MidWest Clinicians' Network

NETWORK NEWS

Winter 2014

MWCN

Message from the President

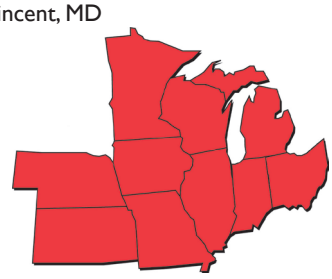
by Laura Pryor, RN, MSN
Director of Quality & Disease Management, Windrose Health Network

Happy New Year everyone,

I'd like to introduce myself. I'm Laura Pryor, your new MidWest Clinician's Network Board President.

I work for Windrose Health Network, a group of community health centers in central Indiana, as the Director of Quality & Disease Management. I am a Registered Nurse; receiving my BSN from Indiana University in 1991 and my MSN from Walden University in 2011. I've worked in various nursing and leadership positions in long term care, rehabilitation, and emergency services before coming to the community health center. To be honest, I really didn't see myself staying there very long. I thought I was going to be bored every day compared to the fast pace and variety of the ED.

After nearly 13 years, I'm still waiting for that first boring day! As the Director of Quality & Disease Management, I help develop systems and processes that help our provider teams deliver the high quality of care that our patients have come to expect from their medical home. I love our mission and feel privileged to help improve the quality of life of the patients we serve. I am truly excited about coming to work each day and look forward to carrying that excitement into my new role as your Board President. ■



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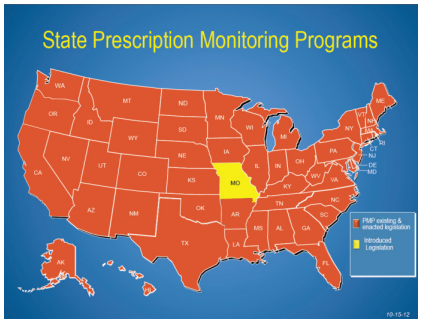
Controlled Substances

Laura Pryor, RN, MSN, Director of Quality & Disease Management, Windrose Health Network

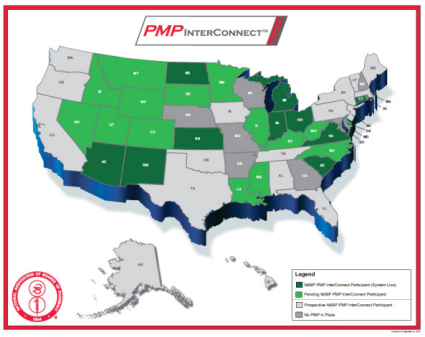
Every day in the United States, 100 people die as a result of prescription drug overdose. Opioids are the cause for nearly three out of every four prescription drug overdoses, accounting for 15,000 deaths every year.

Since drug overdose death rates have more than tripled since 1990, many states are taking action to reverse this trend. According to the Center's for Disease Control (CDC), 36 states have operational prescription drug monitoring programs which are designed to help prescribers and pharmacists:

- Track prescribing and dispensing of controlled substance prescriptions to patients
- Monitor for abuse or diversion
- Provide critical information related to a patient's controlled substance history, and
- Identify those patients who would benefit from early intervention



In addition to the individual state monitoring programs, a national database of interconnected registries is being coordinated by the National Association of Boards of Pharmacy.



Along with the monitoring systems, many states are also enacting legislation with strict guidelines related to the use of controlled substances. The Medical Licensing Board of Indiana has recently set forth an "Emergency Rule" adding provisions under P.L. 185-2013 (SEA 246) regarding providers prescribing opioids for chronic pain. The rule applies to any patient on 60 or more opioid pills per month for 3 months or on greater than 15 milligrams of morphine equivalent dose daily for 3 months. Patients who are terminally ill, in a nursing home, on palliative care or in hospice are excluded.

