Transforming Clinical Practice Initiative (TCPI)
Medication Management and Opioid (MMO) Initiative

July 18, 2017
2:00-3:30 pm ET
Welcome

LCDR Fred Butler, Jr. MBA, MPH
Senior Advisor for Integration and Quality
CMS Quality Improvement & Innovation Group
Move the TCPI community into action on opioid utilization and medication management

Initiate an MMO improvement strategy that will showcase results by December 2017

Introduce “Medication Management” change tactics as a new priority part of the TCPI Change Package

Align with QIN-QIO regional efforts to bring opioid use under control
The New TCPI MMO Initiative

• Focus on opioid management and medication management principles

• Centered on experiences of national faculty
  – Focus on 3 high risk medication classes: opioids, anticoagulants and hypoglycemic agents
  – Identify simple actions practices can build into operations to eliminate medication related problems including opioid misutilization
  – Creation of actionable “add on” to Change Package

• Next Steps
  – Link medication management to PFE and building the Business Case
1. Making Commitments

2. Delivering on the Commitments You Make

3. Securing Commitments from Others

4. Acknowledging Others as They Deliver On Their Commitments
Unlocking Abundance

Requests and Offers are a Way to Defeat the “Deficit Trap”

“We can’t do that because we don’t have the resources.”

Signature Style Solution:
We access the resources we need by unlocking the natural abundance of the world.
Abundance is the Bonus

The Source of Abundance
What action(s) will we take over the next four weeks to put in place advanced medication management to control opioid utilization in my network?
TCPI National Faculty
Medication Management Performance Stories
Integrated specialized pain medicine within the medical home
An improvement solution for managing the opioid epidemic in a rural FQHC:

Dr. Sarah Chouinard
Community Care of West Virginia (CCWV)
Leadership Involvement – State and National Engagement

• National Association of Community Health Centers (NACHC) Expert Panel

• Medical Director at state insurer/payer, PEIA
  – Co-created the SEMPP (safe and effective management of Pain Program) with West Virginia University
  – Safe & Effective Management of Pain Guidelines
Pain Management Integration into a PCMH: Goals

- Reduce overprescribing of opioids
- Reduce number of opioids in rural community
- Reduce primary care providers’ frustration
- Improve quality of evaluation of pain syndrome
- Standardized compliance monitoring
- Offer help to those who have pain
Removing Pain Medication “shopping” from the equation improves ability to focus on primary care

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<tr>
<td>BP Control in Patient with Diabetes</td>
<td>46%</td>
<td>70%</td>
</tr>
<tr>
<td>HbA1C &lt;9</td>
<td>38%</td>
<td>73%</td>
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<td>Opioid scripts written in PCP Clinics (1 month)</td>
<td>741</td>
<td>106</td>
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WV Office of Health Facility Licensure & Certification requires “pain clinics” to go through a comprehensive evaluation every 6-12 months.

Only 6 centers in WV have passed licensure.

Last review:
- 100% compliance with PDMP;
- 99% compliance with UDS;
- 95% compliance with shared care plan.
“First Things First” in Tackling Opioid Management

- Use medication lists or pharmacy data to know who your cohort will be, and refresh the list every month
- Calculate MME for these patients and stratify them for prioritizing your list
- Do an initial evaluation on all patients even if they have been on meds for years
- New patients set goals for stopping meds at initial visit
- Create accountability contracts
- Standardize the tools and use them every time
- Assess, Manage, Monitor
TCPI Medication Management and Opioid Campaign:
A Look at WellSpan’s Journey

Marijka A. Grey, MD, FACP
Regional Medical Director
WellSpan Medical Group
Pennsylvania

...at the heart of the opioid epidemic

FACT
Hospitalization for heroin overdoses in Pennsylvania increased 162% from 2000 to 2014.

COMBATING OPIOID ABUSE
WELLSPAN IS WORKING WITH COMMUNITIES AND PHYSICIANS TO ADDRESS WIDESPREAD ISSUE

Opioid abuse and heroin use have reached epidemic levels nationwide and in Pennsylvania's communities. In 2014, the number of Pennsylvanians who died of drug overdoses was 2,500 – double the number of people who died in traffic accidents that year.
Our Road to Opioid Management

• Physician Champion – Dr. Chris Echterling, Medical Director for Vulnerable Populations
• Committee – Chronic Pain Clinical Effectiveness Team

Mission Statement:

For patients:
Establish a system that enables the most effective and efficient treatment for the causes and effects of chronic pain by making patients and their families active and accountable participants in their care.

