and Training (BH-WET) Program. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsement be inferred by HRSA, HHS or the U.S. Government.
Measuring Provider Competence, Comfort and Attitudes in Treating Transgender & Nonbinary Patients
McKeesport Latterman Family Health Center
Megan Berringer

This project was inspired by the student’s developing expertise in gender-affirming healthcare for transgender and nonbinary patients. This patient population has historically been subject to mistreatment and negligence in the healthcare setting, which has led to avoidance of primary and emergent care facilities. The student observed that the Family Health Center (FHC), located in a medically underserved community, treated several transgender and nonbinary patients. At the same time, providers and staff had frequent discussions about this and voiced interest in training to improve competency.

Transgender and nonbinary patients seen in the FHC could be referred to specialty practices; however, transportation and loss of continuity of care were often cited as barriers. A new faculty physician with a background in treating this patient population started at the FHC around this time, and the student identified an opportunity to survey and train the graduate medical residents. Under the supervision of the behavioral health scientist and the faculty physician, the student circulated a pre- and post-survey to the residents. The survey used Likert-scale responses to quantify residents’ levels of competency, comfort with, and attitudes toward this population. The student and the faculty physician then facilitated a presentation on gender-affirming care, including best practices and medical interventions like hormone therapy and referrals to surgery, for patients who request them.

The student found residents had some training and experience with this population, but were more comfortable treating patients who did not request medical interventions. Many providers reported they don’t ask about pronouns and gender identity unless they suspect their patient may be transgender. They also identified worry if they used the wrong name or pronouns with their patients. According to the post-survey data, residents generally responded positively to the training, and agreed future residents could benefit from this type of training. They requested examples of assessment questions from the training facilitators, to be used when screening patients about gender identity and pronouns, in order to feel more comfortable asking.

Overall, the student found graduate medical residents were receptive to this training and expressed an interest in learning more about treating transgender and nonbinary patients in a primary care setting. Future opportunities to facilitate this training with content requested by the residents will be incorporated in effort to increase provider competency.
Measuring Provider Competence, Comfort and Attitudes in Treating Transgender & Nonbinary Patients

Megan Berringer, Edith Baker Integrated Healthcare Fellowship

Background

- The FHC treats several patients who identify as gender diverse, however it is unknown if providers are comfortable treating them or if they prioritize transition-related care.
- Transgender & nonbinary patients report negative experiences with healthcare providers, leading to avoidance of routine and emergent care.
- Patients may see the same provider for both transition-related care and routine care, indicating an opportunity to treat patients in the FHC, rather than referring to LGBTQ-specific agencies and providers.

Research Questions

- In which circumstances do providers feel more comfortable treating transgender patients?
- Is this training sufficient to help providers feel more comfortable treating this population in a primary care setting?

Objectives

- Measure provider competence, comfort and attitudes via self-assessment administered to graduate medical residents.
- Facilitate training to review best practices, resources in the McKeesport area, and medical interventions for providers to utilize with their patients.
- Identify areas of improvement and focus.

Method

- Formative evaluation, A-B Design
  - Pre-training Likert-scale questionnaire emailed to residents.
  - 41-slide presentation during weekly lecture series facilitated by MSW student and faculty physician.
  - Post-training Likert-scale questionnaire for feedback.

Results

- Pre-lecture survey
  - \( \alpha = .073 \)
  - About half reported being trained to differentiate between biological sex and gender identity in a classroom setting, but not in practice.
  - On average, providers report being more comfortable treating patients who do not want gender-affirming hormones or surgery.
  - 95% of providers agree or strongly agree that they worry about using the wrong names or pronouns with a patient.

- Post-lecture survey
  - Attendees requested future trainings to include modeling and role play.
  - More than half of respondents strongly agree that other graduate medical residents would benefit from this training.

Conclusions

- Future training will incorporate role-play for learners to become more comfortable asking their patients about gender identity and pronouns.
- Practice-based learning is essential to improve provider competency, comfort and attitudes toward transgender patients, and extending this training to preceptors may make this more accessible.
- In general, residents value their patients’ gender identity and want their patients to feel like it is an important aspect of their care.

Competencies

- Improve Interpersonal Communication by measuring & addressing provider competency that may be a barrier to patient care.
- Discuss ways that attitudes impact how Collaboration & Teamwork with other providers is achieved.
- Inform current and future training through Practice-Based Learning and Quality Improvement.

