Medication Assisted Treatment
Community of Practice

Medication Assisted Treatment (MAT) Community of Practice (CoP)
February 13, 2020
Shared Care Planning for MAT Providers
Questions & Answers

Q1. Is it suggested to ensure buy-in from leadership in order to develop shared care planning?

A1. It is recommend to ensure buy in from leadership; however, boots on the ground staff are who really benefits from shared care. Benefits include less restrictive and timelier information sharing which has been proven in home care, elderly, and pediatric care settings. There is currently less evidence-based information available related to shared care planning specifically in SUD care.

Q2. Are Peer Recovery Support Services (PRSS) integrated in shared care planning?

A2. PRSS can be included on the shared care planning team and this could be a vital role. Integration of PRSS would be considered on an individual basis. Additions to the care team should always consider confidentiality, and the team does not want to be too broad. If patient identifies recovery coach as a person that's part of their team, then they should be included.

Southern NH Medical Center -

Q3. Presenters indicated they were moving to a new EMR system and are hoping this will assist with shared care planning. What EMR system are you switching to?

A3. The hospital is moving from Centricity to Epic.

Q4. How does shared care planning work with outside prescribers that are not embedded in your practice?

A4. When working with providers that are outside of their practice, the practice uses 'releases of information' and there is a person on staff to coordinate this. Many of their patients are referred from primary care and their consent form covers primary care practices. With consent obtained, they are able to send notes to PCPs as well as flag them in a note in the EMR.

Q5. What setting are the presenters working in?

A5. The Center for Recovery Management is a provider practice under Foundation Medical Partners (Southern New Hampshire Health). The practice stabilizes the patient and then refers back to primary care.

Q6. Has your practice successfully transferred patients back to their PCP with regularly scheduled appointments?

A6. Yes, we've transferred 3 people so far and they have regular time slots for ongoing care. These patients are receiving Naltrexone (Vivitrol) with their PCP.

Q7. How are the Social Determinants of Health (SDOH) and challenges associated with SDOH addressed?

A7. It is expected that the patient will also be working on addressing the SDOH that present challenges for them and staff assist in a social work capacity. Assistance with SDOH depends greatly on what the patient is eligible for. Obtaining SDOH services happens outside of the provider practice.

Q8. For this patient, have you considered housing options such as Marguerite's Place or Pastoral Care?

A8. The patient considered Families in Transition in Manchester, but didn't want to leave Nashua. The programs in Nashua, such as Marguerite's Place or Pastoral Care are definitely an option.

Q9. Is it difficult to coordinate with external agencies? Do you experience difficulties getting a follow up, finding the right person, getting a call back, etc.?

A9. Sometimes this is difficult, but we are putting a lot of effort into coordinating this. The practice currently has a lower patient load (45 patients) which does make it a bit easier. The current level of effort for each patient would not be sustainable for a larger patient load.

Q10. Are the PCPs screening for alcohol/other drugs?

A10. Screening is done differently at all the practices and PCPs don't always know what to do with the information collected from the screening. However, the shared care planning helps PCPs connect with a program and helps provide a solution.

Weeks Medical Center -

Q11. Is your program abstinence based?

A11. No, it is based in harm reduction principles.

Q12. Since counselling is an expectation of the program, what happens if the expectation is not met?

A12. The program does not discharge people. There have only been about 5-6 individuals that have been discharged due to extreme circumstances. Providers try to find creative ways to work with patients.

Q13. Has there been any integration of telehealth?

A13. Telehealth has not been included in at this point.

Q14. What is your current wait time? Is there ever a need for bridge services?

A14. Currently, there is not a long wait, a few days at the most. Most can just walk-in during business hours. The wait times become more difficult on nights and weekends. During nights and weekends, people utilize The Doorways and the emergency room.

Q15. Have you integrated with local PRSS?

A15. The local RCO (Serenity Center) is not formally integrated at this time, but the practice refers to them on a regular basis. This is something the program would like to pursue further, but it is just referrals at this time.

Q16. Do you have team meetings about patients? If so, do you discuss all patients or only the most complex?

A16. The team meets monthly to discuss programmatic issues and meets weekly to discuss cases. The weekly meeting is scheduled during the lunch hour. During this meeting, the shared care planning team will run through the patient list. More time is spent on more complex cases and they prioritize as needed by time.

Q17. How are you tracking referrals, is there a care coordinator role on the team?

A17. Yes, there is a staff person who keeps track of who is doing what, follows up on referrals and also works closely with case managers.

Q18. How does the team practice self-care to avoid burnout or reduce stress?

A18. They benefit from a close team. At least one day a week the whole team is in the same place and they are able to make connections this way. They are aware and actively concerned about burnout in themselves and their colleagues. Ways they have addressed burnout include:

- *Going home on time*
- *Scheduling within boundaries*
- *Keeping each other accountable*
- *They were doing "acudetox" regularly, would like to do this more often.*

Attendees shared the following self-care practices:

- *Check-in with team members, use instant messenger for direct communication.*
- *Talking about/acknowledging burnout, learning from each other about how to address burn out*

- *Making burnout a safe topic to talk about*
- *Talking to patients about self-care especially as they are progressing in their recovery*
- *Talking about boundaries*
- *Mindfulness/stress reduction courses*
- *Coming to the Community of Practice*