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Health Solutions

Clinical Workflows for Medications Assisted Treatment (MAT) In a Health Network

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Overview

- Collaborative care and the “Referral Loop”
  - “Access” and “Service”
- Participating in the new paradigm – national standards for exchanging information
  - What information is shared
  - When it is shared
  - How it is shared (HIPAA compliant, 42 CFR compliant)
  - Who it is shared with
- Developing information-sharing processes using workflow analysis (applied to “Referral Loop” activities)

Collaborative Care and the Referral Loop

(Medical) Case Information

Patient

- Jeffrey Surrat - 33 year old male, presents at the Community Cares FQHC complaining of back pain.
- After screening for drug/alcohol use and conducting a physical exam, the physician at the FQHC has found evidence that the patient is dependent on heroin.
- Collects samples (blood, urine) for lipid panel, other tests
- Patient also indicates that he was diagnosed with hypertension and has not taken medication in over a year

Conditions

- Physician is qualified to prescribe buprenorphine , has DATA waiver
- FQHC has a contractual relationship with FirstCare, addiction treatment provider, to collaborate in patient care

Patient Access/Service PCP Protocols

1. Establish the diagnosis or diagnoses
2. Determine appropriate treatment options for the patient
3. Make initial treatment recommendations
4. Formulate an initial treatment plan
5. **Plan for engagement in psychosocial treatment**
6. Ensure that there are no absolute contraindications to the recommended treatments
7. Assess other medical problems or conditions that need to be addressed during early treatment
8. **Assess other psychiatric or psychosocial problems that need to be addressed during early treatment**

(Behavioral Health) Case Information

- Jeffrey Surrat - 33 year old male, presents at the FirstCare provider with referral from PC for MAT
- Patient medical condition is stabilized and he is in his 3rd week of opioid replacement therapy
- Psychosocial summary may include information on how the patient presents, family history, social history, previous treatment episodes, detailed information on all drug and alcohol use, etc.
- Referral to psychiatrist may generate another (psychiatric) diagnosis and more medication
- May conduct periodic toxicology screening

BH Patient Access/Service Protocols

- **Be part of the patient care team** (#s 5 & 8 of PCP protocol)
- Can be formal arrangement (health home, patient centered medical home) or contractual between one or more primary care providers
- **Receive** and **transmit** critical patient information, using it to inform patient care
  - Type and level of communication depends on type/level of integration of services

*Function – Access

- ***Minimal Collaboration***: 2 front doors; 2 separate service sites
- ***Basic Collaboration from a distance***: 2 front doors; cross system communication on individual cases

*Function – Service

- ***Minimal Collaboration***: Separate and distinct services and treatment plans; two (or more) physicians prescribing
- ***Basic Collaboration from a distance***: Separate and distinct services with occasional sharing of treatment plans for Quadrant 4 consumers

*Doherty, McDaniels, Baird, Reynolds. Levels of Integration. Retrieved April 2013 from http://www.integration.samhsa.gov/resource/doherty-mcdaniel-baird-reynolds-levels-of-integration

Referral Loop

Two functions in "Basic Collaborative Care from a distance" where loop applies – "Access" and "Services"

1. Critical information is effectively transferred from PCP to Specialty Provider
2. Critical information is effectively transferred to the patient by PCP
3. The specialist communicates critical findings to the patient
4. The specialist communicates the results of the referral to the PCP
5. The PCP has access to these findings, and receives updates if patient situation changes

Referral Loop

How can the PCP access referral results?

What is "critical information?" How is it "effectively" transferred?

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Challenges

Note patient's inclusion in communications among and between primary and specialty care providers

How is the "referral result" defined?" How is it communicated?

Participating in the New Paradigm – National Standards for Sharing Patient Information

What is the "Critical Information" to be Shared between Two Different Worlds? When is it shared?

- Already decided through national standards
- Stage 1 **Core Objective #13** – Provide Clinical Summaries for patients after each office visit
  - **Clinical summaries** provided to patients after each office visit for more than 50% of all office visits within 3 business days
  - Can be used for ***referral follow up***
- Stage 1, **Menu Objective #8** – Transitions of Care or Referral
  - The Eligible Professional who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide **Summary (transition) of Care record** for each transition of care ***or referral***
  - http://www.healthit.gov/

Transition of Care Summary (minimum data set)
Menu Objective #8

Originating Entity Information

Patient Information

http://www.healthit.gov/providers-professionals/achieve-meaningful-use/menu-measures/transition-of-care

1) Allergies and other adverse reactions
2) Medications (including current meds)
   a. Admission medications history
   b. Hospital Discharge Medications (if hospital)
   c. IV Fluids administered (if hospital)
   d. Medications administered
3) The problem list (diagnoses)
   a. Active problems
   b. History of past illness
   c. Hospital Admission Diagnosis (if hospital)
   d. ED diagnosis (if hospital)
   e. Discharge diagnosis
4) List of surgeries (if hospital)
5) Diagnostic results (i.e., labs, imaging, etc.)