As of December 15, 2013, providers must do the following at the start of chronic opioid treatment:

- Perform a detailed history and physical
- Review records from previous healthcare providers
- Have the patient complete an objective pain assessment tool
- Do a risk assessment, including both
  - o Mental Health assessment using a validated tool
  - o Risk of substance abuse assessment using a validated tool
- Tailor a diagnosis and treatment plan with functional goals
- When appropriate, use non-opioid options
- Counsel women on neonatal abstinence syndrome
- Perform a urine drug monitoring test for compliance and unexpected drug use
- Query INSPECT (the Indiana controlled substance prescription registry)
- Meet with the patient every four months
- Sign a treatment agreement that includes:
  - o Goal of treatment
  - o Consent to drug monitoring/ random pill counts
  - o Prescribing policies (including prohibition of sharing medications and requirement to take medications as prescribed)

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Controlled Substances *continued from page 2*

- o Information on pain medications prescribed by other providers
- o Reasons opioid therapy might be changed or discontinued.

- If the patient's opioid dose reaches a morphine equivalent of 60 milligrams/day, face to face review of the treatment plan is required, including consideration of consultation and counseling of risk of therapy, including death.

Our organization has had to do some revision of our current policies and procedures to be in compliance with the new rules. I found two resources to be particularly helpful. The Indiana Prescription Drug Abuse Prevention Task Force's Education Committee developed a physician toolkit, called: "First Do No Harm: The Indiana Healthcare Providers Guide to the Safe,

Effective Management of Chronic Non-Terminal Pain." The toolkit incorporates the new law on prescribing opioids with evidence-based treatment guidelines for chronic pain and can be accessed at http://www.in.gov/bitterpill/toolkit.html. The kit includes useful resources, such as tips for implementing the new rules into one's practice, guidelines for switching or rotating opioids, sample treatment agreements, links to validated tools (AUDIT, PHQ, GAD, DAST-10, etc.) and talking points including scripts for patient discussions.

Additionally, PainEDU (https://www.painedu.org/index.asp) is an educational website for clinicians, serving as an evidence-based resource for teaching about pain assessment and management. The site offers free accredited continuing education for physicians, nurses and psychologists.

So far, we have modified our controlled substance policy , implemented new assessment tools, treatment templates and even added new appointment types/lengths to meet our needs. All of these changes caused some initial anxiety among our staff and patients. While we know this is a work in progress, we are well-practiced in the art of the "P-D-S-A", so I know we'll be alright! ■

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Transitions Clinic Network: A Team Based Approach to Caring for Returning Prisoners

After nine years of incarceration, Mr. "Jones", a 49-year-old man with diabetes, hypertension, and hyperlipidemia was recently released from a state prison without medication or a follow-up appointment with a primary care physician. He has a long-standing history of heroin and cocaine use that was not treated while behind bars, where he has spent the majority of his adult life. During this last prison sentence, he was diagnosed with diabetes; prison nurses managed his medication regimen, and prison policy dictated his diet and physical activity. Upon release, he did not know how to manage his own chronic illnesses, he was unfamiliar with the community health-care system, and he did not know where to obtain medication or find a primary care provider. He was also unemployed and homeless, living at a local shelter.

This is a common scenario in the US, which has the highest rate of incarceration per capita in the world with nearly 1 in 100 adult Americans behind bars [1]. While the US Supreme Court has ruled the eighth amendment guarantees prisoners the right to health care, it does not address what happens to the over 650,000 individuals who are released from prison annually [2]. Communicable diseases like HIV, Hepatitis C, and TB are endemic in prison and can Impact family members and society upon release [3].

