

MASSACHUSETTS



OTP TTA CENTER

Opioid Treatment Program
Training & Technical Assistance Center



Enhancing Access for Medically Complex Patients: An Interdisciplinary Complex Care Model in an OTP

March 31st, 3:30 - 4:30 pm



Presenters




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Session Objectives

By the end of this session, participants will be able to:

- 1 **Identify** patient characteristics and eligibility criteria that indicate the need for a Complex Care Model within an OTP.
 - 2 **Describe** how counseling, nursing, and physicians/ Advanced Practice Providers (APPs) collaborate to support medically complex and homebound patients.
 - 3 **Understand** the role of OTP medical providers in clinical consultation, risk assessment, and coordination with hospital partners.
 - 4 **Apply** practical strategies and lessons learned to adapt an interdisciplinary Complex Care Model within their own OTP.
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Agenda

- Introduction to the Complex Care Model
- Overview of eligibility and the tier system
- The team and collaboration role of the counselor and physicians /Advanced Practice Providers (APPs)
- Homebound patients
- Hospital partnership
- Outcomes and lessons
- Key takeaways

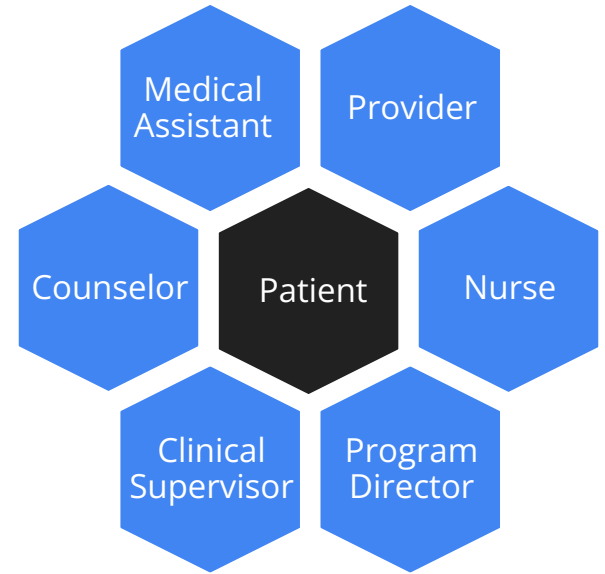
What is the Complex Care Model?

An interdisciplinary team who collaborate on the care of medically complex, high-risk patients.

Ex:

- Recently discharged from hospital
- Patients homebound due to health conditions
- Pregnant or recently postpartum patients
- Patients with cognitive impairment

We meet once weekly to discuss cases, and collaborate throughout the week on care.



Why was it created?

- Rise in chronic medical conditions within our OTP population
- Deaths due to advanced medical complications rather than overdose
- Limitations of traditional OTP model for patients who are homebound, cognitively impaired, or navigating multiple specialists and serious chronic illnesses

We need to adapt our structure to match the changing reality of the patients we serve.

What's being said about Complex Care

Love that it brings together providers, nurses, and clinicians to get all perspectives! - Physician

"I love complex care. One of the things that I really like about complex care is that it keeps me focused on the needs of the client, and it helps me when other people are thinking about my difficult cases... I have so many clients that I wish I could do complex care with... it's a lot but it is really good quality work." – Counselor

"I appreciate having the complex care meetings because it's structurally sound by having clients presented by 3 different priorities based on level of care, risks ,and needs. It serves the purpose to have direct communication between clinicians, providers, and nursing regarding clients who have complex diagnosis and overall important medical needs that require attention and follow-up." - Counselor

ELIGIBILITY

Chronic medical complexity that creates sustained coordination risk.

