MEDS Ed™

Empowering Patients in Advanced Illness

Please fill out the **BEFORE** section of your self-assessment sheet!

PRE-Seminar Self-Assessment (please complete before seminar begins)

1. How do you rate your **current** knowledge of the positive impact that focusing on goals of care can make on patient outcomes? **From 1 (lowest) to 10 (highest)**

1 2 3 4 5 6 7 8 9 10

Remote Attendees, Welcome!
Please leave your phones on **MUTE** – Thank You!

Agenda

8:00-9:00 – Payers, Palliative Care and the Safety Net

9:00-9:15 Break

9:15-9:45 – Patient Medication Experiences Shaping their Care Perspective

9:45 -10:30 – The Nuts and Bolts of Deprescribing

10:30-10:45 Break

10:45-11:30 – Population Health and Care Management Strategies

11:30-12:00 – Panel Q&A

Payers, Palliative Care and the Safety Net

Will Kennedy, DO
Senior Medical Director for Advanced Illness
CareOregon and Housecall Providers

I have no conflicts of interest to disclose

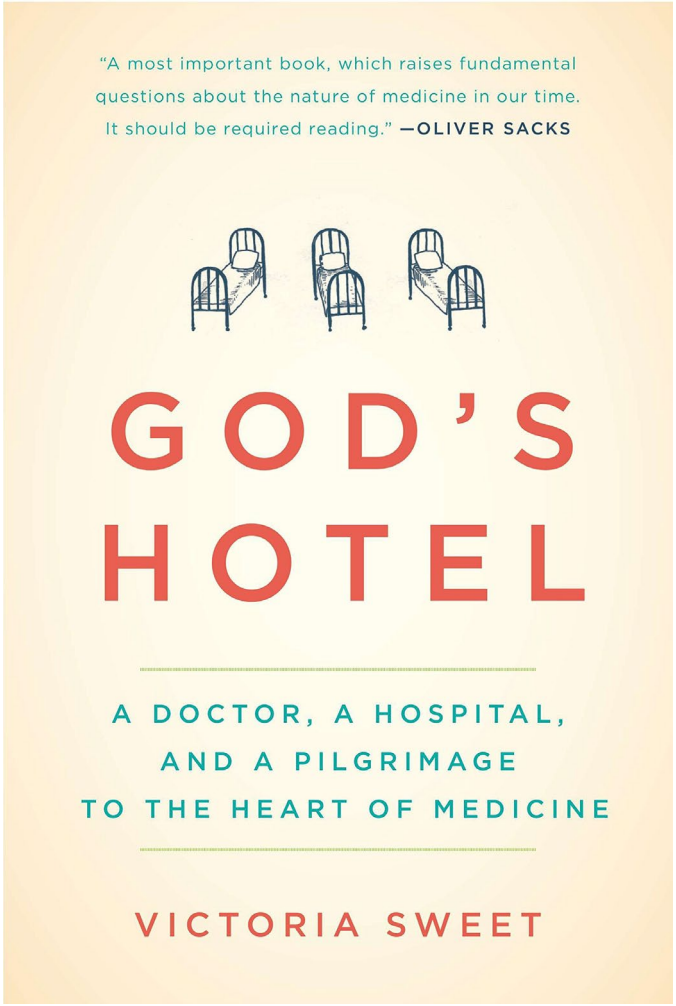
Learning Goals

1. How do we serve our community's most vulnerable members living with advanced illness?
2. What partnerships do we need to provide this care?
3. How do we develop resilience to moral distress and burnout?

"All of us here in this Yard, at one time or another, have seen human tragedies that broke our hearts, and yet we did nothing – not because we didn't care, but because we didn't know what to do. If we had known how to help, we would have acted. **The barrier to change is not too little caring; it is too much complexity**."

