Care Management: Part 1

Training Session 2

Today's Presenters

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Licensed RN in the State of Michigan with expertise in practice transformation, care management, quality improvement, and understanding of models of care and payment models in respect to the healthcare industry.

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Dr. Klima is an adult nurse practitioner and academic nursing professor with over 40 years of experience spanning clinical practice, executive leadership, and nursing education. Her work focuses on leadership development, patient-centered care, and integrating evidence-based practices to improve outcomes across diverse care settings.

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Disclosure

MI-CCSI, or the presenter, does not have any financial interest, relationships, or other potential conflicts, with respect to the material which will be covered in this presentation.

AGENDA

1	TBC Basics – Historical and Current TBC Model (1.5 hours)
2	Care Management & Care Coordination (1.5 hours)
3	Care Management & Care Coordination (1.5 hours)
4	Aims / Measurement / Quintuple Aim (1.5 hours)

Presenter	Topic	Time
Sue and Lynn	Welcome: Status with Action Items from Session 1	15 minutes
Sue	Care Management Process Patient Identification	10 minutes
Lynn	Comprehensive Assessment Medical Needs	15 minutes
Lynn	Comprehensive Assessment Social Needs	10 minutes
Sue	Comprehensive Assessment Behavioral Needs	15 minutes
Sue	Comprehensive Assessment AUD and SUD	15 minutes
Group	Wrap-up and Homework	10 minutes

Report Out on Actions: Session 1

Team Actions

Review the Team Roles and Responsibilities Document.

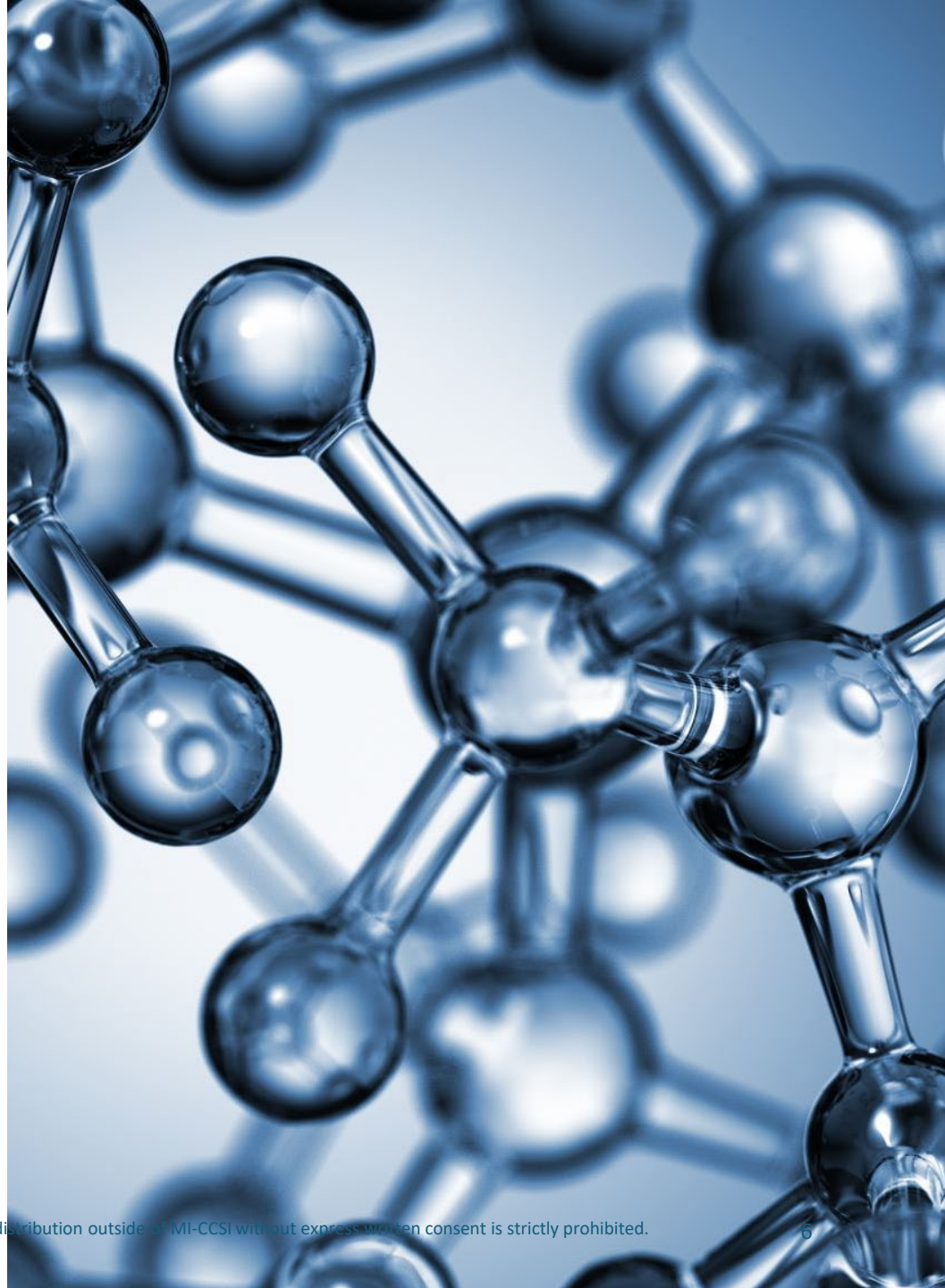
- Where are there opportunities for improvement (minimize rework, fill in gaps, clarify roles and hand-offs)?
- Identify the team member who will lead this quality improvement activity and monitor actions to implement changes.

As a team:

- Finalize the practices Team-based Care elevator speech.
- Create a draft of the patient/provider partnership agreement.
- Establish a plan for implementation and use of these documents.

Review the communication tools. Select 1 tool to start with.

- Create a PDSA to identify what data you will collect to determine what is working and what requires modifications.
- Create an SBAR for one of the conditions the team would like to focus on (COPD, HF, Depression, Diabetes).
- Discuss with the provider and clinical team members the key information needed from the situation and background for the condition in order to make decisions.



Case Management

According to the Commission for Case Management Certification, “Case management is a dynamic process that assesses, plans, implements, coordinates, monitors, and evaluates to improve outcomes, experiences, and value.

