Chronic Pain - Medication Management Visit Activities & Care Planner Information

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Visit Components of Care	Overview / Purpose
Assess patient adherence:	**Understanding Patient Motivations:** • Assess the patient's knowledge of his/her condition and his/her expectations for treatment. • Assess the patient's medication administration process. • Assess the patient's barriers to adherence.
Medication Management Key Points:	**Patient Medication Management:** • For "High Risk" patients (see findings from SOAPP-R) monthly UDT studies should be ordered and reviewed • For "Moderate Risk" patients (see findings from SOAPP-R) UDT studies should be ordered and reviewed at the direction of MD • Overall goal of treatment care plan is to reduce dependence on Class II narcotics and convert to combination medication therapies
Medication Management for Related Conditions (Co-Morbidities):	**Related Condition Medications: *(review of contraindications)*** • Anti-Inflammatories • Anti-Depressants • Anti-Convulsants
On-Going Management of Medications:	**On-Going Medication Management Care:** • When diversion is suspected, refer to "Mental Health" and/or Health Coach Team before considering patient discharge • Integrated care approach objective is to reduce dependence on medications as a core component of care • Utilize medications as a compliance tool for all care components, non-compliance may require medication care plan modification
Medication Management Visit Frequency:	**Modification to Medication Plan of Care:** • Patient visits should be regular when new medications are added to plan of care (weekly). • Regular visits should be scheduled at least every three to six months • More frequent visits may be necessary if treatment goals are not achieved.
Chronic Pain Follow-Up:	**Chronic Pain Follow Up:** • For recreational drug positive findings on UDT studies, implement clinical policy that includes referral to substance abuse provider • Do not discontinue medication management patient care without attempt to implement program, or referral to substance abuse • Medications may be reduced in the event of non-compliance with program, although do not discontinue care for legal protection
Maintain Treatment Goals:	**Nutrition/Physical Activity:** • Work with individual patient to set realistic goals. • When patient is not compliant review with patient the need for compliance as it impacts improvement in overall pain condition • Continually review patient action plans, goals set, and patient's self-care management of condition
Coordinate Action Planning with Health Coaches:	**Care Coordination:** • Coordinate Care with Quality of Life Health Coach Team • Coordinate Care with Functional Health Coach Team • Coordinate Care with Patient Education and Counseling Health Coach Team
Patient Non-Adherence to Medication Management Plan:	Interventions to enhance medication adherence should be directed at risk factors or causes of nonadherence. Interventions may include simplifying the medication regimen, using reminder systems, involving family or caregivers in care, involving multiple disciplines in team care, providing written and verbal medication instructions, setting collaborative goals with patients, and providing education about medications (including potential adverse effects) and about Chronic Pain in general
Staffing & Documentation Requirements:	**Integrated Team Providers & Documentation Criteria:** • Health Coach w/medical condition training • Nurse Practitioner (under MD supervision) or MD Supervisor • CPT Code 99212 or 999213 documentation requirements *(Chronic Medical Condition Management Criteria)*

Patient's Presenting Symptoms Determine Necessity for Services	Quarterly Visit Opportunities:	Q1	Q2	Q3	Q4	Sub-Totals
	Total Quarterly & Annual Visits	3	3	3	3	12