Building the Plane While Flying It: Promising Practices for Substance Use Disorder Treatment

Tuesday, February 12, 2019
2:00pm ET – 3:00pm ET
The National Nurse-Led Care Consortium (NNCC) is a membership organization that supports nurse-led care and nurses at the front lines of care.

NNCC provides expertise to support comprehensive, community-based primary care.

- Policy research and advocacy
- Technical assistance and support
- Direct, nurse-led healthcare services

This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number U30CS09736, a National Training and Technical Assistance Cooperative Agreement (NCA) for $1,350,000, and is 0% financed by nongovernmental sources. 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.
Questions Welcomed

To ask a question or make a comment for our panelists, type it into the Questions pane in the Go To Webinar control panel.

We’ll address all audience questions during Q&A!
Promising Practices for Substance Use Disorder Treatment

BUILDING THE PLANE WHILE FLYING IT: PROMISING PRACTICES FOR SUBSTANCE USE DISORDER TREATMENT

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NO CONFLICTS OF INTEREST TO DISCLOSE

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LEARNING OBJECTIVES

- Review the state of the state of integrated care
- Identify key opportunities for integration nationally
- Recognize different care models to support patients with Substance Use Disorder & Chronic Pain
- Create & implement workflows that incorporate assessment & clinical management tools
- Provide approaches to develop & use effective individualized treatment plans
NATIONAL COUNCIL FOR BEHAVIORAL HEALTH

2900+ healthcare organizations serving over 10 million adults, children, & families living with mental illnesses & addictions

- Advocacy
- Education
- Technical Assistance
Behavioral health (substance use and mental health) issues affect millions in the United States each year.
PRIMARY SUBSTANCE OF ABUSE AT ADMISSION: 2004-2014

SOURCE: SAMHSA, Treatment Episode Data Set, 2014 results

- No Past Year Substance Use Disorder: 249.3 Million People (92.5%)
- Past Year Substance Use Disorder: 20.1 Million People (7.5%)

Bar graph showing the number of people in millions:
- Alcohol: 15.1 million
- Illicit Drugs: 7.4 million
- Marijuana: 4.0 million
- Misuse of Prescription Pain Relievers: 1.8 million
- Cocaine: 0.9 million
- Methamphetamine: 0.7 million
- Heroin: 0.6 million
- Misuse of Prescription Stimulants: 0.5 million
OPIOID EPIDEMIC

SOURCES: "DRUG POISONING MORTALITY IN THE UNITED STATES, 1994–2015" BY LAUREN M. ROSSEN, BRIGHAM BASTIAN, MARGARET WARNER, DIBA KHAN & YINONG CHONG, NATIONAL CENTER FOR HEALTH STATISTICS, CENTERS FOR DISEASE CONTROL & PREVENTION
RATE OF PAST YEAR OPIOID ABUSE OR DEPENDENCE & RATE OF MAT CAPACITY

*Opioid abuse or dependence includes prescription opioids &/or heroin
Source: AJPH 2015; 105(8):e55-63
Source: N-SSATS 2003-2012
The care that results from a practice team of primary care & behavioral health clinicians & other staff working with patients & families, using a systematic & cost-effective approach to provide patient-centered care for a defined population.

Integration Academy, AHRQ
Illustration: A family tree of related terms used in behavioral health and primary care integration

See glossary for details and additional definitions

**Integrated Care**
- Tightly integrated, on-site teamwork with unified care plan as a standard approach to care for designated populations. Connotes organizational integration involving social & other services. “Altitudes” of integration: 1) integrated treatments, 2) integrated program structure, 3) integrated system of programs, and 4) integrated payments. (Based on SAMHSA)

**Patient-Centered Care**
- “The experience (to the extent the informed, individual patient desires ii) of transparency, individualization, recognition, respect, dignity, and choice in all matters, without exception, related to one’s person, circumstances, and relationships in health care”—or “nothing about me without me” (Berwick, 2011).