Progressive or serious
chronic illness

Homebound status

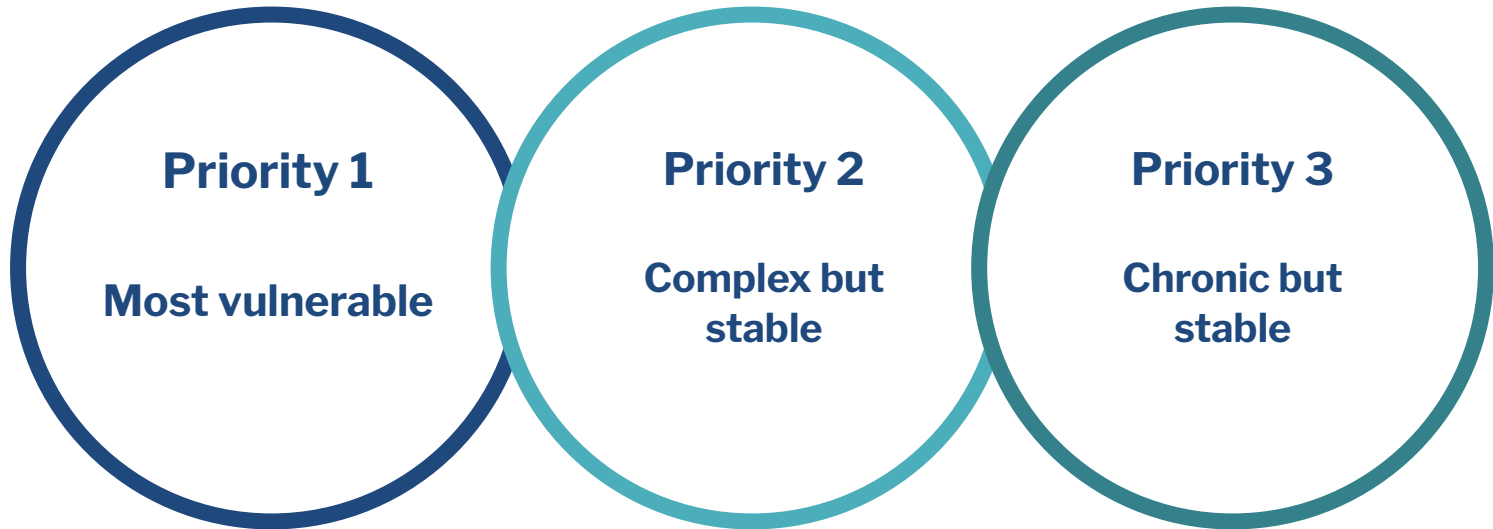
+ acute events creating
