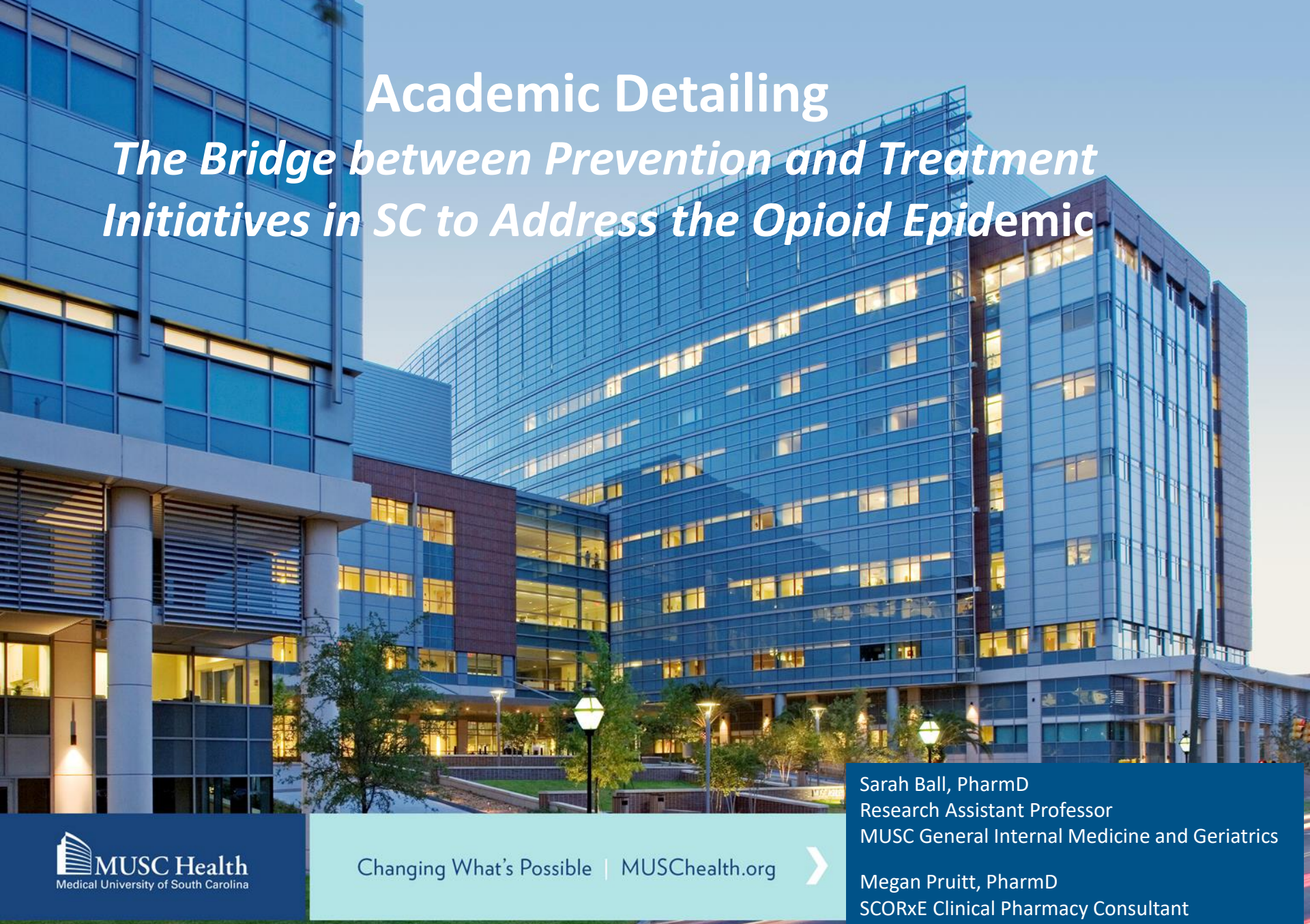
Day 1 field presentations

Academic Detailing

The Bridge between Prevention and Treatment Initiatives in SC to Address the Opioid Epidemic



MUSC Health
Medical University of South Carolina

Changing What's Possible | MUSChealth.org

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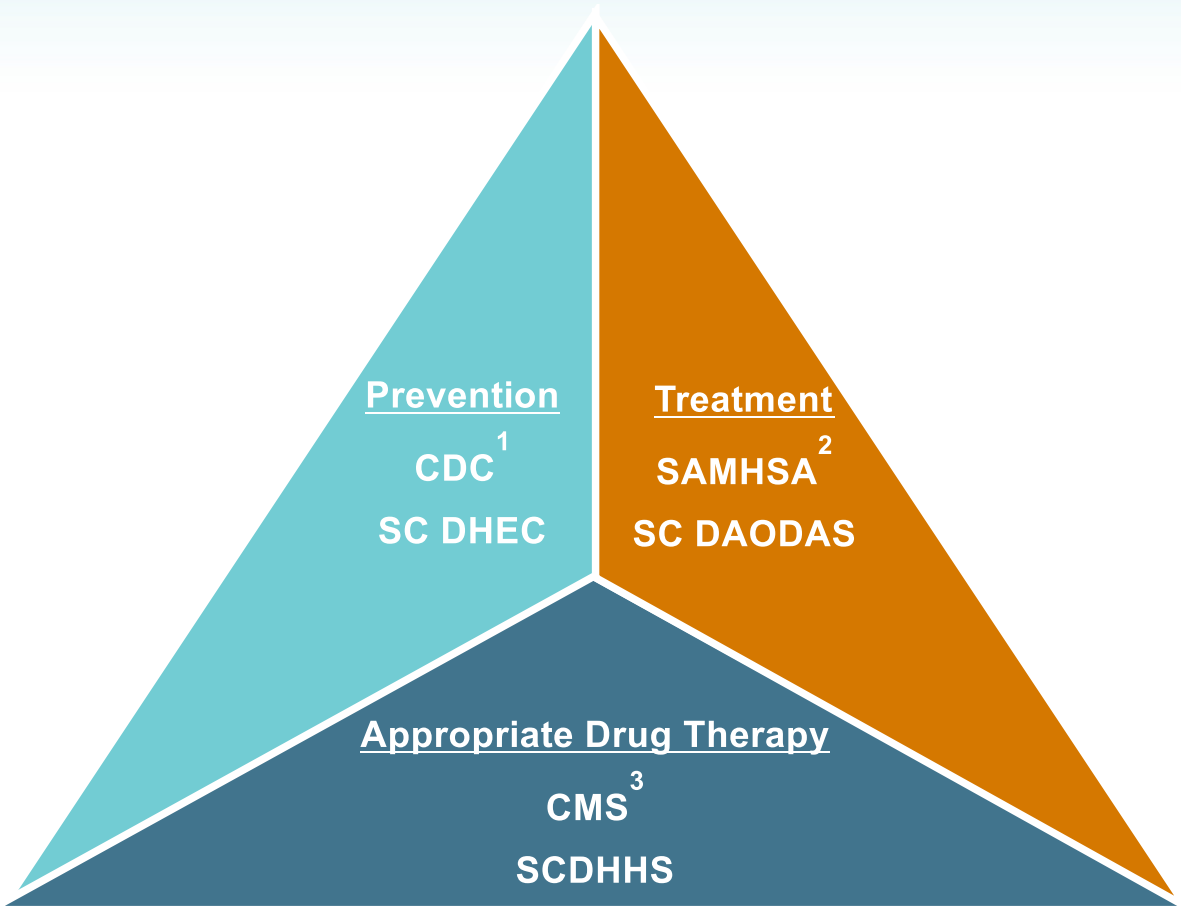
Disclosures

- No conflicts of interest
- Grant funding to acknowledge
  - SC DHEC/Centers for Disease Control and Prevention (CDC) - Prescription Drug Overdose: Prevention for States Program
  - SC DAODAS/Substance Abuse and Mental Health Services Administration (SAMHSA) – 21st Century Cures Act
  - SCDHHS/Centers for Medicare and Medicaid Services (CMS) – Drug Utilization Review Program

Contributors to the Academic Detailing Visits



[1]Prescription Drug Overdose Prevention for States through SC Department of Health and Environmental Control
[2]21st Century Cures Act through SC Department of Alcohol and Other Drug Abuse Services
[3]Drug Utilization Review Program through SC Department of Health and Human Services

Background

SC Opioid Safety Initiative – Military (SCOSI-M) Pilot

- Monitoring Practices for Safer Opioid Prescribing (S.O.S.)
  - ***S**hare a patient provider agreement* *prior to initiating a trial of opioids*
  - ***O**ptimize patient treatment* *(drug/non-drug) using a multi-dimensional rating scale*
  - ***S**creen for appropriate opioid use* *and continued need for opioid therapy*
- Single AD visit changed prescribing behavior, with considerable increase in PDMP utilization
- AD visit itself the most helpful part of the intervention

AD Academic Detailing **PDMP** Prescription Drug Monitoring Program

Barth KS, Ball S, Adams RS, et al. *J Contin Educ Health Prof*. 2017;37(2):98-105.
Larson MJ, Browne C, Nikitin RV, et al. *Subst Abus.* 2018:1-7. Epub 2018 Apr 2.

Identification of ‘Hot Spot’ Counties

SC County*	2016 Naloxone Maps (115 or more injections by first responders)	2014 Ed Visits and 2013 Hospital Admissions for Opioid Overdoses (Top Ten Counties)	Counties with higher counts of opioids per resident or highest # Rx Recipients (2015)	Absence of Addiction Medication Counselors in County
R				
Yo				

Four SC counties identified as ‘high risk’ areas of the state

* Three-digit Zip Code GeoMap for frequency of patient 3-digit zip code for opioids prescriptions dispensed in 2015 when part of multiple provider episodes [i.e., ≥ 5 prescribers AND ≥ 5 dispensers in 6-month period), and geographic location also contributors to county selection

$S_cO.S.$ Snapshot

- Scientifically sound, user-friendly provider packets
  - Physicians '*love the materials*'
- Individualized, interactive office visits with hands on SCRIPTS training
  - *VERY much appreciated*
- Live Continuing Medical Education (CME) Credit
  - *Counts toward mandated CME*
- Reinforcement through subsequent mini-visits
  - *Post-visit survey drop-off*

Provider packets support intervention
Trifold (supports discussion /ready resource after visit)
Sample PPA (with Opioid Fast Facts)
Laminated P.E.G. /dry erase marker
Opioid Chart
SCRIPTS overview
CME insert

“Learning by Doing”

Hands on SCRIPTS training

“This is so great you are here! You are taking something off my plate and making our practice more efficient.”