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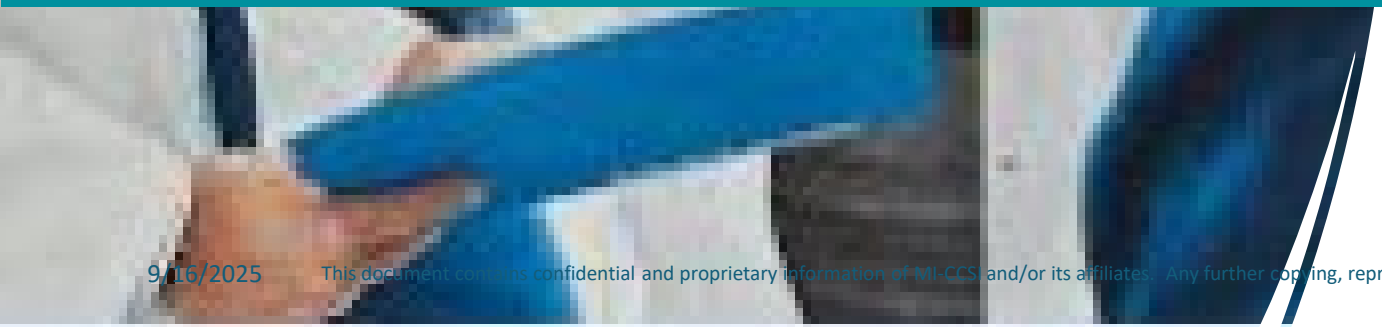
Care Management Process

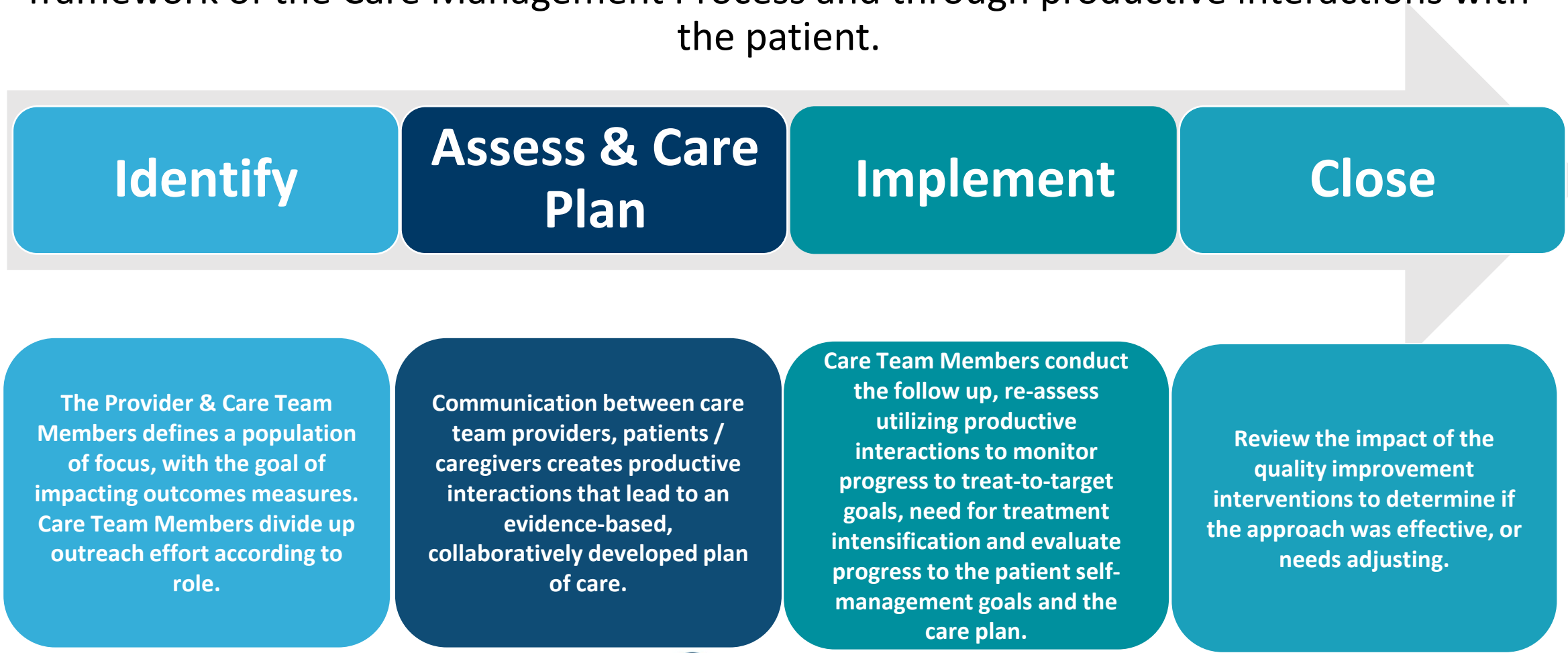
Patient Identification



Case Management Knowledge Framework

https://cmbodyofknowledge.com/sites/cmbok/files/images/2019/KnowledgeFramework-ValueCaseMgmt.v6_1_0.jpg

Care team members improve outcomes by using evidence-based care within the framework of the Care Management Process and through productive interactions with the patient.



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Care Management

Building a Targeted Patient Panel – Takes a Team

- **Referrals:** Physicians and other care team members can identify patients - often through screenings and challenges to optimal health - who would be appropriate and refer them to the optimal team member for support.
- **Screening for risk**: PHQ2/9, GAD 7, SDOH, AUD Out-of-Scope measures for diabetes, HTN, ...
- **Registry or EHR:** Proactive outreach using lists of patients from a registry or EHR can be an easy way to find patients with the diagnoses or gaps of focus.
- **Transitions of Care and Admission/Discharge/Transfer (ADT) Notifications:** Identify how the practice is notified when an individual is discharged from the hospital/ ED; usually on a daily basis, if not in real time!

Care Management
Referral Process

- Develop a simple referral process for providers and care team members to identify patients for care management.
  - A “trigger” list for care management can be useful. *See sample on page 6 of the workbook
- Establish processes for regular short clinical huddles. Review the patients who are coming in for the day or for the week to identify potential referrals to care management and other support persons on the team.
- This engages the full team in identifying and applying a team approach to managing moderate and complex patients.

Care Management
Start with Screening

Screening

- Review of key information related to an individual's health situation in order to identify the need
- Promote early intervention with the purpose of achieving desired outcomes

Objective

- Determine if the individual will benefit from extended services

Key information gathered:

- Risk stratification category or class
- Claims data
- Health services utilization
- Past and current health condition
- Socioeconomic and financial status
- Home environment
- Prior services
- Physical, emotional, and cognitive functioning
- Psychosocial network and support system
- Self-care ability

https://cmbodyofknowledge.com/content/introduction-case-management-body-knowledge

Align Outreach with Desired Outcomes

Work within the practice team and organization to identify patients who need support to improve the key outcomes measures.

Evidence-based Guidelines

Priority Outcome Measures

- Lower Unnecessary Utilization (ER Hospitalizations)
- Decrease Unnecessary office visits
- Optimal management of Medical Conditions; COPD, Asthma, Heart Failure
- Behavioral Goals: Depression/Anxiety

Define the goals the team is working towards:

- % of population in control of diabetes metrics (A1C, retinal eye exam,…)
- % of population with hypertension in control (Targeted diastolic and systolic values)
- % of population with depression meeting remission (PHQ below 5)

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Proactive Identification: A Critical Step

It will take considerable time to build caseloads and impact outcomes if we limited the identification of patients as they present to the office.

- Patients who benefit from more intense services may not seek care or come into the practice.
- Proactive outreach for gaps in care can help re-engage patients with evidence-based preventive care, disease management, and behavioral health care.
- Having a definition for risks will ensure the patient is referred to the right team member.
- Review patient schedules. Identify patients coming in with certain conditions.
- As patients call into the triage nurse/practice/after hours, provide a “red flag” list for care management.