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Transportation is a barrier to health care access. Patients who miss appointments or don’t reschedule missed appointments with providers because of transportation issues may delay critical intervention which could prevent or reduce negative health status outcomes, including chronic disease exacerbations. Patients who have a lower socioeconomic status (SES) also tend to have more transportation barriers to regular care than those with a higher SES (Syed, Gerber, Sharp, 2013).

Allegheny County addresses this issue for patients with Medical Assistance (MA), and for those who may be especially vulnerable because of their SES, through MATP. The goal of MATP is to eliminate transportation as a barrier to seeking routine medical care among this population. However, many of the eligible patients seen at AGH Internal Medicine are not signed up for this program, and many who are signed up do not utilize the service or are unaware they are even enrolled.

This project was designed to increase the ability of patients to connect to MATP and utilize this resource. During the project period (January 6, 2020 - February 7, 2020) the Social Work Intern reviewed the weekly patient schedule and identified patients with MA. These patients were then compared with the Social Work team’s current list of patients approved for MATP. The Social Work Intern also confirmed the enrollment status of patients with the practice’s MATP contact at Traveler’s Aid, as some patients may have enrolled for the benefit with another medical/social service provider.

For those patients who were already enrolled, an alert note was placed in the EHR (Epic) on their appointment alerting the physicians and care team the patient should receive bus tickets from the Social Work Department before leaving the office. For those who were eligible but unenrolled, an alert note was placed in their file stating the patient was eligible for free transportation and to consult with the Social Work Department if the patient endorsed transportation issues.

Hypotheses:
- Adding an alert note to MATP enrolled patients’ profiles in the EHR will lead to an increase in the utilization of benefits (number of bus tickets distributed)
- Adding an alert note to MATP eligible (but unenrolled) patients’ profiles in the EHR will lead to an increase in the number of patients who are enrolled by the Social Work team

A total of 387 alert notes were placed in the EHR during the intervention period. These alert notes led to an increase in the number of bus tickets distributed to patients and in the number of new patients enrolled in MATP by the Social Work team (see poster for data). Thus, the findings supported both of the hypotheses.

Lack of transportation is a significant barrier to health care for many AGH Internal Medicine patients, which makes it difficult for them to receive needed care. This project was successful in lowering the transportation barrier by ensuring that more patients were enrolled in and utilizing MATP. It also demonstrated that the EHR can be an effective tool to promote interdisciplinary collaboration among all care team members to address the social determinants of health.
Promoting Improved Access to Transportation Resources for Patients Receiving Medical Assistance

Emma Hosack, Edith Baker Integrated Healthcare Fellowship

AGH Internal Medicine

Allegheny General Hospital Internal Medicine is a practice serving patients 18 years and older on the Northside of Pittsburgh. Services offered include wellness visits, sick visits, nurse visits, a diabetic clinic, and the Bridges Clinic (serving individuals who are homeless). There are over 6,000 patients attributed to the practice and the staff can see up to 120 patients a day. The staff operates from a team-based approach and is made up of:

- Registered Nurses
- Certified Medical Assistants
- Health Coaches
- Physicians
- Medical Residents
- Clinical Pharmacist
- Social Worker
- Behavioral Health Consultant
- Dietician

Medical Assistance Transportation Program

The Medical Assistance Transportation Program (MATP) can provide free bus tickets or mileage reimbursement to eligible patients for non-emergency medical appointments. Patients who reside in Allegheny County and receive Medical Assistance (MA) are eligible for the program. AGH Internal Medicine is an approved site through MATP, which means the Social Work team can distribute bus tickets onsite when patients come for appointments.

Findings/Results

- A total of 387 alert notes were placed in the EHR during the intervention period.
- Led to an increase in the number of bus tickets distributed and in the number of new patients enrolled by the Social Work team.

Methodology

- The Social Work Intern reviewed the weekly patient schedule and identified patients with MA.
- These patients were then compared with the current list of patients approved for MATP. The Social Work Intern also confirmed enrollment status of patients with the MATP Site Coordinator for the practice.
- Those patients who were already enrolled had an alert note placed in the EHR on their appointment.
- Patient receives free bus tickets — see SW Kelsey before leaving appt.
- Those who were eligible but unenrolled, had an alert note placed in the EHR on their appointment.
- Eligible for free bus tickets — see SW Kelsey if needed

Introduction

Transportation often acts as a strong barrier to health care access. Patients who miss visits or don’t schedule visits with providers because of transportation issues may delay critical intervention which could prevent or reduce negative health outcomes, including chronic disease exacerbations. Patients who have a lower socioeconomic status (SES) also tend to have more transportation barriers to regular care than those with a higher SES (Syed, Gerber, Sharp, 2013).