–Primary Care Provider

Equivalents per day (MME/day) suggests concern for adverse events or overdose

04/15/2017	1	02/15/2017	ALPRAZOLAM 0.5 MG TABLET	100.0	7	Bo Tes	305860	Gutko (1119)	2		Comm Ins	SC
03/15/2017	1	02/15/2017	OXYCODONE-ACETAMINOPHEN 5-325	100.0	7	Bo Tes	305862	Gutko (1119)	1	107.14 MME	Comm Ins	SC
03/15/2017	1	02/15/2017	ALPRAZOLAM 0.5 MG TABLET	100.0	7	Bo Tes	305860	Gutko (1119)	1		Comm Ins	SC
02/15/2017	1	02/15/2017	OXYCODONE-ACETAMINOPHEN 5-325	100.0	7	Bo Tes	305861	Gutko (1119)	1	107.14 MME	Comm Ins	SC
02/15/2017	1	02/15/2017	ALPRAZOLAM 0.5 MG TABLET	100.0	7	Bo Tes	305860	Gutko (1119)	0		Comm Ins	SC
02/02/2017	3	02/01/2017	OXYCODONE-ACETAMINOPHEN 5-325	60.0	30	DA TES	4455	Dave' (0000)	0	15.0 MME	Comm Ins	SC
01/26/2017	3	01/26/2017	OXYCODONE HCL 20 MG TABLET	60.0	30	AL TES	3344	Carol (8506)	0	60.0 MME	Comm Ins	SC
12/26/2016	3	12/26/2016	OXYCODONE HCL 20 MG TABLET	60.0	30	AL TES	2233	Carol (8506)	0	60.0 MME	Comm Ins	SC
11/26/2016	3	11/26/2016	OXYCONTIN 80 MG TABLET	60.0	30	CA TES	1122	Carol (5555)	0	240.0 MME	Comm Ins	SC

DAODAS/MUSC MAT Support

Connecting Prevention and Treatment

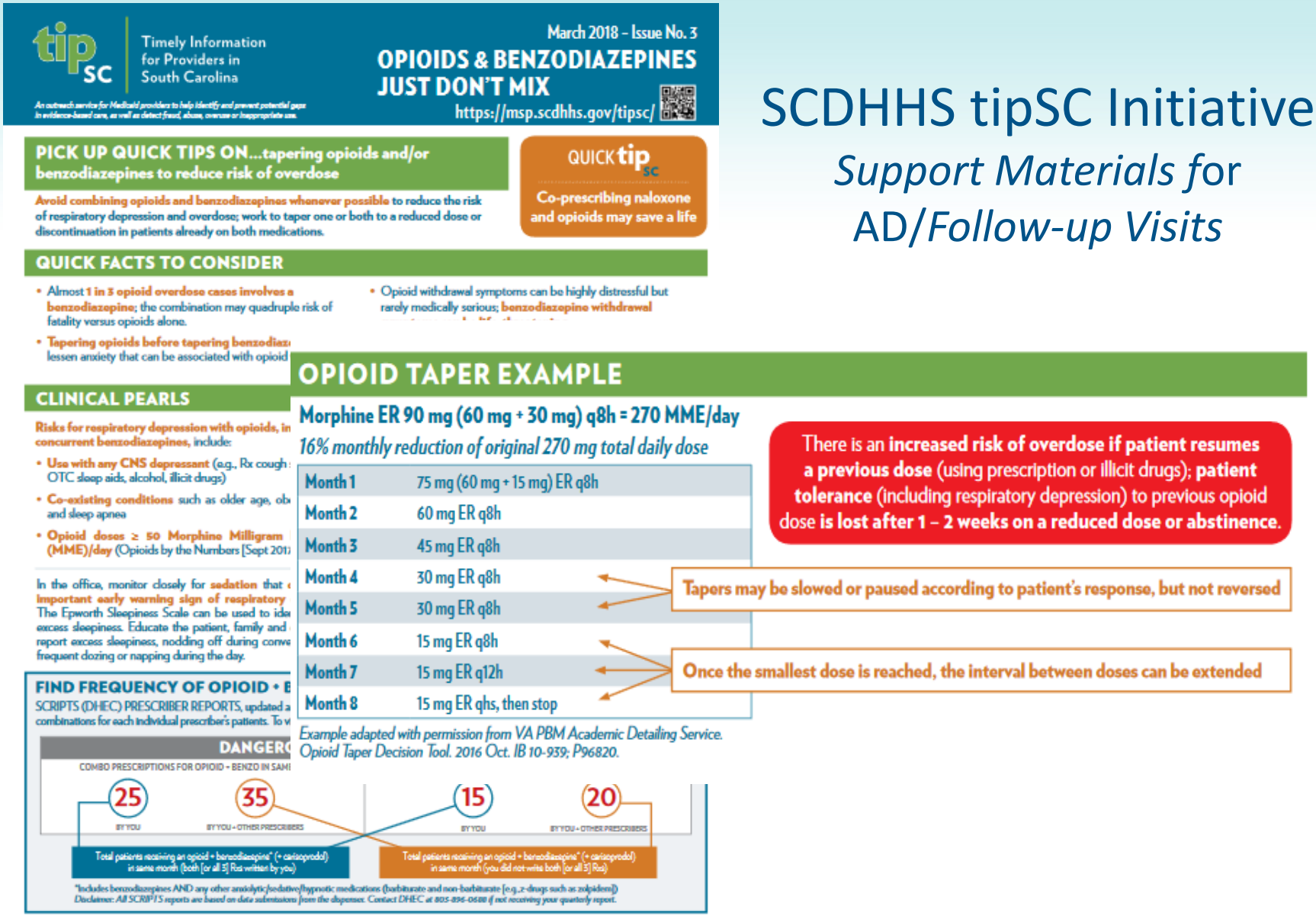
	SELECT REFERENCES	WEB LINK/KEY CONTACT INFORMATION
SC Specific Resources (various)	SCRIPTS Prescription Monitoring Program at SC DHEC	https://www.scdhec.gov/Health/FHPF/DrugControlRegisterVerify/PrescriptionMonitoring/ Phone: 803-896-0688 Email: scripts@dhec.sc.gov
	SC Department of Alcohol and Other Drug Abuse Services (DAODAS)	http://www.daodas.state.sc.us/ Phone: 803-896-5555
	SC DHEC Bureau of Drug Control	Phone: 803-896-0636
	Joint Position on Pain Management (SC Boards of Medical Examiners, Dentistry and Nursing), 2014	http://www.llr.state.sc.us/POL/Medical/PDF/Joint_Revised_Pain_Management_Guidelines.pdf
Guidelines	CDC Guideline for Prescribing Opioids for Chronic Pain – United States, 2016	https://www.cdc.gov/mmwr/volumes/65/rr/pdfs/rr6501e1.pdf
	Clinical Practice Guideline for the Management of Opioid Therapy for Chronic Pain – VA/DoD, 2017	https://www.healthquality.va.gov/guidelines/Pain/cot/VADoDOTCPG022717.pdf
	Model Policy for the Use of Controlled Substances for the Treatment of Pain – FSMB, 2013	http://www.fsmb.org/Media/Default/PDF/FSMB/Advocacy/pain_policy_july2013.pdf
Patient Provider Agreements	Opioid Treatment Agreement	http://musc.edu/cop/SCORxE
	Low Literacy Opioid Treatment Agreement	https://www.medicalmutual.com/assets/pdf/forms/pain_low_literacy.pdf
Calculations for Total MME/Day	Opioid Dose Calculator	http://www.agencymeddirectors.wa.gov/Calculator/DoseCalculator.htm
Screening and Assessment Tools	PEG (pain assessment) ORT (addiction risk pre-treatment) COMM (addiction risk during treatment)	http://mytopcare.org/prescribers/
	PHQ-2 and PHQ-9 (depression screening)	http://www.cqaimh.org/tool_depscreen.html
	GAD-7 (anxiety screening)	http://www.integration.samhsa.gov/clinical-practice/GAD708.19.08Cartwright.pdf
	DSM-V (diagnostic checklist for Opioid Use Disorder)	http://www.buppractice.com/node/19556
	Urine Drug Testing	http://mytopcare.org/prescribers/about-urine-drug-tests/
	Epworth Sleepiness Scale	http://www.proqolid.org/instruments/epworth_sleepiness_scale_ess
Substance Abuse Treatment Locators	Substance Abuse ... Administration (SA...	
	Buprenorphine/Nal...	
Drug Information	DailyMed (official ... [package inserts])	https://dailymed.nlm.nih.gov/dailymed/
	List Price for US Street Drugs	http://www.streetrx.com
	NIDA Commonly Abused Drug Charts	https://www.drugabuse.gov/drugs-abuse/commonly-abused-drugs-charts
Safe Drug Disposal	FDA Safe Drug Disposal	https://www.fda.gov/Drugs/ResourcesForYou/Consumers/BuyingUsingMedicineSafely/EnsuringSafeUseofMedicine/SafeDisposalofMedicines/ucm186187.htm
	Prescription Drug Drop Box Locator	http://rxdrugdropbox.org/map-search/
Opioid Tapering	Clinical Practice Guideline for Opioid Therapy for Chronic Pain Pocket Card – VA/DoD, 2017	https://www.healthquality.va.gov/guidelines/Pain/cot/VADoDOTCPGPocketCard022817.pdf
Chronic Pain Tele-Education	Project ECHO from University of NM (conference call available to present challenging cases)	http://echo.unm.edu/nm-teleecho-clinics/chronic-pain-and-opioid-management/
Overdose Prevention (Naloxone)	Prescribe to Prevent	http://prescribetoprevent.org/

Where to refer

- Provide resource for referring patients to treatment
- Identify providers interested in learning about MAT and/or MAT training
- Connect providers to MAT-Access team
- Connect providers to ongoing tele-mentoring ECHO service
- Share MAT Access website (www.scmataccess.com)

SCDHHS tipSC Initiative

Support Materials for AD/Follow-up Visits



tipSC — Timely Information for Providers in South Carolina

An outreach service for Medicaid providers to help identify and prevent potential gaps in evidence-based care, as well as detect fraud, abuse, overuse or inappropriate use.

March 2018 – Issue No. 3

OPIOIDS & BENZODIAZEPINES JUST DON'T MIX

https://msp.scdhhs.gov/tipsc/

PICK UP QUICK TIPS ON...tapering opioids and/or benzodiazepines to reduce risk of overdose

Avoid combining opioids and benzodiazepines whenever possible to reduce the risk of respiratory depression and overdose; work to taper one or both to a reduced dose or discontinuation in patients already on both medications.

QUICK tip SC

Co-prescribing naloxone and opioids may save a life

QUICK FACTS TO CONSIDER

- Almost **1 in 3 opioid overdose cases involves a benzodiazepine**; the combination may quadruple risk of fatality versus opioids alone.
- **Tapering opioids before tapering benzodiaz** lessen anxiety that can be associated with opioid
- Opioid withdrawal symptoms can be highly distressful but rarely medically serious; **benzodiazepine withdrawal**

CLINICAL PEARLS

Risks for respiratory depression with opioids, in concurrent benzodiazepines, include:

- **Use with any CNS depressant** (e.g., Rx cough OTC sleep aids, alcohol, illicit drugs)
- **Co-existing conditions** such as older age, ob and sleep apnea
- **Opioid doses ≥ 50 Morphine Milligram (MME)/day** (Opioids by the Numbers [Sept 201

In the office, monitor closely for **sedation** that **important early warning sign of respiratory** The Epworth Sleepiness Scale can be used to ide excess sleepiness. Educate the patient, family and report excess sleepiness, nodding off during conve frequent dozing or napping during the day.

