Integrated Care Group Visits

A team approach to treating opioid use disorders

Franciscan HEALTH

Family Medicine Residency
Carrie Anderson, MD (Family Physician)
Stephanie Case, PsyD (Clinical Psychologist)

Acknowledgment : Jacqueline Maxwell, PsyD

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Housekeeping Items

- ✓ No Disclosures
- ✓ No intended distressing or traumatic content, images, or activities
- ✓ Slides and handouts are available
- ✓ Intended audience:

  Physicians, nurses, medical assistants, pharmacists, behavioral health clinicians, and anyone else playing a role in a treatment team.

Learning Objectives:

1. Participants will be able to list at least 3 benefits relevant to a patient centered medical home utilizing a team based approach to treatment.

2. Participants will be able to identify a target population specific to chronic and/or complex illness group in their own clinic.

3. Participants will be able to clearly define the role of each provider in an integrated care group.

Integrative

Health Care

- Care given by **single** provider
- Utilizes conventional and alternative practices accordingly (e.g., pharmaceuticals, acupuncture, meditation, chiropracty, etc.)

Integrate

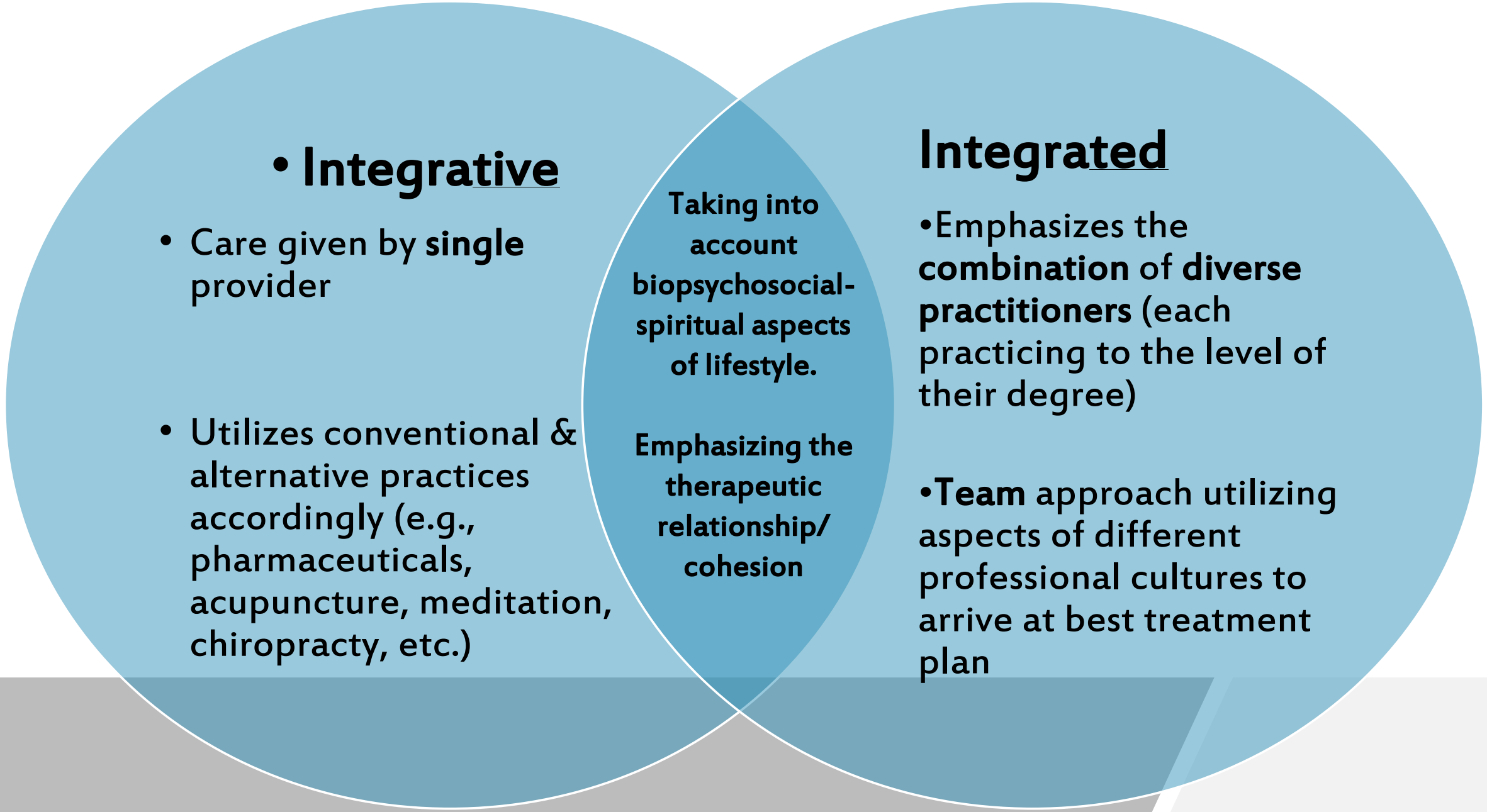
- To make into a whole by bringing all parts together
- To join with something else
- Unite
- To make part of a larger unit