Care Management
Risk Stratification

In healthcare, identifying patients as low, moderate, or high-risk involves categorizing individuals based on their likelihood of experiencing adverse health outcomes or needing increased care.

- Helps healthcare systems tailor interventions and resources to better meet the specific needs of different patient populations
- Involves using historical patient data, such as age, gender, diagnoses, and patterns of healthcare utilization, to predict future health risks.

Care Management
Using the EHR for Patient Identification

Search by -

- Diagnosis codes for chronic diseases of focus (Heart Failure COPD/Asthma Depression/Anxiety)
- Medication list (Common medications used to manage the chronic conditions)
- Hospital/ER admission discharge diagnosis

Sharing: How has or can your team identify patients based on tools, resources and services you have in place?

AAFP Risk Stratification: 2 Step Process

RISK-STRATIFICATION ALGORITHM

Step 1: Use objective data to risk stratify the patient.

HIGH RISK

Risk scoring data:
Significant claims history; significant severity according to ICD-10 or hierarchical condition category (HCC) codes, electronic health record (EHR), health information technology (HIT) database, etc.

Utilization:
- Three or more ED visits.
- Any readmission.
- One hospitalization related to chronic conditions.
- Admission to hospice or palliative care.

Clinical:
- One unstable behavioral health diagnosis.
- Two or more stable behavioral health diagnoses.
- Three or more active chronic conditions.
- Active cancer.
- Clinical metric critically out of bounds (e.g., A1C > 9, stage D heart failure).

MODERATE RISK

Risk scoring data:
Moderate claims history; moderate severity according to ICD-10 or HCC codes, EHR, HIT database, etc.

Utilization:
- One ED visit related to chronic condition.
- Any hospitalization.

Clinical:
- One stable behavioral health diagnosis.
- Fewer than three active chronic conditions.
- History of cancer.
- Clinical metric moderately out of bounds (e.g., A1C < 9, stage B or C heart failure).

LOW RISK

Risk scoring data:
Low claims history; low severity according to ICD-10 or HCC codes, EHR, HIT database, etc.

Utilization:
- No ED visits or hospitalizations.

Clinical:
- No chronic health condition.

Step 2: Use subjective data to assign a risk-stratification level for the patient.

LEVEL 6
Patient is potentially in danger of dying or being institutionalized within the next year.

LEVEL 5
Patient has complications of chronic conditions or high-risk social determinants of health.

LEVEL 4
Patient has chronic conditions that are out of control but without complications.

LEVEL 3
Patient has chronic conditions but is doing well.

LEVEL 2
Patient is healthy with no medical problems but with out-of-range biometrics.

LEVEL 1
Patient is healthy with no medical problems and in-range biometrics.

*See page 9 of the workbook

https://www.aafp.org/pubs/fpm/issues/2019/0500/p21.html#fpm20190500p21-bt5

Care Management
Tips for Successful Risk Stratification

Use of the two-step approach, incorporates objective and subjective data.

- Consider the whole care team's perception of risk when assigning risk levels.
- Use daily huddles and weekly team meetings to discuss patient risk scores.
- Adjust risk levels as the patient's situation changes or based on new information from staff or other sources.
- Reassess individual risk levels regularly as they tend to change over time.
- Make risk levels easy to find in the EHR.
- Consider patients' risk levels when allocating resources. Higher-risk patients may need more access (e.g., same-day or longer appointments) and more resources (e.g., extra time with a nurse for care coordination).

https://www.aafp.org/pubs/fpm/issues/2019/0500/p21.html#fpm20190500p21-bt8

Care Management
Why Risk Stratification Helps

Targeted Interventions:

- High-risk patients can be proactively provided with tailored interventions to prevent complications, reduce hospitalizations, and improve outcomes.

Resource Allocation:

- Risk stratification helps healthcare systems allocate resources more efficiently by focusing on patients who need them most.

Improved Patient Outcomes:

- By identifying and addressing risks early, healthcare systems can improve overall patient health and quality of life.

Cost Reduction:

- Preventing complications and hospitalizations can lead to significant cost savings.

https://www.numberanalytics.com/blog/care-stratification-in-family-medicine#:~:text=The%20importance%20of%20care%20stratification%20lies%20in,complications%20and%20reducing%20the%20likelihood%20of%20hospitalizations.

Care Management Level Comparison and Resources

	Level 1	Level 5
Care plan	• Preventive care • Immunization	• Preventive care • Immunization • Annual wellness visit • Chronic disease management • Monitor for second-degree complications • Medication reconciliation • Shared decision-making • Self-management support • Advanced directives • Transitions of care (as needed)
Goal	• Prevent disease	• Treat the later stages of disease and minimize disability
Access	• Annual face-to-face visit • Virtual health • Brief acute encounters	• Quarterly face-to-face visits (at least) • Prolonged acute encounters • Alternative visit types (e.g., video conference, telephone, group visit)
Team	• Physician • Medical assistant	• Physician • Medical assistant • Care coordinator • Care manager • Behaviorist • Social worker • Pharmacist
Resources needed	• Low	• High

