DAY 1 FIELD PRESENTATIONS
Academic Detailing
The Bridge between Prevention and Treatment Initiatives in SC to Address the Opioid Epidemic

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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

Prevention
- CDC
- SC DHEC

Treatment
- SAMHSA
- SC DAODAS

Appropriate Drug Therapy
- CMS
- SCDHHS
Background

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

• Monitoring Practices for Safer Opioid Prescribing (S.O.S.)
  – **Share a patient provider agreement** prior to initiating a trial of opioids
  – **Optimize patient treatment** (drug/non-drug) using a multi-dimensional rating scale
  – **Screen 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

# Identification of ‘Hot Spot’ Counties

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

* 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.

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

<table>
<thead>
<tr>
<th>Trifold</th>
<th>(supports discussion /ready resource after visit)</th>
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<td>(with Opioid Fast Facts)</td>
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<td>Laminated P.E.G. /dry erase marker</td>
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<td>Opioid Chart</td>
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<td>SCRIPTS overview</td>
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<td>CME insert</td>
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</table>

**SCRIPTS** SC PDMP

Changing What’s Possible | MUSCHealth.org
“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
**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](http://www.scmataccess.com))
SCDHHS tipSC Initiative
Support Materials for AD/Follow-up Visits

**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 q3hs, then stop

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.

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.

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**FIND FREQUENCY OF OPIOID TREATMENT REDUCTION (OFT)**

Example adapted with permission from VA PBM Academic Detailing Service. Opioid Taper Decision Tool 2016 Oct 19-20, P96820.

**DANGER**

- **25** by you
- **35** by you, other prescribers
- **15** by you
- **20** by you, other prescribers

Total patients meeting an opioid ‘harbors dangerous’ (> equivalent) in same month (both [or all] 3 risk factors) by you

Includes benzodiazepines AND any other analgesics/medications: (sedative/hypnotics, barbiturates, and non-barbiturates [e.g., z-drugs such as zolpidem]).

Disclaimers: All SCRIPTS reports are based on data submissions from the dispensing. Contact DHME at 803-736-0480 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%

![Bar chart showing changes in monitoring practices](chart.png)
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)*

### 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**

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**Report excludes continuation AD activity funded by SAMSHA**

**Phone calls and e-mails not tracked**

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

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

**Collaboration with SC Department of Health and Human Services/CMS**
AD Activity in Action

Program Manager/LCSW

interested

ECHO

Delegate

NP

waiver

Delegate

NP

waiver

Delegate

CMO

interested

interested

interested

MD

MD
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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Academic Detailing Reduces Behavioral Health Polypharmacy in a Medicaid Population

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SCOTTSDALE, AZ
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

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

Magellan Healthcare

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

Magellan Health

One company, two unique platforms
A Fortune 500 company

Offices in 26 states & D.C.

10,700 Employees
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 drugs¹

“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

Agenda

1. Background/Context
2. Intervention Details
3. Intervention Evaluation & Results
4. Discussion
Whole Health Rx
Our approach to whole patient management

Whole Health Rx℠
High-touch, academic detailing focused on improving best practice prescribing

- Improved patient care
- Outreach to prescribers of all specialties
- Comprehensive healthcare data identification (medical and pharmacy claims)
- Robust health informatics and reporting capabilities
- Multi-channel outreach: provider mailing, face-to-face visits, and telephonic consultations with clinical pharmacist
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 psychoactive medications increased from 42.6% to 59.2%, and those with 3 or more psychoactive medications increased from 16.9% to 33.2%.
- An association between psychiatric comorbidities and psychoactive 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:**

**Patients identified for this protocol: 1**

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1. Background/Context
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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

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<th>Intervention Period</th>
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<td>48,290</td>
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<td>$ 866</td>
<td>$ 767</td>
<td>$(99)</td>
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### 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 $767 during the six month post intervention period
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<td>6 Month Post</td>
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<td>Distinct Claim Counts PEPM – BH Medications</td>
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<td>7.257</td>
<td>(0.529)</td>
</tr>
<tr>
<td></td>
<td>Pharmacy Spend PEPM – BH Medications</td>
<td>$ 968</td>
<td>$ 888</td>
<td>$ (80)</td>
</tr>
</tbody>
</table>

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

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

I can’t believe so many of my patients are getting duplicate therapy.

