INTERPROFESSIONAL, EAM-BASED CARE FOR CHRONIC PAIN MANAGEMENT

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LEARNING OBJECTIVES OF THIS WEBINAR

At the completion of this session, participants should be able to:

Overview of Populated Health Management

Benefits of Team-Based Care

Describe five attributes of effective, team-based care.

Identify five potential areas of intervention associated with a bio-psyc social model to address chronic pain.

Engage in discussion with your care team on specific ideas that suppor team-based care of chronic pain and contribute to a care pathway fo your facility.

OVERVIEW OF THE MPCA CHRONIC PAIN INITIATIVE TRAINING PROGRAM

Key Components of the Team-Based Training

Identifying the Care Team

Didactic training on Medical and Behavioral Interventions for Chronic Pa

Manuals for clinical interventions and patient education

Protocols for a Primary Care Pain Management program

Implementation of Team-Based Care for Chronic Pain Management

IMPACT OF CHRONIC PAIN

Leading cause of disability for Americans < 45 y/o

1 in 3 American adults lose more than 20 hours of slee each month due to pain

1/10 adults experience pain for one year or more

Opportunity costs

WHAT IS "POPULATION HEALTH MANAGEMENT"

A treatment delivery model that utilizes resources to impact a population vs. just an individual

Identifies a patient population by common chronic conditions, healthcare utilization, or high-risk health behavior

Considers the physical, mental, and social needs of the targe patient population

Utilizes interprofessional care teams to implement strategies that provide quality and cost effective care to the target gro

Documents outcomes and utilizes information in decision maki

WHY TARGET CHRONIC PAIN MANAGEMENT AS A POPULATION HEALTH ISSUE?

Patients require increased clinical time

Lack of access to specialty services, formal pain programs, physical therapy

Effective management requires multifaceted assessmen interventions, and collaboration by an Interprofessiona team

Patient/Care Team interactions directly impact patient outcomes

A TEAM OF EXPERTS, IS NOT AN EXPERT TEAM..

THE GOOD NEWS.. DEVELOPING EFFECTIVE TEAMS

WHO LEADS THE TEAM?

"SHARE THE CARE" MODEL

(Ghorob and Bodenheimer, 2015)

Who Does It **Now**?

	PCP	MA	LPN	RN	BHC
TASK A					

Who **Could** Do it?

	PCP	MA	LPN	RN	BHC
TASK A					

INTERPROFESSIONAL, TEAM-BASED CARE

There is a growing body of research, especially in nursing literature, that confirms a healthy climate among the health care team leads to:

- greater job satisfaction,
- healthier workforce,
- lower turn-over,
- higher patient satisfaction, and
- improved patient outcomes

FORMULA FOR CONSISTENT, QUALITY OUTCOMES

Individual Clinical Skills × **Effective Teamwork Skills** × **Effective Systems & Processes**

= **Consistent, Quality Clinical Outcomes**

Saint Louis University, IPE/CP Model. David Pole, Fred Rottnek, 2014 // Riley, et.al. 2010, *Journal of Nursing Management* 18, 556-563

EFFECTIVE TEAM-BASED CARE SHARES FIVE PRINCIPLE BEHAVIORS

- Shared Goals
- Clear Roles
- Mutual Trust
- Effective Communication
- Measurable Outcomes

OM Round Table Report: P. Mitchell, et.al. October, 2012.

WHAT DOES INTERPROFESSIONAL COLLABORATIVE PRACTICE (IPCP) LOOK LIKE

When multiple health workers from different professional backgrounds
ork together with patients, families, care givers, and communities to deli
e highest quality of care.

Collaboration-ready members of interprofessional health care teams a
ble to optimize the skills of team members, share in care management, a
rovide better health services to patients and communities.