**Coordinated Care**
- The organization of patient care activities between two or more participants (including the patient) involved in care, to facilitate appropriate delivery of healthcare services. Organizing care involves the marshalling of personnel and other resources needed to carry out required care activities, and often managed by the exchange of information among participants responsible for different aspects of care” (AHRQ, 2007).

**Shared Care**
- Predominately Canadian usage—PC & MH professionals (typically psychiatrists) working together in shared system and record, maintaining 1 treatment plan addressing all patient health needs. (Kates et al, 1996; Kelly et al, 2011)

**Co-located Care**
- BH and PC providers (i.e. physicians, NP’s) delivering care in same practice. This denotes shared space to one extent or another, not a specific service or kind of collaboration. (adapted from Blount, 2003)

**Collaborative Care**
- A general term for ongoing working relationships between clinicians, rather than a specific product or service (Doherty, McDaniel & Baird, 1996). Providers combine perspectives and skills to understand and identify problems and treatments, continually revising as needed to hit goals, e.g. in collaborative care of depression (Unutzer et al, 2002)

**Integrated Primary Care or Primary Care Behavioral Health**
- Combines medical & BH services for problems patients bring to primary care, including stress-linked physical symptoms, health behaviors, MH or SA disorders. For any problem, they have come to the right place—“no wrong door” (Blount). BH professional used as a consultant to PC colleagues (Sabin & Borus, 2009; Haas & deGruy, 2004; Robinson & Reiter, 2007; Hunter et al, 2009).

**Behavioral Health Care**
- An umbrella term for care that addresses any behavioral problems bearing on health, including MH and SA conditions, stress-linked physical symptoms, patient activation and health behaviors. The job of all kinds of care settings, and done by clinicians and health coaches of various disciplines or training.

**Patient-Centered Medical Home**
- An approach to comprehensive primary care for children, youth and adults—a setting that facilitates partnerships between patients and their personal physicians, and when appropriate, the patient’s family. Emphasizes care of populations, team care, whole person care—including behavioral health, care coordination, information tools and business models needed to sustain the work. The goal is health, patient experience, and reduced cost. (Joint Principles of PCMH, 2007).

**Mental Health Care**
- Care to help people with mental illnesses (or at risk)—to suffer less emotional pain and disability—and live healthier, longer, more productive lives. Done by a variety of caregivers in diverse public and private settings such as specialty MH, general medical, human services, and voluntary support networks. (Adapted from SAMHSA)

**Substance Abuse Care**
- Services, treatments, and supports to help people with addictions and substance abuse problems suffer less emotional pain, family and vocational disturbance, physical risks—and live healthier, longer, more productive lives. Done in specialty SA, general medical, human services, voluntary support networks, e.g. 12-step programs and peer counselors. (Adapted from SAMHSA)

**Primary Care**
- Primary care is the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. (Institute of Medicine, 1994)

Thanks to Benjamin Miller and Megan Unitzer for advice on organizing this illustration.
Behavioral health is a key part of a person’s overall health. It is just as important as physical health. Includes emotional, psychological, & social well-being

- One in four experiences a mental illness or substance use disorder each year
- No difference than physical illnesses
- Often co-occurring physical health concerns
- Stigma
- Access
Primary Care Settings

High prevalence of a range of behavioral health conditions
- Anxiety
- Depression
- Substance use Anxiety
- ADHD
- Behavioral problems in children

People with common medical disorders have high rates of comorbid behavioral health conditions
- Diabetes
- Heart disease
- Asthma with depression

(Worse outcomes & higher costs if both problems aren’t addressed)
INTEGRATION IN PRIMARY CARE MAY INCLUDE:

- Universal Screenings (MH/SU/Suicide/Trauma)
- Clinical teams with embedded behavioral health clinicians
- Prescribing with Psychiatric consultation
- Medication assisted treatment for substance use disorders
- Treatment plans that include mental health/recovery goals
- Wellness services
- Quality Improvement Measures
- Community Linkages
<table>
<thead>
<tr>
<th>LEVEL 1</th>
<th>LEVEL 2</th>
<th>LEVEL 3</th>
<th>LEVEL 4</th>
<th>LEVEL 5</th>
<th>LEVEL 6</th>
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<tbody>
<tr>
<td>Minimal</td>
<td>Basic</td>
<td>Basic</td>
<td>Close</td>
<td>Close</td>
<td>Full</td>
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<td>Collaboration</td>
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<tr>
<td>at a Distance</td>
<td>Onsite</td>
<td>Onsite</td>
<td>Onsite</td>
<td>Attending</td>
<td>Integration</td>
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**In separate facilities, where they:**

- Have separate systems
- Communicate about cases only rarely and under compelling circumstances
- Communicate, driven by provider need
- May never meet in person
- Have limited understanding of each other’s roles

- Have separate systems
- Communicate periodically about shared patients
- Communicate, driven by specific patient issues
- May meet as part of larger community
- Appreciate each other’s roles as resources

- Have separate systems
- Communicate regularly about shared patients, by phone or e-mail
- Collaborate, driven by need for each other’s services and more reliable referral
- Meet occasionally to discuss issues due to close proximity
- Feel part of a larger yet ill-defined team

- Share some systems, like scheduling or medical records
- Communicate in person as needed
- Collaborate, driven by need for consultation and coordinated plans for difficult patients
- Have regular face-to-face interactions about some patients
- Have a basic

- Actively seek system solutions together or develop work-a-rounds
- Communicate frequently in person
- Collaborate, driven by desire to be a member of the care team
- Have regular team meetings to discuss overall patient care and specific patient issues
- Have an in-depth un-

- Have resolved most or all system issues, functioning as one integrated system
- Communicate consistently at the system, team and individual levels
- Collaborate, driven by shared concept of team care
- Have formal and informal meetings to support integrated model of care
- Have roles and cultures
WHAT CAN INTEGRATION LOOK LIKE?

- Behavioral Health Consultants (BHCs) work alongside primary care providers (PCP) & make recommendations to the PCP.
- Immediately accessible for both curbside & in-exam room consults, same-day visits (15 – 30 minute consultation), prevention education/anticipatory guidance.
- Shared records: Chart in the medical record using a SOAP note format.
- No office, No Caseload, No “no shows”
CCBHC: A NEW MODEL

- **National definition** re: scope of services, timeliness of access, etc.
- **Standardized data & quality reporting**
- **Payment rate** that covers the real cost of opening access to new patients & new services...
  - ...including non-billable activities like outreach, care coordination, & more...
ADD’L REQUIREMENTS

- Staffing
- Staff training
- Evidence-based practices
- Care coordination
- Timeliness & ease of access
- Quality reporting
- Organizational authority & governance
CCBHCS & INTEGRATED CARE

Behavioral health & primary care

- Primary care screening/monitoring is a required CCBHC service
- Some CCBHCs also provide primary care on site (not required)
- Numerous required care coordination activities
- Financial support (via PPS) for non-billable activities associated with integration & coordination
CCBHCS ARE MOVING FROM INTEGRATION TO POPULATION HEALTH

- Hiring **dedicated population health analysts**, clinicians, other staff
- Using **data analysis** to understand utilization & risk among client population
- Developing **care pathways** to ensure comprehensive, assertive service delivery to high-risk populations
- Partnering with hospitals to receive **notifications** when patients are discharged
- Assessing for **non-health needs** that are determinants of health (e.g. housing, food, etc.)
- & much, **much more**!
KEY STAFF EXPANSIONS

Within the first 6 months, CCBHCs hired:

- **72** psychiatrists
- **64%** hired peer recovery specialists

90% of CCBHCs have a psychiatrist on staff with an addiction specialty/focus

Within the first year:

- **398** new staff with an addiction specialty or focus
94% of CCBHCs report an increase in the number of patients treated for addiction.

