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Project ECHO®

Opioid Review and MAT Clinic
Patient Centered Medical Home

July 25, 2018

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Announcements

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- CME evaluation forms are due to Katie Stangl by Friday, July 27th at 4:00pm.

Upcoming Presentations

- **Coming soon!**
  - **August 1:** Dr. Sarah Spencer, DO in Homer, AK presenting on Opioid Overdose Response Training
  - **August 8:** Dr. Peter Stiles from TRIA Orthopedic presenting on comprehensive management.
  - **August 22:** Dr. Lisa Lindquist, psychiatrist in Anchorage

Outcomes

- Demonstrate understanding of patient centered medical home care concept
- Construct your opioid care team around the PCMH model

Team Based Care

- A provision of evidence-based health services for consumers led by at least two health professionals who work collaboratively with patients and their caregivers to accomplish shared goals within and across care settings to achieve care that is efficient, effective, and patient-centered.

Professional Collaboration

- Establish a partnership style of interaction **between and among professionals** to share information, engage in collective decision-making, and develop effective interventions for an agreed upon goal that is in the best interest of the patient

Controlled Substance Care Team

- Nurse
  - Medication list, PMP, images, labs
- Social Worker
  - Documents, social needs, other relevant
- Physician
  - Appropriate diagnosis for pain meds, next steps

Suboxone

- Nurse
  - History, PMP, health, medications
- Social Worker
  - Social needs, treatment, releases
- Physician
  - Suboxone dose, etc.

Top of Licensure

- Promote care model development to ensure all healthcare providers and support staff are practicing to the full extent of their education, training, skill and **expertise**.

Optimized Care Delivery

- Improve patient outcomes
  - Remove variability
- Enhance patient experience and ensure cost-effectiveness
  - Fiscal viability/sustainability

Team Based Care

- A continuous relationship with a personal physician coordinating care for both wellness and illness
  - Mindful clinician-patient communication: *trust, respect, shared decision-making*
    - Patient engagement
    - Provider/patient partnership
    - Culturally sensitive care
    - Continuous relationship
    - Whole person care

Mission Statement of our Clinic

- *Family Medical Center will work in partnership with our patients to deliver patient-centered care with the intent of improving coordination of care, enhancing patient experience, and reducing the cost of care for a healthier Morrison County.*

Care Team Development

- PCMH Leadership Team
- RN Health Coaches - RN Health Navigators
- Care Team evolution
- CSCT (Controlled Substance Care Team)
- Care Conference with In-Patient DC's
- Daily Huddles (provider/nurse & full teams)

Care Coordination

- Identified Populations (Registries)
  - Diabetes
  - OB
  - Coumadin
  - **CCS – Chronic Controlled Substance**
- Care coordination Registry
  - RN Navigator Actionable listing (non Registry) for the not yet enrolled or declined.
- DC/Lace Score- SGH Discharge

Access and Communication

- After Hours Care:
  - Care Coordinated Patients: 24/7 nurse #
    - Education at staff meetings
    - Use of the FYI Flag & CC Dx on prob list
    - Pt's are instructed with their care plan
  - After Hr's Care Link # success stories
    - Reduced ER utilization
    - Avoidable Admits
    - Decrease in ER Dx related to therap. drug monitoring

Buprenorphine Patients

- Care coordinated patients have direct number to CSCT nurse and social work team
- After hours → ER
  - This is a difference, however NONE have

Outcomes

#1

In 2014, the #1 Emergency Department diagnosis was therapeutic drug monitoring

As of Nov. 2015, Emergency Department diagnosis for therapeutic drug monitoring is no longer on the Top 20 list

#20

D.I.R.E. Risk Assessment Tool

Table 1. D.I.R.E. Score: Patient Selection for Chronic Opioid Analgesia

Score	Factor	Explanation
	Diagnosis	1 = Benign chronic condition with minimal objective findings or no definite medical diagnosis. Examples: fibromyalgia, migraine headaches, non-specific back pain. 2 = Slowly progressive condition concordant with moderate pain, or fixed condition with moderate objective findings. Examples: failed back surgery syndrome, back pain with moderate degenerative changes, neuropathic pain. 3 = Advanced condition concordant with severe pain with objective findings. Examples: severe ischemic vascular disease, advanced neuropathy, severe spinal stenosis.
	Intractability	1 = Few therapies have been tried and the patient takes a passive role in his/her pain management process. 2 = Most customary treatments have been tried but the patient is not fully engaged in the pain management process, or barriers prevent (insurance, transportation, medical illness). 3 = Patient fully engaged in a spectrum of appropriate treatments but with inadequate response.
	Risk	(R = Total of P + C + R + S below)
	Psychological:	1 = Serious personality dysfunction or mental illness interfering with care. Example: personality disorder, severe affective disorder, significant personality issues. 2 = Personality or mental health interferes moderately. Example: depression or anxiety disorder. 3 = Good communication with clinic. No significant personality dysfunction or mental illness.
	Chemical health:	1 = Active or very recent use of illicit drugs, excessive alcohol, or prescription drug abuse. 2 = Chemical coper (uses medications to cope with stress) or history of CD in remission. 3 = No CD history. Not drug-focused or chemically reliant.
	Reliability:	1 = History of numerous problems: medication misuse, missed appointments, rarely follows through. 2 = Occasional difficulties with compliance, but generally reliable. 3 = Highly reliable patient with meds, appointments & treatment.
	Social support:	1 = Life in chaos. Little family support and few close relationships. Loss of most normal life roles. 2 = Reduction in some relationships and life roles. 3 = Supportive family/close relationships. Involved in work or school and no social isolation.
	Efficacy score	1 = Poor function or minimal pain relief despite moderate to high doses. 2 = Moderate benefit with function improved in a number of ways (or insufficient info- hasn't tried opioid yet or very low doses or too short of a trial). 3 = Good improvement in pain and function and quality of life with stable doses over time.

Care Plan

- Care Plan Creation & Smart Goals
  - *Example- CSCT Goal Setting*

Access & Communication

- Shared Decision Making: upon enrollment & goal setting
  - Involved in preference for treatment
  - Collaborative decision on when treatment since treatment isn't rushed

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Non Punitive

Patient Care and Registry Tracking

- Pre-Visit Plans for All New Patients
- Diabetes Registry: Updated, to providers for review, recalls by registration
- Care Coordinated Tracking Sheets
  - Care Coordinated enrollee's
  - C2 Identified Registry, Care Plans CS, Tapered/stable
- ***DAR (Follow up appt report/Recalls)***
- MyChart Portal – Prev. Services Reminders
- Refill Protocol – includes appts, last urine drug screen
- Coumadin – INR reminders
- Referral Process includes follow up for missed/un-kept referral
- OB registry – Hospital communication, consents (reg)
- SCHA/UCare: Pt list for services

Enrollment Process

- Explain to patient what a medical home is
- Nurse explains what he/she can help with- the care is tailored to the patients' needs
- Go through intake process with patient. Review:
  - Medications
  - Medical issues
  - Social issues
- Sign enrollment paperwork
- Signed releases from family or other facilities
- Develop care team for patient. Includes anyone involved in care such as dentist, home care service, etc.
- Provide resources for medication patient needs

Enrollment Process

- Put in referrals
- Connect patient to homecare/nursing home if needed
- Set goals
- Develop emergency care plan
- Enroll in EMR
  - Complexity of patient used to tier level of care
    - Billing based off of complexity

  - Medicare requires 20 minutes of contact a month to bill
  - Medicaid/South County allows for monthly billing regardless of contact with patient