OPIOID TAPER EXAMPLE

Morphine ER 90 mg (60 mg + 30 mg) q8h = 270 MME/day

16% monthly reduction of original 270 mg total daily dose

Month 1	75 mg (60 mg + 15 mg) ER q8h
Month 2	60 mg ER q8h
Month 3	45 mg ER q8h
Month 4	30 mg ER q8h
Month 5	30 mg ER q8h
Month 6	15 mg ER q8h
Month 7	15 mg ER q12h
Month 8	15 mg ER qhs, then stop

Tapers may be slowed or paused according to patient's response, but not reversed

Once the smallest dose is reached, the interval between doses can be extended

Example adapted with permission from VA PBM Academic Detailing Service. Opioid Taper Decision Tool. 2016 Oct. IB 10-939; P96820.

There is an **increased risk of overdose if patient resumes a previous dose** (using prescription or illicit drugs); **patient tolerance** (including respiratory depression) to previous opioid dose **is lost after 1 – 2 weeks on a reduced dose or abstinence.**

FIND FREQUENCY OF OPIOID + B

SCRIPTS (DHEC) PRESCRIBER REPORTS, updated a combinations for each individual prescriber's patients. To v

DANGERO

COMBO PRESCRIPTIONS FOR OPIOID + BENZO IN SAM

25 BY YOU

35 BY YOU + OTHER PRESCRIBERS

15 BY YOU

20 BY YOU + OTHER PRESCRIBERS

Total patients receiving an opioid + benzodiazepine* (+ carisoprodol) in same month (both [or all 3] Rxs written by you)

Total patients receiving an opioid + benzodiazepine* (+ carisoprodol) in same month (you did not write both [or all 3] Rxs)

*Includes benzodiazepines AND any other anxiolytic/sedative/hypnotic medications (barbiturate and non-barbiturate [e.g.,z-drugs such as zolpidem])

Disclaimer: All SCRIPTS reports are based on data submissions from the dispenser. Contact DHEC at 803-896-0688 if not receiving your quarterly report.

Evaluation of AD Intervention

Adoption of Practice Behaviors Promoted at Visit

Provider Self-Report

- Baseline CME assessment form
- Post-AD visit survey (delivered 6 – 8 weeks post-visit)

Detailer Self-Report

- Visit records (closed and open-ended items)

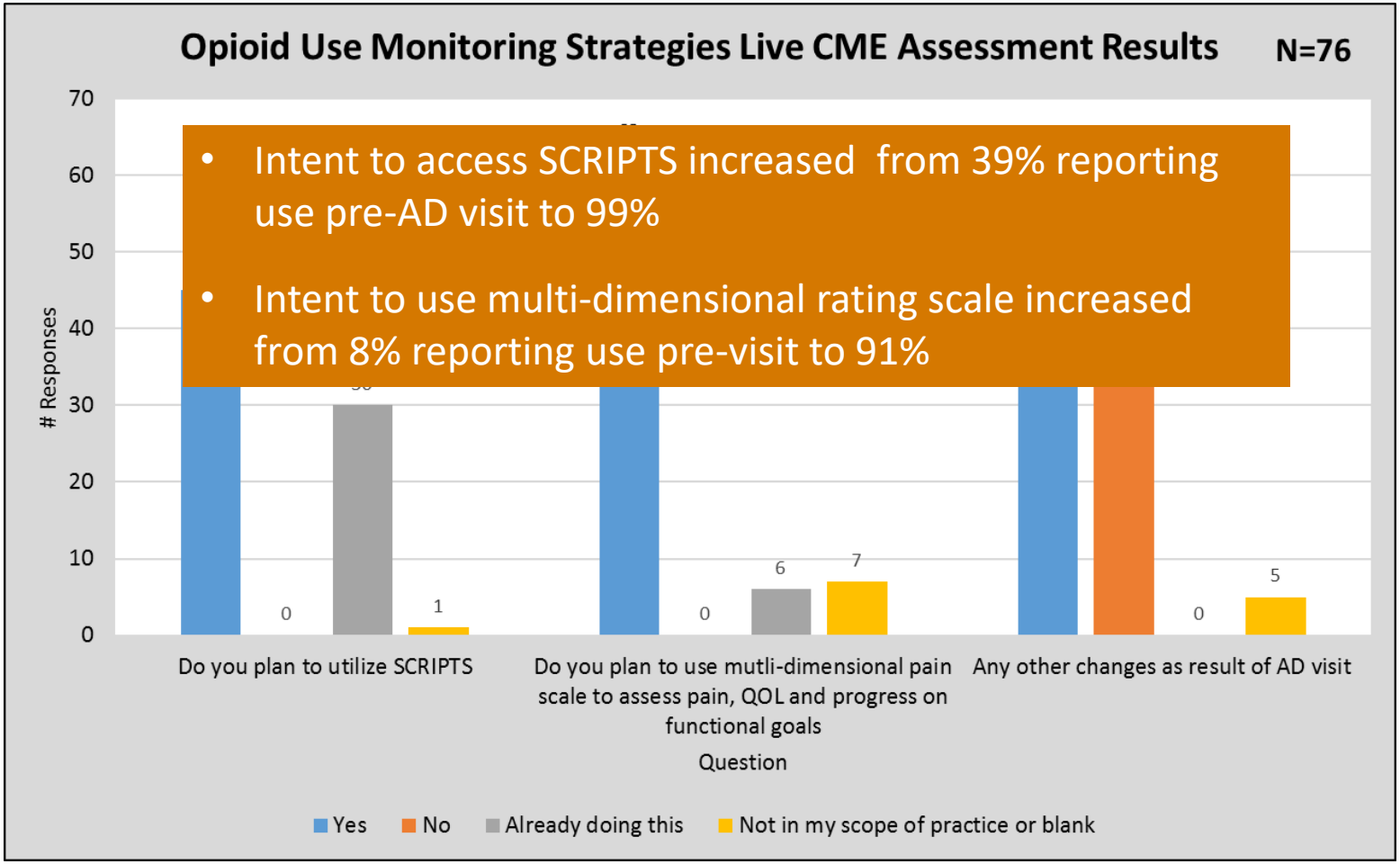
Quantitative Analysis of SCRIPTS data

- Pre- /post-analysis of de-identified data in an interrupted time series analysis
- Pending delivery of data required for analysis

N = 87

Intended Changes in Provider Monitoring Practices

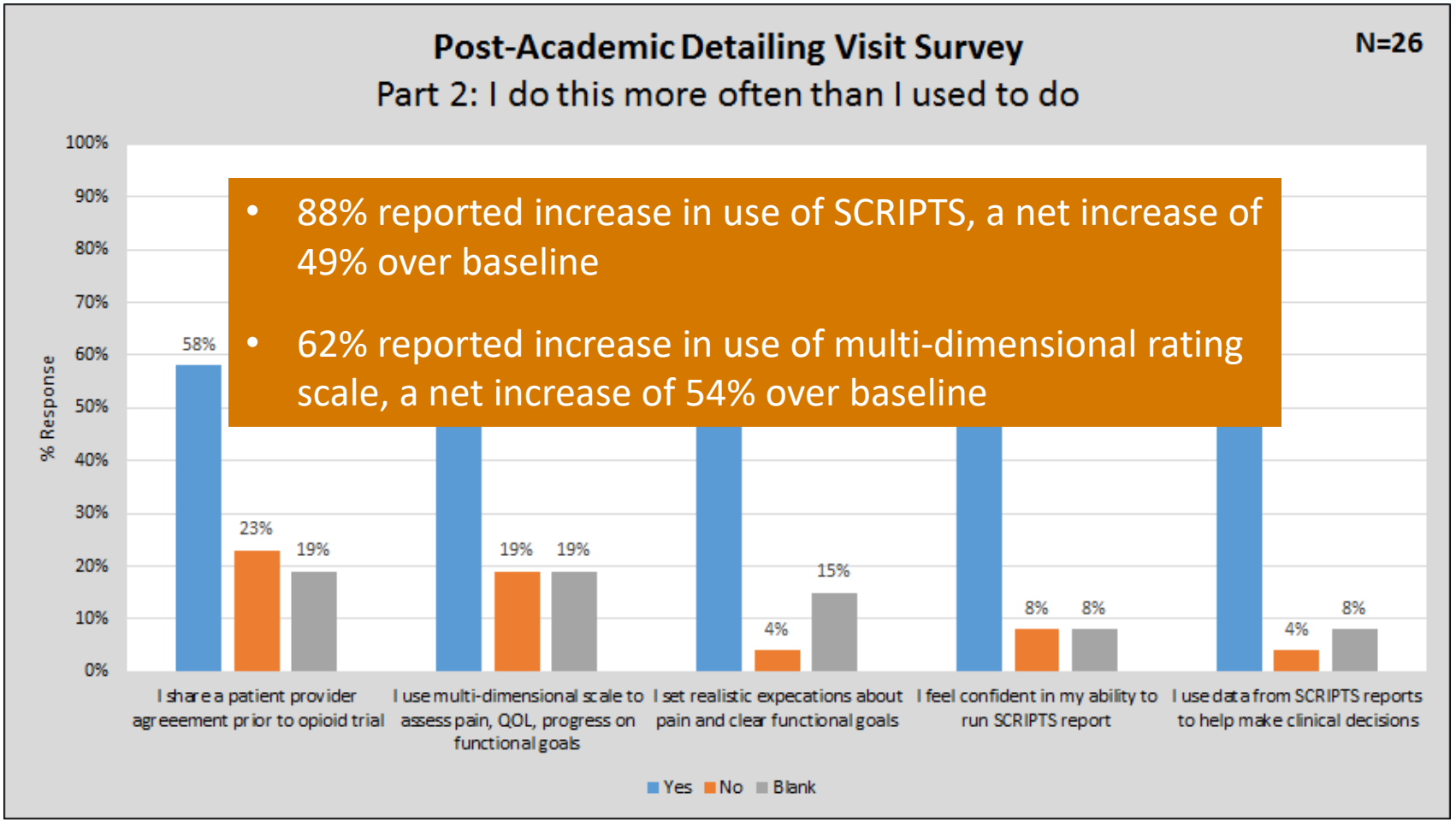
CME Assessment Self-Report at Visit



- Intent to access SCRIPTS increased from 39% reporting use pre-AD visit to 99%
- Intent to use multi-dimensional rating scale increased from 8% reporting use pre-visit to 91%

Substantiation of Changes in Monitoring Practices

Post-AD Visit Survey Form



- 88% reported increase in use of SCRIPTS, a net increase of 49% over baseline
- 62% reported increase in use of multi-dimensional rating scale, a net increase of 54% over baseline

AD Activity Summary

(June 15, 2017 – September 30, 2018)

Month	Jun-17	Jul-17	Aug-17						
Outreach to Schedule AD Visits									
Total Phone Calls/e-mails	11	80	122						
		88	71						
			140						
			0						
			32						
			23						
			8						
			5						
			0						
			6						
			5	7	1	2	0	0	25
			9						
			0						
		550	2695						
County Outreach	Beu Col Dor Ogb	Col Dor Geo Ogb	Col Dor Geo Ogb						Ogb

KEY: Beu - Beaufort Chs - Charleston Col - Colleton Dor - Dorchester Geo - Georgetown Ogb - Orangeburg

[1]Report excludes continuation AD activity funded by SAMSHA

[2]Phone calls and e-mails not tracked

[3]A completed visit may be counted more than once as a scheduled visit (e.g., scheduled/cancelled/rescheduled)