17% of CCBHCs have seen a >50% increase in their number of new patients with addiction.

68% of CCBHCs report a decrease in patient wait times, with nearly half providing same-day access to care.
OPPORTUNITIES OTHER 40 STATES

- Future program expansion
- Medicaid waiver
- Participation in alternative payment models
INTEGRATED CARE SUPPORT

- **Trauma-informed coaching on all aspects of integration**
  - State & local governments
  - Safety Net MH providers
  - Primary Care Providers
  - Funders

- **Trainings**
  - Mental Health First Aid
  - Case to Care Management
  - SBIRT & Motivational Interviewing
  - Medication Assisted Treatment
  - Whole Health Action Management
Implementation: A Population Health Approach

Engages both individuals & the entire population to improve outcomes using interventions to address the health & health needs of both individuals, subgroups, & the whole population

Key System Components

- **Coordinate** care effectively between care team & patient
- **Communicate**, engage & educate patients
- **Use policies/interventions** following clinical guidelines
- **Use patient registries** with valid provider attribution
- **Monitor** & measure clinical metrics
- **Track** specific health outcomes
Models of Care
For Patients on Opioids for Chronic Pain

Traditional

- Patient
- Clinician
- RN/LPN
- SW
- MA
- CM
- Front desk staff

Interdisciplinary Team

- Clinician
- Lab
- RN/LPN
- Front desk
- BH
- Psych/SW/CM

For Patients on Opioids for Chronic Pain
## Practice-Base Models

<table>
<thead>
<tr>
<th>Model</th>
<th>Description</th>
<th>Meds</th>
<th>Ed/Outreach</th>
<th>Coordination/Integration of Care</th>
<th>Psychosocial</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>OBOT</td>
<td>Rx’d by Waivered PCPs</td>
<td>Mostly Bup / Nx</td>
<td>Not major, PCSS-MAT available to mentor PCPs</td>
<td>Non-clinician to coordinate</td>
<td>MD or other staff (on &amp; off site); incl: integrated CBT, MI</td>
<td>na</td>
</tr>
<tr>
<td>Buprenorphine HIV Evaluation &amp; Support Collaborative model (BHIVES)</td>
<td>Rx’d by Waivered PCPs in PC HIV clinic</td>
<td>Bup / Nx</td>
<td>Pt &amp; Clinicians online Ed materials</td>
<td>Treatment for OUD &amp; PC integrated into same setting, Non-physician clinical staff coordinates care &amp; collaborates with HIV &amp; PC Providers</td>
<td>On-site Psychosocial services vary: Indiv.&amp; Grp counseling</td>
<td>Coord. w/ OTP for Pts switching to or from Methadone</td>
</tr>
<tr>
<td>One-Stop Shop</td>
<td>Integrated in Mental Health Ctr, one-stop comprehensive mgmt. of HIV/HCV/MAT</td>
<td>Mostly Naltrexone</td>
<td>Clinician Ed in MAT &amp; mgmt. of HIV/HCV infections</td>
<td>Treatment for OUD &amp; PC provided same setting, Peer navigators &amp; SW coordinate care PCPs</td>
<td>Centered in MHC providing comprehensive psych services; See Psychiatrist weekly</td>
<td>SIP, Model responds to rural HIV/HCV outbreaks</td>
</tr>
<tr>
<td>Integrated Prenatal</td>
<td>Prenatal care to women Rx’d MAT</td>
<td>Bup</td>
<td>Not major, PCSS-MAT available to mentor PCPs</td>
<td>PC clinic provides MAT &amp; Perinatal care up to 1 year after delivery, Some pgrms women can work as Doulas</td>
<td>na</td>
<td>na</td>
</tr>
</tbody>
</table>