Allegheny County addresses this issue for patients with Medical Assistance, who may be especially vulnerable because of their SES, through MATP. The goal of MATP is to eliminate transportation as a barrier to seeking routine medical care among this population. However, many of the eligible patients seen at AGH Internal Medicine are not signed up for this program, and many who are signed up do not utilize the service or are unaware that they are even enrolled.

Implications for Social Work Practice

- It is within the scope of Social Work to ensure that patients are being connected with the resources that they need, especially if they are unaware these resources exist.
- This project also promoted interdisciplinary collaboration, an essential part of Social Work practice in primary care, by pulling in the entire care team as part of the intervention.

Integrated Healthcare Competencies

Screening and Assessment:
- Brief verbal screening of transportation issues for patients who have MA and a more detailed assessment by Social Work, if needed

Practice-Based Learning and Quality Improvement:
- Allowing patients who are eligible for and can benefit from transportation services to “slip through the cracks” because they do not see the Social Work team while they are in the office is considered a poor care outcome and a systemic problem due to the relationship between transportation access and appropriate treatment

Informatics:
- The communication method for screening transportation access was an alert note in the Electronic Health Record (EHR), utilizing information technology which is available to all care team members

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SBIRT Implementation in a Nontraditional Setting: Facilitators & Barriers
UPMC Children’s Adolescent and Young Adult Medicine
Alexandria Gariepy, Renee Kirsch, Roberto Cruz

The mission of UPMC Children’s Hospital of Pittsburgh-Division of Adolescent and Young Adult Medicine is to improve the health and well-being of youth and young adults through holistic health care. Adolescent and young adults undergo several different developmental underpinnings (physiological, interpersonal, biological, etc.) coupled with an increased risk of comorbid mental health diagnoses (Arnett, 2000). Despite the amplified prevalence of mental health diagnoses, studies indicate that young adults are less likely to seek professional help and to access resource referrals (Salaheddin, 2016).

The primary objective of our research was to assess whether it would be beneficial if we provided both SBIRT and CRAFT screenings to every patient who engages in clinic. These efforts, coupled with motivational interviewing techniques and a warm hand off, would be an important step towards increasing likelihood of treatment. The SBIRT data was collected by the Baker Fellows from the Adolescent and Young Adult Medicine at the 412 Youth Zone site. The Adolescent & Young Adult Medicine clinic (funded through Children’s Hospital), serves the role of a community clinic within the Youth Zone. The Youth Zone (initially created by the Allegheny County Department of Health and funded by Auberle) is a facility providing services to youth age 16-23 that are transitioning out of the foster care system and eligible for independent living services, or are experiencing unstable housing. Individuals registered in the Youth Zone can access all clinical resources, including STD testing, pregnancy tests, flu shots, physicals, and other basic first aid measures. Prior to the implementation of the SBIRT and CRAFT screenings, there weren’t any procedural measures in place to address substance use amongst this at-risk population. Youth who have been in foster care, and those who have experienced unstable housing, are at a 39% to 70% increased risk compared to their peers to develop a substance use disorder (Samhsa, 2020).

Over the course of the year, the Baker Fellows evaluated the facilitators and barriers that comprised the implementation of adding preventative measures into an already hectic clinic flow. The initial screening tool was the S2B1, with the CRAFT screening tool also being employed when the S2B1 renders a positive screen. Patients that screen positive then receive the brief intervention and referral for treatment targeting an initial outcome of the patient's knowledge. A total of 69 encounters were recorded, of which 65 (94%) resulted in a completed S2B1 and CRAFT assessment. Of the completed screens, 37 of them (57%) were positive for substance misuse or abuse.

Conclusion
Our research concluded that the major implications prevalent within the facilitators and barriers were a combination of the patient’s perceived need to change surrounding their substance use and not seeing marijuana as an issue. More importantly, during our time at the Youth Zone, we developed a greater appreciation for the importance of social worker placement within non-traditional environments. While social workers are an important aspect of any healthcare setting, those operating in a non-traditional setting are even more important because of the nature of that unique environment. These placements are not only essential to patients, they can contribute to the development of an individual and collective sense of professional identity for the social worker as well.
SBIRT IMPLEMENTATION IN A NON-TRADITIONAL SETTING: FACILITATORS & BARRIERS

Alexandra Gariepy, Roberto Cruz, Renee Kirsch

BACKGROUND

- The mission of UPMC Children’s Hospital -Division of Adolescent and Young Adult Medicine is to improve the health and well-being of youth and young adults.
- Adolescents and Young Adults are at a higher risk of developing a substance use disorder (National Institute on Drug Abuse, 2019).
- Substance abuse is rampant amongst high school students, with over 40% of students admitting use of alcohol, narcotics, illegal prescription drugs and/or nicotine use (National Institute on Drug Abuse, 2019).