The rates of chronic medical, substance abuse, and mental health problems amongst this population are staggering—over 70% by some estimates—and without proper reintegration services, these patients face a multitude of obstacles accessing health care, housing, employment, and legal aid [3]. To make matters worse, returning prisoners' risk of death in the first two weeks after release is 12 times higher than that of the general population [4]. While services catered to formerly incarcerated individuals may exist, they are often too fragmented and fall short of addressing the unique needs of this vulnerable population. Established in January 2006, the Transitions Clinic (TC) program was founded to provide patient-centered healthcare services for returning prisoners and support clinics in caring for this complex population. In order to address the high rates of emergency department (ED) utilization and lack of primary care services prisoners face upon return, TC program provides immediate access to a culturally-competent health care provider and support by a formerly incarcerated specially-trained community health worker (CHW). These CHWs help patients navigate both the

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Transitions Clinic Network: A Team Based Approach to Caring for Returning Prisoners Continued on page 5

unfamiliar healthcare system and social services needed to help them successfully re-integrate into their families and communities. Patients can relate to the CHWs who have walked in their shoes and get both mentorship and ongoing emotional support from the clinic's CHWs. The success of this trusting relationship is evidenced by the high rates of primary care utilization and the 50% reduction in ED utilization by our patients [5].

In the case of Mr. "Jones", he met the TC CHW at a mandatory parole meeting a few days after his release. The CHW scheduled an appointment for him two days later, and called him the day before to remind him of the appointment and offer directions to the clinic. The patient arrived at the clinic and was seen by a TC physician, who refilled his medications, screened him for infectious diseases, discussed health risks specific to his recent incarceration and made referrals to the appropriate specialists. The clinic's CHW found temporary shelter for the patient and referred him to community substance abuse treatment. As he did not have a primary care provider prior to incarceration, he was followed longitudinally in TC. During the next few weeks, the CHW visited him in the shelter, accompanied him to his first appointments with the psychiatrist, and provided diabetes self-management support. During the next few months, the patient began taking methadone and was referred to various employment agencies. He is currently working full-time in Goodwill Industries and has not been re-arrested.

As community clinics struggle to provide care to this vulnerable and complex population, many have adapted the Transitions Clinic program at their site to best care for returning, chronically ill prisoners. Together we make up the Transitions Clinic Network, a network of community based clinics providing patient-centered services for returning prisoners by employing CHWs with a history of incarceration. Through our network, we train former prisoners as CHWs and support clinics in employing them and tailoring primary care services to fit the needs of patients coming home from prison. As recipients of the Innovations Award through the Centers for Medicare & Medicaid, and with the support of the Langeloth Foundation, we are currently expanding our network throughout the United States and Puerto Rico.

The Transitions Clinic Network offers consultation, technical assistance and evaluation support for clinics seeking to improve practices in caring for this high risk, complex population. Through a targeted needs assessment, we help clinics identify their strengths and weaknesses in caring for this population and provide ongoing support and training for implementation of best practices in caring for returning prisoners. Our network provides quality improvement tools, evaluation tools, cultural competency training and CME credits for clinical trainings targeted to working with this population. Additionally, we train former prisoners online to be CHWs in our Post Prison Health Worker Certificate Program based at City College of San Francisco. We invite you to join us in the Transitions Clinic Network! If interested, please contact Dr. Shira Shavit at sshavit@fcm.ucsf.edu or 415-476-2148. ■

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5. *Wang EA, Hong CS, Shavit S, Sanders R, Kessell E, Kushel MB. Engaging individuals recently released from prison into primary care: a randomized trial. Am J Public Health. 2012 Sep;102(9)*

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Coaching in Healthcare: The Lombardi Way

Pamela Lester, Performance Improvement Manager, Iowa Primary Care Association

Many of you, I'm sure, don't know who Lombardi is… unless you are a Green Bay Packer's fan. Vince Lombardi is considered one of the greatest football coaches that ever lived http://www.vincelombardi.com/. Coaching a health center is very similar to coaching football.

As a PCMH Coach, I have found it can be difficult to help teams see the big picture. We use the same plays we've used previously and get the same poor results. We tell our team that healthcare is changing and it's much easier to plan and prepare for the new game than to make changes during the play. Our team is still not convinced. It may be time to change our approach.

Coaching teams for success requires that we identify what motivates teams to show their true potential. What motivates your team? How can you get an easy first win to begin the momentum? Start by addressing the biggest barrier. Does your team have barriers related to staffing and capacity? You may need to begin by addressing work that appears not to be specific to PCMH. This preliminary work is often necessary before you can expect the team to work with you on becoming recognized or certified as a PCMH. Is it a matter of relationship building? Never underestimate the power of a quick call, email or note to let the team know you are thinking of them. Consider including a helpful and easy to use "tool" in that note. Let the team know you want to work with them and how that can be accomplished.