## System-Based Models 1

<table>
<thead>
<tr>
<th>Model</th>
<th>Description</th>
<th>Coordination/Integration of Care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hub &amp; Spoke</strong></td>
<td>Centralized intake, initial mgmt. (induction) at “Hub”; Pt then connected to spokes in the community for ongoing mgmt.</td>
<td>Coord/integrate btw hub &amp; spoke &amp; within each PC site spoke; RN, Clinician, CMs, a/o Care Connector coord/integrate care at spokes</td>
</tr>
<tr>
<td><strong>Medicaid Health Home</strong></td>
<td>MAT in combination w/ Behavioral health therapies &amp; integrated with Primary care,</td>
<td>Required, but coordination mechanism varies</td>
</tr>
<tr>
<td><strong>Project ECHO</strong></td>
<td>rural primary care clinics linked to university health system, NP &amp; PA screening &amp; MAT, Rx combined w/ counseling/behavioral therapies</td>
<td>Initial eval/screening by NP/PA; educate &amp; refer Pt to an MD/NP/PA for MAT. NP/PA: monitoring, treatment, &amp; FU appts. Drug testing, monitoring, Pt ed &amp; support</td>
</tr>
<tr>
<td><strong>Collaborative</strong></td>
<td>Links OTP w/ OBAT providers, initial intake, induction/stabilization at OTP then to Primary Care clinic</td>
<td>Initial assessment, PS Rx &amp; expert consultation initiated in drug Tx prog. Transition to Primary care at FQHC after stabilized</td>
</tr>
<tr>
<td><strong>Mass Nurse Care Manager</strong></td>
<td>Primary Care based; NCM/PCP team. NCM screening, intake, education, induction (observed/supported), FU, maintenance, stabilization, &amp; medical mgmt. w/ MD/Team</td>
<td>NCM manage 100-125 pts alongside an MD w/ MA support</td>
</tr>
<tr>
<td><strong>ED Initiation of OBOT</strong></td>
<td>ED id of OUD; bup/nx induction in ED; coord. w/ OBOT nurse w/ expertise in bup working in collaboration with PCP</td>
<td>OUD id’d in ED &amp; pts started on bup, linked to OBOT by MDs &amp; NPs for 10 wks., then transfer to OBAT maintenance treatment or detox.</td>
</tr>
<tr>
<td><strong>Inpatient Initiation of MAT</strong></td>
<td>Identify OUD in hospital/link patients to office-based MAT &amp; primary care</td>
<td>Multidisciplinary inpatient addiction consult initiates MAT, linkage &amp; Bup “bridge” clinic for transition to treatment in primary care</td>
</tr>
<tr>
<td><strong>Southern Oregon Model</strong></td>
<td>A local &amp; informal model for delivery of MAT in a rural primary care network</td>
<td>limited support for coordination/integration of care</td>
</tr>
</tbody>
</table>
## System-Based Models 2