"Transition of Care" Summary May also contain

- Vital signs
- Insurance information
- Health care providers
- Encounter information
- Procedures
- Necessary medical equipment
- Social history
- Family history
- Care plan

- http://www.corepointhealth.com/sites/default/files/whitepapers/understanding-the-continuity-of-care-record-ccr.pdf

Patient: Jeffery Surrett
347 Grove Street
Williamsport, PA, 17701
tel: +1-(570)837-9933

MRN: 00004201

Birthdate: September 24, 1990

Sex: Male

Allergies and Adverse Reactions

Substance	Adverse Event Type	Reaction	Status	Note
AMPICILLIN TR 250 MG CAPSULE	propensity to adverse reactions		Active	Diarrhea, nausea, vomiting

Medications

Medication	Instructions	Start Date	Status
Atorvastatin (LIPITOR 10 MG TABLET)	1 tablet(s), oral, QD		Active
Potassium Chloride (KLOR-CON 10 MEQ TABLET)	1 tablet(s), oral, BID		Active
Furosemide (LASIX 20 MG TABLET)	1 tablet(s), oral, BID		Active
Glyburide (DIABETA 2.5 MG TABLET)	1 tablet(s), oral, OD, AM		Active
Buprenorphine nalexone (SUBOXONE 12 MG FILM)	1 film sublingual, OD, AM		Active

Problems

Problem Name	Type	ICD-9-CM	Status
DIABETES UNCOMP TYPE II UNCONT	Diagnosis	250.02	Active
401.9 - HYPERTENSION ESSENTIAL	Symptom	401.9	Active
272.4 - HYPERLIPIDEMIA OTH/UNSPEC	Condition	272.4	Active
304.00 - OPIOID DEPENDENCE	Diagnosis	304.00	Active

Results

Test	LOINC	
HDL Cholesterol (40 - 999mg/dl)	14646-4	43mg/dl
Total Cholesterol (0 - 200mg/dl)	14647-2	162mg/dl
Creatinine (0.5 - 1.4mg/dl)	14682-9	1.0mg/dl
Fasting Blood Glucose (70 - 100mg/dl)	14771-0	178mg/dl*
Triglycerides (0 - 150mg/dl)	14927-8	177mg/dl*
BUN (7 - 30mg/dl)	14937-7	18mg/dl
LDL cholesterol (0 - 100mg/dl)	2089-1	84mg/dl
Toxicology screen (0-2000 ng/mL)	8220-6	2500 ng/mL
Chest X-ray, PA	24648-8	No disease is seen in the lung fields or pleura

Clinical Summary (Core Objective #13)

- Provided to patient after visit
- ***Provided to referring entity for coordination and consultation***
- Includes basic clinical information regarding the care you have provided,
  - Medications
  - Upcoming appointments
  - Other instructions
- Affords better communication around pertinent medical information than Summary of Care

Summary of Today's Visit

Patient: 00001234 Mr. JEFFREY SURRAT M/33 yrs DOB: 9/24/1990
Encounter Provider (s): Mark Smith, LICSW, RN
Signed off by: Mark Smith, LICSW, RN (4/1/2013 11:00 AM)
Encounter date: 4/1/2013

Subjective

CC / Reason for Visit

Referral, other health care provider, for MAT (Dr. Ben Butler, Community Cares)

History of Present Illness

Primary substance: Other opiates and synthetics (oxycodone)
Route of administration: Oral Freq. 1-3 times past month Age first use: 30
Secondary substance: None

Social History

V15.82-HX TOBACCO USE, tobacco consumption (10 yr duration, 1 pack/day

Medications

Recorded – Atorvastin (LIPITOR, 10 MG tabs) | Potassium Chloride (KLOR-CON, 10 MEQ tab) LASIX, 20 mg tab) | Glyburide (DIABETA, 2.5 MG tab) | Buprenorphine naloxone (SUBOXONE, 12 MG tab)