See the AAFP Risk Strat tool in the workbook – Page 9

Comprehensive Assessment

Medical Needs

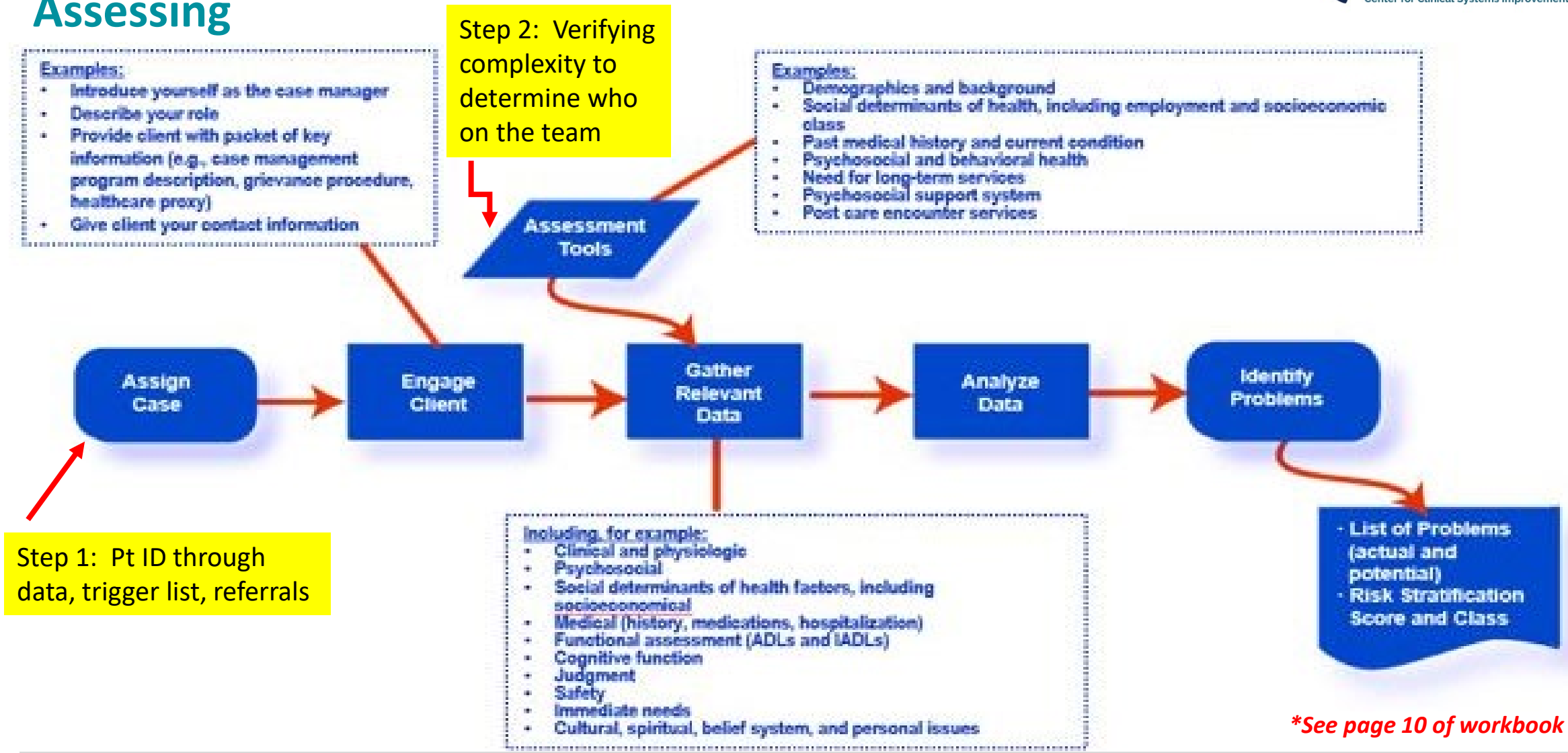
Care Management

Care Management Process

- Engage with the patient to build and maintain a good relationship
- Review the Physical, Behavioral, Social of the patient needs, as well as the patient's desire and ability to change
- Co-develop a plan of care that might include a Symptom Management plan
- Co-develop a Self-Management Action Plan with patient
- Determine the follow up plan

Care Management

Assessing



*See page 10 of workbook

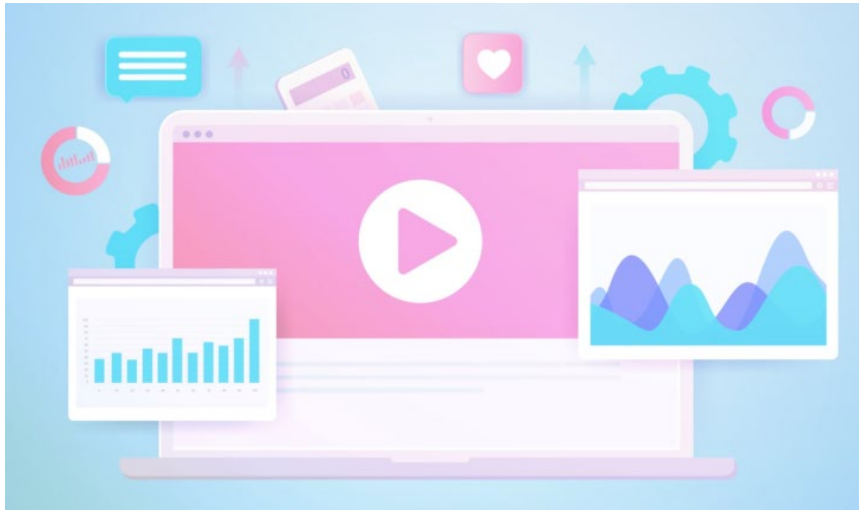
https://cmbodyofknowledge.com/content/introduction-case-management-body-knowledge

MOTIVATIONAL INTERVIEWING

Encouraging Positive Changes in Your Patients

ThoroughCare

Observations from the video?



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Engage the Patient for a Successful Assessment

- Gently guide the conversation
- Balance active listening with advice giving
- Use respect and curiosity; genuinely get to know the patient
- Ask more open questions, repeat back what you heard to check your understanding
- Empower change by focusing on patient identified motivating factors

Key Areas of Focus

- Linguistic and Cultural Needs
- Health Literacy
- Health Status
- Psychosocial Status/Needs
- Patient Knowledge/Awareness/Ability

Group Activity: Create an open question for each of the Key Areas of Focus

3 Primary Objectives of the Assessment

1. Identifying the patient's key problems to be addressed, as well as individual needs and interests (needs and ability)
2. Determining the expected care goals and target outcomes (Treat-to-Target and Treatment Intensification Monitoring)
3. Developing a comprehensive plan of care that addresses these problems and needs based on patients needs, desire and ability

https://cmbodyofknowledge.com/content/introduction-case-management-body-knowledge

The Comprehensive Assessment

Includes:

- Behavioral Health
- Social Needs
- Medical Status

Incorporates the patients:

- Ability
- Knowledge
- Desire

Care Management

Patient Assessment

The assessment provides patient context and supports co-development of the Plans of Care.

Review historical screenings, gather information from the provider or other care team members as possible, and talk with the patient to understand the patient's understanding of and situation.

Medical/Physical: This includes a review of medical history, physical examination, assessment of current symptoms, and evaluation of medications and potential drug interactions.

- **Functional:** This evaluates how well the individual can perform daily activities, including self-care, mobility, and social interactions.
- **Environmental:** This looks at the individual's living and working environment, potential hazards, and other external factors that might impact health.

Behavioral: This component focuses on mental health, including cognitive function, mood, behavior, and potential issues like anxiety, depression, or substance use.

Social: This examines social support networks, family dynamics, living situation, cultural background, and any social factors that might affect health and well-being.

https://www.upretyhomecare.com.au/what-is-comprehensive-health-assessment/

Medical Physical Health

- Current Health Status and Medical History
- Family Medical History
- Medication Reconciliation
- Functional Assessment or ADLs
- Knowledge of Current Management/ Perception of Health

*See sample assessment on pages 11-13 of workbook

Care Management
Screening Tools

Screening Instruments (documented via LOINC):

- MAHC 10 Fall Scale
- Davis Home Environmental Health & Safety
- Edmonton Frailty Scale
- Katz Index for Assessing ADL's
- Lawton Instrumental ADL
- Palliative Performance Scale
- FICA Assessment of Spirituality
- Spector Heritage Assessment Tool
- Spirituality- Brief R-COPE
- Modified Caregiver Strain Index
- Food Insecurity Assessment
- CDC I Prepare Environmental Assessment

*See an example of the screening tools in the workbook on page 16 - 17

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Tools for Assessing Health Literacy

TOOL	DESCRIPTION	EXAMPLE QUESTIONS
Test of Functional Health Literacy (TOFHLA)	• Designed for use in research • Measures reading comprehension and numeracy • Uses actual client instructions and forms • Takes approximately 22 minutes	Do not eat _____ a. appointment b. walk-in c. breakfast d. clinic
Rapid Estimate of Adult Literacy in Medicine (REALM)	• Designed for use in clinical setting • Person reads 66 medical terms aloud • Score based on number of words read and pronounced correctly • Takes 2-3 minutes to administer	Words include: flu, smear, stress, gallbladder, inflammatory, diagnosis, potassium
Newest Vital Sign (NVS)	• Assesses numeracy and comprehension • Uses nutrition label that clients must read and interpret • Total of six questions related to label provided • Takes approximately 3 minutes	Give client the nutrition label and ask: • If you eat the entire container, how many calories will you eat? • If you usually eat 2,500 calories in a day, what percentage of your daily value of calories will you be eating if you eat one serving?