-Bill Gates

Photo: Chris Carlsson


"A most important book, which raises fundamental questions about the nature of medicine in our time. It should be required reading." —OLIVER SACKS
GOD'S HOTEL
A DOCTOR, A HOSPITAL, AND A PILGRIMAGE TO THE HEART OF MEDICINE
VICTORIA SWEET


LAUREEN
MARVIN
GEORGIA
BROWNIE MARY


Malcom
1925 ~ 2003
Our Love is he
to stay
Stephen
1918

30% of all Californians are in the safety net population

-California Health Care Foundation

“Those providers that organize and deliver a significant level of health care and other related services to uninsured, Medicaid, and other vulnerable populations”

-Institute of Medicine


CareOregon

What We See

YOUNGER AGE

MENTAL HEALTH

ADDICTION

LACK OF SOCIAL SUPPORTS

FOOD INSECURITY

HOUSING

LOWER HEALTH LITERACY

SAFETY

Underneath the Surface

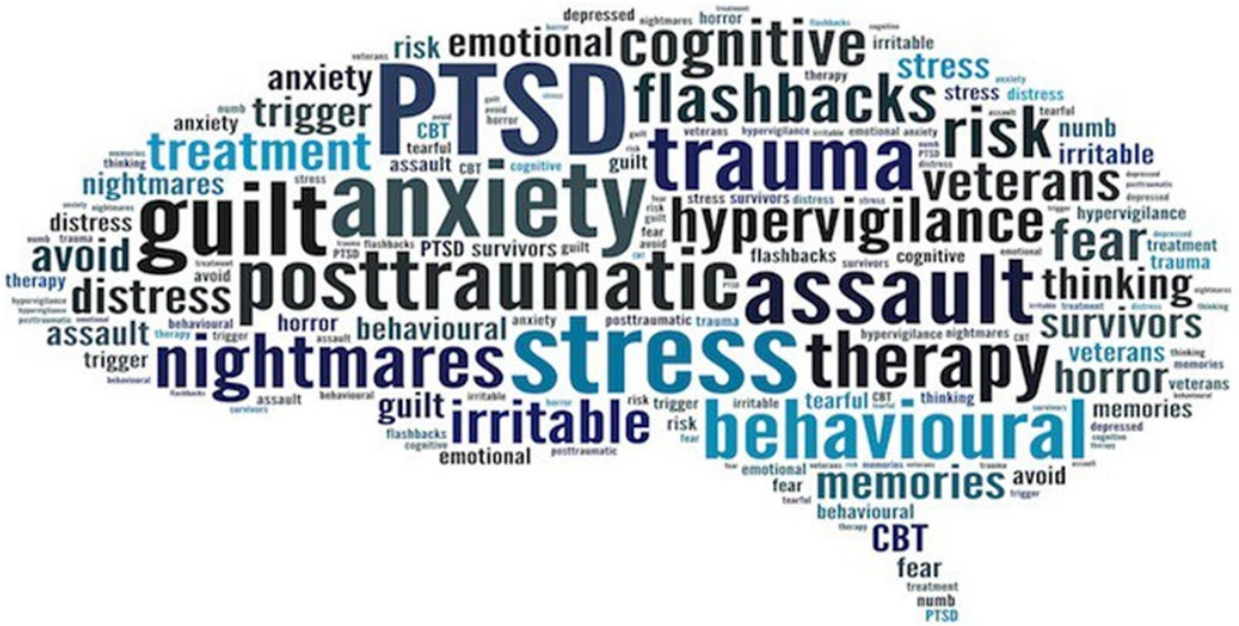
System Barriers:

- No insurance
- Complicated Eligibility Requirements
- Disorganized Services
- Inaccessible Service Locations
- No documents/No Transportation
- Complex Health Problems – fragmented treatment silos

Cultural Barriers:

- Provider Attitudes
- Discrimination
- Cultural Incompetence
- Prior Bad Experiences
- Distrust of System
- Language/Illiteracy
- Disorganized Lifestyle