Integrated

Health Care

- Emphasizes care utilizing a combination of **diverse practitioners** (each practicing to the level of their degree)
- **Team** approach utilizing aspects of different professional cultures to arrive at best treatment plan

Nomenclature


• Integrative
• Care given by single provider
• Utilizes conventional & alternative practices accordingly (e.g., pharmaceuticals, acupuncture, meditation, chiropracty, etc.)
Taking into account biopsychosocial-spiritual aspects of lifestyle.
Emphasizing the therapeutic relationship/ cohesion
Integrated
•Emphasizes the combination of diverse practitioners (each practicing to the level of their degree)
•Team approach utilizing aspects of different professional cultures to arrive at best treatment plan

Shared Medical Appointments/Group Visits

American Academy of Family Physician Definition

WHEN MULTIPLE PATIENTS ARE SEEN AS A GROUP FOR FOLLOW-UP CARE OR MANAGEMENT OF CHRONIC CONDITIONS.

PROVIDE A SECURE BUT INTERACTIVE SETTING IN WHICH PATIENTS HAVE IMPROVED ACCESS TO THEIR PHYSICIANS, THE BENEFIT OF COUNSELING WITH ADDITIONAL MEMBERS OF A HEALTH CARE TEAM AND CAN SHARE EXPERIENCES AND ADVICE WITH ONE ANOTHER.

INCLUDE INDIVIDUAL EVALUATION AND MANAGEMENT OF EACH PATIENT AS WELL AS COUNSELING WITH THE GROUP AS A WHOLE.

"...GROUP VISITS ARE A PROVEN, EFFECTIVE METHOD FOR ENHANCING A PATIENT'S SELF-CARE OF CHRONIC CONDITIONS, INCREASING PATIENT SATISFACTION, AND IMPROVING OUTCOMES."

Why Integrated Care Group Visits?

GROUP VISITS INCREASE RATE OF PREVENTATIVE, SCREENING, AND SURVEILLANCE FOR A VARIETY OF CONDITIONS COMPARED TO INDEPENDENT PRACTITIONERS

(MEHROTA, ET AL, 2006)

GROUP VISITS IN IMPROVE PATIENT AND PHYSICIAN SATISFACTION, QUALITY OF CARE, QUALITY OF LIFE, AND DECREASING EMERGENCY DEPARTMENT AND SPECIALIST VISITS

(JABER & TRILLING, 2006)

PREGNANCY:

IMPROVED MENTAL HEALTH, KNOWLEDGE, AND BEHAVIORS TO OPTIMIZE OUTCOMES FOR MOTHERS AND CHILDREN

(BENEDIKTSSON, 2013)

CHRONIC ILLNESS:

REDUCED HOSPITAL ADMISSIONS, EMERGENCY VISITS, AND UTILIZATION OF PROFESSIONAL SERVICES, AND COSTS/PATIENT. HIGHER SATISFACTION WITH THEIR PCP, BETTER QUALITY OF LIFE, AND GREATER SELF-EFFICACY

(SCOTT ET AL, 2004)

DIABETES:

REDUCED A1C, WEIGHT, DIASTOLIC BLOOD PRESSURE, DEPRESSIVE SYMPTOMS AND INCREASED PATIENT SATISFACTION

(RILEY, 2012)

PAIN:

REDUCTION IN PAIN SEVERITY AND DEPRESSIVE SYMPTOMS

(GARDINER, 2014)

SUBSTANCE USE:

INCREASED COMMUNICATION SKILLS AND SOCIAL SUPPORT TO FOSTER RECOVERY AND REDUCE RELAPSE

(SOKOL, 2018)

Addressing the Biopsychosocial-spiritual context

Why start any type of integrated group visit?

Access to care:

- Improves access to medical care and direct medical needs

Education:

- Provide health education and teaching skills for self management

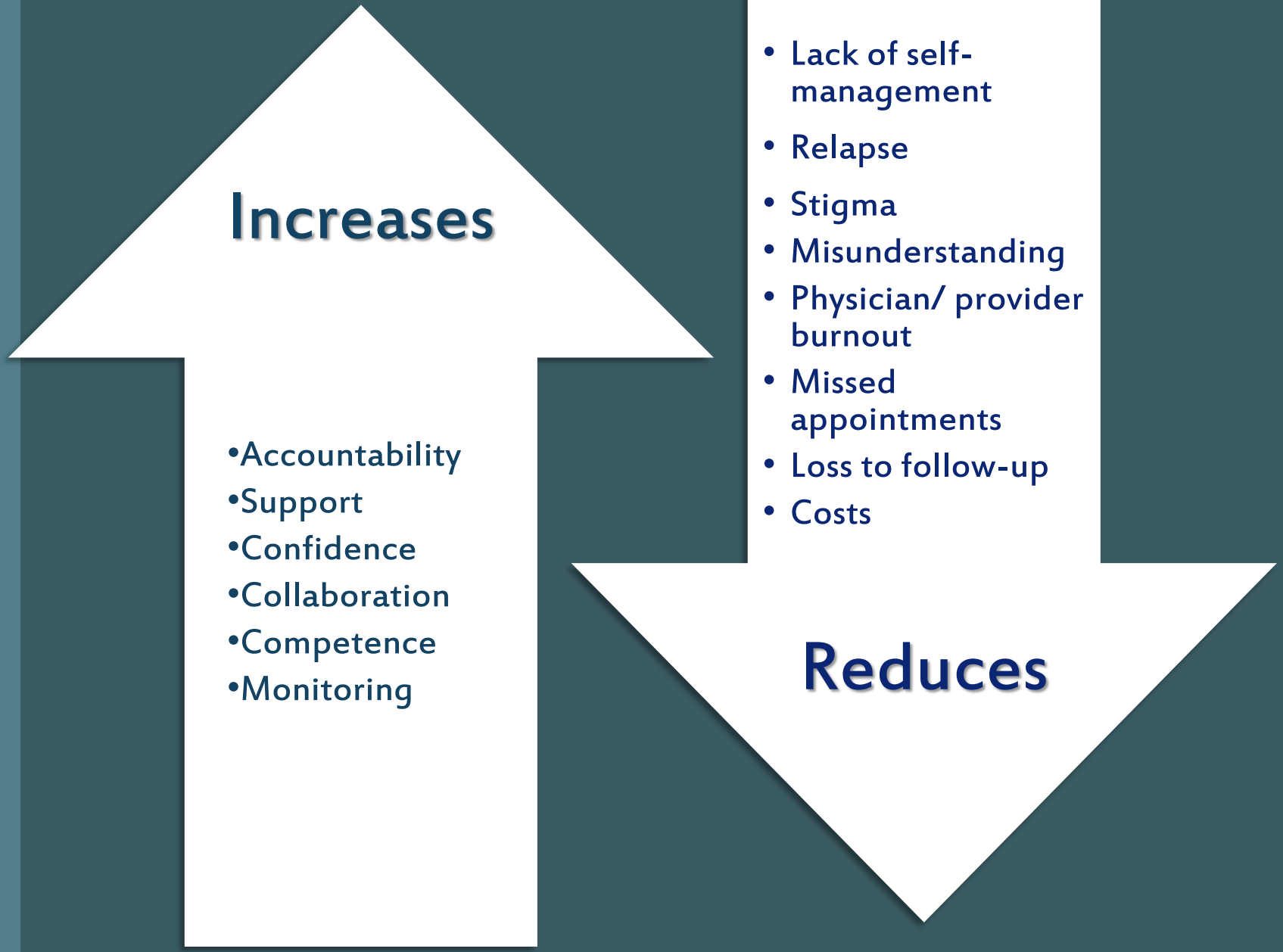
Behavioral health:

- Promotes and enhances strategies for lifestyle and behavioral change and address psychosocial stressors

Addresses gaps in treatment and removes barriers

- Multiple facilities
- Different providers
- Different treatments
- Different cultures
- Costs and coverage
- Transportation

Integration Addresses gaps in treatment and removes barriers



Role of Providers: Meeting group members where they are…

Needs change from week to week

- Biological – Nursing, Physician, Physical therapy, Pharmacist
- Psychological- Behavioral health
- Social – Social work; Case manager; other group members
- Spiritual – Chaplin; meditation

Types of Groups

	ACCESS To improve access to medical care and address direct medical needs	EDUCATION To provide health education and teaching skills for self management	BEHAVIORAL CHANGE To promote and enhance strategies for lifestyle and behavioral change
Main Focus of the Group			
Examples of Group by Focus	• Shared Medical Appointments • Group medical clinics, veterans Administration hospital	• Diabetes self-management education groups by CDE diabetes nurse educators • Health coaching	• Medical group visits • Group psychotherapy • Patient peer-to-peer support groups

Adapted from: (Eisenstat et al., 2012)

Diabetes

Access to care
- Endocrinologist
- Dietician
- Behavioral Health

Education
- Insulin dosing
- Diet/nutrition

Behavioral health
- Psychosocial barriers
- Social support

Weight Loss

Access to care
- Bariatric specialist
- Dietician
- Behavioral Health

Education
- Interventions
- Diet/nutrition
- Safe exercise

Behavioral health
- Emotional triggers for eating
- SMART goals
- Social support

Chronic Pain

Access to care
- Physical therapy
- Pain management
- Behavioral health
- Occupational therapy