Coaches who can outline plays on a black board are a dime a dozen. The ones who win get inside their player and motivate. ~Vince Lombardi

As a coach, it is important to look within ourselves and believe that our team can accomplish the work that is set before them and that we have amazing team members that can do great things. If you can't visualize your team and health centers as a PCMH, you can't help them become one. Once you can see your team's potential, you can meet them where they are at and help them realize that potential.

We would accomplish many more things if we did not think of them as impossible. ~Vince Lombardi

It is important as a coach to have a playbook. Lombardi didn't have lots of plays but he coached his team to execute them perfectly which made them unstoppable. It's not the amount of plays you have in your playbook; it's coaching them to be executed perfectly that creates success. These playbooks are already available to assist you as you coach your teams. For a tactical playbook for your team to transform their practice consider using the updated Qualis guides. Each one provides you with the "plays" you need to transform your center. Coleman and Associates also have some great "plays" to assist with capacity. ■

Qualis guides and tools:
www.safetynetmedicalhome.org/change-concepts

Coleman and Associates:
www.patientvisitredesign.com/coleman-associates/

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Integrating Oral & Primary Healthcare: One Patient at a Time

The Primary Care Associations from Illinois, Michigan and Ohio have collaborated with the DentaQuest Foundation to arrange a Medical/Dental Integration Summit. Through our extensive participation in the DentaQuest initiative to "Strengthen the Oral Health Safety Net", we aspire to continue the strong tradition of Public Health professionals sharing best practices and spreading new and innovative models of learning with each other. The focus of this Summit is to collaborate and promote interprofessional relationships among healthcare providers responsible for overall patient health.

Click here to register!

Resources from SAMHSA-HRSA Center for Integrated Health Solutions

Creating the business case for integrated care

Primary care organizations, including health centers with integrated primary and behavioral health care services, have the potential to deliver higher quality, more cost-effective care. In addition to making sense for your clients, integration must also make sense to the bottom line. As you integrate behavioral health and primary care, you are accountable to your board, staff, and community. One of the biggest barriers to change centers face is the question, "But how will we pay for it?"

To help you share the value of integrated care with your stakeholders and decision makers, CIHS has a series of tools to create this business case.

Most primary care organizations underestimate the positive impact behavioral health has on their bottom line in terms of clinical productivity. In many environments, even when there is no direct reimbursement for behavioral health, if you can do warm hand-offs to an appropriate team member, the return on investment is realized quickly. To show the impact that providing integrated services can have on your organization's bottom line, calculate the savings potential of an integrated approach.

CIHS' tools include:

- A monograph explaining a suggested approach for creating the business case for the integration of behavioral health and primary care.
- An excel template to calculate your center's costs and revenues in providing integrated services.
- An online presentation from health centers who've made the business case, and their lessons in integrating care.
- Go beyond the numbers – check out our tips for mapping out a client's experience to help tell the whole story of the potential personal impact of integrated care.

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Job Postings

ILLINOIS

Various Positions: Illinois Primary Health Care Association seeks the following providers for rural and urban health center opportunities. Physicians (FP, IM, PED, OB/GY, PSY), Medical Directors, Dentists, Dental Hygienists, Nurse Practitioners, Physician Assistants, Certified Nurse Midwives, LCPCs, LCSWs and Psychologists. To take advantage of our complimentary service, send your CV to Ashley Colwell, acolwell@iphca.org.

Family Practice Physician: Family Christian Health Center (Harvey, IL) is seeking to hire a motivated full-time family practice physician. We are a federally qualified, state-of-the-art health center. FCHC offers a competitive salary and benefit package. Contact Regina Martin via email, rmartin@familychc.org or phone, 708.589.2017 for more information.