Assessment

Diagnosis

304.00 Opioid Dependence, in remission

Plan

Diagnostic tests

Psychiatric assessment - patient will be assessed for mental health disorders next visit

Medications

Deferred until diagnostic psychiatric testing

Referrals

Internal– intensive outpatient treatment program (group sessions, 2:00 PM – 3:00 PM daily, Individual sessions 1:00 – 2:00 PM weekly (every Monday afternoon) for 12 weeks beginning 4/2/2013)

Counseling

Tobacco Cessation Counseling provided to patient

"Clinical Summary" for referral follow up and for session follow up with patient

- Full Clinical Summary is given to the patient after they visit
- Can also be used to follow up with referring entities

http://www.healthit.gov/providers-professionals/achieve-meaningful-use/core-measures/clinical-summaries

Clinical Summary, BH Perspective

- Clinical summary
  - Include additional diagnoses (often psychiatric)
  - Medications (often psychiatric)
  - Diagnostic test results (periodic toxicology lab results)
  - Changes to medication allergy list
  - Treatment (i.e., “Patient admitted to intensive outpatient treatment services beginning 5/1/2013 for three months”)

- Meaningful Use Specialty Provider CMS Tipsheet

http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/Meaningful_Use_Specialists_Tipsheet_1_7_2013.pdf

How is Critical Information Shared?

- Does not require an EHR - can use existing, paper-based systems, existing processes and procedures for managing consents and sharing information – **as long as data standards are followed!**
- RECOMMENDED - Nationwide Health Information Network "Direct"
  - Simple, secure, scalable (a type of email system)
  - Point-to-point transmission / receipt on network of verified providers
  - Supports policies and procedures that ensure adherence to HIPAA and 42 CFR Part 2
  - More info http://nwhin.siframework.org/Direct+Project+Basics

Referral / Collaboration Loop

1. Critical information is effectively transferred from PCP to Specialty Provider

Transmit "Transition of Care" Record to BH via NwHIN Direct / or other means

2. Critical information is effectively transferred to the patient

Patient receives "Clinical Summary" from PCP, includes Tx referral information

3. The specialist communicates critical findings to the patient

Generate "Clinical Summary" (BH perspective) after biopsychosocial assessment and eval, (for patient)

4. The specialist communicates the results of the referral to the PCP

Transmit "Summary of Care" Record (BH perspective) to PCP via NwHIN Direct /or other means

5. The primary care provider has access to the results of the referral

BH Summary of Care Received by PC

PPFs addressed using national data standards

Developing the Information Sharing Processes and Procedures using Workflow Analysis