For providers:
Establish a structured, accountable, evidence-based method of caring for patients with chronic pain while minimizing problems related to patient addiction and diversion of drugs.
Our Road to Opioid Management

• Consensus in the community – chronic narcotic pain medications would be handled by primary care

• Common controlled substance agreement across all our sites
  • Education and video co-created with our patients for our patients

• Common way of documenting in the EHR about Controlled Substance Agreements and violations

• Availability of Urine Drug Screening in all primary care offices
Our Road to Opioid Management

• Education of physicians/APCs:
  • Primary care: Medication alternatives for chronic pain
  • Specialty care: Appropriate post-operative/post-procedure dosing and reaching consensus within the group

• The caring broken record
Our Road to Opioid Management

Pts w/ >1 script in 60 days

Period Ending
- Series:
Using Data for Medication Management in High Risk Patients

Greg Wolverton
Chief Information Officer
AR Care
Medication Management: Using Data to Drive Improvements

• Created new medication management rules in EMR to identify patients, real-time, for current analgesic narcotic prescribed patients.

• Created real-time, “passive” risk stratification determination notifications in patient chart overview for clinicians.

• Brought in new care management team members – Behavioral Health, PharmD, Care Coordinators – Now automatic referrals and alternative TX options

• Interoperability to Arkansas Prescription Monitoring Program and Kentucky All Schedule Prescription Electronic Reporting.

• EVERY VISIT REQUIRED Med reconciliation with PharmD

• Every detail is documented in discreet fields with data being prepped for prescriptive analytics to determine “why – why-not, If – If-not” potentials for future decision support.
Medication Management Change Tactics

Christine Rash-Foanio, Pharm D
TCPI National Faculty
University of Illinois at Chicago - College of Pharmacy
TCPI Change Package: MMO Tactics

1. Person and Family-Centered Care Design
   1.5 Coordinated care delivery
   1.5.5 Manage medication reconciliation:

   - With patients and families, manage and reconcile medications to maximize use, effectiveness, and safety

   Change Tactics
   - Reconcile medications at each visit
   - Provide follow up on medication use after hospital discharge
   - Include a pharmacist on the care team
   - Conduct medication reconciliation at every encounter
   - Coordinate medications across transitions of care settings and providers
   - Conduct periodic, structured medication reviews
   - Develop a medication action plan for high-risk patients
   - Provide collaborative drug therapy management for selected conditions or medications
   - Provide support for medication self-management
   - Always think about health literacy when talking about prescriptions
   - Include a pharmacist review of all meds at initial visit/consult; share information with all co-managing providers
TCPI Change Package: MMO Tactics

Practice Level

- Have an organizational plan for pain management that does not include medications (i.e. integrated behavioral health team)
- Use medication lists or pharmacy data to know who your cohort will be. Refresh this list every month. Check your state’s Prescription Drug Monitoring Programs (PDMP) and/or pharmacies the patient has visited to see if patients have existing opioid prescriptions.
- Calculate morphine milligram equivalents (MME) for these patients and stratify them for prioritizing your list
- Do an initial evaluation on all patients even if they have been on meds for years
- New patients set goals for *stopping* meds at initial visit
- Create accountability contracts
  - Ensure that the contract insists that patients only use one pharmacy and prescriber for needed medications
- Standardize the tools and use them every time – such as 28 day prescribing, limit days of the week that patients can get routine pain medicine refills to maximize coordination at the practice level
- Assess, Manage, Monitor
  - Assess- run a monthly list to see if patients have been compliant with required office visits, UDS, pill counts
  - Manage- outreach to patients and make them aware of upcoming testing or visits so that they stay compliant with contract terms
  - Monitor- run monthly and PREvisit reports from the PDMP to see if patients have been compliant with contract terms of one provider, one pharmacy for opioids
### Health System Level