Education
- Mind/body connection
- Reasonable movement
- Accommodations

Behavioral health
- Psychological impact on pain
- Meditation/relaxation
- Social support

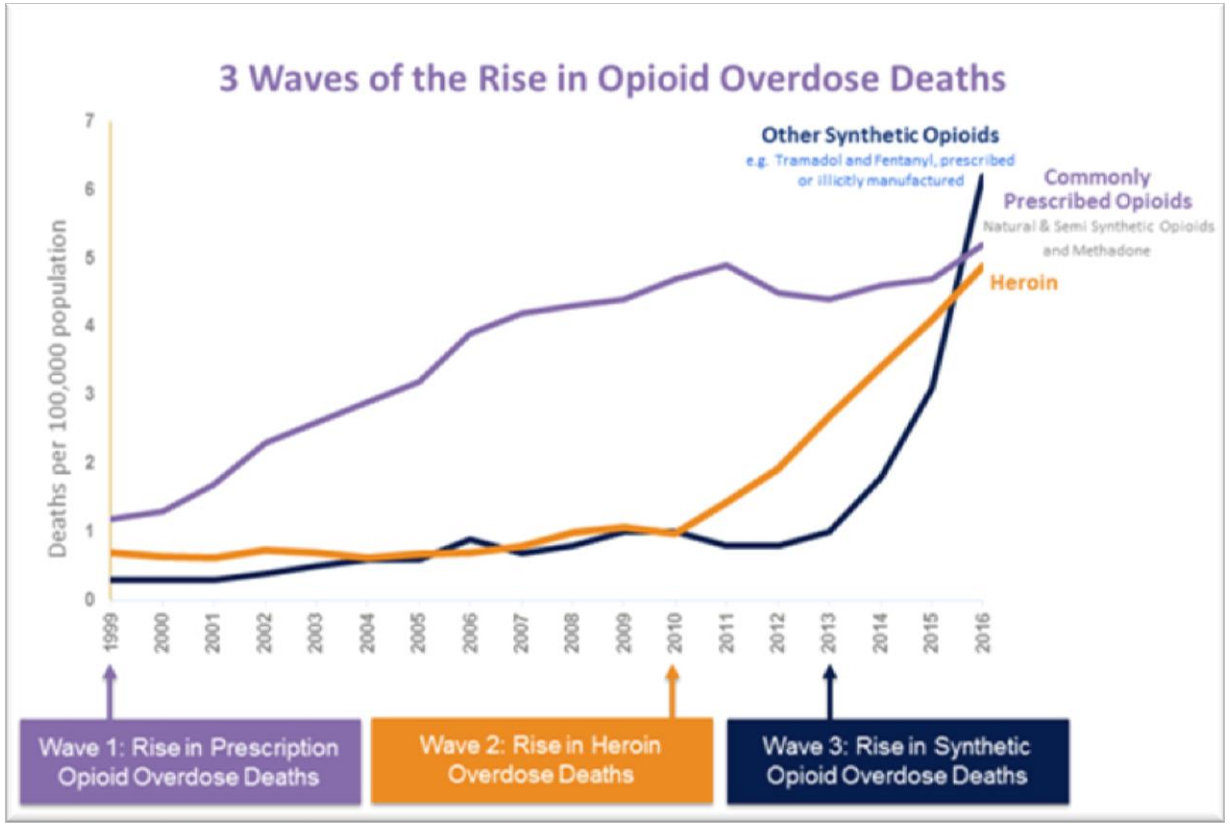
Cancer

Access to care
- Oncologists
- Behavioral health
- Nursing specialties

Education
- Course of treatment
- Evidence based alternatives
- Course of illness