[4]Collaboration with Department of Alcohol and Other Abuse Substances (DAODAS)/SAMSHA CURES funding

[5]Collaboration with SC Department of Health and Human Services/CMS

Treatment

84 providers interested in MAT

21 registered at MAT-Access website

18 providers attended DATA2000 waiver trainings

10 providers attended ECHO tele-mentoring

Prevention

173 provider visits

117 delegate visits

32 providers registered for SCRIPTS

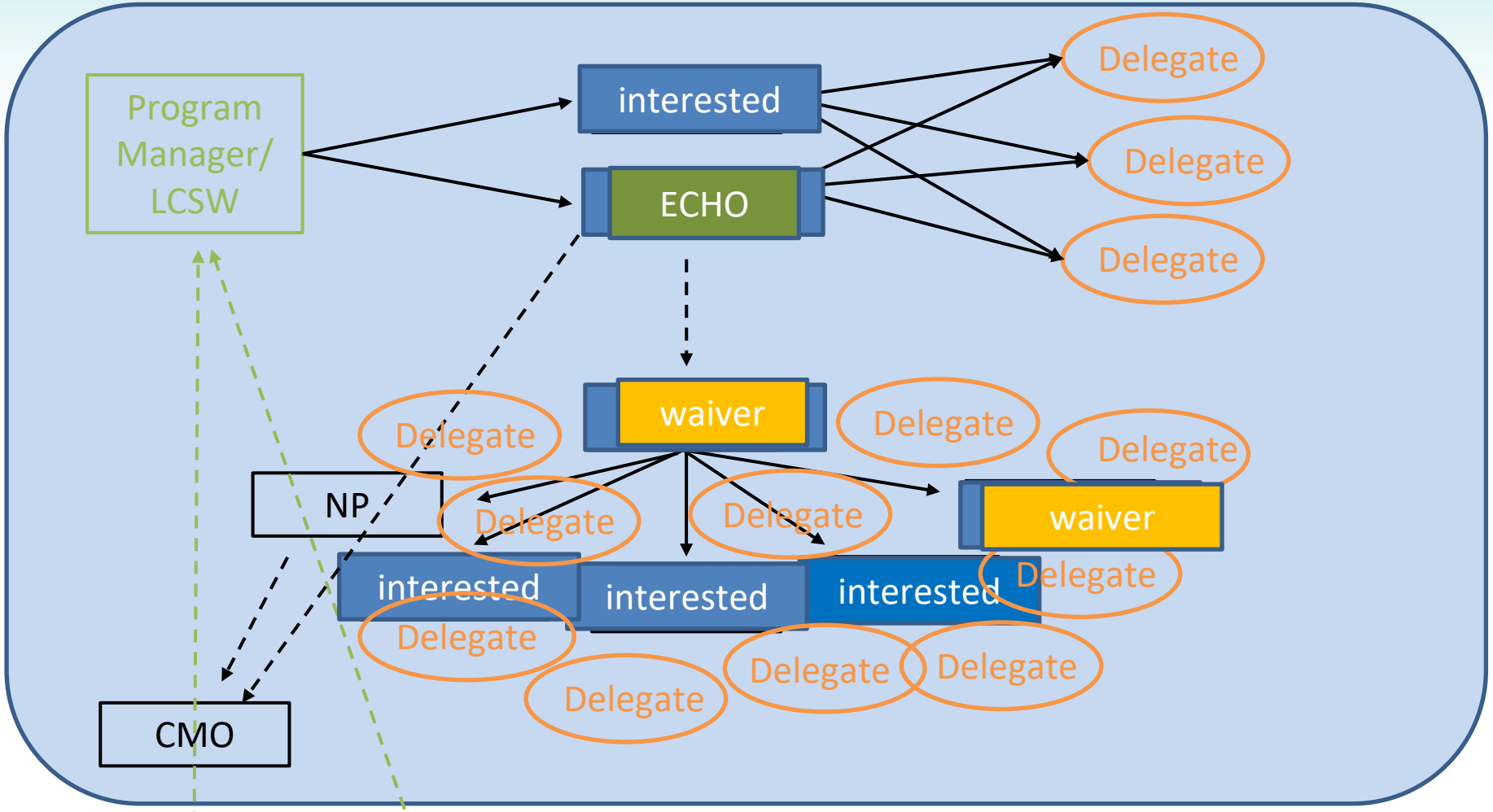
68 delegates registered for SCRIPTS

Appropriate Drug Therapy

368 tipSC deliveries (SCDHHS newsletters)

48 tipSC AD visits

AD Activity in Action



Discussion & Conclusions

- Results point to a sizable adoption of practice behaviors promoted at AD visits
- AD is a viable strategy to connect opioid initiatives of multiple state agencies
- State agencies and interprofessional team partners perceive value of AD
  - Additional full-time SCORxE AD hired September 2018 (100% increase)
  - SCDHHS Funds Support AD through 2021

Cooper River Bridges

Photo Taken By: C. Frank Starmer
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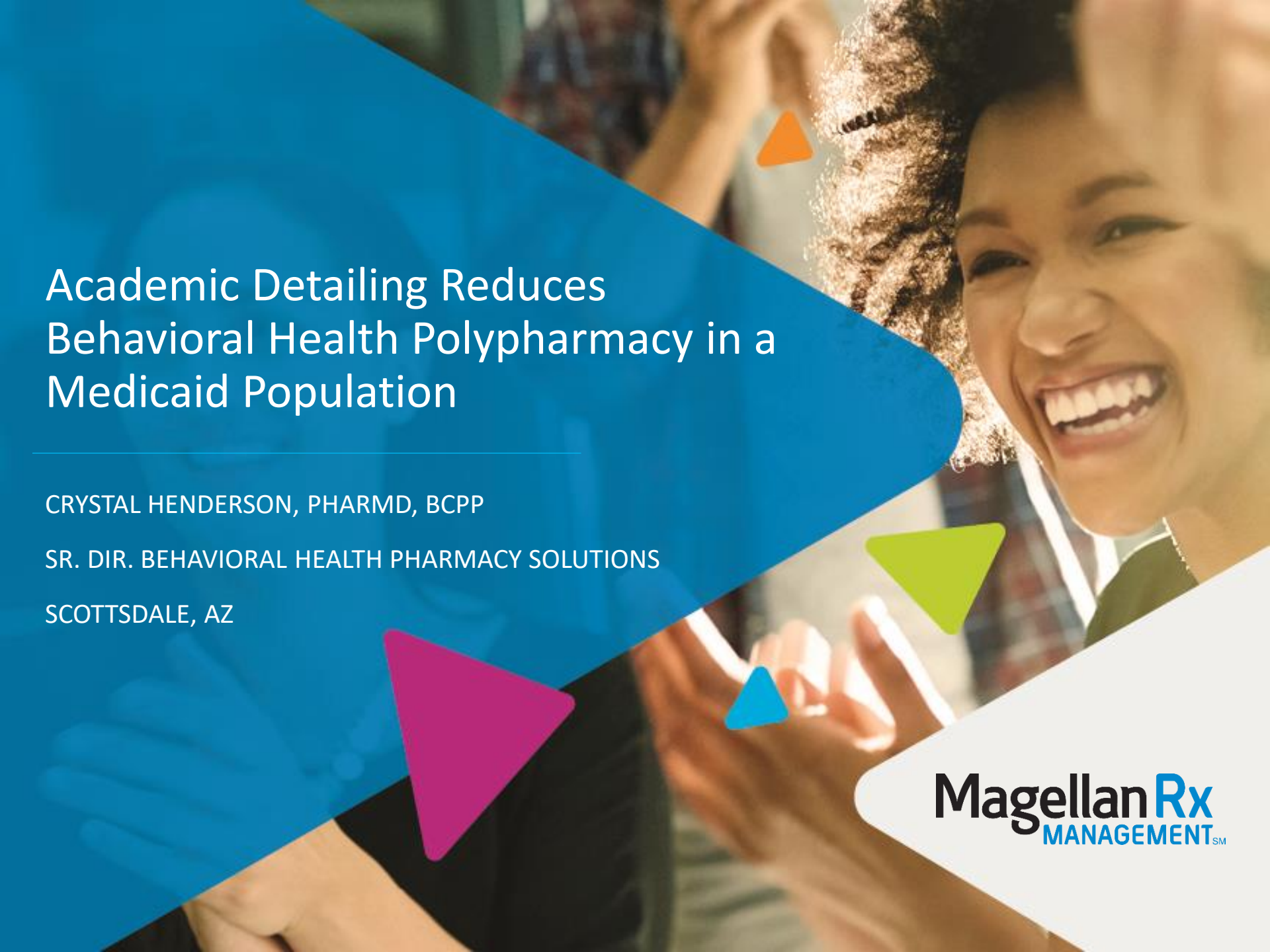
5-MINUTE
Q & A



Academic Detailing Reduces Behavioral Health Polypharmacy in a Medicaid Population

CRYSTAL HENDERSON, PHARMD, BCPP

SR. DIR. BEHAVIORAL HEALTH PHARMACY SOLUTIONS

SCOTTSDALE, AZ

Magellan Rx MANAGEMENT℠

Speaker has no pertinent conflicts of interest

ALL RESEARCH WAS CONDUCTED BY MAGELLAN RX MANAGEMENT, SCOTTSDALE, AZ WITHOUT EXTERNAL FUNDING

SPEAKER IS EMPLOYED BY MAGELLAN RX MANAGEMENT

Magellan Rx MANAGEMENT℠

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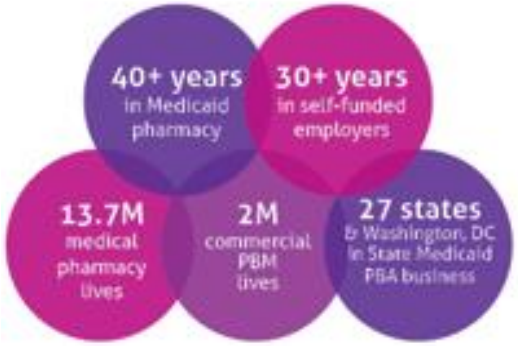
One company, two unique platforms

A Fortune 500 company

Offices in 26 states & D.C.