- Consensus in the community – chronic narcotic pain medications would be handled with a clear set of workflows and accountability (ex. by primary care only)
- Common controlled substance agreement across all our sites
  - Education and video co-created with our patients for our patients
- Common way of documenting in the EHR about Controlled Substance Agreements and violations
- Tight processes and protocols for all involved with handling opioid management
  - Common response protocol in addressing specific situations
- Availability of Urine Drug Screening in all primary care offices
- Education of physicians/APCs:
  - Primary care: Medication alternatives for chronic pain
  - Specialty care: Appropriate post-operative/post-procedure dosing and reaching consensus within the group
- Repeatedly and calmly express concern and your sincere desire to help the patient, even if it does not include opioids
  - In response to a patient’s resistance to the treatment plan, keep repeating sincere expressions of caring in a calm way, but adhere to the treatment plan
### TCPI Change Package: Additional Medications

#### Anticoagulation Management

- Provided by healthcare professionals (physicians, nurses, pharmacists) who have completed a core-competency related to anticoagulation
- Written policies and procedures should be established by the party responsible for anticoagulant care delivery (i.e. Medical director)
- Efficient system for identifying, scheduling, testing, and tracking patients to keep patients engaged in their care
- Tailor appointments and scheduling to patients
  - Schedule phone follow-up calls
  - Ensure patients have singular and responsive point of contact in the office
- Systematic, evidence-based clinical decision support to guide
  - Initial selection of therapy and duration, lab monitoring, assessment of bleed/thrombotic risk, follow-up intervals, adjustments and interruptions in therapy, emergency management, medication reconciliation
- Use of an accurate and accessible documentation system
- Care plan should address the individual educational needs of the patient and caregiver(s)
TCPI Change Package: Additional Medications

Hypoglycemic Agents Management

• Prescription data to identify patients on hypoglycemic agents
  o Risk-stratify based on age, renal function, number of concomitant medications, co-morbid diseases
• Clinical decision support to guide selection of therapy and frequency of laboratory monitoring and follow-up
• Provide appointments solely dedicated to discussion of diabetes
  o Time to discuss concerns such as hypoglycemic events, medication adherence, side-effects, level of comfort with therapy, and lifestyle changes to minimize medications
  o Individualize treatment plan and goals of diabetic therapy and document notes
  o Patient-centered intensification of treatment
  o Age, health status, co-morbidities, life expectancy, financial status, social support, fall-risk
• Medication reconciliation at all visits → patients bring all medications
  o Identification of non-adherence, medication errors, poly-pharmacy
  o Lowest number of medications, easy dosing schedule, ease of administration
• Adaptive education strategies that are individualized to the patient
  o Disease state, diet, medications, self-monitoring of blood glucose, self-treatment of hypoglycemia, emergency procedures
Where to find MMO Change Tactics

Secondary Drivers:
- 1.1 Patient and Family Engagement
- 1.2 Team-based Relationships
- 1.3 Population Management
- 1.4 Practice as a Community Partner
- 1.5 Coordinated Care Delivery
- 1.6 Organized Evidence-based Care
- 1.7 Enhanced Access

1. Person and Family-Centered Care Design

Change Concepts:
- 1.5.1 Manage care transitions: Manage care transitions collaboratively with patients and families
- 1.5.2 Establish medical neighborhood roles: Establish clear expectations among primary care team, specialists and others in the medical neighborhood and the role each will play in a patient's care and the information that each will share
- 1.5.3 Coordinate care: Provide effective care coordination across the medical neighborhood
- 1.5.4 Ensure quality of care: Engage members of the medical neighborhood to ensure high level of service and quality of care
- 1.5.5 Manage medication reconciliation: With patients and families, manage and reconcile medications to maximize use, effectiveness, and safety

Change Tactics

CDC Guideline Resources: Opioid Overuse

MMO Initiative Change Tactics

TCPI National Faculty - 2017 - Medication management has a direct impact on several TCPI aims, and PTNs are being asked to incorporate medication management into the technical assistance provided to enrolled clinicians. To facilitate this, the TCPI National Faculty pulled together specific change tactics that they utilize under medication management to address opioid misuse. These align with the existing change tactics but are more specific to the use of medication management.

MMO Initiative Change Tactics

MMBSA9 Medication Management
AGS Updated Medication-Use Criteria
PCPCC Using Medications Successfully
AHRQ Rx Medicine Instructions Guide
AMA Medication Adherence Module
Group Activity

What is your level of commitment to be engaged in medication management over the next 6 months?

• Very committed and In Action
• Very committed
• Committed
• Some what committed
• Not committed
PTN Discussion:
How are PTNs engaging clinicians and practices on medication management and opioid control?