Getting There from Here: Workflow Analysis

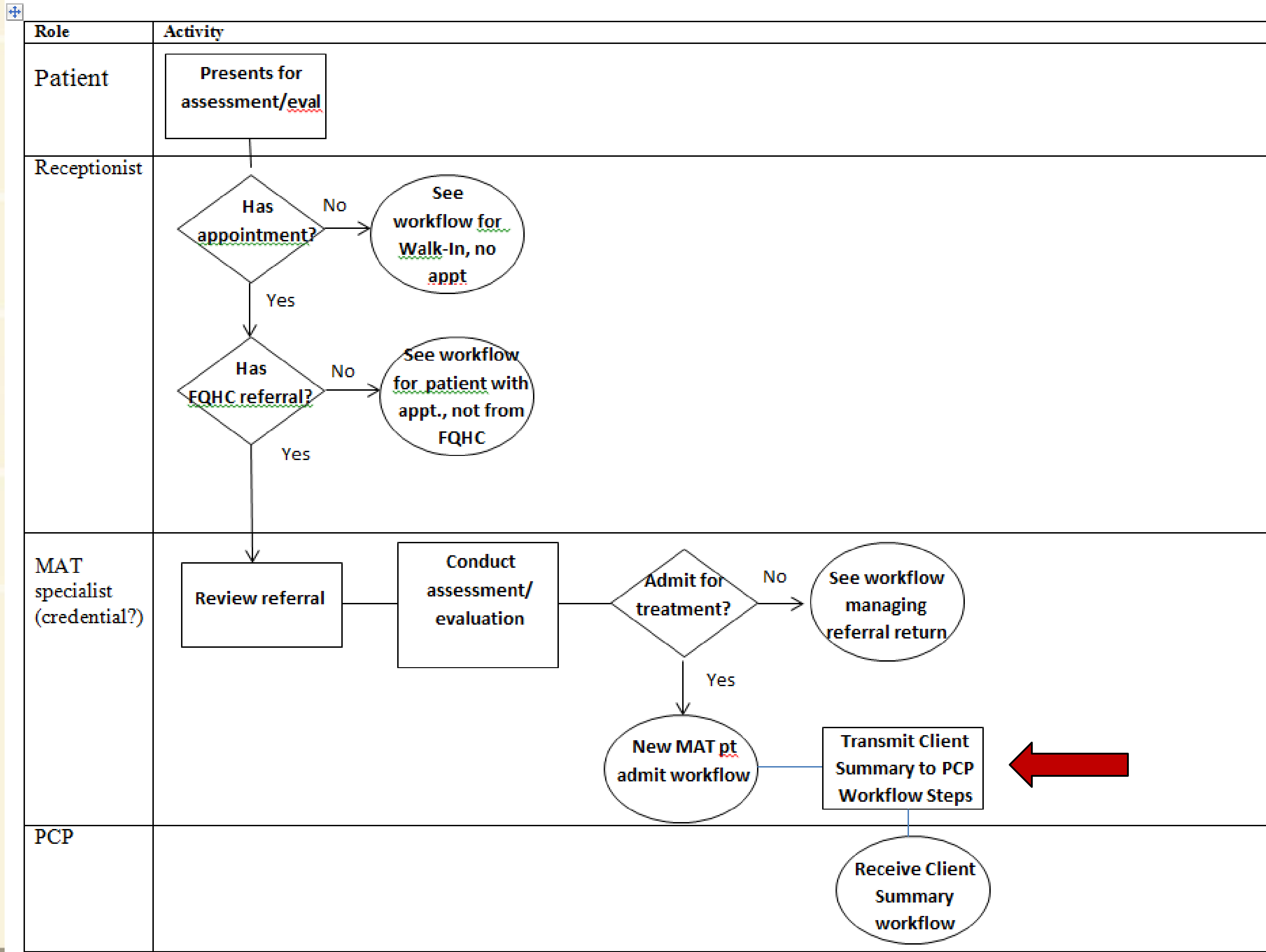
1. Select any process identified in the "Referral Loop"

   "Biopsychosocial assessment, evaluation, preliminary diagnosis used to generate "Clinical Summary"

   3 - Communicated to patient

   4 - ***Communicated to PCP***
2. In consultation with all involved in workflows
3. Document "As Is" workflow
4. Create vision for "To Be" workflow
5. Identify steps to bring you closer to "To Be" workflow
6. Document and test "As Is" > "To Be" workflow changes using change management tools

Document "As Is" Workflows



- Receptionist, MAT Specialist, PCP at the table
- Can take any step in this process, drill down into details of step and "explode" it into another workflow diagram
- Can analyze for billable events; credentials; duration of overall process; time (how long each step takes)

New Patient > FQHC Referral > Admitted > Transmit Client Summary To PCP (AS IS)

Role	Activity
MAT Specialist	Generate "Client Summary" by completing online form — Send to admin as email attachment to mail / FAX to
Admin assistant	Send to admin as email attachment to mail / FAX to PCP
PCP	Receives client summary

- As a group, diagram the workflow you are currently using (use a whiteboard)
- Capture discussion
- Conduct analysis

Capture Discussion / Analysis

	New Patient > FQHC Referral > Admitted > Transmit Client Summary (AS IS)		
	Role	**Task**	**Comments**
Brief description of the process you using now for transmitting patient information to PCP			
	MAT Specialist	Complete "Clinical Summary" (on computer form)	Entering same data multiple times – would be better if the Client Summary was extracted from the EHR (easier to locate information in the client paper-based assessment)
	MAT Specialist	Send to admin as email attachment or hand deliver to admin as paper-based form	One MAT specialist once copied several staff by accident. Now giving as paper-based form to be faxed.
	Admin assistant	Transmit by email or fax	Email security? FAX often offline, or receipt of transmittal not acknowledged. Does not happen when admin is out of office.
	Admin assist	Place original copy in chart and check off task from list	Can difficult to locate chart
Associated forms (names of forms or identifying numbers)			
Clinical Summary – Meaningful Use Core Objective #13			
Associated reports (names of reports or identifying numbers)			
Associated reports – number of referrals accepted from FQHC for MAT			

How It's Created

Step 1 – Build the Workflow Diagram

Staff with deep knowledge of targeted business processes

Facilitator

White Board

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Snapshot of "As Is" Workflow