<table>
<thead>
<tr>
<th>Model</th>
<th>Education/Outreach</th>
<th>Psychosocial</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hub &amp; Spoke</strong></td>
<td>Outreach to community-based prescribers to increase # of MDs with Bup waivers</td>
<td>Embedded in spike sites including SWs, counseling, &amp; Community health teams</td>
<td>Hubs provide consultative services, Manage complex pts, support med tapers / methadone</td>
</tr>
<tr>
<td><strong>Medicaid Health Home</strong></td>
<td>Clinician &amp; Community Education to increase uptake &amp; decrease stigma</td>
<td>Comp. care mgmt.; care coord, health promotion; comp. transitional care/FU, individual &amp; family support, &amp; referral to community &amp; social support svcs</td>
<td>Some telehealth services offered</td>
</tr>
<tr>
<td><strong>Project ECHO</strong></td>
<td>Mentored Bup/Nx Rx for clinicians (Online AV network). Free waiver training. 1-to-1 or in a group setting</td>
<td>Counseling &amp; behavioral therapies offered by ECHO team (CHW &amp; NPs provide ed/support; PS support include 12-step prgms, crisis counseling, refs., relapse prev.</td>
<td>Refer pts with high/moderated risk for Opioid use to NP for further assessments a/o referral to an OTP</td>
</tr>
<tr>
<td><strong>Collaborative</strong></td>
<td>Outreach by Counselors to community physicians</td>
<td>Provide concurrently via OTP. Incl. ongoing counseling &amp; monitoring</td>
<td>Facilitates/coordinates access to Medicaid</td>
</tr>
<tr>
<td><strong>Mass Nurse Care Manager</strong></td>
<td>training: to incr. physician participation, DPH on Best practices, NCM (8 hrs.) on MAT, model MAT site shadow, site-visits, email/ tele support, case review, quarterly training &amp; addiction listserv)</td>
<td>Psychological support services Integrated onsite or nearby</td>
<td>Pt req higher level of care referred into OTP, assist. w/h transfers &amp; day-care prgms</td>
</tr>
<tr>
<td><strong>ED Initiation of OBOT</strong></td>
<td>NA</td>
<td>“Medical management” counseling visits with physician &amp; nurse</td>
<td>NA</td>
</tr>
<tr>
<td><strong>Inpatient Initiation of MAT</strong></td>
<td>NA</td>
<td>Provided at primary care site</td>
<td>NA</td>
</tr>
<tr>
<td><strong>Southern Oregon Model</strong></td>
<td>Local prescriber stakeholders opioids, meet &amp; develop guidance &amp; education</td>
<td>On-site LCSW w/ experience in treating pain &amp; addiction, not only MAT.</td>
<td>Access to OTPs for complex patients not formally integrated.</td>
</tr>
</tbody>
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## Controlled Substance Prescribing Policies

### Patient Provider Agreement (PPA)
- Informed consent of risk & benefits of treatment
- Universal precautions (every patient, every visit)

### Treatment Planning
- Individualize care & treatment plan
- Medication management
- Monitoring for benefits (PEG scale*) & harms

### Procedures
- Refills, Urine Drug Test (UDT), pill counts, Prescription Drug Monitoring Program (PDMP, e.g. CURES 2.0§), etc., PEG scale*
- Promotion to increase intensive level of care (e.g. Intensive Outpatient Program (IOP), Pain Clinic)
- Electronic Health Record (EHR) templates & forms

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§ Controlled Substance Utilization Review & Evaluation System 2.0

Referral, Support, Educational Resources

• Develop referral & support resources
  • Co-prescribing naloxone ([www.prescribetoprevent.org](http://www.prescribetoprevent.org))
  • Pain, Addiction specialists
  • Mental health, case management/advocacy (e.g. housing)
  • Patient-level resources (e.g. AA; American Chronic Pain Assn.)
  • Key online resources such as [www.mytopcare.org](http://www.mytopcare.org) (for clinicians, pharmacists & patients)

• Obtain educational materials
  • Medication interaction/overdose prevention
  • Safety, storage & disposal training
  • For healthcare staff ([www.scopeofpain.org](http://www.scopeofpain.org))
Patient Registry

Policies

Patient Registry (def.): An organized system using observational study methods to collect uniform clinical data to evaluate specified outcomes for a population defined by a particular disease, condition, or exposure, & that serves a predetermined clinical or policy purpose(s).

• Require consistent, universal use of registry/tracking system
• Establish & enforce documentation expectations
• Determine if paper-based vs. electronic
• Establish process system use & report distribution
  • Practice/provider level reporting
Registry Components

Core Components/Track Key Quality Indicators

• Last & next
  • Medication refill; pill count; UDT; PDMP check

• PPA signed

• Risk assessment & monitoring data
  • Aberrant medication taking behaviors
  • Clinical monitoring data (UDT, PEG, etc.)

• Reporting tools
  • By level: Patient/Provider/Practice/System Level

Key Design Factors:
  o Must follow & facilitate prescribing & refill workflow
  o Must avoid/minimize double data entry
Intake, Treatment Planning, Referral, Discontinuation

- **Intake encounter**
  - Procedure/template
  - Evidence-based SBIRT (Screening, Brief Intervention, & Referral to Treatment)
  - PDMP checking (by delegates if permitted)

- **Individualized treatment planning**
  - Procedure/process/template
  - Revise treatment plan components as necessary

- **Referral for other services**
  - Mental health, specialty pain service, addiction treatment, etc.