10,700 Employees

Magellan Rx MANAGEMENT℠



Solving Complex Pharmacy Challenges

Customers:

- Employers
- Managed care organizations
- Unions
- State & local governments
- Medicare & Medicaid

Solutions:

- Core PBM capabilities
- Targeted clinical programs
- Traditional & specialty drug management
- Insights & analytics
- Member engagement programs

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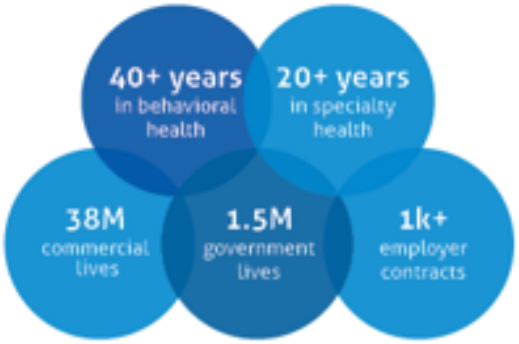

Improving Outcomes for Complex Populations

Customers:

- Employers
- Health plans
- Provider groups
- State governments
- Federal government

Solutions:

- Behavioral health
- Specialty medical
- Employee assistance programs
- Full-service specialty health plans
- Complex populations

Today's Agenda

1. Background/Context
2. Intervention Details
3. Intervention Evaluation & Results
4. Discussion

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Literature Review of Behavioral Health Polypharmacy

Up to one-third of patients visiting outpatient psychiatry departments have been found to be on three or more psychotropic drugs[1]

"During the study period, the proportion of outpatient medical visits in which psychotropic medications from two or more medication classes were prescribed to children increased from one in seven visits to one in five visits…"[3]

"The concurrent administration of multiple drugs increases the risk of drug interactions and adverse effects including morbidity and mortality…" [2]

[1] Mojtabai R, Olfson M. National trends in psychotropic medication polypharmacy in office-based psychiatry. *Arch Gen Psychiatry*. 2010;67:26–36

[2] Sarkar, S.; et al. Polypharmacy in Psychiatric Practice, Etiology and Potential Consequences. *Curr Psychopharmacol. 2017;6(1): 12-26.*

[3] Comer JS, Olfson M, and Mojtabai R. National Trends in Child and Adolescent Psychotropic Polypharmacy in Office-Based Practice, 1996-2007. *J Am Acad Child Adolesc Psychiatry*. 2010 Oct;49(10):1001-10

Agenda

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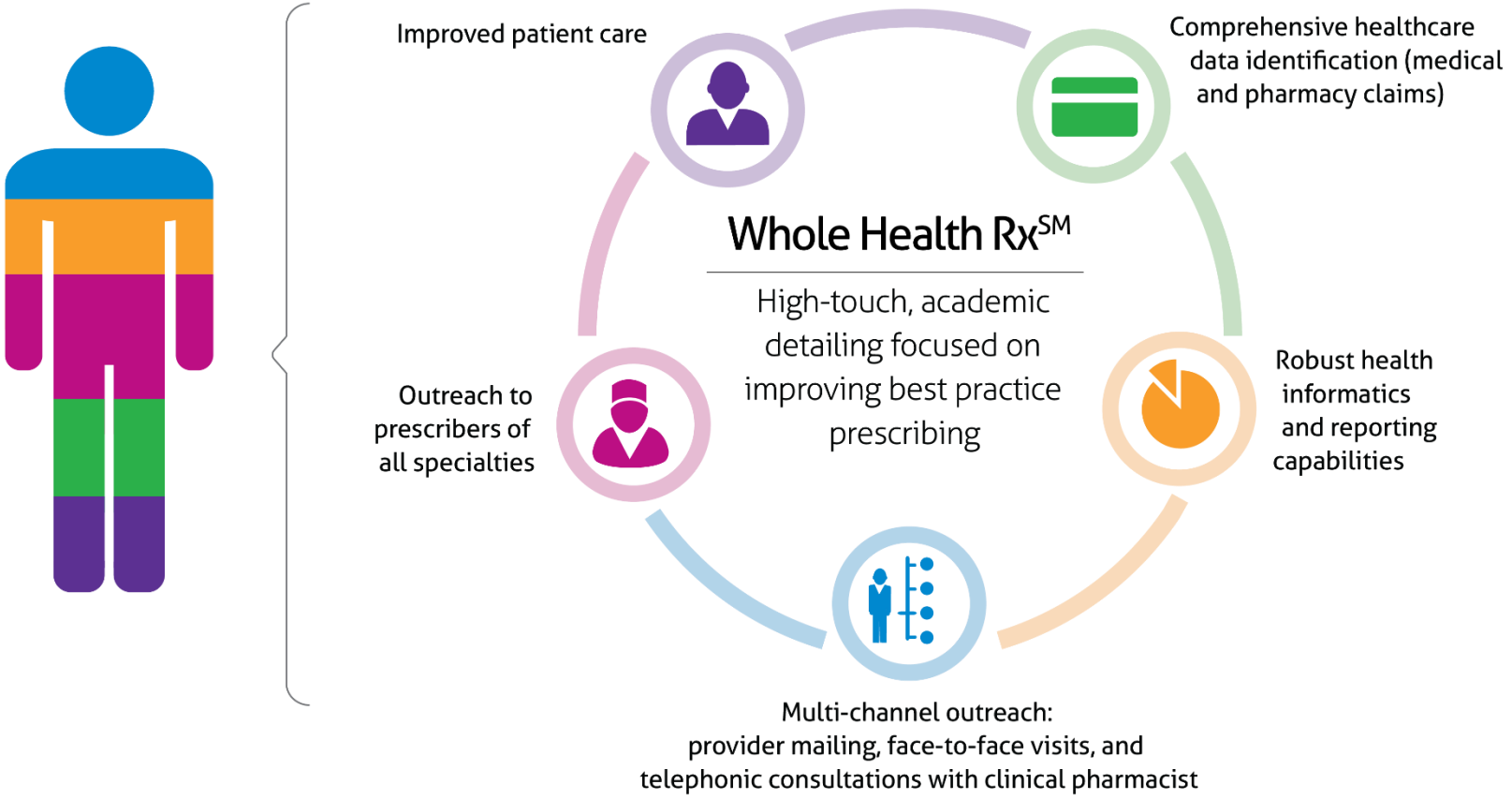
Whole Health Rx

Our approach to whole patient management



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Actionable Data

Behavioral Health Polypharmacy 6 or More

Clinical Considerations:

- Per our most recent pharmacy claims data, the patients below have been identified as receiving 6 or more concomitant behavioral health medications
- Evidence for the efficacy of combinations of antipsychotics and other forms of polypharmacy is poor.
- Between 1996-1997 and 2005-2006, the percentage of visits with 2 or more psychotropic medications increased from 42.6% to 59.8%, and those with 3 or more psychotropic medications increased from 16.9% to 33.2%.
- An association between psychiatric comorbidities and psychotropic polypharmacy has been previously noted.

Potential Actions:

- Review patient's medication profile for accuracy and opportunities to optimize therapy.
- Assess medication adherence. Frequently multiple therapies are thought to be necessary, when non-response may be due to poor adherence
- If the patient has a partial response to one medication at maximal dose, review medication profile for other medications that can decrease plasma levels or efficacy of the drug.
- Assess safety of regimen and potential for drug interactions.

References:

- Ramin M., Olfson M. (Jan 2010). National Trends in Psychotropic Medication Polypharmacy in Office-Based Psychiatry. Arch Gen Psychiatry. Vol 67(1), 26-36.
- Langle G., Stinert T., Weiser P., et al (Jan 2012). Effects of Polypharmacy on Outcome in Patients with Schizophrenia in Routine Psychiatric Treatment. Acta Psychiatrica Scandinavica. Vol 125, 372-381.
- Essock S., Scholer N., Stroup T., et al (2011). Effectiveness of Switching from Antipsychotic Polypharmacy to Monotherapy. Am J Psychiatry. Vol 168, 702-708.
- Clinical Pharmacology (2013). Retrieved from http://www.clinicalpharmacology-ip.com/default.aspx. Accessed 1/29/2013.

Patients identified for this protocol: 1

Patient Name	DOB	Medication	Date of Last Fill	Quantity	Day Supply	Prescriber Name
Sample PT A	8/08/1974	Abilify 20 mg	11/8/2018	30	30	DR. SMITH
Sample PT A	8/08/1974	Ativan 1 mg	11/5/2018	90	30	DR. SMITH
Sample PT A	8/08/1974	Depakote ER 500 mg	11/5/2018	90	30	DR. KITE
Sample PT A	8/08/1974	Ambien	10/30/2018	60	30	DR. KITE
Sample PT A	8/08/1974	Wellbutrin XL 300 mg	10/30/2018	30	30	DR. KITE
Sample PT A	8/08/1974	Latuda 80 mg	10/25/2018	30	30	DR. SMITH
Sample PT A	8/08/1974	Xanax 2 mg	10/15/2018	60	30	DR. BERNARD

Agenda

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Magellan Rx MANAGEMENT℠

Behavioral Health Polypharmacy (6 or more medications) Evaluation

- Purpose
  - To evaluate the clinical and economic impact of the Whole Health Rx Academic Detailing Program on Behavioral Health Polypharmacy (6 or more) from January through March of 2017
- Methodology
  - Employed a six month cross-sectional study design
  - SAS version 9.4 was used to extract claims data and intervention data for all members that were prescribed six or more psychotropic agents during a 60 day window
  - Proxy for continuous enrollment – URAC's Pharmacy Benefit Management Performance Measurement Specifications
    - Two or more claims
    - Claims with a date of service that spanned 150 or more days
  - Members without claims during the post intervention period were excluded
- Eligible Sample
  - 546 distinct prescribers received an intervention
  - 1,340 distinct members identified as being prescribed six or more behavioral health medications during a 60 day window
  - A combination of mail, telephonic and face-to-face consultations were conducted between January and March 2017
    - Mail: 540 providers and 1,311 members
    - Telephonic: 14 providers and 69 members
    - Face-to-Face: 25 providers and 93 members

Outcomes

Outcome	Intervention Period		Difference	%Difference
	6 Month Pre	6 Month Post		
Distinct Prescriber Counts	546	546	0	NA
Distinct Member Counts	1,340	1,340	0	NA
Distinct Claim Counts – BH Medications	51,872	48,290	(3,582)	-6.91%
Distinct Claim Counts Per Member Per Month (PEPM) – BH Medications	6.452	6.006	(0.446)	-6.91%
Pharmacy Spend – BH Medications	$ 6,966,658	$ 6,171,318	$ (795,341)	-11.42%
Pharmacy Spend PEPM – BH Medications	$ 866	$ 767	$ (99)	-11.42%

Key Takeaways

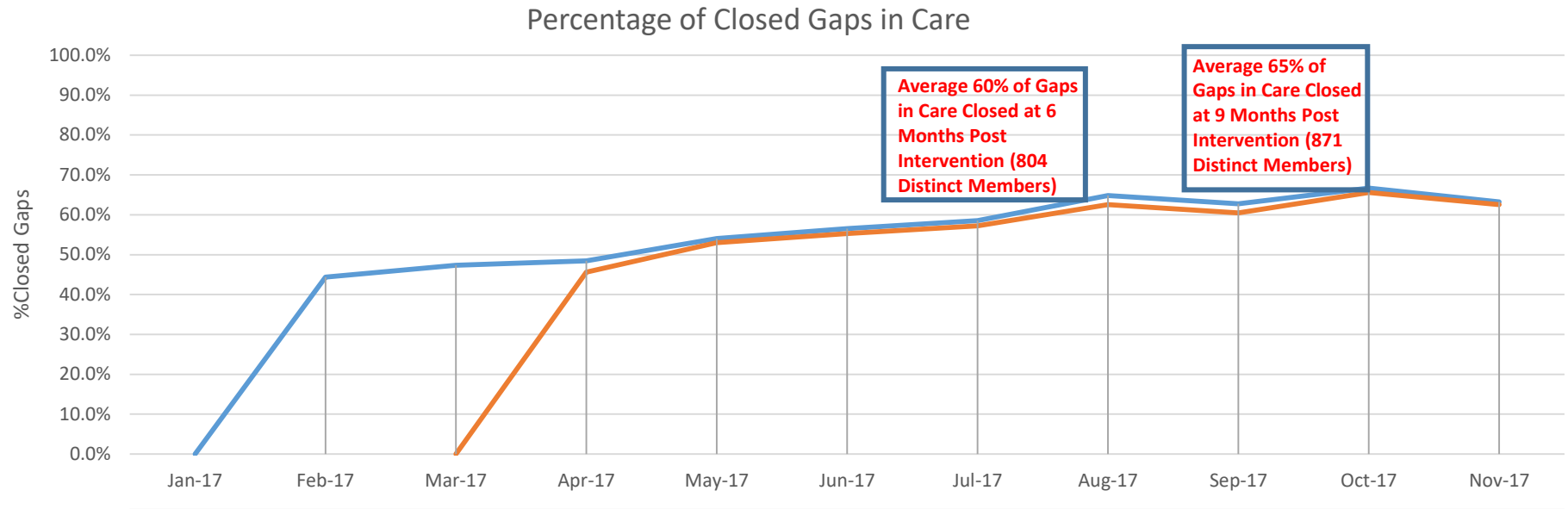
- ✓ Observed a **6.9% reduction in utilization** of target BH medications
- ✓ **Pharmacy spend decreased by $795,341 (11.4%),** which resulted in the PEPM pharmacy spend decreasing by $99 from $866 during the six month pre intervention period to $767 during the six month post intervention period