ROLE
PROCESS – NEW PATIENT CENTRAL INTAKE

NEW PATIENT – Presents
INTAKE DIRECTOR – SCREENING – ELIG? – N – referral
INTAKE COUNSELOR – ASSESS – elig – N – referred
PCP APPT + MODALITY
PRIMARY CLINICAL COUNSELOR – TX PLAN ADMIT PROC – N – Cont. existing plan
PCP – PCP (vitals)
care coordinator (MANAGER) – INTAKE EVAL (WORS) SERVICE PLAN – FOLLOW UP PCP ORDERS + Referrals REASSESSMENT
Nurse Prac.
Psych – ditto

PROCESS
START/END
DECISION
see other workflow

– Billable events
– Timing
– Data collection points
– Physical locations
– ETC.

Forms
– Reassessment / Census form
– Contact sheet
Reports

Workflow Diagram – “As Is” snapshot of current business practices

a) Draw a swim lane flow chart and agree on the shapes

b) Select a discrete workflow with specific conditions

c) Identify all of the **ROLES** that are involved in the workflow

d) Start identifying the discrete tasks in the workflow “What happens first…then what happens…then what happens next” (one activity per process box)

e) Diagram on a white board as you proceed, matching the discrete activities/tasks to the professional **ROLE**

Create "To Be" Vision Narrative and Diagram

New Patient > FQHC Referral > Admitted > Transmit Client Summary (TO BE)			
	Role	Task	Comments
Brief description of the process you using now for transmitting patient information to PCP			
	MAT Specialist	Generate "Clinical Summary" in screen view a. Review for errors and correct as needed. b. Ensure consents are in place c. Give to patient	The "Clinical Summary" is generated as a report from the EHR as a Meaningful Use requirement. This is a simple task that any provider of services who can use a computer should be able to complete. It can be conducted prior to giving the summary to the patient.
	MAT Specialist	Notify administrative assistant when ready to transmit	This is a quality assurance step. The MAT Specialist can review the summary in the electronic format for information that may have been added since the patient visit, to ensure it is complete
	Admin Assistant	Generate clinical summary as .pdf	Again a simple computer task that can be entrusted to an admin
	Admin Assistant	a. Use 7WIN to encrypt. b. Transmit to PCP via NwHIN Direct c. Follow up with password for de-encryption	This process is appropriate for mid-level admin staff. The steps are similar to sending an email attachment, except it is encrypted first and a password to de-encrypt is also sent in a separate email
Associated screens (None- data is collected throughout EHR)			
Clinical Summary – Meaningful Use Core Objective #13			
Associated reports (names of reports or identifying numbers)			
Associated reports – patient Clinical Summary			

Moving Closer "To Be" Vision, Step-by-Step

- You know where you are, where you want to be
- What can you do NOW to move "As Is" workflows closer to "To Be" vision?
  - Review forms for adherence to national data standards?
  - Processes for creating Clinical Summary and Client Summary record (in certified EHR, these are required reports)?
  - Scan completed forms as image files or enter information into an editable .pdf template?
  - Obtain an NwHIN account to manage consents, transmissions and receipts of MAT patient data?

Plan Do Study Act – A Path for Change Management and for Setting Measures

- **PLAN – DO**: You have planned and implemented a small change (obtained an NwHIN Direct account to receive patient consent form and "Summary of Care" from PCP)
- **STUDY** the impact of the change – how will you know if it is effective and efficient, improving the quality of care?
  - "We will set a baseline of receiving the Transition of Care record for 50% of all referrals from Community Cares"
  - Does intake process take more or less time? Is HIPAA compliance improved? 42 CFR Consent adhered to? Communication improved?
  - Does information influence patient treatment planning?
- **ACT –** If not working, review and revise plan, start again
- http://www.integration.samhsa.gov/search?query=plan+do+study+act

Summary

- Set up a diagram of the loop for managing referrals from FQHC (Access) and following-up with FQHC (Service)
- Select one discrete process in the loop
- Diagram the "As Is" process 1) by professional roles, 2) capturing both the steps in the process and 3) the discussion about each step in the process (use the Narrative table)
- Create a "To Be" vision. What is the best case scenario, if you had all of the tools you wanted?
- What steps can you take NOW to move towards the "To Be" vision?
- Take one of the steps. Make changes in small increments, with Plan-Do-Study-Act

Questions?

We're here to help!

Contact CIHS for all types of primary and behavioral health care integration training and technical assistance needs

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