AUBERELE 412 YOUTH ZONE

- Program designed to assist youth ages 16-23 who are either transitioning out of the foster care system or are experiencing unstable housing.
- The center provides a variety of services designed to help the youth become self-sufficient adults.
- Baker Fellows will be evaluating the implementation of SBIRT within a community healthcare setting.

SBIRT

Screening, Brief Intervention, and Referral to Treatment

- Evidence-based practice utilized to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drug use.
- All SBIRT data was collected by the Baker Fellows at the Auberele 412 Youth Zone.

SBIRT Scoring:

- Once or Twice (light use), Monthly (Moderate), Weekly or Daily (Heavy to Severe).

CRAFT Scoring:

- 1-2 (low risk), 2 or more (Moderate to High Risk)

METHODS

Step 1: Rapport
- Baker Fellow receives patient and begins building rapport

Step 2: Administration
- Baker Fellow completes intake process with patient
- Administration of S2BI and CRAFT screening

Step 3: Screening
- Negative Screen- Provide client with positive reinforcement
- Positive Screen- Conduct Brief Intervention

Step 4: Brief Intervention- Motivational Interviewing
- Elicit and provide education about benefits/Risks of SUD
- Assess readiness to change by eliciting change talk

Step 5: Brief Intervention- Readiness to Change
- Patient not ready to change- Provide resources/contact information.
- Patient ready to change- Engage in referral process.

Step 6: Referral to Treatment
- Baker Fellow provides warm handoff to Youth Zone’s SUD inhouse therapist.

WHAT ARE THE FACILITATORS & BARRIERS OF THE SBIRT IMPLEMENTATION IN A NON-TRADITIONAL HEALTHCARE SETTING?

SBIRT SCREENS

- 100%
- 90%
- 80%
- 70%
- 60%
- 50%
- 40%
- 30%
- 20%
- 10%
- 0%

REFERRAL TO TREATMENT

- 100%
- 90%
- 85%
- 80%
- 75%
- 70%
- 60%
- 50%
- 40%
- 30%
- 20%
- 10%
- 0%

BARRIERS TO TREATMENT

- 100%
- 90%
- 80%
- 70%
- 60%
- 50%
- 40%
- 30%
- 20%
- 10%
- 0%

- Other
- Time
- Marijuana
- Ambivalence

IMPLICATIONS

- The SBIRT intervention solidifies the need for social workers in nontraditional settings while simultaneously increasing patient flexibility.
- Motivational Interviewing empowers both patients and social workers alike by providing a positive patient centered space to talk about issues relevant to them.
- Many patients expressed gratitude that they were given the opportunity to talk to someone who wouldn’t “judge them.”
- Perceived need is an important perspective to be mindful of when discussing SUD with patients.

IHC COMPETENCIES

Interpersonal Communication
Established rapport quickly and communicated effectively with consumers and providers of Behavioral Health.

Collaboration & Teamwork
Worked on an interdisciplinary team.

Screening & Assessment
Administered an evidence-based screening to all youth who engaged in clinical services at the 412 Youth Zone.

Care Planning & Care Coordination
Assisted in the implementation of integrated care plans to ensure access to an array of linked support services.

Intervention
Provided a range of preventative, treatment, and recovery-based services to consumers of Behavioral Health and their families.

Practice-Based Learning & Quality Improvement
Improved service delivery standard of care at the 412 Youth Zone by implementing SBIRT screening.

RESULTS

Barriers

- All the patients who declined to fill out the assessments cited time as being the inhibiting factor.
- Patient Not Ready
- 21% of patients who declined the referral to treatment said they were not ready to make any changes to their use.
- Client Ambivalence Towards Marijuana
- 60% of patients indicated that they did not believe marijuana was a danger to their health.

Facilitators

- Staffing
- Baker Fellows were able to obtain 94% of S2BI screens.
- Brief intervention completed with 28 clients who screened positive for SUD.