I was surprised and unaware of the adherence issues with some patients and polypharmacy with others. I am glad you brought me this information.

It is great that the state provides a program like this focusing specifically on patients with mental illness.

I support this initiative and would be willing to assist with any changes Magellan proposes.

This is a great program. Would you be willing to present the trends of my providers?

Your algorithms are in line with a number of our performance improvement projects. Could you send our provider’s monthly reports?
5-MINUTE
Q & A
Public Health Detailing to Increase Naloxone Access in New York City Pharmacies

Carla Foster, MPH
City Research Scientist
Bureau of Alcohol and Drug Use Prevention, Care and Treatment
New York City Department of Health and Mental Hygiene

November 12, 2018

Co-authors: Emily Winkelstein, MSW, Ellenie Tuazon, MPH, Alice E. Welch, DrPH, MPH, RPh, Denise Paone, EdD, Hillary V. Kunins, MD, MPH, MS, Jessica A. Kattan, MD, MPH
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

Rates per 100,000 residents
- 1.0 - 10.0
- 10.1 - 15.0
- 15.1 - 22.0
- 22.1 - 30.0
- 30.1 - 43.0

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
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

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

*McNemar’s test used to test for significance
## Self-reported naloxone dispensing and proactive naloxone offering

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

*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
Acknowledgements

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- Michelle Dresser, MPH
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- Emma Raser, MPH
- Ellenie Tuazon, MPH*
- Alice E. Welch, DrPH, MPH, RPh*
- Emily Winkelstein, MSW*

*Co-authors
5-MINUTE Q & A
Stigma and reporting requirements pertaining to women who are pregnant and experiencing substance use disorder.

Tanya Kraege APSW, CSAC, MSW, CCAR COACH
Drug Poisoning Prevention Team Supervisor

SAFE COMMUNITIES MADISON - DANE COUNTY
www.safercommunity.net
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 sex 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 try 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 correlates to SUD risk
3. Gain understanding of reporting requirements for pregnant women with SUD
4. Understand and feel comfortable using non-stigmatizing language

**Themes:**

<table>
<thead>
<tr>
<th>Date of Detailing</th>
<th>Time spent</th>
<th>Name of Prescriber Detailed</th>
<th>Individual needs assessment</th>
<th>Key messages delivered (1-4)</th>
<th>What did prescriber commit to change?</th>
<th>Date of Survey Sent Pre-Academic Detailing</th>
<th>Survey Sent Post-Academic Detailing</th>
<th>Date of Follow-up</th>
<th>Prescriber change in the committed</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.3.18</td>
<td>20 minutes</td>
<td>Nurse</td>
<td>Questions about resources–how to help</td>
<td>1, 2, 3, 4</td>
<td>Awareness Of Language</td>
<td>4/26/18</td>
<td>7/1/18</td>
<td>7/16/18</td>
<td>Y</td>
</tr>
<tr>
<td>5.3.18</td>
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<td>5.3.18</td>
<td>20 minutes</td>
<td>Nurse</td>
<td>Stigmatizing language</td>
<td>1, 2, 3, 4</td>
<td>Awareness Of Language</td>
<td>4/26/18</td>
<td>7/1/18</td>
<td>7/16/18</td>
<td>Y</td>
</tr>
<tr>
<td>5.3.18</td>
<td>20 minutes</td>
<td>Nurse</td>
<td>Stigmatizing language</td>
<td>1, 2, 3, 4</td>
<td>Learning more about the topic</td>
<td>4/26/18</td>
<td>7/1/18</td>
<td>7/16/18</td>
<td>Y</td>
</tr>
<tr>
<td>5.3.18</td>
<td>25 minutes</td>
<td>Nurse</td>
<td>Stigmatizing language</td>
<td>1, 2, 3, 4</td>
<td>To learn more resources</td>
<td>4/26/18</td>
<td>7/1/18</td>
<td>7/16/18</td>
<td>Y</td>
</tr>
<tr>
<td>5.3.18</td>
<td>25 minutes</td>
<td>Nurse</td>
<td>Stigmatizing language</td>
<td>1, 2, 3, 4</td>
<td>Educate self more about opioid</td>
<td>4/26/18</td>
<td>7/1/18</td>
<td>7/16/18</td>
<td>Y</td>
</tr>
<tr>
<td>5.3.18</td>
<td>25 minutes</td>
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<td>Stigmatizing language</td>
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</table>
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