Outcomes Stratified by Intervention Method

Intervention Method	Outcome	Intervention Period		Difference	%Difference
		6 Month Pre	6 Month Post		
Face-to-Face	Distinct Prescriber Counts	25	25	0	NA
	Distinct Member Counts	93	93	0	NA
	Distinct Claim Counts PEPM – BH Medications	7.264	6.373	(0.889)	-12.24%
	Pharmacy Spend PEPM – BH Medications	$ 759	$ 627	$ (132)	-17.42%
Telephonic	Distinct Prescriber Counts	14	14	0	NA
	Distinct Member Counts	69	69	0	NA
	Distinct Claim Counts PEPM – BH Medications	7.771	7.101	(0.669)	-8.61%
	Pharmacy Spend PEPM – BH Medications	$ 874	$ 730	$ (143)	-16.47%
Mail	Distinct Prescriber Counts	540	540	0	NA
	Distinct Member Counts	1,311	1,311	0	NA
	Distinct Claim Counts PEPM – BH Medications	7.786	7.257	(0.529)	-6.79%
	Pharmacy Spend PEPM – BH Medications	$ 968	$ 888	$ (80)	-8.30%

Key Takeaway ***FACE-TO-FACE MAKES A DIFFERENCE!***

Outcomes, Cont.



	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17
January	0.0%	44.4%	47.4%	48.4%	54.0%	56.5%	58.6%	64.8%	62.8%	66.7%	63.2%
March			0.0%	45.6%	53.0%	55.3%	57.2%	62.6%	60.4%	65.6%	62.6%

Key Takeaways

- ✓ At 6 months post intervention, **60% of the gaps in care were closed** (804 members no longer receiving 6 or more BH medications)
- ✓ At 9 months, **65% of the gaps in care were closed** (871 members no longer receiving 6 or more BH medications)

Magellan Rx MANAGEMENT

Agenda

1. Background/Context
2. Intervention Details
3. Intervention Evaluation & Results
4. Discussion

Magellan Rx MANAGEMENT℠

Key Takeaways

- ✓ **Providers are often unaware their patients are nonadherent to medications**
- ✓ **Access to psychiatrists can be limited or non-existent in some areas. Wait time to see a specialist may be lengthy.**
- ✓ **Off-label use, augmentation, polypharmacy are common practice and acceptable in this field; often use additional medications to treat side effects of primary medications**
- ✓ **Providers nervous to change medications from patients they have inherited. Not sure what symptoms each medication is treating.**
- ✓ **Due to the demographics of this population, follow up can be difficult**
- ✓ **Lack of coordination of care**
  - ✓ **Hospital discharge**
  - ✓ **Patient may be seeing multiple types of providers, Dr. Shopping**
  - ✓ **Patients continue to refill medications that their providers have told them to discontinue**
- ✓ **Providers want help, education/resources, sharing of best practices**

Our highest impact was in those providers who received a face-to-face visit

Barriers

- **Getting the appointment**
  - Incorrect contact information
- **Developing rapport and connection with your audience**
- **Navigating large territories**
- **IT/Reporting lag time**
- **Time management**
- **Setting yourself apart from pharmaceutical representatives or other vendors**

Successful Strategies

Verify all contact information

Introduce program to your targeted audience

Get buy-in from additional people that can impact the provider

Make at least 3 call attempts to secure an appointment

Map out the people you need to meet with

When all else fails, just show up

Impactful leave behind materials/educational resources

Provide expertise and support beyond academic detailing

OUTCOMES, OUTCOMES, OUTCOMES!!

Provider Comments

5-MINUTE
Q & A

Public Health Detailing to Increase Naloxone Access in New York City Pharmacies

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November 12, 2018

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Disclosure statement

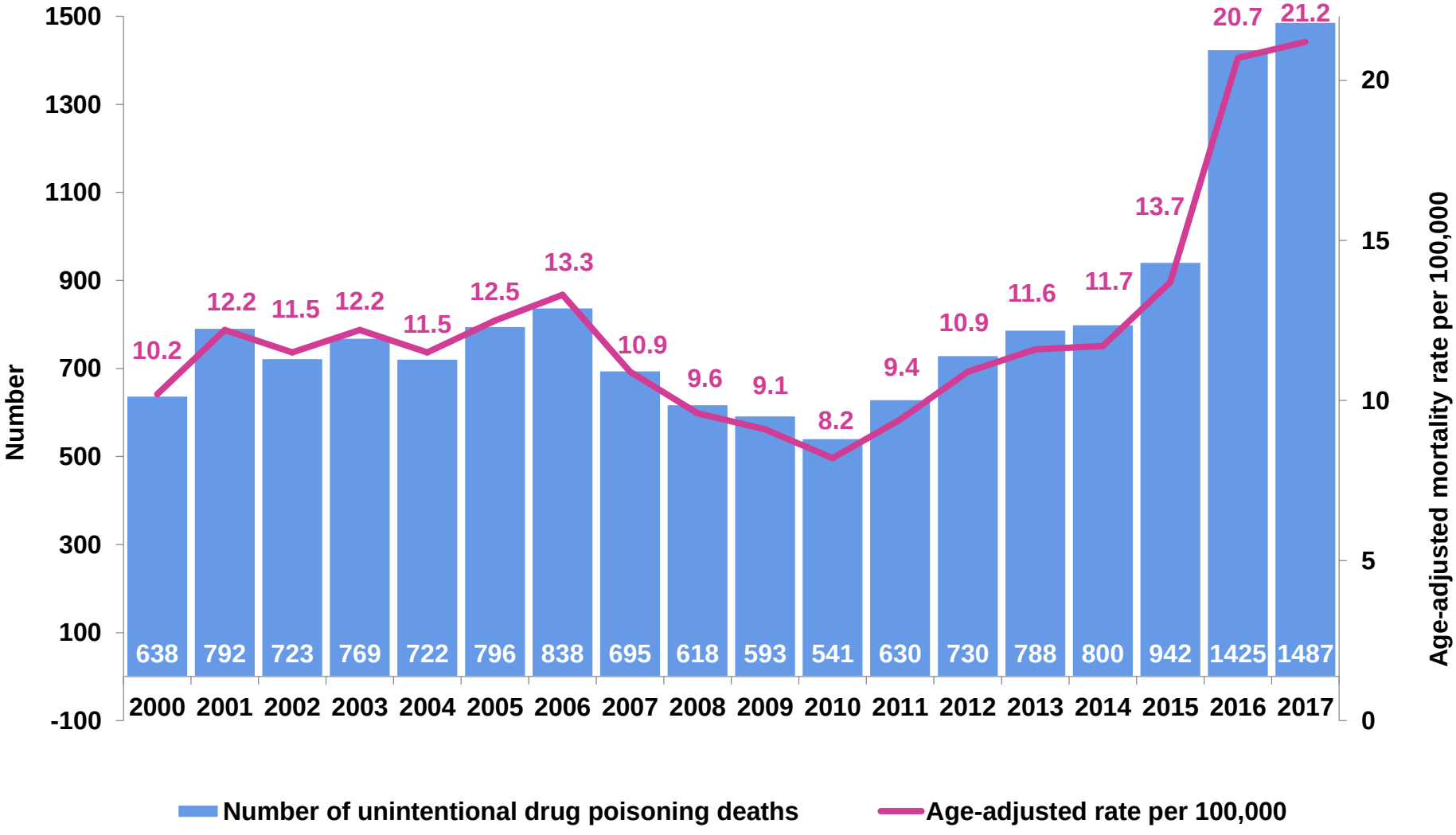
I have no relevant financial or nonfinancial relationships to disclose.

Background

The burden of overdose in NYC

- NYC experiencing a public health crisis
- More New Yorkers die from overdose than from suicides, homicides and motor vehicle crashes combined
- Drug overdose is a leading cause of premature death among NYC residents
- In 2017, 82% of overdoses involved an opioid

Number of overdose deaths in NYC has increased for 7 consecutive years



Source: New York City Office of the Chief Medical Examiner & New York City Department of Health and Mental Hygiene, 2017
**Data for 2017 are provisional and subject to change.*

Every 6 hours, someone dies of a drug overdose in New York City

HealingNYC

- HealingNYC: NYC's overdose response, announced in March, 2017
- Goal: reduce overdose deaths in NYC by 35%
- 13 overall strategies
- Collaborative effort among multiple NYC agencies

A multi-pronged public health approach to opioid misuse and overdose

Goal 1: Prevent opioid overdose deaths	• Naloxone expansion
Goal 2: Prevent opioid misuse and addiction	• Rapid Assessment and Response (RAR) • Judicious opioid prescribing • Non-fatal overdose response system • Public awareness campaign
Goal 3: Connect New Yorkers to effective treatment	• Access to medications for addiction treatment • Health Assessment and Engagement Teams (HEAT)

What is naloxone?