Medications-Polypharmacy

individuals over age 85

patients with renal impairment

patients with low body weight and poor nutrition

patients diagnosed with six or more chronic diseases

patients taking over 12 dosages of medications daily

individuals with a history of adverse drug reactions.

Resources

- https://www.healthinaging.org/medications-older-adults
- https://hign.org/
- https://my.clevelandclinic.org/health/articles/24946-beers-criteria
- https://transculturalcare.net/cultural-assessment-tools/

Care Management
Symptom Management Plans

Helps patients recognize and monitor their symptoms:

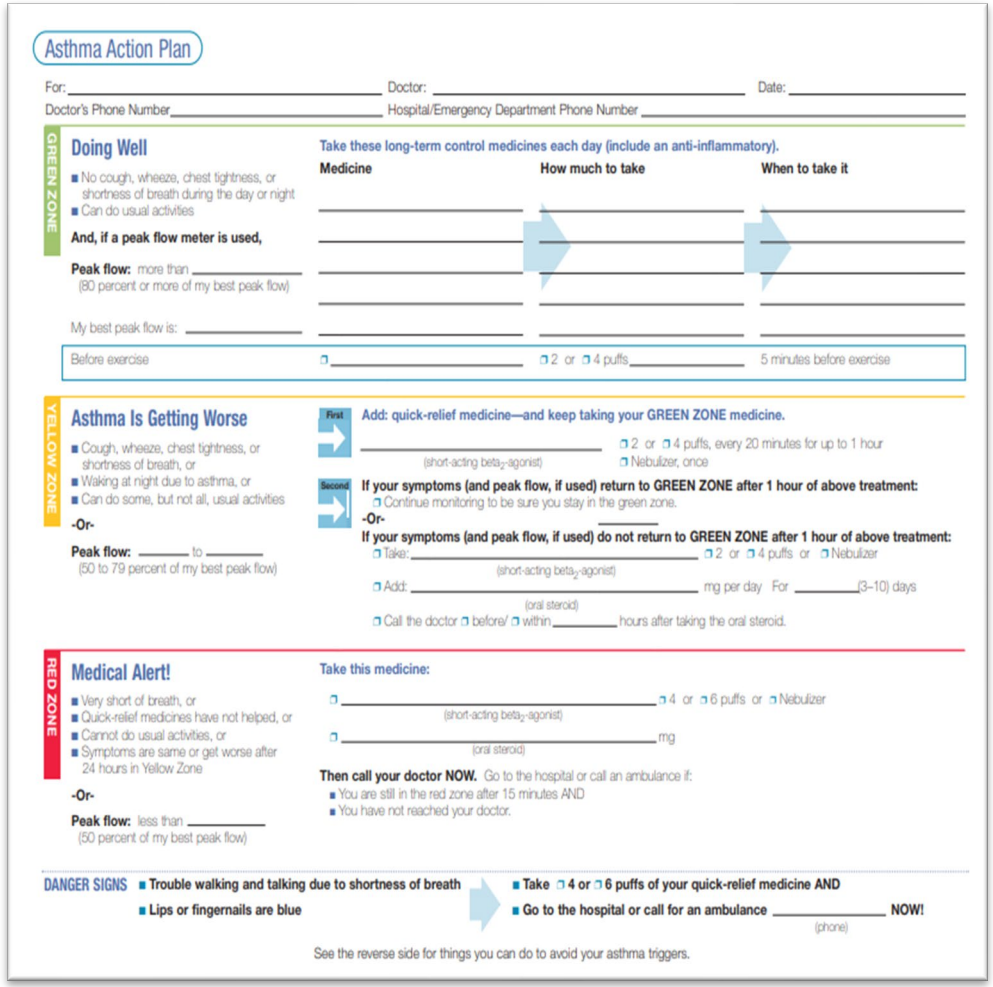
- Assist patients in recognizing early symptoms with the goal of avoiding unnecessary utilization.
- Identifies the symptoms to be aware of and appropriate corresponding actions.

Frequently follows the ‘stoplight’ model:

- **Green**: Maintaining Goal(s)
- **Yellow**: Warning when to call provider/office
- **Red**: Emergency symptoms

Example Action Plans

Asthma



Asthma Action Plan

For: _____ Doctor: _____ Date: _____

Doctor's Phone Number _____ Hospital/Emergency Department Phone Number _____

GREEN ZONE

Doing Well

- No cough, wheeze, chest tightness, or shortness of breath during the day or night
- Can do usual activities

And, if a peak flow meter is used,

Peak flow: more than _____ (80 percent or more of my best peak flow)

My best peak flow is: _____

Take these long-term control medicines each day (include an anti-inflammatory).

Medicine	How much to take	When to take it

Before exercise ❒ _____ ❒ 2 or ❒ 4 puffs _____ 5 minutes before exercise

YELLOW ZONE

Asthma Is Getting Worse

- Cough, wheeze, chest tightness, or shortness of breath, or
- Waking at night due to asthma, or
- Can do some, but not all, usual activities

-Or-

Peak flow: _____ to _____ (50 to 79 percent of my best peak flow)

First: **Add: quick-relief medicine—and keep taking your GREEN ZONE medicine.**

_____ (short-acting beta$_2$-agonist) ❒ 2 or ❒ 4 puffs, every 20 minutes for up to 1 hour ❒ Nebulizer, once

Second: **If your symptoms (and peak flow, if used) return to GREEN ZONE after 1 hour of above treatment:**

❒ Continue monitoring to be sure you stay in the green zone.

-Or-

If your symptoms (and peak flow, if used) do not return to GREEN ZONE after 1 hour of above treatment:

❒ Take: _____ (short-acting beta$_2$-agonist) ❒ 2 or ❒ 4 puffs or ❒ Nebulizer

❒ Add: _____ (oral steroid) mg per day For _____ (3–10) days

❒ Call the doctor ❒ before/ ❒ within _____ hours after taking the oral steroid.

RED ZONE

Medical Alert!

- Very short of breath, or
- Quick-relief medicines have not helped, or
- Cannot do usual activities, or
- Symptoms are same or get worse after 24 hours in Yellow Zone

-Or-

Peak flow: less than _____ (50 percent of my best peak flow)

Take this medicine:

❒ _____ (short-acting beta$_2$-agonist) ❒ 4 or ❒ 6 puffs or ❒ Nebulizer

❒ _____ (oral steroid) mg

Then call your doctor NOW. Go to the hospital or call an ambulance if:

- You are still in the red zone after 15 minutes AND
- You have not reached your doctor.