Clinic Flow
- Clinic flow was conducive to the implementation of SBIRT.
- Warm Referral
- 46% of patients accepted a warm referral facilitating a smooth transition for the patient.

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The primary objective of our research was to identify the most pressing issues affecting the health and well-being of our clients and their families in the Pediatric Intensive Care Unit (PICU) at Children’s Hospital of Pittsburgh (CHP). Based on stressors families identified, a resource packet specific to their needs was distributed. In collaboration with the Pediatric Critical Care Medicine Whole Child Team at CHP, we screened families of patients admitted to the PICU using a survey administered through the use of an iPad equipped with the Redcap PICU Social Determinants of Health (SDOH) pilot survey. In order to understand the social determinants of health that affect patients and their families admitted to the PICU, we assessed the following domains: food, housing, transportation, and utilities. Through these questions, our goal was to enhance our understanding of the needs of our families and how those needs might be affecting our ability to work together and provide the best possible healthcare for their child.

The PICU Social Determinants of Health Pilot Study aimed to serve three purposes:

1) Survey PICU families to identify Social Determinants of Health and resource needs
2) Develop an approach to respond to positive screens for each SDOH domain assessed to support patients and families
3) Analyze which factors are contributing to at risk SDOH to help inform future interventions

Along with other colleagues in the PICU, we developed a survey that would be given to families in the PICU via iPad to assess SDOH and the family’s resource needs. We successfully surveyed 32 parents and caretakers of a child in the PICU. After analyzing the data, we found that some demographic factors, such as age and race, had little effect on the individuals who requested resources from the social workers administering the surveys. However, factors such as sex and job status seemed to have an effect on the likelihood of an individual asking for resources. For example, females compromised 75% of the individuals surveyed and they requested 82.1% of the resources. Therefore in our data set, it was more likely for a female to request resources than a male. In addition, when examining job status, the individuals with full-time employment and those who were not currently employed were more likely to request resources (6.2% and 13% increase from their proportional percentage). Those who were employed part-time and who were stay-at-home parents were less likely to request resources (2.7% and 17% decrease from their proportional percentage). The “prefer not to answer category” stayed about the same. Additionally, job status did not have a strong correlation with housing status.

The implications of the study permitted us to infer the following: 1) Unexpected outcomes remind us to gather information about clients instead of assuming an individual’s situation. For example, job status was not related to housing status. In addition, individuals with full-time employment asked for a higher proportion of resources than average; 2) Individuals may want resources even though their SDOH do not indicate so. There were individuals who requested housing and food resources that did not indicate on the survey that they were struggling in these areas; and 3) Our small data set produces a high chance that our results would not be replicated on a higher scale. We were unable to collect more surveys due to procedures and red tape which delayed our start date, and COVID-19 forced us end the study prematurely.
Social Determinants of Health (SDOH) have significant impact on the health trajectory of children. What SDOH most affect families in the PICU of Children’s Hospital of Pittsburgh? How can this knowledge inform future care?

In order to understand the SDOH’s that affect patients and their families admitted to the Pediatric Intensive Care Unit (PICU) at Children’s Hospital of Pittsburgh (CHP), we will assess the following domains: food, housing, transportation, and utilities.

**Methodology**

- Work with interdisciplinary Pediatric Critical Care Medicine Whole Child Team at CHP to screen for current stressors in families of patients admitted to the PICU
- Only Green Team PICU Families (PICU trauma team) will be screened to focus sample
- Baker Fellows attempt to meet with families within 72 hours to administer survey and provide resources specific to the need(s)
- Screen for Social Determinants of Health and current stressors using iPads at admission and discharge when possible
- Provide resource guide for transportation, housing, food, and utilities (scan below)
- Analyze data in REDCap to determine the resources most requested, the demographics served in the PICU, and relationships between SDOH and requesting resources

**Findings**

- Differing Job Statuses were proportionally more or less likely overall to ask for resources
  - **Full-time employment:** Percent of responses (43.8%); Percent of requests (50%)
  - **Part-time employment:** Percent of responses (6.3%); Percent of requests (3.6%)  
  - **Stay-at-home parent:** Percent of responses (31.3%); Percent of requests (14.3%)
  - **Not current employed:** Percent of responses (15.6%); Percent of requests (26.8%)
- Females made up 75% of the surveyed individuals, but requested 82.1% of the responses
- Job Status did not have a strong correlation to housing status
- Age and Race did not have a strong correlation to requesting resources
- We were able to survey 32 individuals total in the PICU

**Implications**

1. Unexpected outcomes remind us to gather information about clients instead of assuming an individual’s situation.
   For example, job status was not related to housing status. In addition, individuals with full-time employment asked for a higher proportion of resources than average.