- **Discontinuation process**
**Suggested New Patient Workflow**

**Receptionist Intake**

- **New Patient:** Calls for appointment for treatment of chronic pain
  - Patient instructed to obtain medical records/permission to speak to previous clinician
    - Currently on opioids? NO: Schedule appointment with Case Manager
    - YES: Check PDMP
      - Evidence of Misuse or Diversion?
        - YES: Review with Clinician
        - NO: Patient meets with Case Manager
          - • Orient Patient
          - • Obtain histories
          - • Risk assess

**Care Manager Assessment & Monitoring**

- Check PDMP
- Patient meets with Case Manager
  - Evidence of Misuse or Diversion?
    - YES: Review with Clinician
    - NO: • Orient Patient
    - • Obtain histories
    - • Risk assess

**Clinician Diagnosis & Treatment**

- Review with Clinician
- Patient meets with Clinician
  - Clinician writes opioid Rx
    - • Rx recorded in registry
    - • Next refill date noted
  - Can patient be safely & effectively treated/managed for chronic pain?
    - YES: Clinician signs Rx
    - NO: Patient referred to another provider

**Treatment Planning & Coordination**

- Case reviewed with TEAM
  - • First Visit
  - • Schedule visit with Clinician
  - • Follow-up Visit
Suggested Established Patient Workflow

**Receptionist**
- Intake
  - Patient: Schedules FU appt. for treatment of chronic pain
  - Patient placed on registry list for TEAM review prior to next visit

**Care Manager**
- Assessment & Monitoring
  - FU with Clinician
    - Meets with Care Manager
      - • Hx since last visit
      - • Monitor for risk
    - Treatment Plan informs clinical actions & decision making
      - • Rx recorded in registry
      - • Next refill date noted
    - Meets with Care Manager
      - • Hx since last visit
      - • Monitor for risk

- Next visit schedule with Clinician
  - Evidence of aberrant med taking behaviors or diversion
    - No
      - Care Manager writes opioid Rx
    - YES (YES)

**Clinician**
- Diagnosis & Treatment
  - Patient meets with Clinician
  - Clinician writes opioid Rx
  - Clinician signs Rx
  - Discuss with Clinician
  - Case reviewed with TEAM

**TEAM**
- Treatment Planning & Coordination
  - Treatment plan created/revised
  - Purpose of visit
    - FU with Clinician
    - Monitoring only
  - Med refill
  - Patient presents for appointment
  - Med refill or monitoring only
  - Purpose of visit

- Next visit schedule with Clinician
Ongoing Evaluation Encounter

- Develop a Procedure
- Create an Health Record template
- Monitor for:
  - Aberrant medication taking behaviors etc.
    - Use: PEG/COMM (Current Opioid Misuse Measure)
  - PDMP Checking (by delegates if allowed by law)
  - Diversion &/or use disorder using supervised:
    - Pill counts (scheduled/random)
    - UDT (scheduled/random)
  - Work with the UDT lab
    - Send out vs. Point of Care
    - Confirmatory testing

- Review Patient-Provider Agreement (PPA)
  - at least annually
Roles

• **Nurse:**
  • Needs specific skill set; provide development training
  • Key behaviors (TOPCARE*)
  • Develop & maintain therapeutic alliances with patients
  • Participate in treatment planning
  • Intake (initial assessment) & Monitoring encounters
  • Facilitate medication refills/maintain patient registry

• **Medical Assistant**
  • Rooming patients / Routing patient calls
  • Manage sample collection for drug testing

• **Behavioral Health (if onsite)**
  • Intake & initial assessment
  • Participate in treatment planning
  • Facilitate/provide counseling

• **Other team members (onsite vs. offsite)**
  • Behavioral Health
  • Pharmacists