Traumatic Life Experience

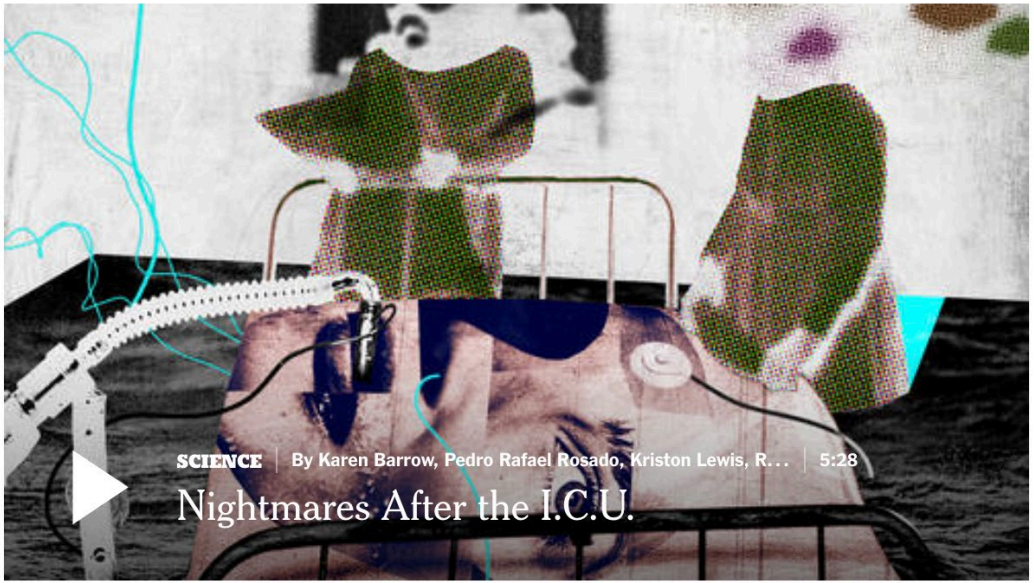


Well

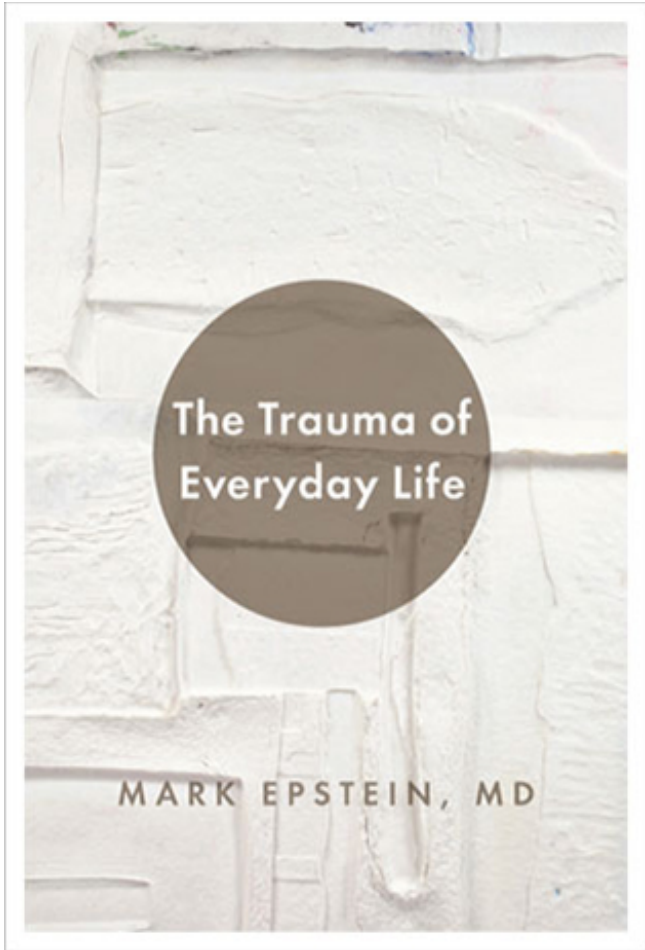
MIND

Nightmares After the I.C.U.

BY JAN HOFFMAN JULY 22, 2013 5:41 PM Comment



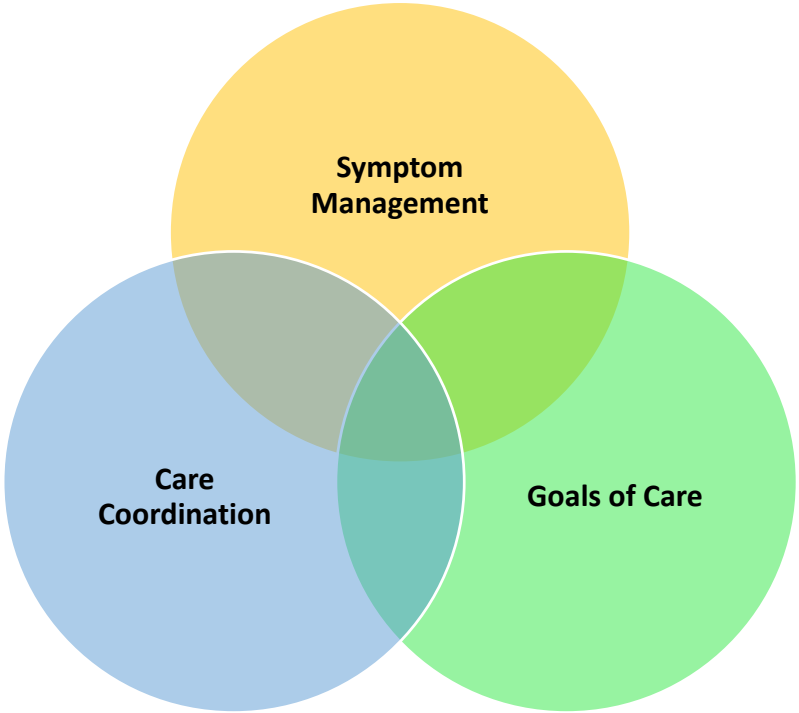
https://well.blogs.nytimes.com/2013/07/22/nightmares-after-the-i-c-u/