DANGER SIGNS

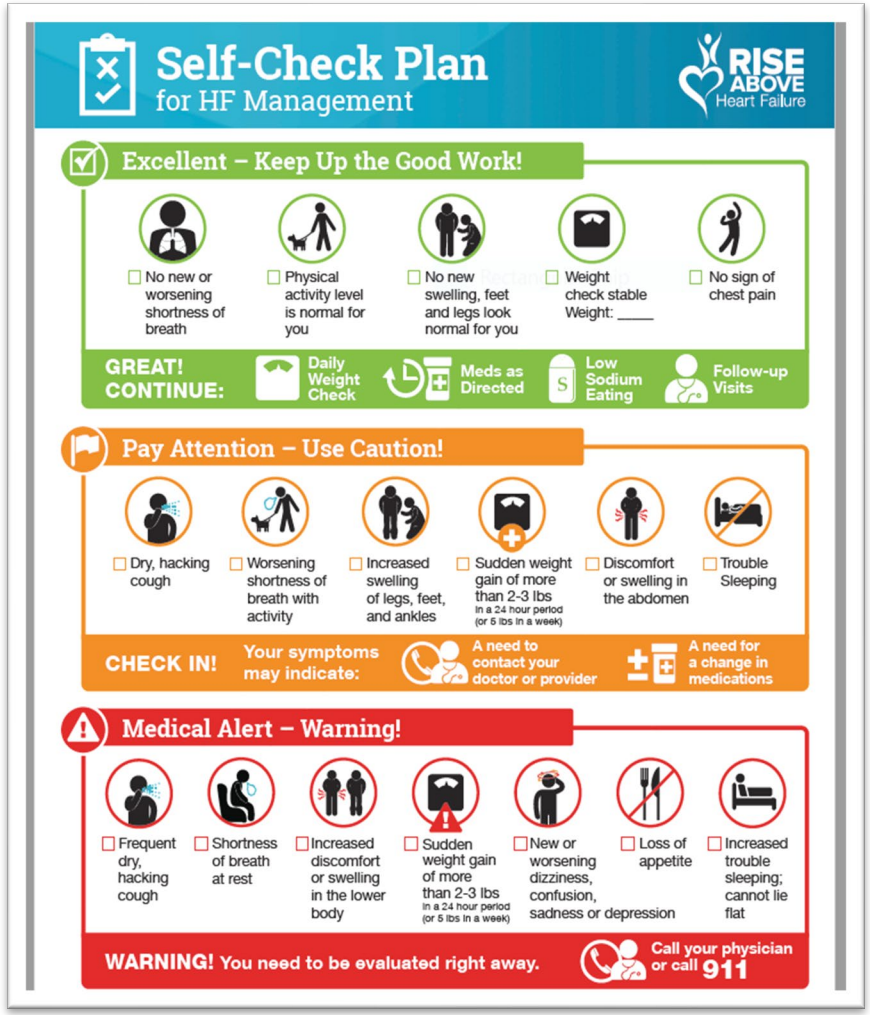
- **Trouble walking and talking due to shortness of breath**
- **Lips or fingernails are blue**

- **Take ❒ 4 or ❒ 6 puffs of your quick-relief medicine AND**
- **Go to the hospital or call for an ambulance _____ (phone) NOW!**

See the reverse side for things you can do to avoid your asthma triggers.

https://www.nhlbi.nih.gov/files/docs/public/lung/asthma_actplan.pdf

Heart Failure



Self-Check Plan for HF Management

RISE ABOVE Heart Failure

Excellent – Keep Up the Good Work!

- ☐ No new or worsening shortness of breath
- ☐ Physical activity level is normal for you
- ☐ No new swelling, feet and legs look normal for you
- ☐ Weight check stable Weight: ____
- ☐ No sign of chest pain

GREAT! CONTINUE: Daily Weight Check · Meds as Directed · Low Sodium Eating · Follow-up Visits

Pay Attention – Use Caution!

- ☐ Dry, hacking cough
- ☐ Worsening shortness of breath with activity
- ☐ Increased swelling of legs, feet, and ankles
- ☐ Sudden weight gain of more than 2-3 lbs in a 24 hour period (or 5 lbs in a week)
- ☐ Discomfort or swelling in the abdomen
- ☐ Trouble Sleeping

CHECK IN! Your symptoms may indicate: A need to contact your doctor or provider · A need for a change in medications

Medical Alert – Warning!

- ☐ Frequent dry, hacking cough
- ☐ Shortness of breath at rest
- ☐ Increased discomfort or swelling in the lower body
- ☐ Sudden weight gain of more than 2-3 lbs in a 24 hour period (or 5 lbs in a week)
- ☐ New or worsening dizziness, confusion, sadness or depression
- ☐ Loss of appetite
- ☐ Increased trouble sleeping; cannot lie flat

WARNING! You need to be evaluated right away. Call your physician or call 911

http://mqic.org/physician-tools.htm

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*See sample page 14-15 of workbook

Social Needs

- Housing
- Food
- Financial Strain
- Transportation
- Personal Safety

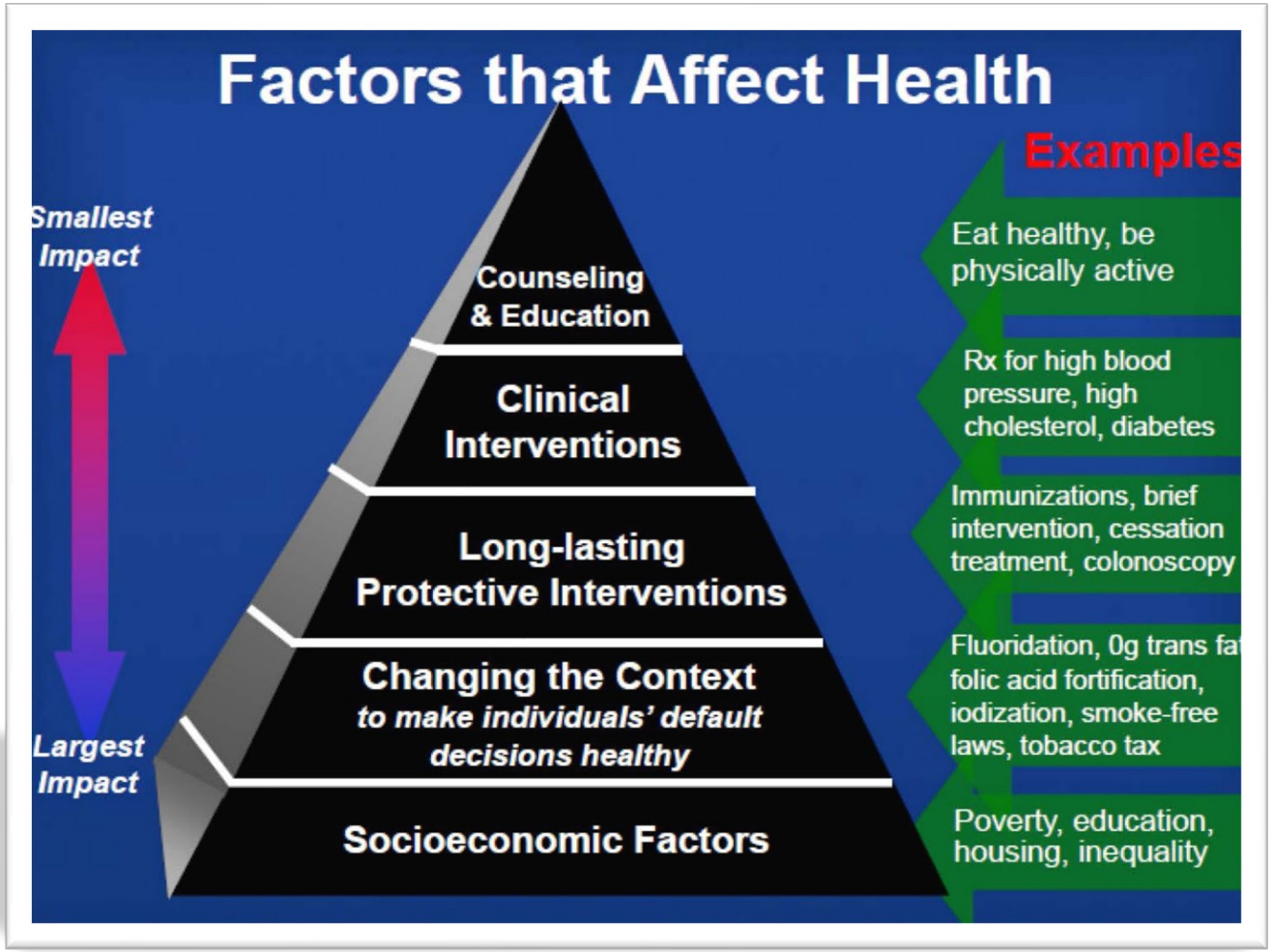
Care Management
Screening Tools for SDOH