Hiring
Key interview questions
Care philosophy (safety oriented)
Documentation & Tracking

• Health record (electronic or paper) encounter templates
  • Intake
  • Treatment planning
  • Ongoing visits
    • Refills
    • Monitoring (callbacks for UDT & pill counts)

• Key elements to support safe prescribing

• Work with EHR vendors to:
  • Support practice of safe opioid prescribing
  • Develop customized encounter forms & processes (local EHRs)
The Implementation Team

Monitors the System

Employ principles of “Diffusion of Innovations”

• Leverage peer-to-peer communication networks
• Anticipate time for process to unfold through key stages
  Knowledge / Persuasion / Decisions / Implementation / Confirmation
• Identify, recruit & engage opinion leaders, early innovators/early adopters
• Deputize a *Program Champion*
  • A recognized & respected practice opinion leader
  • Critical to project success

The Implementation Team

Implements the System

• Create multidisciplinary Implementation Team
  • Medical Clinicians & Nursing
  • Behavioral Health/Pharmacy
  • Meet weekly

• Huddle/problem-solve during each clinic
  • About first 6 months

• Policy & procedures won’t be perfect initially
  • Anticipate need to further improve systems based on real experience

NB: It’s an iterative process…
Transition from Implementation to Care Team

Aim for Smooth

• Ensure use of clinical data tools
  • Risk assessment (ORT, SOAPP, DIRE*)
  • Ongoing risk monitoring (COMM, UDT, pill counts, PDMP)
  • How will manage different risk levels?
• Keep program up to date with rapidly changing state laws/regulations
• Provide clinicians & staff ongoing training
  • Review & revise policies & procedures
  • Communicate with patients & with each other

*ORT: Opioid Risk Tool
SOAPP: Screener & Opioid Assessment for Patients with Pain®
DIRE: Diagnosis, Intractability, Risk & Efficacy Score
Concrete Steps when Starting & Tuning

Timing

• Expect weeks to months of development with lots of uncertainty, iterative testing & revision...

• BUT, start sooner rather than later
  • No more than 6-8 weeks of planning before you start

• Engage & get leadership buy-in for a fluid implementation/adjustment period of 6-12 months
Concrete Steps when Starting & Tuning

During the Transition

• Weekly Implementation Team meetings

• Continue to:
  • Collect data, share amongst team
  • Devise strategies (with low investment) to test effect & effectiveness

• If it works, keep it; if not, jettison & try something else

• Don’t overanalyze — Just do it
Get the Clinical Team up to Speed
Meet before &/or after each clinic

- **Discuss patients**
  - Each new & existing patient seen during clinic
  - Other patients with active issues

- **Review key topics**
  - Treatment plans/active issues
  - Case management
    - Adjunct Therapies (counseling, PT, acupuncture, etc.)
  - Pain control/pain medications
    - Dose (effective & appropriate?)
    - Prescriptions & refills (aberrancy?)
  - Review monitoring reports
    - UDT & pill counts: aberrancies?
    - PMDP: patterns of opioid use disorder &/or diversion?
Transition from Implementation to Treatment

Implementation Period

- Create TEAM & meet weekly
- Huddle/problem-solve during each clinic
- It’s an iterative process...

Treatment Period

Discuss patients:
- Every patient seen/every clinic
  - Other patients with active issues
- Review key topics
  - Treatment plans/active issues
  - Case management
  - Pain control/pain medications
  - Review monitoring reports

Actual team members may change during transition
Prepare for Growing Pains

• Work with providers non-adherent to practice policy & procedures
  • e.g. “My colleague is overprescribing. What should I do?”
  • Consider periodic practice reviews to make sure the practice is following best practices

• Work with patients unhappy with new procedures
  • Getting buy-in & cooperation from all staff
  • Avoiding patients “dividing” staff

• Respond to unanticipated clinical issues
Questions?

• Slides available in Handouts pane (right side of your screen)
• CME/CNE credit link in chat box and follow-up email

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