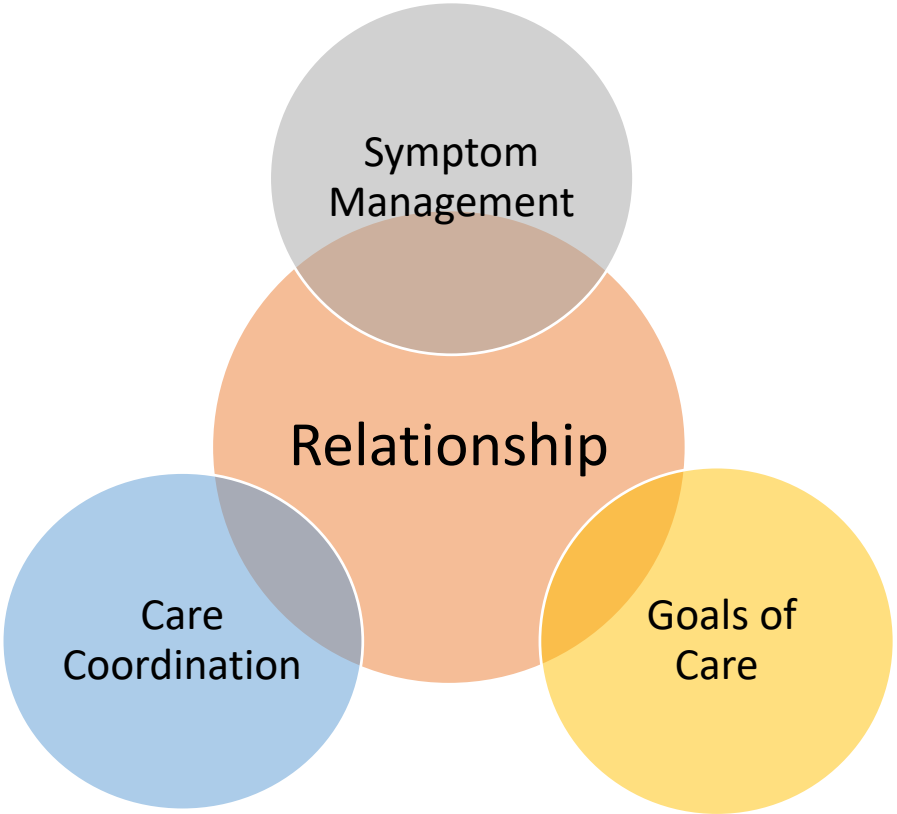
"Trauma is not just the result of major disasters. It does not happen to only some people. An undercurrent of trauma runs through ordinary life."