IOWA

Various Positions: Peoples Community Health Clinic, Inc. Waterloo. Full time FP Physician, both Urgent Care and Primary care; Full time General Dentist. Loan repayment possible. Go to www.peoples-clinic.com for more information or to submit CV to Human Resources.

KANSAS

Various Positions: Shawnee County Health Agency is seeking a Medical Director for a FQHC Clinic. This position offers competitive wages, strong benefits including a CME package. For more information contact Kay Morgan, Personnel Specialist by email kay.morgan@snco.us or you can call at 785.251.2095.

MICHIGAN

Family Medicine Physician: The Center for Family Health is looking for a full-time Family Medicine Physician. CFH offers a competitive salary and benefit package. For more information please contact Cheryl Melville, HR Manager by email cmelville@cfhinc.org, call at 517.748.5500, ext. 1518 or our website at www.centerforfamilyhealth.org.

MICHIGAN

Physician and Nurse Practitioner: Family Medicine, Barry County; Hastings MI: Cherry Street Health Services, a community health center, is seeking a Family Medicine Physician and Nurse Practitioner to care for the medically underserved in Barry County, (Barry Community Health Center) Hastings, MI. This Family Medicine Physician and Nurse Practitioner will have the opportunity to work w/multi specialties. Competitive salary with I including generous loan forgiveness programs. contact Robert Lackey, by phone at 616.776.2124, by fax at 616.943.5366, or via e-mail Boblackey@cherryhealth.com.

MINNESOTA

Dentists: Lake Superior Community Health Center is seeking to hire 3 full time Dentists at our Duluth or Superior locations. DDS/DMD degree is preferred. LSCHC offers excellent wages & benefits and the opportunity for loan repayment. Please refer to www.lschc.org, fill out an application and submit along with resume to lschhr@sisunet.org or mail to LSCHC, 4325 Grand Ave, Duluth, MN 55807.

Physician: Work-Life in balance? Minneapolis FQHC seeks Primary Care/ Internal Medicine Physician 4-5 days/week. No in-patient calls. Competitive salary and benefits. For more info visit www.neighborhoodhealthsource.org/jobs.html

Medical Director:
Family Tree Clinic in St. Paul is seeking a Medical Director who is committed to social justice and sexual health. The position is 10 hours per week. Contact Clinical Operations Director Natalie Harter at nharter@familytreeclinic.org with questions or to apply. See www.familytreeclinic.org/resources/jobs/for full details.

MISSOURI

Various Positions: The Missouri Primary Care Association seeks dedicated healthcare professionals in the specialties of: Family Medicine, Internal Medicine, Pediatrics, OB/GYN, Psychiatry, and Dentistry to fill positions throughout Missouri's rural and underserved areas. Competitive compensation and benefit package including Loan Repayment incentives. Contact Joni Adamson jadamson@mo-pca.org, 573.636.4222 or visit www.3rnet.org/locations/missouri.

Ob/Gyn: Family Care Health Centers in St. Louis, Missouri has an opening for an Ob/Gyn. Contact Johnetta M. Craig, MD jcraig@fchcstl.org or Abbe Sudvarg, MD asudvarg@fchcstl.org.

OHIO

Various Positions: Neighborhood Family Practice is seeking to hire a full-time Family Physician, Family Nurse Practitioner and Midwife. We currently have three facilities; a fourth facility is scheduled to open the beginning of the New Year. All facilities are located on the near west side of Cleveland. NFP offers a competitive salary and benefit package. Contact Barb Sutherland, HR Coordinator, by e-mail bsutherland@nfpmedcenter.org. Visit our web site for more information at www.nfpmedcenter.org

Director of Clinical Quality: Community Health Centers of Greater Dayton in Dayton, OH has several career opportunities for physicians (family practice/internal medicine and pediatricians), nurse practitioners, and a General Dentist. CHCGD offers a competitive salary and benefits. Contact Sheryl Fleming, Human Resource Manager, at sfleming@chcgd.org, or visit our website, www.communityhealthdayton.org.