**\_\_\_\_PROGRAM PC-A\_\_\_\_\_\_**

 **Primary Care Setting**

**POLICY AND PROCEDURE**

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| --- | --- |
| **DIVISION:**  |  |
| **SUBJECT:**  |
| **SECTION:**  | **PAGE**: **OF**  |
| **REVIEWED BY**:  | **EFFECTIVE DATE:**  |
| **TO BE PERFORMED BY**:  | **REVIEWED DATE:** **REVISED DATE:**  |

**PURPOSE**:

Our Vision

Collaboration, innovative teams, and unique perspective drive high-value care that engages adults living with substance use disorder, social dysfunction, health disparities, and complex illness to achieve to their highest potential.  We support the journey to sobriety and provide detail-oriented specialty, primary, and alternative care to maximize function, ability, and wellness. For individuals engaged in the legal system, either trying to avoid or returning from incarceration, we provide a warm, supportive, and non-judgmental environment to maximize wellness and social integration.

**PROCEDURE:**

Scheduling Criteria

1. Patient must be eligible for care at any DHP site
2. Age 18 or greater
3. History of or current substance use disorder

Rescheduling Criteria

1. See above

PRW

1. Confirm financial eligibility on the day of the appointment
	1. If a patient lacks health insurance, they should be referred to member services for assistance in enrolling in health insurance if eligible
	2. If a patient is already enrolled but needs verification of eligibility only, complete the verification screen
2. Verify demographic information
3. Establish a new patient record according to accepted \_\_\_ policy as needed for patients who have not been seen in the DHS system before
4. Give patient packet of screening forms

Nursing Team (CMA / LVN / RN)

1. Long intake in ORCHID including tobacco screen, PHQ 9, GAD and Audit C at first visit
2. Perform and record vital signs, including pain screening and oxygen saturation
3. Complete Reproductive Life Screen
4. Inter-visit case management at the direction of the primary or recovery provider
5. Population management at the direction of the primary or recovery provider
	1. Run pre-determined reviews of assigned patients for health care indicators including: cervical cancer screening, mammography, colon cancer screening, immunizations (Pneumococcal, Tetanus-Diptheria-Pertussis and Influenza Vaccines)
	2. Order urine based substance abuse markers to include buprenorphine and standard urine toxicology, pregnancy testing (females), STI panel (HIV, RPR, CG/CT, Hepatitis C), Hepatitis B panel, Quantiferon, and complete metabolic panel.
6. Facilitate screening tools as needed
7. Participate in all team meetings

Integrated Behavioral Health (Social Worker)

1. Complete initial intake to include: review of PHQ 9, GAD, and Audit C responses and completion of DAST 10 and or ASSIST with pt.
2. Accept referrals for all individuals with PHQ9 or GAD 7 greater or equal to 10
3. Accept referrals for other patients at recommendation of any member of the clinical team
4. Provide short term (8-12 weeks) individual therapy using an IMPACT model
5. Provide linkage to community-based organizations for additional resources as appropriate
6. Provide linkage to Department of Mental Health when Tier 1 mental health conditions are identified
7. Support transfer to \_\_\_ for patients with urgent mental health issues
8. Support transfer via PET team or 911 for psychiatric emergencies
9. Provide linkage to community based organizations for support on social determinants of health as appropriate.
10. Participate in all team meetings

Patient Navigator

1. Serve as a greeter for patients, providing support and guidance through the intake process
2. Facilitate patients as they complete screening tools
3. Communicate needs of individual patients to the appropriate member of the clinical team as needed
4. Phone calls pre and post visit
5. Participate in all team meetings

Primary Care Provider

1. Complete Initial Health Assessment (IHA) per \_\_\_ policy in compliance with all Managed Care Standards at first visit and yearly thereafter
2. Review Reproductive Life Plan
3. In addition to general health history, document elements of history that are specific SUD
4. Ensure that all primary care health maintenance indicators are met
5. Supports the MAT provider in monitoring patients on MAT for adherence to therapy and compliance with conditions of participation
6. Participates in all team meetings

MAT Provider

1. Evaluates individuals for eligibility for MAT
2. Initiates MAT per protocol; with induction as needed
3. Conducts group visits as planned with additional individual sessions as needed
4. Writes and manages all prescriptions provided as MAT
5. Participates in team meetings

EXPECTED SCREENINGS:

Health Maintenance Tools

1. Staying Health Assessment, yearly for all patients regardless of payer source
2. Mental Health Screen: PHQ9 and GAD7
	1. Refer to Integrated Behavioral Health for PHQ>9 or GAD > 9 or
	2. at discretion of primary care, MAT provider, or any other team member
3. Audit C form
4. Drug Abuse Screening Test (DAST-10)
5. WHO-ASSIST V 3.0

Laboratory

Initial

1. Primary Care: Draw ordered labs per standard procedure
2. Complete Blood Count / Complete Metabolic Panel/ Hepatitis B & C screen / HIV / GC / CT/ RPR
3. Quantiferon
4. Urine toxicology and buprenorphine
5. Pregnancy test (if applicable)

Routine

1. Urine toxicology each visit
2. Pregnancy testing (if applicable)

Immunizations:

1. ACIIP Recommendations for adults

CLINIC WORKLFOW

1. Pre-Visit Plan: Patient Navigators will do an enhanced “reminder” call to patients three days prior to visit
	1. Identify barriers to arriving on time for visit
	2. Resolve transportation barriers if any exist
	3. Consider completing a pre-screening intake by phone
	4. Identify required screening tests and order in advance so that results are ready at the time of the visit
2. Clinic Day – New Patients
	1. Check in with PRW
	2. Screening with Patient Navigator
	3. 60 min intake with provider
	4. Visit with social worker
3. Clinic Day – Initiation patients
	1. Check in with PRW
	2. Unscheduled check in with Patient Navigator
	3. Hour long group meeting
	4. Individual session for dose initiation
	5. Follow up phone call by nursing 1-2 days after start and as needed
4. Clinic Day Maintenance
	1. Check in with PRW
	2. Unscheduled check in with Patient Navigator
	3. Hour long group meeting
	4. Individual session for dose adjustments
5. Group Meeting
	1. Group size maximum 15
	2. Time 60 minutes
	3. Check in 30 minutes prior to meeting
	4. Perform urine testing
	5. Review of Ground Rules for Group participation
	6. Sign Group Consent Form
6. Inter-visit care
	1. Patient Navigator calls patient as predetermined during intake to review self-management goals
	2. Navigator identifies any new barriers that have arisen
	3. Navigator confers with team as needed
	4. Population management as per schedule