New York Times Opinion
The Trauma of Being Alive
By Mark Epstein
Aug. 3, 2013

Traditional Palliative Care



Safety Net Palliative Care



JAMA Oncology | Original Investigation

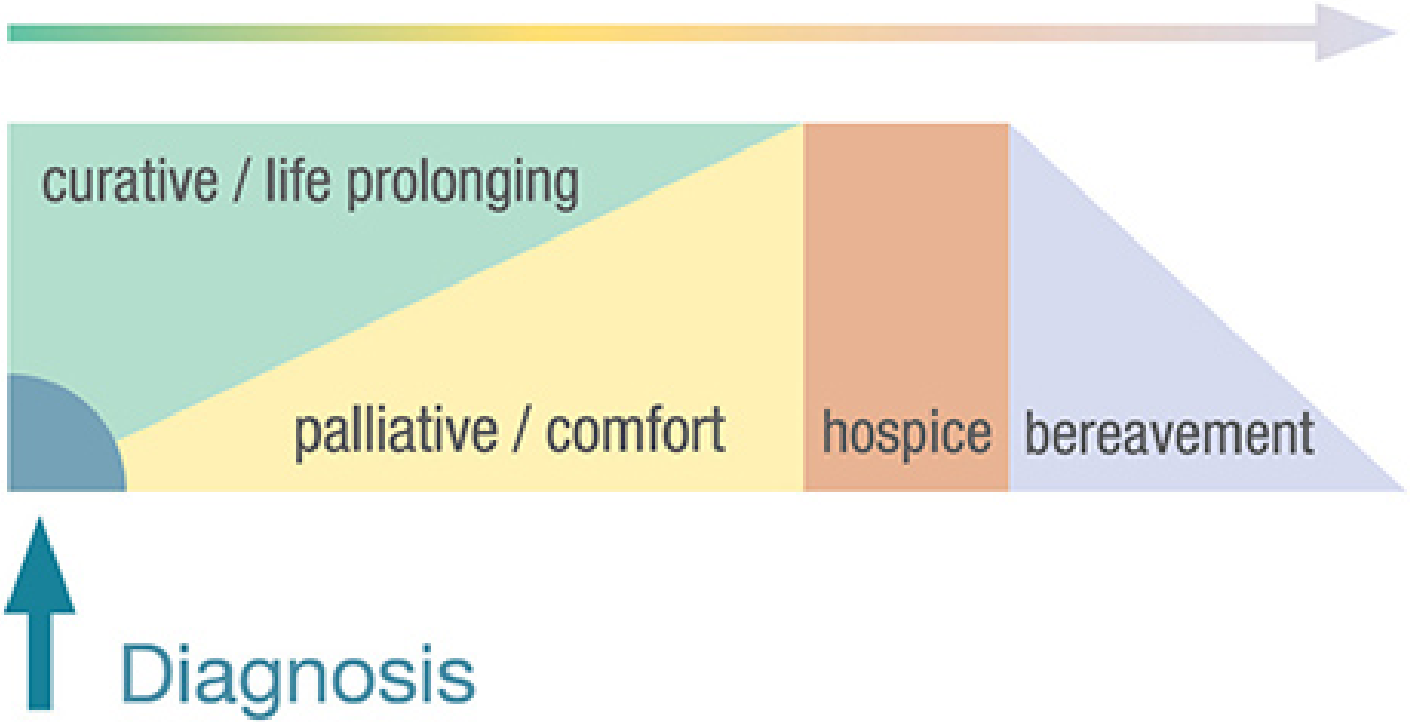
Effect of a Lay Health Worker Intervention on Goals-of-Care Documentation and on Health Care Use, Costs, and Satisfaction Among Patients With Cancer

A Randomized Clinical Trial

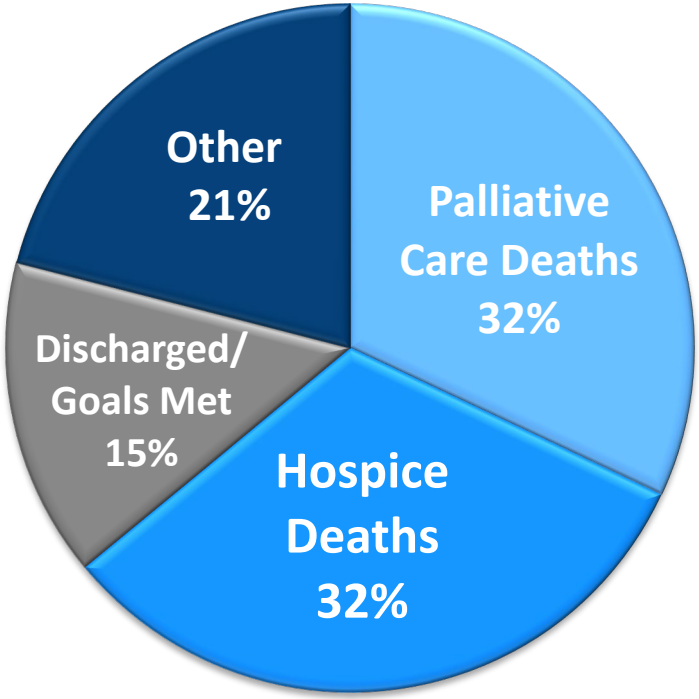
Manali I. Patel, MD, MPH, MS; Vandana Sundaram, MPH; Manisha Desai, PhD; Vyjeyanthi S. Periyakoil, MD; James S. Kahn, MD; Jay Bhattacharya, MD, PhD; Steven M. Asch, MD, MPH; Arnold Milstein, MD, MPH; M. Kate Bundorf, PhD