Screening Instruments (documented via LOINC):

- Accountable Health Communities
- AAFP Social Needs Screening Tool
- Health Leads Screening Panel
- Hunger Vital Sign ™
- PRAPARE
- Safe Environment for Every Kid (SEEK)
- We Care Survey
- WellRx Questionnaire
- Housing Stability Vital Signs™
- Comprehensive Universal Behavior Screening
- PROMIS
- USDA Food Security Survey

*See an example of the AAFP screening tool in the workbook on page 16 - 17

Why Social Detriments of Health



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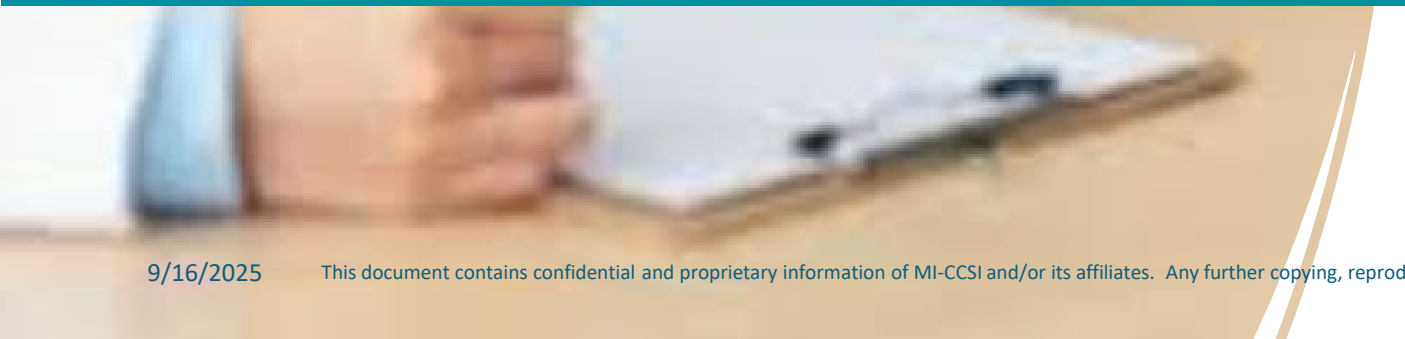
SOCIAL DETERMINANTS OF HEALTH

Comprehensive Assessment

Behavioral Needs



Behavioral Health Needs

- Diagnosis History and Treatment
- Depression
- Anxiety
- Alcohol and Substance Use

Care Management

Behavioral Health Screenings Managed in Family Practice Settings

- Depression: Patient Health Questionaire (PHQ2/PHQ9)
- Anxiety: Generalized Anxiety Disorder (GAD7)
- Alcohol and Substance Use Disorder: 2 question conjoint (TICS) for Alcohol and Substance Use Disorder)

CONSIDERATIONS

- Frequency of screening, monitoring, and verifying diagnosis
- Determine the targeted goal (PHQ/GAD 7 at remission, below 10, improvement of 5)
- If high risk, what treatment options are available to the patient

See PHQ and GAD 7 screening tools in the workbook pages 18 and 19

Care Management
Behavioral Health History

- Course of illness
  - “How long has this been going on?”
  - “Is this something that is always present for you, or does it come and go?”
  - “What tends to bring on these feelings, if anything?”
- Diagnostic history
  - “What mental or behavioral health diagnoses, if any, have you received from a health care provider?”
  - What is your understanding of your diagnosis of depression/anxiety?
  - “Who was it that gave you that diagnosis? When?”
  - Screen for history of psychosis (AH/VH)
- Trauma history – consider timing, comfort and engagement when addressing this
  - It is often appropriate to wait until a trusting relationship is established before screening for trauma
  - Screening tools include the PC-PTSD and the PCL-5

Care Management
Treatment History- Medications

- Current and past medication names and dosages, (both medical and psychotropic) – what is/was the medication for?
- Prescriber(s) of the medication(s)
- Length of medication trials
  - “How long did you take that medication?”
  - “What made you decide to stop the medication?”
- Effectiveness and side effects
  - “What did you notice when you took that medication?”
  - “Was it helpful? Why/why not?”
  - “What side effects, if any, did you experience?”
- Perceptions and beliefs – about taking medications?

Care Management
Treatment History - Therapy

- Current and past engagement in therapy
- Where
- Type
  - “What kinds of things did you work on? What did you learn?”
- Length
- Effectiveness
  - “What was helpful about it? What wasn’t?”

Care Management
Psychosocial Needs

Detailed information to include in the assessment.

- Support system
- Financial issues
- Disability/work status
- Transportation
- Living situation
- Access to phone and adequate minutes for phone-based care management contacts

Response to Question 9 on the PHQ9 Screening

"Thoughts that you would be better off dead or hurting yourself in some way"

Does the practice have a suicide policy?

Do all members of the team know what to do if a patient indicated they are suicidal and have the means to carry it out?