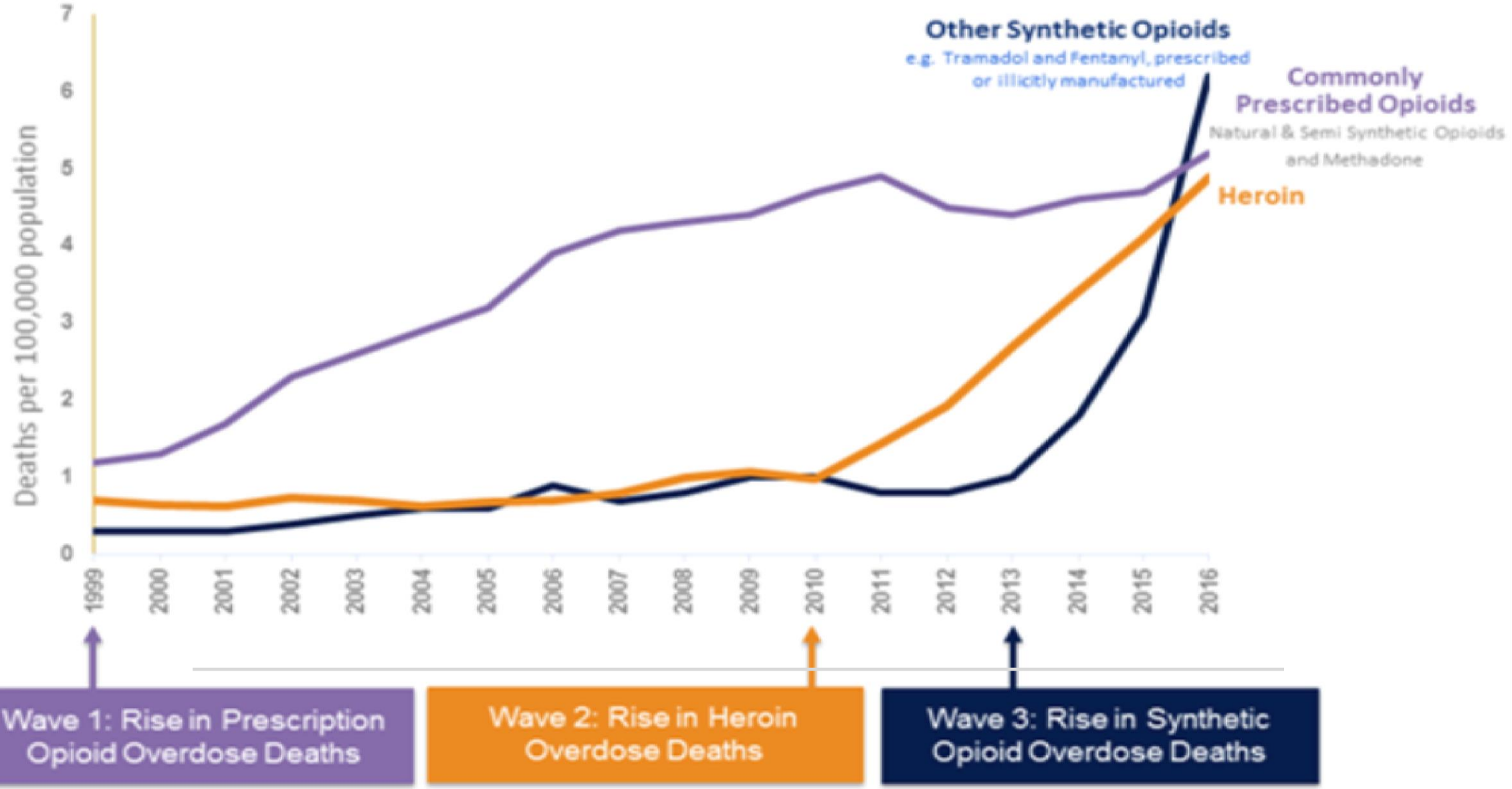
Behavioral health
- Impact of chronic illness on spiritual/psychological/ physiological connection
- Social support

- From 1999 to 2016, more than 630,000 people have died from a drug overdose, more than 350,000 people died from an overdose involving *any* opioid, including prescription and illicit opioids
- Around 66% of the more than 63,600 drug overdose deaths in 2016 involved an opioid
- In 2016, the number of overdose deaths involving opioids was 5 times higher than in 1999
- On average, 115 Americans die every day from an opioid overdose