- Only function is to reverse opioid overdose
  - Zero effect if opioids are not present
  - Will not reverse overdoses caused by non-opioids
- No known negative effects
  - Non-addictive
- Not a controlled substance

New York State Public Health Law Section 3309

- Created the NYS Opioid Overdose Prevention Program (OOPP), which allows naloxone to be dispensed to, and used by, laypeople

- Pharmacists and pharmacy interns are able to dispense naloxone as part of NYC Department of Health and Mental Hygiene's (DOHMH) OOPP via non-patient specific prescription

Standing order

- Also called “non-patient specific prescription”
- In 2015, NYC Commissioner of Health issued a standing order for the City of New York, authorizing pharmacists practicing in NYC to dispense naloxone without a prescription
- Similar to mechanism that allows for access to the flu vaccine

Naloxone access in NYC

- From a pharmacy participating in standing order program without a prescription
- From a pharmacy with a prescription
- For free at a registered OOPP

Public health detailing at NYC DOHMH

- “Selling” good health and promoting public health interventions
- Train knowledgeable and persuasive Health Department representatives
- Total office call
- Tailor presentation to each contact
- Assess current practice at initial and follow-up visits during 8 week campaign

Seven steps of one-to-one public health detailing visit

1. Introduction
2. Framing the issue
3. Assessment questions
4. Stating recommendations
5. Promoting materials in kit (e.g., tailoring information presented based on responses to assessment questions)
6. Handling objections
7. Gaining a commitment

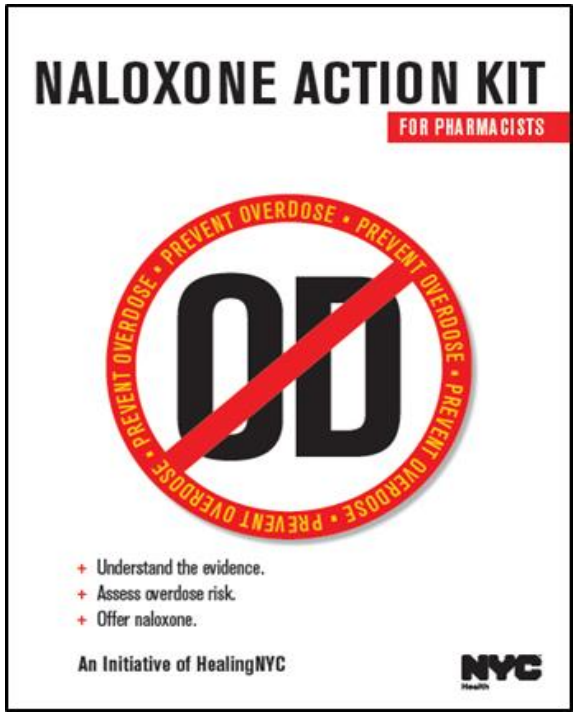
Intervention

Naloxone pharmacy public health campaign overview

Campaign goals:

1. Recruit independent pharmacies to sign on to Health Commissioner's standing order to dispense naloxone without a patient- specific prescription

2. Promote naloxone standing order use in the 105 independent pharmacies signed on pre-campaign



Target:

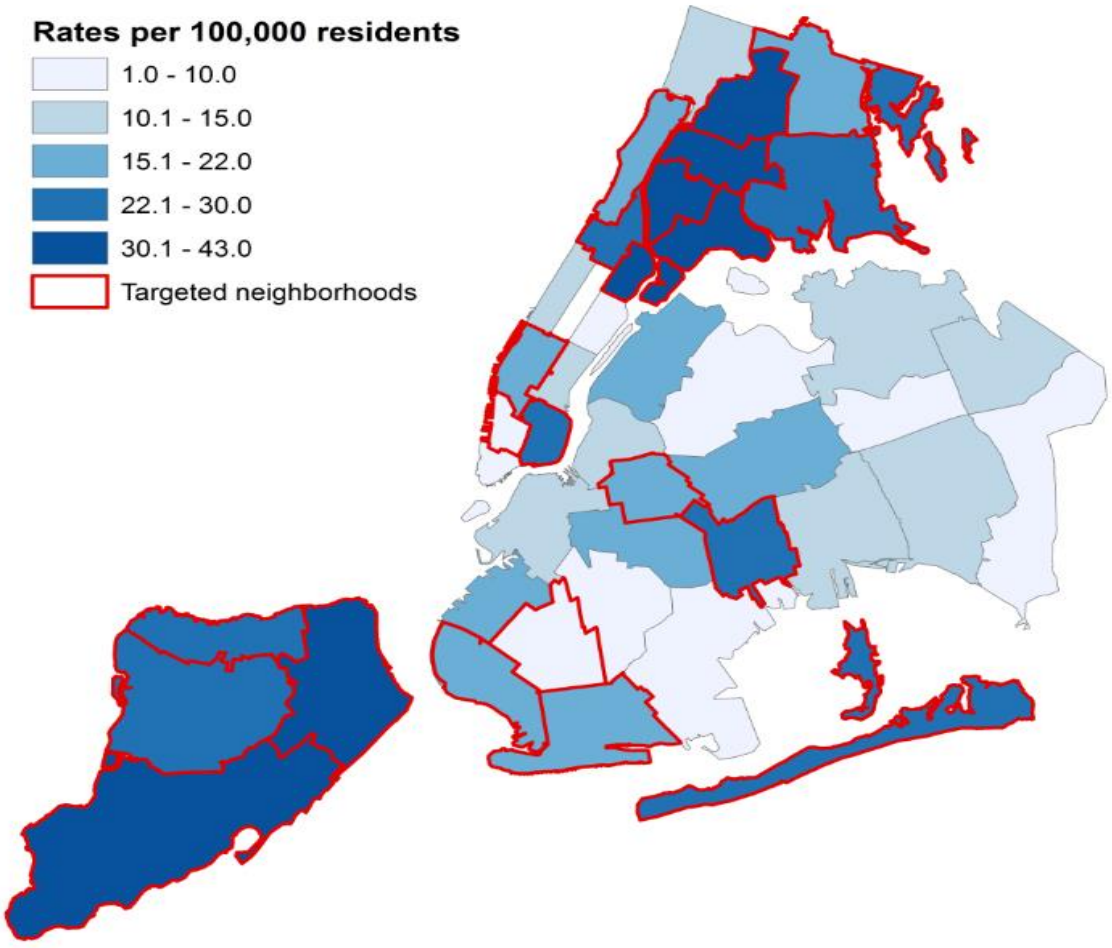
- 800 independent NYC pharmacies during 8-week campaign (March–April, 2018)
- NYC neighborhoods with high rates of opioid overdose death

Deliver:

- 3 key recommendations
- Action kits with pharmacist and patient materials

Targeted neighborhoods

Rates of unintentional drug poisoning (overdose) death by neighborhood of residence, 2016



Source: Bureau of Vital Statistics/Office of the Chief Medical Examiner, New York City;
Rates calculated using NYC DOHMH population estimates, modified from US Census Bureau intercensal population estimates 2000-2016 updated September 2017.
Analysis by Health Department's Bureau of Alcohol and Drug Use Prevention, Care and Treatment.

**Data for 2016- 2017 are provisional and are subject to change.*
^The United Hospital Fund (UHF) classifies New York City into 42 neighborhoods, comprised of contiguous ZIP codes.

Key recommendations

- **Sign up for the NYC standing order** so that your pharmacy can dispense naloxone without a prescription.

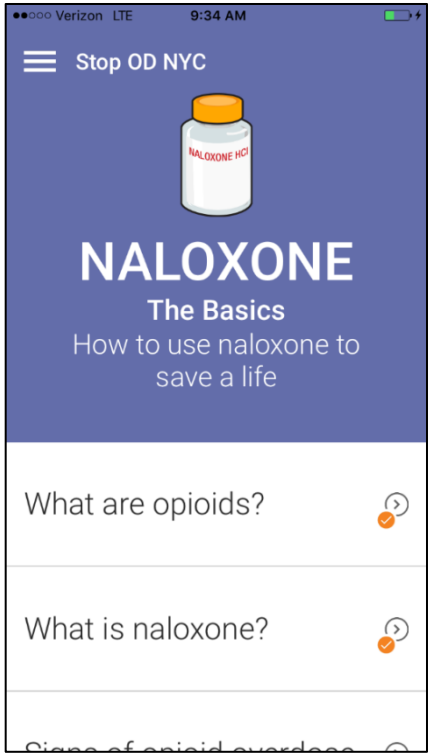
- **Offer naloxone to at-risk patients**, including those who receive chronic opioid therapy (for three months or longer); high-dose opioid prescriptions (100 or more daily morphine milligram equivalents); concurrent opioid and benzodiazepine prescriptions, as well as those who purchase syringes through the Expanded Syringe Access Program (ESAP).

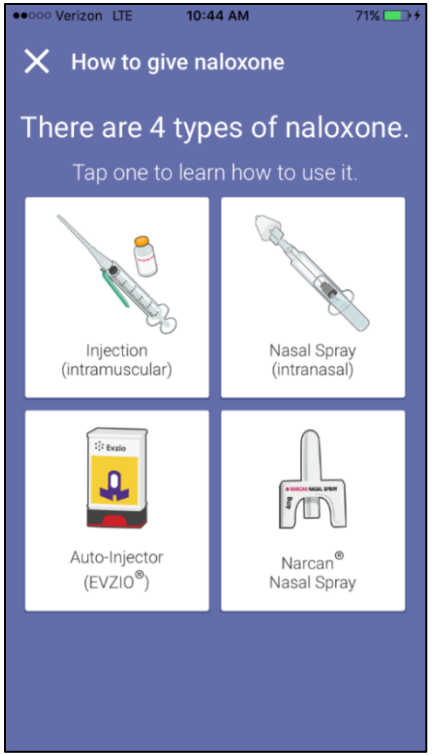
- **Educate patients on how to use naloxone**. You can also recommend the Health Department's free Stop OD NYC app, which provides information on recognizing and responding to an overdose.

Naloxone Action Kit

- Clinical tools
- Provider resources
- Patient education materials

Download the app: Stop OD NYC





Evaluation methods

Methods

- Brief survey verbally administered to pharmacists at initial and follow-up visits to assess:
  - Naloxone dispensing and proactive naloxone offering practices
  - Intent to enroll in the standing order program
  - Comfort with educating patients
- More than one pharmacist per pharmacy could participate
- Tracked the number of pharmacies newly enrolled in the standing order program
- Analyzed data using McNemar’s test and Fisher’s exact test in SAS 9.4

Brief survey

NYC Naloxone Pharmacy Detailing Campaign
Representative:

Participant Name/Title:
Practice Name:
Date:

1. **Are you signed up for the standing order to dispense naloxone?**
   - ❑ Yes → If **YES**, go to 1a and 1b
   - ❑ No → If **NO**, **SKIP** to 1c
   - ❑ Do not know
   - ❑ Did not answer
   - ❑ Did not ask

   1a. Have you dispensed naloxone under the standing order?
   - ❑ Yes
   - ❑ No
   - ❑ Do not know
   - ❑ Did not answer
   - ❑ Did not ask

   1b. Have you proactively offered naloxone to patients at risk for an opioid overdose?
   - ❑ Yes
   - ❑ No
   - ❑ Do not know
   - ❑ Did not answer
   - ❑ Did not ask

   1c. Do you intend to sign up for the standing order?
   - ❑ Yes
   - ❑ No
   - ❑ Do not know
   - ❑ Did not answer
   - ❑ Did not ask

2. **On a scale of 1 to 4, what is your level of comfort with educating patients on how to use naloxone?** ***(1 being not comfortable and 4 being very comfortable)***
   - ❑ 1
   - ❑ 2
   - ❑ 3
   - ❑ 4
   - ❑ Did not answer
   - ❑ Did not ask

Results

Process outcomes

- 1,001 unique independent pharmacies visited
- 1,153 pharmacists detailed at initial visits and conducted follow-up visits with 467 (40%)
- 519 pharmacies enrolled in standing order program

Self-reported standing order status, intention to join standing order program, and comfort educating on naloxone

Recommendation	Initial Visit % Yes (n/N)	Follow-up visit % Yes(n/N)	P-value*
Signed up for standing order	4.9% (22/446)	77.3% (188/446)	<0.001*
For those not in standing order program: Do you intend to sign up?	46.5% (107/230)	62.2% (143/230)	<0.001*
Comfort with educating patients on how to use naloxone	52.3% (205/392)	93.6% (340/392)	<0.001*