Geriatrics is a condition, not an age

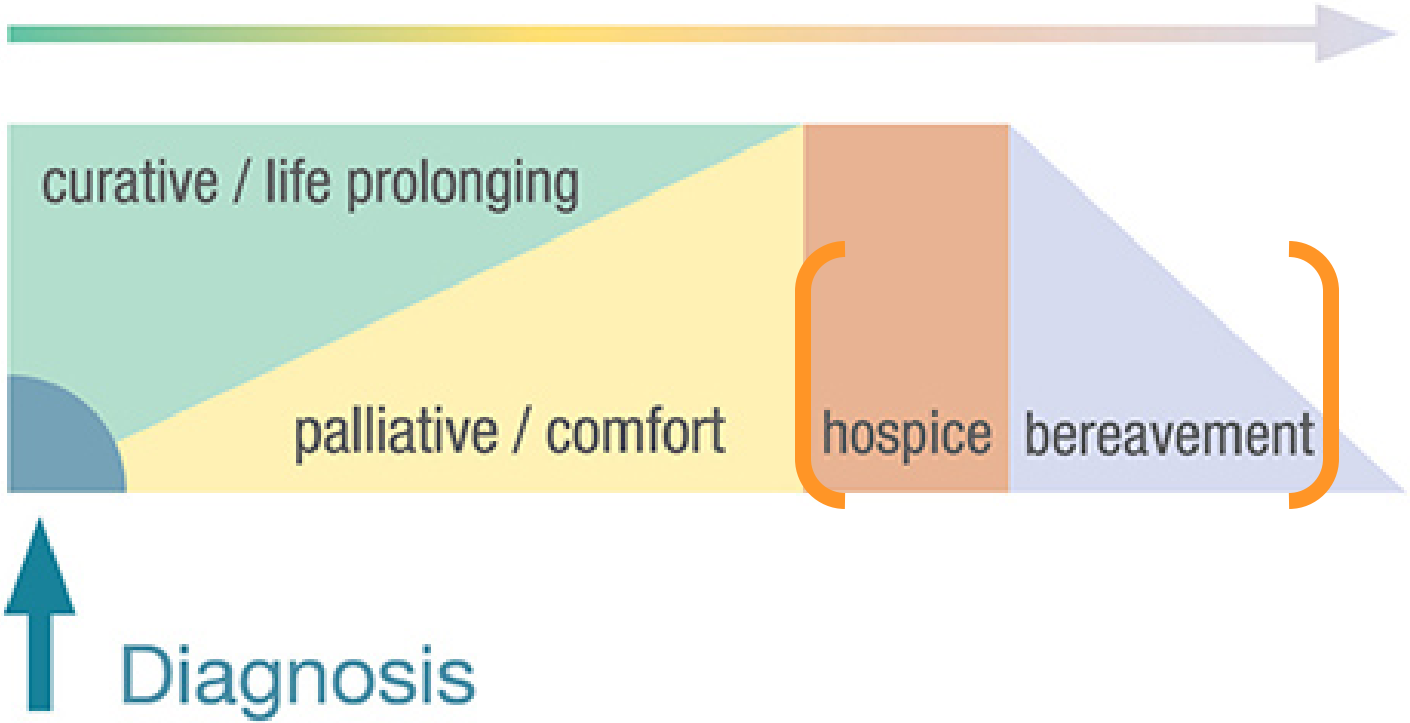
Continuum of illness



CareOregon Palliative Care Outcomes



Continuum of illness



Parallel not Sequential


LAUREEN
MARVIN
GEORGIA
BROWNIE MARY


RIDEAU


In Memory of our friends who
were loved and cared for at
The Mission Hospice. We miss you.
DAVID WRIGHT
CARL HUNTER

A person is a person because of other people

photo by david marks

Why Now

- 30% of all Americans uninsured or on Medicaid
- Lack of structures in place
- America's Essential Hospitals= 0% Margin
- Very little data to guide advanced illness strategy in this population*

2016 (https:/ /essentialhospitals.org/wpcontent/uploads/2016/06/2014-Essential-Data-OurHospitals-Our-Patients.pdf).