Care Management
Suicide Risk Assessment

- Thoughts of death, harming oneself, and suicide can be common within this population
- When clinically indicated, risk assessments and safety planning should be completed
- Consider your organization's suicide protocol
- Engage in further training if needed

Key Acute Suicide Risk Factors and Behaviors

- Current ideation, intent, plan, and access to means
- Rehearsing a plan (e.g., holding a gun, loading a gun, counting pills)
- Previous suicide attempt/s
- Alcohol/substance use
- Recent discharge from an inpatient psychiatric unit

Example: Columbia – Suicide Severity Rating Scale (C-SSRS)

Care Management
Strategies for Suicide Risk Assessment

- Normalize the conversation (“thoughts of suicide are a common symptom of mental health disorders”)
- Be direct
- **You won’t increase the risk of suicide by asking directly about it**. Use specific language, such as:
- *“Are you feeling hopeless about the present or future?”*
- *“Thoughts of suicide, even very fleeting thoughts such as not wanting to wake up in the morning, are common in people with depression and anxiety. Is this something that you’ve experienced?”*
- *“Have you had thoughts of taking your life?”*
- *“Do you have a plan to take your life?”*

See page 20-22 Suicide Policy example

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Patient Safety Plan Template

Step 1: Warning signs (thoughts, images, mood, situation, behavior) that a crisis may be developing:

1. _____
2. _____
3. _____

Step 2: Internal coping strategies – Things I can do to take my mind off my problems without contacting another person (relaxation technique, physical activity):

1. _____
2. _____
3. _____

Step 3: People and social settings that provide distraction:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Place_____ 4. Place_____

Step 4: People whom I can ask for help:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Name_____ Phone_____

Step 5: Professionals or agencies I can contact during a crisis:

1. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact # _____
2. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact # _____
3. Local Urgent Care Services_____
   Urgent Care Services Address_____
   Urgent Care Services Phone_____
4. Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255)

Step 6: Making the environment safe:

1. _____
2. _____

The one thing that is most important to me and worth living for is:

Safety Plan Template – page 23

Screening Brief Intervention Referral to Treatment
Screening and Assessing Risk

	Adults	Teens
Screens	• Single Alcohol Screening Question • Alcohol Use Disorders Identification Test - Concise (AUDIT-C) • Single Drug Screening Question • Two-Item Conjoint Screen (TICS)	Pre-CRAFFT Questions
Assessments	• Alcohol Use Disorders Identification Test (AUDIT) and Drug Abuse Screening Test (DAST) • Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) • Short Index of Problems - Alcohol and Drugs (SIP-AD) and Severity of Dependence Scale (SDS)	CRAFFT

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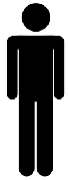
Single Action Screening Question

How many times in the past year have you had X or more drinks in a day?

 X = 5

 X = 4

a. None
b. 1
c. 2 to 5
d. 6 to 10
d. 11 to 20
e. more than 20

Smith, Journal of General Internal Medicine, 2009

For alcohol screens, define standard drinks

12 fl oz of **regular beer**	=	8-9 fl oz of **malt liquor** (shown in a 12-oz glass)	=	5 fl oz of **table wine**	=	3-4 oz of **fortified wine** (such as sherry or port; 3.5 oz shown)	=	2-3 oz of **cordial, liqueur, or aperitif** (2.5 oz shown)	=	1.5 oz of **brandy** (a single jigger or shot)	=	1.5 fl oz shot of **80-proof spirits** ("hard liquor")
												
about 5% alcohol		about 7% alcohol		about 12% alcohol		about 17% alcohol		about 24% alcohol		about 40% alcohol		about 40% alcohol

Ounces in a standard drink = 60 / % alcohol by volume

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*See page 24 of the workbook

Single Drug Screening Question

How many times in the past year have you used an illegal drug or used a prescription medication for non-medical reasons?

a. None
b. 1
c. 2 to 5
d. 6 to 10
d. 11 to 20
e. more than 20

Smith, Journal of General Internal Medicine, 2009

Two-Item Conjoint Screen

May be added to 2 single screening questions to identify more drug disorders.

1. In the last year, have you ever drunk alcohol or used drugs more than you meant to?
2. In the last year, have you felt you wanted or needed to cut down on your drinking or drug use?

Positive screen: Yes to either or both questions

Does not identify <u>at-risk</u> alcohol or drug use

Brown, Journal of the American Board of Family Practice, 2001

*See page 25 of the workbook

Care Management
Interpreting Screen Results

- Screens identify most risky users, problem users and dependent individuals
- False-positives and false-negatives are not unusual
- Because of false-positives …
  - Positive screens are not definite indicators of risky use, problem use or dependence
  - Screens merely indicate which asymptomatic individuals should undergo further assessment
- Because of false-negatives …
  - Screens should not be administered to individuals with symptoms of mental health disorders
  - Those individuals should undergo more in-depth assessment

Care Management
Alcohol and Substance Use Assessment

- Engage, ask permission, and be nonjudgmental
  - “Would it be okay if I asked you a few questions about how you use substances?”
- Current and past substance use
- Treatment history
- Gain initial understanding of how they feel about their substance use
  - Brief assessment, Intervention/referral to treatment
  - “You’re not worried about how this is impacting you right now.”

AUDIT-C

DAST

CRAFFT

**See tools on page 26 – 27 of workbook*

Accuracy of Alcohol and Drug Screens

	Sensitivity	Specificity
	Of those with the condition, what proportion screen positive?	Of those without the condition, what proportion screen negative?
	True positive vs. false negative	True negative vs. false positive
Single Alcohol Screening Question	82%	79%
AUDIT-C	♂: 79% ♀: 80%	♂: 56% ♀: 87%
NIAAA Quantity- Frequency Questions	83%	84%
Single Drug Screening Question	83%	94%
Two-Item Conjoint Screen (TICS)*	79%	77%

*Screens for problem use and dependence, not risky use

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Smith, Journal of General Internal Medicine, 2009; http://www.integration.samhsa.gov/images/res/tool_auditc.pdf; Friedmann, Journal of Studies on Alcohol, 2001; Smith, Journal of General Internal Medicine, 2009; Brown, Journal of the American Board of Family Practice, 2001

Team Actions

Review the AAFP Risk Stratification tool

- Based on the practice goals and desired outcomes, how will the team identify patients who will benefit from care management activities?
- Based on the Risk Stratification model, which care management activities will be delegated to the different team roles?
- Such as low, moderate or high- risk patients.

As a team

- Determine which conditions the team will screen or are currently screening for.
- For new screenings, decide which screening tool you can reasonably start using
- Determine if the screening tool is available in the EHR or other resources. If yes, is the tool sufficient, or do you need to embed a new tool.
- Establish a plan for administering the screening tool to the patient. Who will do this?
- Establish a plan to share the results with the provider and determine what actions will/can occur for any positives.

Assessments

- From step 1 (to include screening) what is the team process for referral to the care manager to initiate step 2 (gathering of subjective information) during the comprehensive assessment?
- How will you know who will require step 2 (conducting the comprehensive assessment by gathering subjective information) to verify complexity?
- Discuss how the assessment will be documented and communicated across the team.
  - Where or how will this take place? (In person, telephonically, virtual)
- How will the patient be assigned to the appropriate team member based on the complexity and needs of the patient (align with the roles and responsibilities table).
- Who and how will you monitor these actions to validate the process is being followed?
- Will there be a policy/workflow created and an auditing process to identify challenges that may require modifications to the process?

Questions?