**McNemar's test used to test for significance*

Self-reported naloxone dispensing and proactive naloxone offering

Recommendation	Initial Visit % Yes (n/N)	Follow-up visit % Yes(n/N)	P-value*
Among those on standing order: Dispensed naloxone?	33.3% (9/27)	40.7% (11/27)	<0.001**
Among those on standing order: Proactively offering naloxone?	39.1% (9/23)	69.6% (16/23)	0.0189**

***Fisher's exact test used to account for expected counts less than 5*

Limitations

- Irregular pharmacist schedules hindered follow-up visit completion
- Some standing orders were submitted after campaign completion and were not captured in evaluation outcomes
- Some pharmacists unaware of standing order status, limiting ability to answer standing order-related assessment questions
- Pharmacy owner approval needed for standing order submission

Conclusions

- An 8-week detailing campaign achieved a five-fold increase in the number of NYC pharmacies signed onto the standing order
- Brief education may be sufficient to change pharmacist comfort with educating patients about naloxone
- Education and technical assistance needed for pharmacies to increase naloxone dispensing
- Public health detailing is an effective educational strategy for increasing enrollment in standing order programs

Next steps

- Further evaluation using naloxone dispensing data needed to assess impact of campaign on naloxone distribution
- Qualitative follow-up needed to assess barriers and facilitators to naloxone dispensing

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- Ellenie Tuazon, MPH*
- Alice E. Welch, DrPH, MPH, RPh*
- Emily Winkelstein, MSW*

*Co-authors

5-MINUTE
Q & A

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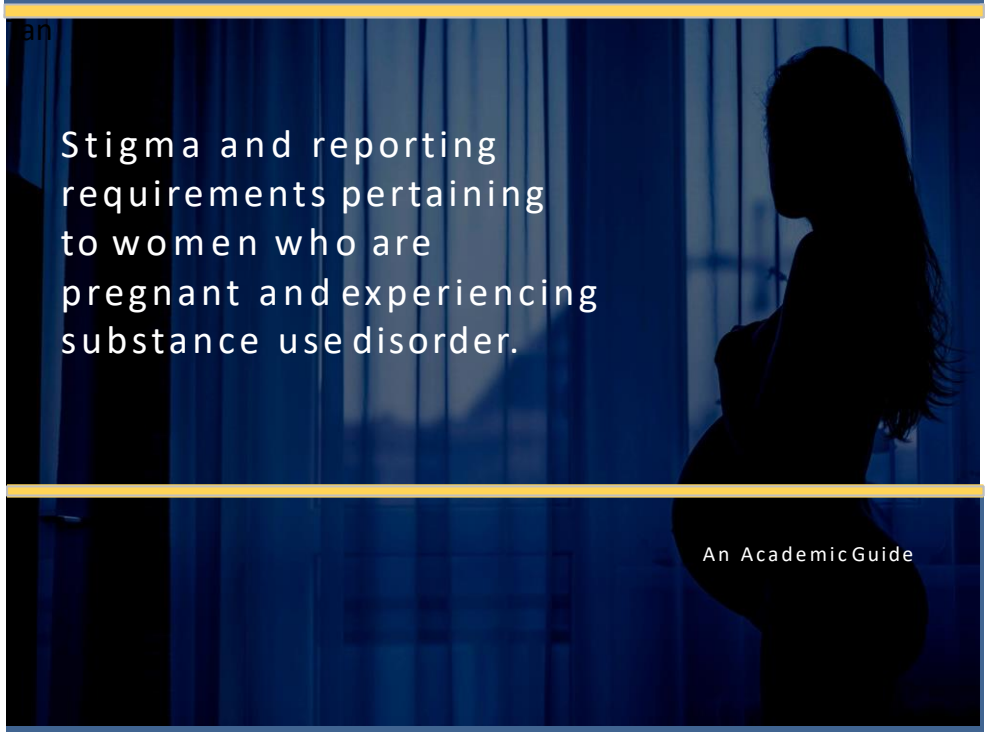
Stigma and reporting requirements pertaining to women who are pregnant and experiencing substance use disorder.



An Academic Guide

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Drug Poisoning Prevention Team Supervisor

SAFE COMMUNITIES MADISON - DANE COUNTY
www.safercommunity.net

Background

- **Safe Communities began a program with Recovery Coaches to help pregnant women with opioid use disorder in August of 2017 with SSM Healthcare Organization.**
- **After not getting referrals for a few months we began to examine why there were not referrals coming in.**
- **Champion doctors within the SSM Healthcare Organization identified they felt their staff had pre-conceived ideas about people with substance use disorder, particularly regarding beliefs about women who used substances during pregnancy.**
- **Applying the evidence based practice of Academic Detailing was explored to suggest change of practice occur when working with women who are pregnant with substance use disorder.**

What Happened?

- A pre-Academic Detailing survey was sent out to SSM staff and providers via email on April 25, 2018.
- 52 SSM staff and providers participated in the surveys prior to the Academic Detailing sessions.
- Large group meeting for the providers to set the stage for the AD sessions.
- People with lived experience/recovery coaches in long term recovery joined in on the sessions.
- Five ob/gyn clinics staff participated in 7 small group AD sessions determined by the team they worked with.
- One on one time was allotted for staff members after the sessions for more information and questions.

What Happened? Cont..

- 43 SSM staff members participated in Academic Detailing sessions.
- 20 SSM providers participated in the large group meeting after Academic Detailing was completed with staff.
- A post-Academic Detailing survey was sent out to SSM staff and providers via email on July 1, 2018.
- 19 SSM staff and providers participated in the post-Academic Detailing surveys.

Pre-Academic Detailing Survey

- What is your date of birth?
- What is the date of you stigma training?
- I know what it is like to personally experience stigma related to substance abuse.
- I may not agree with them, but at times I have feelings of prejudice (automatic thoughts or feelings) toward people who use substances.
- At times I am not comfortable around people who I perceived to be different than me.
- Talking about my own use of substances with patients I interact with is not appropriate.
- I trust people who use substances as much as people who do not use substances.
- A woman has the responsibility to cease substance use if she is pregnant.
- People who use substances have the inability to practice safe sec consistently.
- People who use substances or have used substances in the past have meaningful participation in developing policies and procedures at my organization.
- I am aware of the language that can stigmatize people who use substances.
- I tray and avoid language that is stigmatizing to people who use substances.
- As difficult as it is to admit, at times I judge people who cannot cease using substances.
- I am committed to changing my practice of stigmatizing individuals (if applicable) who are addicted to using substances and be an advocate for change.

Evidence Based Information

- Why stigma matters
- What is addiction
- If addiction is portrayed as treatable, is it less stigmatized
- Drug addiction is more stigmatized than mental illness
- What causes addiction
- There is a high correlation between substance use and trauma
- The Ace studies
- Map of overdoses in Wisconsin 2017

Evidence Based Information

- Faces of addiction versus statistics
- Results of needs assessment pertaining to women who are pregnant and using substances.
- Wisconsin reporting requirements for pregnant women
- What can we do?
  - Compassion and accountability
  - Awareness of stigmatizing language
  - Self-Care
- Success stories
- Bill of rights for people in recovery

Post-Academic Detailing Survey

- **Academic detailing sessions about stigma were beneficial to me?**

14 people either agreed or strongly agreed
4 either agreed or disagreed
1 disagreed

- **I have used techniques learned in the Academic Detailing sessions on Stigma?**

9 people either agreed or strongly agreed
5 either agreed or disagreed
5 disagreed

- **I have noticed a decreased level of stigma among my colleagues since Academic Detailing sessions were done.**

5 people either agreed or strongly agreed
12 either agreed or disagreed
2 disagreed

- **As a result of Academic Detailing sessions I am more comfortable making referrals to community resources for people who have substance use disorder.**

12 people either agreed or strongly agreed
6 either agreed or disagreed
1 disagreed

Tracking Tool

SSM Stigma and Reporting Requirements for Pregnant Women Project Tracking Tool 2018

Focus of the Academic Detailing:

1) Decrease stigma towards pregnant women with SUD and increase awareness of reporting requirements

Key Messages:

1. Gain understanding of the harms of stigma and how decreasing stigma leads to better interventions
2. Gain familiarity with the correaltes to SUD risk
3. Gain understanding of reporting requirements for pregnant women with SUD
4. Understand and feel comfortable using non-stigmatizing language

Themes:

	Date of Detailing	Time spent	Name of Prescriber Detailed	Individual needs assessment	Key messages delivered (1-4)	What did prescriber commit to change?	Date of Survey Sent Pre-Academic Detailing	Survey Sent Post-Academic Detailing	Date of Follo w-up	prescriber change what the committed
1	5.3.18	20 minutes	Nurse	Questions about resources-how to help	1,2,3,4	Awareness Of Language	4.26.18	7.1.18	7.16.18	Y
2	5.3.18	20 minutes	Nurse	Questions about resources-how to help	1,2,3,4	Awareness of Language	4.26.18	7.1.18		
3	5.3.18	20 minutes	Nurse	Questions about resources-how to help	1,2,3,4	Awareness of Language	4.26.18	7.1.18		
4	5.3.18	20 minutes	Nurse	Stigmatizing language	1,2,3,4	Awareness of Language	4.26.18	7.1.18		
5	5.3.18	20 minutes	Nurse	Stigmatizing language	1,2,3,4	Learning more about the topic	4.26.18	7.1.18		
6	5.3.18	25 minutes	Nurse	Stigmatizing language	1,2,3,4	To learn more resources	4.26.18	7.1.18		
7	5.3.18	25 minutes	Nurse	Stigmatizing language	1,2,3,4	Educate self more about opioid	4.26.18	7.1.18		
8	5.3.18	25 minutes	Nurse	Stigmatizing language	1,2,3,4	Awareness of Language	4.26.18	7.1.18		
9	5.3.18	25 minutes	Nurse	More information on addiction	1,2,3,4	Awareness of Language	4.26.18	7.1.18		
10	5.3.18	25 minutes	Nurse	Reporting requirements/trust	1,2,3,4	Pathways nurses take for referr	4.26.18	7.1.18		

What We Learned

- **People seemed to be extremely honest when they took the surveys in regard to their thoughts, feelings and values pertaining to stigma and pregnant women who use substances.**

- **In the small groups, the staff admitted their challenges and struggles of working with the population that has substance use disorder.**
  - **Not knowing resources.**
  - **Not knowing how to ask women if they were using.**
  - **Seeing patients as their diagnosis and not the whole person.**
  - **Not knowing stigmatizing language.**

- **Staff was open to committing to a goal for change that would directly effect this population and affect the work culture within SSM Healthcare Organization.**

- **Changes happen all the time in Healthcare Organizations and we have to be flexible to accommodate those changes so we can still do the work we set out to do.**

- **Creating the awareness of the beliefs and values can affect a change in the culture in many areas of discrimination by having difficult discussions in small groups.**

Questions

?’s

Thank you!
Tanya Kraege APSW, MSW, CSAC,
CCAR COACH

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5-MINUTE
Q & A

Thank you,
day 1 field presenters