An Inflection Point?

- Older Minority Americans will increase by 160% compared to 59% for non-Hispanic whites in coming years
- In some urban, low income neighborhoods, the percentage of decedents receiving hospice care was less than 5%
- Opioid epidemic as palliative care access issue

Racial and ethnic disparities in palliative care. *J Palliat Med*. 2013;16(11):1329-34.

O'Mahony S, McHenry J, Snow D, Cassin C, Schumacher D, Selwyn PA. A review of barriers to utilization of the medicare hospice benefits in urban populations and strategies for enhanced access. *J Urban Health*. 2008;85(2):281-90.

Photo by Moupali Das

"For me, an area of moral clarity is: you're in front of someone who's suffering and you have the tools at your disposal to alleviate that suffering or even eradicate it, and you act."


THE HEATHMAN HOTEL

“Just how important it is to us. I am sure some of us, as patients, are not able to show our appreciation, to verbalize it. So, I'll say it for them. Don't stop.”

- Cynthia


Medscape
NATIONAL
PHYSICIAN
BURNOUT &
DEPRESSION
REPORT 2018

Overall 42%

Internal Medicine 46%

Family Medicine 47%

Original Article

Prevalence and Predictors of Burnout Among Hospice and Palliative Care Clinicians in the U.S.

Arif H. Kamal, MD, MHS, Janet H. Bull, MD, Steven P. Wolf, MS, Keith M. Swetz, MD, MA, Tait D. Shanafelt, MD, Katherine Ast, MSW, Dio Kavalieratos, PhD, Christian T. Sinclair, MD, and Amy P. Abernethy, MD, PhD

>62% Burnout

Quadruple Aim

Special Article

Building Resilience for Palliative Care Clinicians: An Approach to Burnout Prevention Based on Individual Skills and Workplace Factors

Anthony L. Back, MD, Karen E. Steinhauser, PhD, Arif H. Kamal, MD, MHS, and Vicki A. Jackson, MD, MPH

Prototype & Iterate. Don’t sink all your resources into one way.

- Anthony Back, MD

Build Bridges. We need a multi-stakeholder approach.

- Anthony Back, MD

WE HAVE MADE OVER
135,000
HOUSE CALLS

1,400
patients receiving primary & hospice care at home

The average age of our patients is **79**

We currently have **26** patients who are at least **100** years old.

20% of our patients are below age **65**.

2015

HCP WILL SERVE
1,850
PATIENTS THIS YEAR

Why are our patients at home? They are often disabled and have multiple chronic conditions making a trip to a medical clinic very taxing and difficult.

30 DAYS

Housecall Providers' patients make a third fewer return trips to the hospital within 30 days of release than does the general Medicare population.

Our team follows patients wherever they need help: at home, in the ER, at the hospital and in hospice care.

Better Care, Better Health, Delivered at a Lower Cost


CareOregon
housecall providers
bringing health care home

Advanced Illness Care (AIC) Support

The Housecall Providers Advanced Illness Care (AIC) team provides outpatient palliative care support to CareOregon members living with a serious illness.

The Advanced Illness Care team includes nurses, social workers, community health workers, a pharmacist and a chaplain who all have the flexibility to make home, clinic and hospital visits.

The AIC team works closely with patients and their health care team. focusing on the patients' goals of care, symptom management and care coordination. The team identifies and aligns additional community resources while providing support as the illness progresses.

How to describe the Advanced Illness Care program to patients

The Advanced Illness Care team will support your well-being in the home or in the clinic. They can help you manage your symptoms and help coordinate care while focusing on what is most important to you.

Enrollment considerations

Advanced illness conditions such as advanced cancer (lung, pancreatic, brain and ovarian), multiple chronic conditions (heart, lung, kidney, liver) or cognitive failure, with evidence of active decline. are appropriate for AIC referrals.

Active decline is defined as **any** of the following:

1. One hospitalization or six emergency department visits in the prior 12 months.
2. Progressive and significant decline in one or more activities of daily living (ADL) in the prior three months. ADL's are walking, eating, dressing, toileting, bathing and transferring.
3. Nutritional decline: albumin <3 g/d or 5% weight loss over six months.