sustained vulnerability

Long-term functional impairment

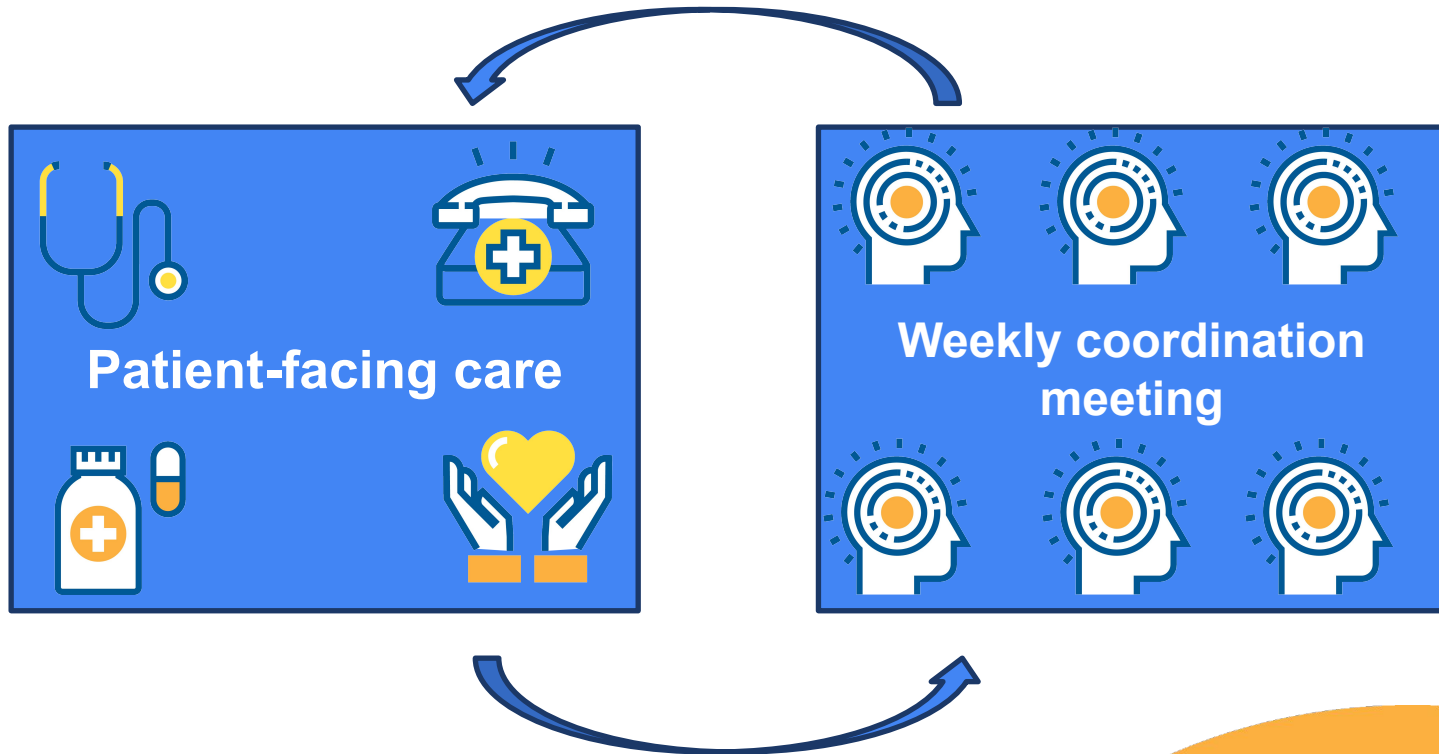
Specialty/medical care
coordination needs