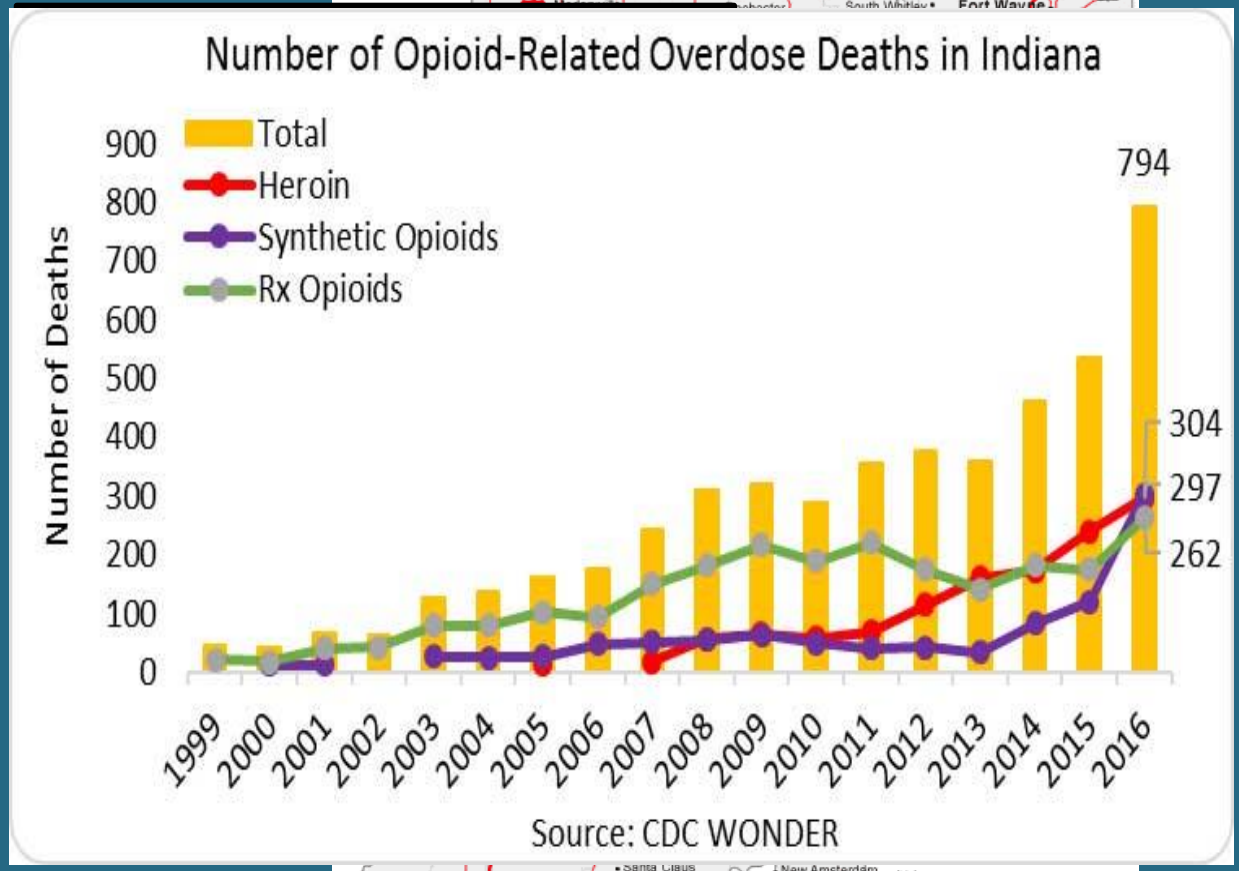
Why start group visits *SPECIFIC* to opioid use disorder?

3 Waves of the Rise in Opioid Overdose Deaths



Our Clinic

- Family Medicine Residency
- South-side Indianapolis, Indiana
  - Marion, Hancock, Johnson Counties
  - Demographics
    - Refugee population
    - 12.3% 65y+
    - 51.8% Female
    - 45% Non-white
  - Insurance
    - 20% Commercial
    - 60% Medicaid
    - 20% Medicare



Effective Treatments for Opioid Use Disorder

Medication Assisted Treatment

Methadone

Buprenorphine

- Suboxone®
- Subutex®
- Zubsolv®

Naltrexone

- ReVia®
- Vivitrol®
- Depade®

- Suboxone treatment in an office-based setting yields the largest percentages of opioid-free urine samples, opioid detoxification, and treatment retention rates (Shah et al., 2014).

- The use of medications in *combination* with counseling and behavioral therapies for the treatment of substance use disorders.

- Successful detoxification and behavioral therapy are highly associated with sustained opioid abstinence.

MAT

- Lack of available prescribers
- Lack of support for existing prescribers
- Workforce attitudes and misunderstandings about the nature and use of medications
- Limits on dosages prescribed Initial authorization and reauthorization requirements
- “Fail first” criteria requiring other therapies be tried first

- Multiple facilities
- Different providers
- Different treatments
- Different cultures
- Costs and coverage
- Lack of self-management
- Relapse
- Stigma
- Misunderstanding
- Physician/provider burnout
- Missed appointments
- Loss to follow-up

Behavioral Health

- Minimal counseling coverage
- Stigma associated with long term use of “replacement”
- Does not fit current model of chemical dependency
- Behavioral health records protected and prescriber may have limited information regarding progress
- Limited access to appointments with BH

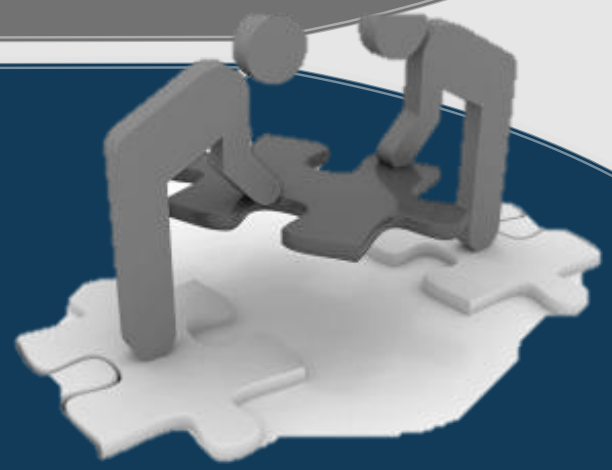
- Childcare
- Working hours
- Caregiver dependence
- Different cultures/belief systems
- Gas
- Transportation
- Lack of support
- Interpersonal conflicts