2. Individuals may want resources even though their SDOH do not indicate so.
   There were individuals who requested housing and food resources that did not indicate on the survey that they were struggling in these areas.

3. Our small data set produces a high chance that our results would not be replicated on a higher scale.
   We were unable to collect more surveys due to procedures and red tape that delayed our start date and COVID-19 that forced us to leave our field placement early.

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Social Work Job Satisfaction and the Impact on Patient Care
West Penn Hospital
Alli Carton

As a Social Work Intern at West Penn Hospital, I examine the link between the social workers’ job satisfaction and patient care. The project was developed after a series of events impacted both hospital morale and the structure of the Care Management Department. While the sample of social workers employed in the Care Management Department is small (N=9), I wanted to assess the way in which improved communication among social workers and other health care providers could have a more positive impact on patient care. My research questions included the following:

1. What impact, if any, does the social worker’s satisfaction rating have on patient care?
2. How do social workers see themselves impacting care?
3. How does the larger interdisciplinary team approach impact the social worker’s role?

The study was an ethnographic study employing both open-ended survey questions and a pre-existing job satisfaction questionnaire that gave quantitative scores for satisfaction. Each social worker was given a packet including a disclaimer statement, five demographic questions, a copy of the short form Minnesota Satisfaction Questionnaire (MSQ) survey, and seven open-ended questions developed by the social work intern. Social workers returned the packets in a sealed envelope to ensure anonymity.

The MSQ scores showed scores in line with other helping professionals. The mean for general satisfaction was 71.78 out of 100, with a standard deviation of 7.74. Intrinsic scores were slightly higher, with extrinsic being several points lower. There were seven major barriers identified by the social workers: patient/social worker ratio, lack of respect for social workers, lack of understanding related to job duties, inappropriate social work consults, lack of network support, limited resources for patients, and social work not being equal to the discharge planner roles.

Themes from the open-ended questions provided 4 main implications. First, continued education on the appropriate roles for social workers in healthcare can promote more effective teamwork. Seven (7) of the 9 respondents reported inappropriate referrals and/or the misuse of social work services as a major stressor. Secondly, macro level change regarding resources is a continued barrier to assisting patients. Social workers’ responsibilities are limited by referrals, insurance, and finances. Third, opportunities for more clinical social work can improve social worker’s intrinsic job satisfaction. Every survey returned mentioned social workers often felt like discharge planners and not a therapeutic resource. Finally, network wide support is needed to decrease turnover and promote productivity among social work staff. The responses highlighted a positive relationship with the social work staff and social work manager but reported minimal appreciation and support external to the Care Management Department.
Social Work Job Satisfaction and the Impact on Patient Care  
Alli Carton, Edith M Baker Fellow

Methodology
Each social worker was presented with a packet including an explanation of the packet, five demographic questions, a copy of Minnesota Satisfaction Questionnaire Short Form survey and seven open ended questions. The project is an ethnographic look into job satisfaction and the impact on patient care. Surveys were returned in unmarked envelopes to a designated location to ensure anonymity.

Demographic Information

Results

Satisfaction Score
Mean
• General: 71.78
• Extrinsic: 66.69
• Intrinsic: 73.34

Satisfaction Score
Standard Deviation
• General: 7.74
• Extrinsic: 6.67
• Intrinsic: 8.98

Barriers
1. Patient-Social Worker Ratio
2. Lack of respect
3. Lack of understanding
4. Inappropriate consults
5. Lack of support from network
6. Limited resources for patients
7. Discharge planning is not equal to social work

Power Structure

How Value is Shown

System
1. Patient Centered Care
2. Values of AHN align somewhat with social work values

Hospital
1. Social Work Week
2. Social Work Luncheon

Department
1. Social Work Manager
2. Shout Outs

Implications
1. Continued education on the appropriate use of SW could promote effective teamwork
2. Macro level change regarding resources is a continued barrier to practice
3. Opportunities for clinical skills and work can improve SW satisfaction
4. Support for social workers can decrease turnover and increase productivity

IHC Competencies
• System Oriented
• Interpersonal Communication
• Collaboration/Teamwork

Study Limitations
• Sample Size
• Unanswered questions in returned surveys
• Ensuring honesty/transparency

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