Lori Armistead, Pharm D
CCNC PTN

Jennifer Sommers
AzHeC PTN
Medication Management Optimization

- PTN practices are asked to complete a needs assessment survey regarding medications
- Our team of pharmacists work with these practices and their coaches to optimize medication management
  1. Connect practices to pharmacy and pharmacist resources in their local community
  2. Develop and test medication-related process improvements that support chronic disease management
  3. Explore the impact of medication-related process improvement strategies on quality metrics (e.g., BP, A1c, Asthma, ED utilization)

Opioid Management

- Goal: Launch a PTN Opioid Initiative using CCNC’s chronic pain management and opioid safety resources and expertise
Opioid Actions

Identify high volume prescribers using Health Plan data (MCP and MMIC)

Promote “Turn the Tide”; get commitment to attest *

Promote the current message to prescribers: reduce or avoid prescribing opioids (i.e., the legal supply)

Provide medication alternatives and case-based training (promote rehab and CBT, nerve blocks)

Patient/consumer education is essential!

Use statewide Health Information Exchange (HIE)

- Integrating with Prescription Monitoring Program (PMP)*AZ State requirement
- Access controlled substance prescriptions from PMP
- Aligns with physical and behavioral health information exchange:
  - Emergent – access to Part 2 SA data

Confirm action plans with network

Review their commitment to “Turn the Tide”

Use Morphine Equivalent Daily Dose (MED) to address high dose members and prescribers *any with Benzodiazepines are considered high risk
Discussion Questions

How can we leverage what we are already doing?

Hit *# to get in queue
Discussion Questions

How can this body of work be used to energize our networks?

Hit *# to get in queue
Discussion Questions

How will we **be in action** over the next 6 months?

*Hit *# to get in queue*
Based on the PTN discussion, what sounds like it will have a big payoff in 6 months?

What additional actions can PTNs take over the next 6 months?
Coordinated Care Delivery

Change Concepts

1.5.1 Manage care transitions: Manage care transitions collaboratively with patients and families.

1.5.2 Establish medical neighborhood roles: Establish clear expectations among primary care team, specialists and others in the medical neighborhood about the role each will play in a patient's care and the information that each will share.

1.5.3 Coordinate care: Coordinate care to provide effective care coordination across the medical neighborhood.

1.5.4 Ensure quality and safety: Engage members of the medical neighborhood to ensure high level of service and quality of care.

1.5.5 Manage medication reconciliation: With patients and families, manage and reconcile medications to maximize use, effectiveness, and safety.

Documents

CDC Guideline Resources: Opioid Overuse

MMO Initiative Change Tactics

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MMO Initiative Change Tactics

- MMSAG Medication Management
- AGS Updated Medication-Use Criteria
- PCPCI Using Medications Successfully
- AHRQ Rx Medicine Instructions Guide
- AMA Medication Adherence Module
Welcome from HRSA’s Bureau of Primary Health Care
July 18, 2017

Shannon K. McDevitt, MD, MPH
Medical Officer, Expansion Division
Office of Policy and Program Development
Bureau of Primary Health Care (BPHC)
Health Resources and Services Administration (HRSA)
Health Center Program

- Nearly 1,400 health centers
- More than 10,400 service delivery sites
- 69% provide substance abuse services on site or by paid referral
- 88% provide mental health services
Expand access to mental health services, and substance abuse services focusing on the treatment, prevention, and awareness of opioid abuse.
Summary of AIMS Funding

$195 million in FY17 AIMS funding

- $100 million (up to $75,000 per health center) in ongoing supplements to expand:
  - Mental Health Services (up to $37,500)
  - Substance Abuse Services focusing on the treatment, prevention, and awareness of opioid abuse (up to $37,500)

- $95 million (up to $75,000 per health center) for one-time supplements for investments in:
  - Health information technology (IT)
  - Training

- Applications are due July 26, 2017
Shannon K. McDevitt, MD, MPH
Medical Officer, Expansion Division
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Twitter: twitter.com/HRSAGov
Facebook: facebook.com/HHS.HRSA
What requests and offers do PTNs and SANs have of the HIINs and the QIN-QIO community?

How will you collaborate with HIINs and QIN-QIOs over the next 2 weeks?
Closing Remarks

Paul McGann, MD
Chief Medical Officer
Quality Improvement & Innovation Group

Paul Rosen, MD
Medical Officer of TCPI

LCDR Fred Butler, Jr.
Senior Advisor for Integration and Quality
CMS Quality Improvement & Innovation Group