Gaps in clinical care AND patient Recovery

Structure of Group

Hybrid (semi-open/semi-closed)Model

- No end date
- Rolling admission
- Some predetermined specific goals
- Predetermined population / illness
- Open access appointments (somewhat)



- 2x per month
- Vitals
- Visit with PCP
- Psychotherapy/education group
- Check-ins between groups if needed

Design: Screening

Protocol:

Identified by PCP →

Referred to trained provider (prescriber) →

BH intake →

Attend group

Inclusion criteria

-At least **one** month after initiated MAT

-Established patient

-Availability

Exclusion criteria

-Needs higher level of care

-Patients on other forms of MAT

-Patients without childcare

-Well established in another setting

Typical group outline (90 minutes total)

	5 minutes	10 minutes	5-10 minutes	50 minutes	5minutes	5minutes
	BH/Nursing	Nursing	Physician	BH/other	Everyone	BH/other
	Check-in	**Pre-visit**	**Medical visit**	**Group**	**Feedback**	**(Optional)**
	• Check in – mood/status • Indicate next group appointment – schedule next appointment • Patient completes self-report COWs	• Check in – changes to physical health • Record vitals (weight, blood pressure, temperature, heartrate) • UDS (if necessary)	• Review COWs • Pill/strip count • Discuss status and challenges • Urgent issues	• Education • Support • Processing • Focus on topic – determined by direct feedback from group or current group climate	• How has group been going • How can you use what we talked about today to apply to your life outside of group	• Quick meditation/ relaxation to decompress

Demographics

	Non-group (*n* =9)	Group (*n* =8)
Gender (% Female)	66	86
Average age	39	34
Insurance (%):		
State	78	75
Medicare	11	0
Commercial	11	25
Custody of children(%):		
Yes	22	75*
No	22	0
Does not apply	33	25
Unknown	22	0
Method of use (%):		
IV heroin	56	13
Intranasal heroin	22	13
Pills oral or intranasal	22	74

*All have lost in the past

Outcomes: Comparing group visits to treatment as usual

Outcome	Non-group (*n* =9)	Group (*n* =8)
Average Number of Relapses after starting buprenorphine/person	1	0.75
Inconsistent Drug screens (%)	15.3	39 (2 participants had 82%)

- #1 = Majority Marijuana – unable to get a few patients to stop use (pain, sleep)
- #2 = Benzo – often not perceived as "problem"
- #3 = Alcohol – similar
- #4 = Meth
- #5 = Ultram – not a relapse, pt unaware of opioid properties

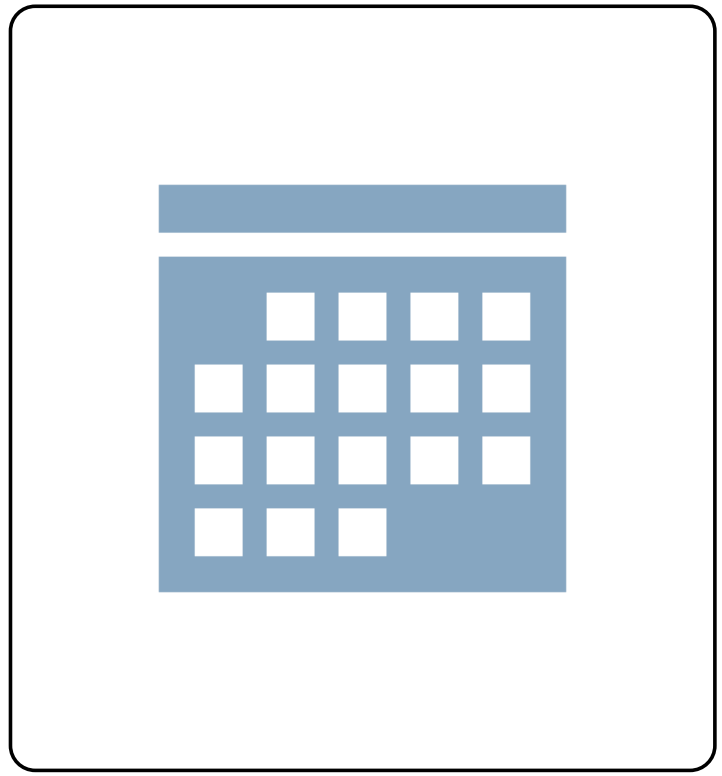
Discussion

Limitations

- Payment method (Insurance commercial vs. Medicaid)
- Billing/coding/reimbursement
- Childcare
- Transportation
- Group scheduling

Scheduling

- Struggles:
  - Group scheduling on same provider
  - Front office –not all members clear on group scheduling
  - 2 providers schedules
- Pearls:
  - Have one point person for all group scheduling
  - Get confirmation from patient which group they will be at next (2 vs 4 week)
  - Discuss billing plans with appropriate people to confirm workflow allows