Interprofessional Collaborative Practice (IPCP) helps strengthen the hea
are system and improves outcomes.

orld Health Organization 2010. *Framework for Action on Interprofessional Education and Collaborative Practice*

CHALLENGE – CHOICE – OUTCOME MO. PCHH TEAMS CAN DO THIS…

allenge: Come up with a new model of care to improve Chronic Disease nagement for patients across Missouri.

oice: Develop and improve an Integrated Care Model that includes the P, Nurse Care Manager, and BHC

oice: Move from multi-professions working side-by-side, to an erprofessional Collaborative Practice approach

tcome: Significant improvements in clinical measures, improved herence, decreased use of the Emergency Department for non-ergent care, increased cost-savings and improved care and outcomes.

CHALLENGE: TRIPLE AIM AND CHRONIC PAIN

Individual Care & Outcomes

COMMUNITYhealth

Population/Community Health

Cost Effective Care

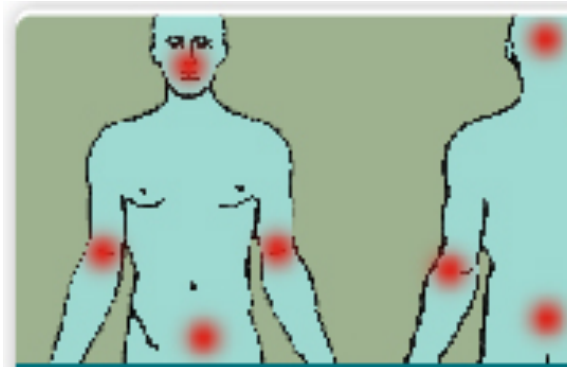
A BRIEF INTRODUCTION TO THE MULTIPLE ASPECTS OF PAIN MANAGEMENT

https://www.uclh.nhs.uk/OurServices/ServiceA-Z/Neuro/PMC/Pages/Whatischronicpain.aspx

(Length of Video: 5 min.)

WHAT IS CHRONIC PAIN?

University College London Hospitals NHS
NHS Foundation Trust



COMPONENTS OF CHRONIC PAIN MANAGEMENT

Medical Management and Medications

Thoughts, Emotions, & Stress Impact on CNS

Diet and Lifestyle

Deeper Meaning & Pt. Story regarding Pain

Physical Activity and Function

o is needed? Who can provide these functions on your team?

UTILIZE TEAM-BASED CARE FRAMEWORK TO GUIDE MEETINGS FOR CHRONIC PAIN

SHARED GOALS that reflect patient/family priorities, & can be clearly articulated, understood, and supported by all team members.

CLEAR ROLES and expectations for each team member's functions & responsibilities, optimize the efficiency & effectiveness of the team and care delivery.

MUTUAL TRUST is earned and developed across team, creating strong norms of reciprocity & opportunities for shared achievement (treatment and team efficacy).

EFFECTIVE COMMUNICATION demonstrates team priorities, creates consistent chan for candid and complete communication regarding team and patient progress.

MEASURABLE OUTCOMES that include timely feedback on successes and failures in the functioning of the team and achievement of the team's goals.

P. et.al. 2012. *Core principles & values of effective team-based health care*. Discussion Paper, Institute of Medicine, Washingto

TEAM: COMMUNICATION, COORDINATION, AND COLLABORATION

- mproved understanding, teamwork behaviors, and care pathw tems, and treatment efficacy for CP Management
- mproved understanding of how co-morbid conditions and atments interact with CP (depression, anxiety, CHD, Hypertensi abetes, etc.)
- Monitoring of overall patient condition, risk of suicidality and/o f-harm
- Monitoring of overall patient shift from passive role of only armacological management to behaviors and practices in CP nagement plan

OTHER TEAM FUNCTIONS/ DISCUSSIONS

se of resources to build capacity for team-based care of Chronic Pain

Case presentations and CE through the ECHO Program

Development of measures to monitor progress and outcomes for patients

ncrease understanding of care options and treatment efficacy by the te
eryone able to explain to patients

ncrease skills to validate the patient's story regarding pain, causes, impa
ADLs – what does the patient feels caused the pain, what does the team
ed to know, connections between trauma and chronic pain…

ncrease trust in working as a team, value of every members' contributio

TEAM-BASED CARE TO IMPROVE CHRONIC PAIN MANAGEMENT

Questions and Discussion