Recurrent hospitalization

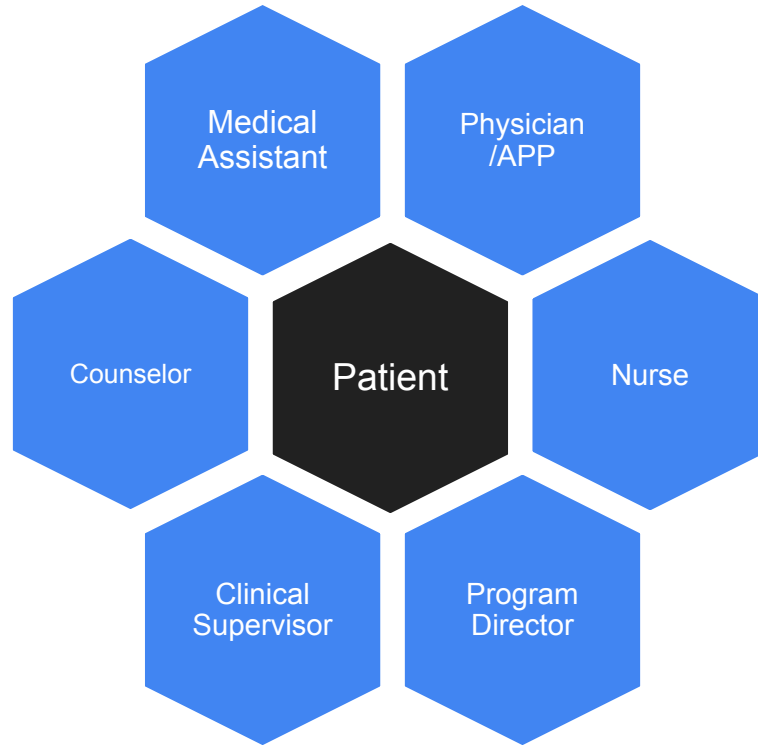
Tier system



Collaboration



THE TEAM

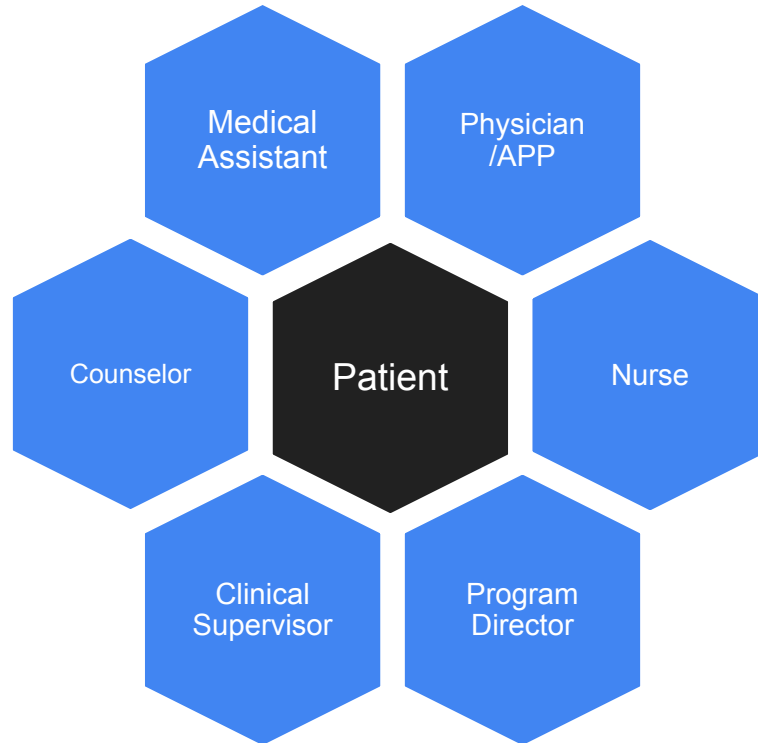


Role of the Counselor

- Case preparation
 - Initial Case Presentation Template
 - Follow-up Update Template
- Case presentation
- Tracking spreadsheet
- Follow up



THE TEAM



Role of the physicians/Advanced Practice Providers (APPs)



CLINICAL
EVALUATION



RISK
ASSESSMENT



COLLABORATION
ON SOLUTIONS

Case

70 yo man with severe opioid use disorder, cognitive impairment, depression, congestive heart failure, cardiorenal syndrome, myasthenia gravis, multiple ulcerative wounds and recent hospitalization of >1 month at which the recommendation at discharge was hospice and comfort care.

Patient and family caregiver decline hospice as it does not align with their goals. Patient is in significant pain from his wounds.