Discussion

Future Directions

- Family/significant other support group visits
- Grant to support more programs
- Childcare
- Evening group
- More resident involvement
- Smooth transitions to new residents

Questions

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Supplemental Sides

Practical Resources to get you started

- Putting Group Visits Into Practice (Eisenstat, 2012)
- Development and implementation of group medical visits at a family medicine center (Barud, 2006).
- Introduction to group medical appointments (Schmucker, 2005).
- Group medical visits: a glimpse into the future? (Enhancing Your Practice) (Noffsinger, 2003).
- Thinking outside the box! Enhance Patient Education by Using Shared Medical Appointments (Kuiken & Seiffert, 2005)
- Expanding the Use of Medications to treat individuals with substance Use disorders in safety-net settings (SAMHSA)

Sample Syllabus

- Neurobiology of addiction
- Connecting our thoughts, behaviors, feelings/emotions to events
- SMART goals
- Communication (non-verbal vs. verbal)
- Identifying emotions and valance associated with level of intensity
- Barriers to treatment and relapse planning
- Adaptive vs. Maladaptive coping
- Internal vs. external triggers and coping
- Forgiveness
- Identifying stages of change and self-reflection of past, present and future
- Promoting social support and safety planning
- Role of trauma in chemical dependence
- Art therapy to assess barriers to change
- Mindfulness
- Unhelpful thinking patterns
- Acceptance and commitment for triggers for relapse

Demographic		Non-group (*n*=9)	Group (*n*=8)
Gender (% Female)		66	86
Average age		39	34
Insurance (%):	State	78	75
	Medicare	11	0
	Commercial	11	25
Custody of children(%):	Yes	22	75 (All have lost in past)
	No	22	0
	Does not apply	33	25
	Unknown	22	0
Method of use (%)	IV Heroin	56	13
	Intranasal heroin	22	13
	Pills – oral or intranasal	22	74
Average Number of Relapses after starting buprenorphine		1	0.75
Inconsistent Drug screens (%)		15.3	39 (2 participants had 82%)

	Patient Satisfaction Survey	Completely False	Mostly False	Neither True nor False	Mostly True	Completely True
1	The group was well organized	1	2	3	4	5
2	The facilitator(s) cared about me as a person	1	2	3	4	5
3	The group members worked together to achieve goals	1	2	3	4	5
4	The facilitator(s) noticed and told me when I did something well	1	2	3	4	5
5	I was able to participate and express myself in the group	1	2	3	4	5
6	The facilitator(s) encouraged me to achieve my goals	1	2	3	4	5
7	The focus of the group was on the right issues	1	2	3	4	5
8	The facilitator(s) understood me and my needs	1	2	3	4	5
9	I learned what I was hoping to learn	1	2	3	4	5
10	The group/information was easy to understand	1	2	3	4	5
		Poor	Fair	Good	Very Good	Excellent
11	Overall rating of the facilitator(s)	1	2	3	4	5
12	Overall rating of the group	1	2	3	4	5
	Would you recommend this group to others				Yes	No

Self-Reported "COWS"

QUALITY CARE
THERAPY PROGRESS REPORT
(Adapted from Subjective Opiate Withdrawal Scale)

Instructions:

- Patient fills out "COMPLETED BY PATIENT" section and brings form to counselor
- Counselor fills out and signs "COMPLETED BY COUNSELOR" section and returns form to patient
- Patient brings form to physician. Physician fills out "COMPLETED BY PHYSICIAN" section and files with patient records

Patient Name _____ Medication dose _____ mg/day Date _____

COMPLETED BY PATIENT

Circle the answer that best fits the way you feel now

	Not at all				Extremely
I feel anxious	0	1	2	3	4
I feel like yawning	0	1	2	3	4
I am perspiring	0	1	2	3	4
My nose is running and/or my eyes are watery	0	1	2	3	4
I have goosebumps and/or chills	0	1	2	3	4
I feel nauseated or like I may need to vomit	0	1	2	3	4
I have stomach cramps and/or diarrhea	0	1	2	3	4
My muscles twitch	0	1	2	3	4
I feel dehydrated and/or have not had much appetite	0	1	2	3	4
I am having difficulty sleeping	0	1	2	3	4
I have a headache	0	1	2	3	4
My muscles and bones ache	0	1	2	3	4
I feel like using right now	0	1	2	3	4
I would rate my overall level of withdrawal as	0	1	2	3	4

Do you feel you need a dosage change?	☐ No	☐ Yes	☐ Up	☐ Down
Have you used alcohol or other drugs since your last visit?	☐ No	☐ Yes		
If "yes," please describe what, when, and how much				

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Please describe any life changes, triggers, or stressors that have occurred since your last visit.