Role of the physicians/APPs: Clinical Evaluation



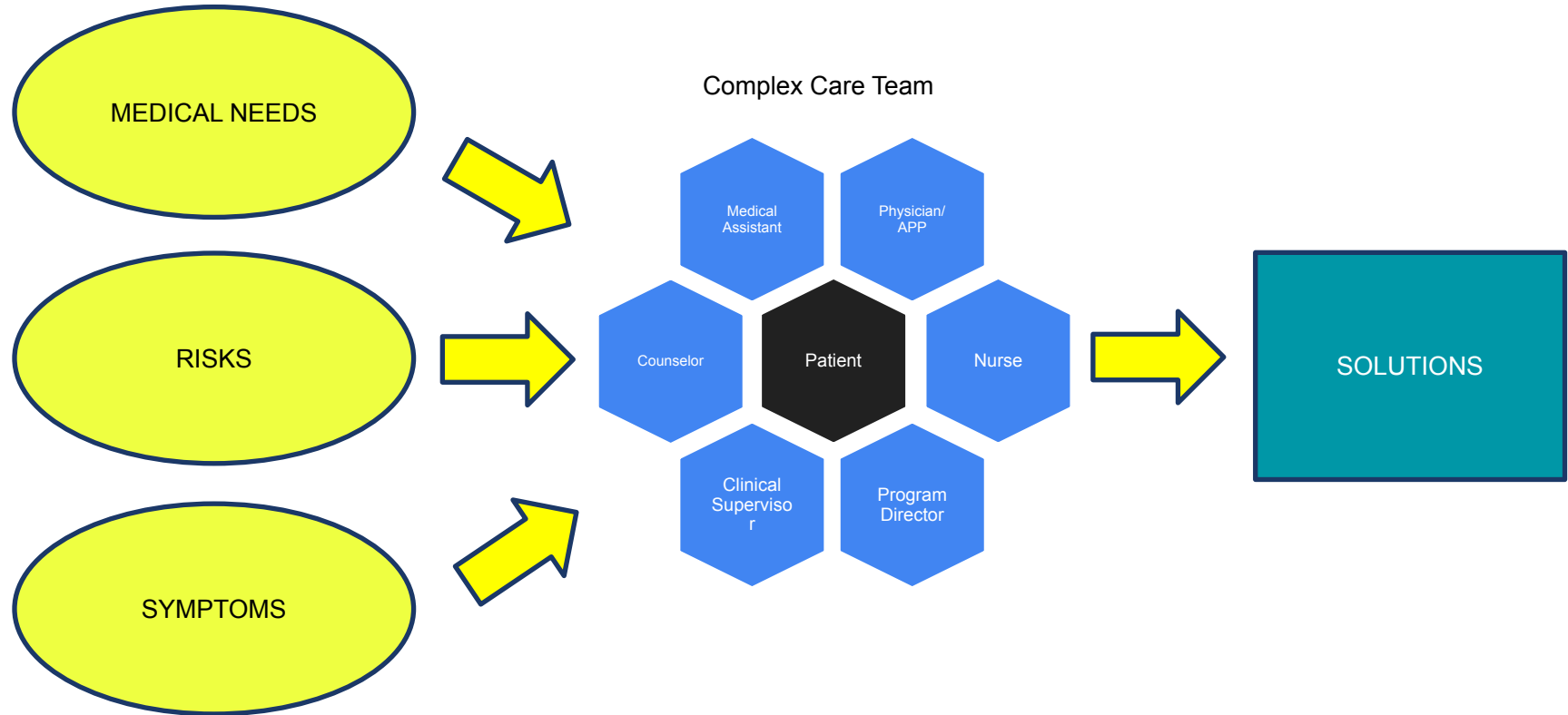
- Reviewing hospital documentation
- Evaluating comorbidities (COPD, CHF, cirrhosis, dialysis)
- Assessing medications
- Assessing unmanaged symptoms

Role of the physicians/APPs: Risk Assessment



- Re-evaluating appropriateness for treatment:
 - What are the benefits and risks of methadone treatment in this patient as their condition evolves?
- Re-evaluating dose:
 - Is their dose safe with their comorbidities and other medications?
 - Is their dose adequate to treat their substance use disorder and manage their symptoms?
- Assessing if their condition affects their ability to dose safely:
 - Home environment
 - Caregiver supports
 - Transportation and mobility limitations
 - Cognitive limitations

Role of the physicians/APPs: Collaborative Solutions



Case

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Collaborative Solutions



PROBLEM

SOLUTION

Can't manage dose safely at home and daily clinic visits too taxing for frail patient

Caregiver to manage dose through chain of custody (alternative would be VNA)

Poorly controlled pain

Dose already split
Small cautious dose increase, close monitoring by caregiver
Advocacy with PCP for short-acting opioid for pain

High risk polypharmacy

Collaboration with psychiatrist and PCP on managing medications at high risk for interaction with methadone

Evolving medical needs

Family meeting about care trajectory and re-consideration of hospice

Complex Care at work: Homebound Patients



Hospital coordination



Scheduling



VNA Services



Telehealth



ROI's



SAMHSA Extranet exception request



Chain of custody

Complex Care at work: Hospital Partnership



CONSULTATION



Memorandum of Understanding (MOUs),
Qualified Service Organization Agreements (QSOAs)



VNA ENGAGEMENT



PRIMARY CARE AND
SPECIALITY PHYSICIANS

Outcomes and Lessons

- Increase in coordination
- Increase in communication
- Proactive/structured discharge planning
- Documentation
- Follow up
- Formal structure is essential
- Partnerships are essential
- Creative Solutions



Key Takeaways

- Medical complexity in OTP is increasing
- Patient- Centered care means flexible/creative workflows to meet patient needs
- Interdisciplinary review/collaboration improves safety and continuity
- OTP physicians/APP's balance risk and lead to intentional decision
- Policy alignment
- Partnerships are key

Thank you!

Questions?



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