To refer a patient

Call our intake specialist: **971-202-5504**

Housecall Providers

Referral and enrollment process

Housecall Providers

Patient ID & referral

Referral source: clinic, hospital, CareOregon, other

- Identify patient based on general descriptions through usual care encounters
- Discuss referral with AIC intake or team member, or submit referral directly to Housecall Providers:

  Fax: 503-416-1323

  Phone: 971-202-5504

Assessment/triage/ enrollment

Advanced Illness Care team

- Enrollment can take place in the home, clinic, hospital or community setting
- If patients do not qualify or enroll, the AIC team will coordinate with the referral source to collaborate on other available resources

Assessment/triage/ enrollment

Advanced Illness Care team

- Ongoing symptom management, education, care coordination, goals of care conversations, medication reconciliation, acute care and transitions support
- Coordination with the primary care provider, specialists and members of the health care team across the continuum of care
- Facilitation of smooth transfers to hospice or Housecall Providers primary care if appropriate


EAST STREET


IF YOU WANT TO GO FAST,
GO ALONE.
IF YOU WANT TO GO FAR,
GO TOGETHER.
- African Proverb
MOCHA.UK.COM

"**But humanity's greatest advances are not in its discoveries** – but in how those discoveries are applied to reduce inequity. Whether through democracy, strong public education, quality health care, or broad economic opportunity – **reducing inequity is the highest human achievement.**"

-Bill Gates


35
Break

Patient Medication Experiences Shaping their Care Perspective

Moving from "Medication Trauma" to “Medication Trust”

Jim Slater, PharmD
CareOregon Pharmacy

Miranda

birth: Tumultuous, violent relationship between parents, unstable housing

5 yo: Parents split, dad got "left behind"

11 yo: Lived with multiple caretakers in various locations

15 yo: First pregnancy/ birth. Stepbrother is father

18 yo: 3 children, still living in abusive household

21 yo: 3 more children born

Moves back in with mom, daily sexual abuse from stepfather

Drops out of school

Begins heavy drug use and selling

Goes to prison on drug charges

Suicide attempt

Heavy alcohol use, drug relapses, cancer, car accidents

47 yo

Age 47 – 6 Children, ages 15-32

No GED/diploma, no employment

In recovery from severe substance use

Chronic pain, cancer, multiple surgeries; no teeth or dentures – Multiple psychiatric medications


Life
Trauma

Medication Trauma

Medication Complexity

1:7


EMOTIONAL DISTANCE
POST-TRAUMATIC STRESS DISORDER
IRRITABILITY
INSOMNIA
HYPER-VIGILANCE
ANXIETY
TERRIFYING EVENT
UNCONTROLLABLE THOUGHTS
FLASHBACKS
IMPATIENCE
JUMPY
PTSD
ABUSE
DRUGS ABUSE
MENTAL HEALTH
VETERAN
NERVOUS
NIGHTMARES
ON EDGE
VICTIM
FEAR
WITNESSING TRAUMA
ALCOHOL ABUSE
PSYCHOTHERAPY

1:20


The
Silent Killer

Medication Muddle

- High medication burden
- Low health literacy
- Little time/support

Confusion

- Multiple prescribers
- Don’t know why they’re taking it – **Indication/purpose often not spelled-out on label**
- Too many medications
- Unsure how to have the conversation
- Feel rushed – miss opportunity

A Human-Centered Design Solution

Members needed a tool to use with their healthcare provider or caregiver to discover:

- What do you want us to know?
- What is important to you?
- What would you like to work on?
  - **Let your voice be heard**

MEDS™ My Easy Drug System™ (MEDS) Chart

Name: _____

Date: _____

Primary Doctor: _____

Any Allergies? _____

Which					
HYDROCO OPHEN					
SIMVASTA TIN					
LEVOTHYROXINE SODIUM					
DICLOFENAC SODIUM DR					
NEOMYCIN/POLYMYXIN/DE XAME					
TESTOSTERONE CYPIONATE					
CYCLOBENZAPRINE HCL					
VALACYCLOVIR HCL					

If you have marked a ☹ next to any of your medications, get in touch with your doctor or pharmacist to talk about your options.

If you have marked a ☹ next to any of your medications, get in touch with your doctor or pharmacist to talk about your options.

How Do You Feel About Your Medications?

Why I take this	How do I feel about it?	Notes
Anxiety	◉ 😊 ○ 😐 ○ ☹	Helps me feel calmer
High blood pressure	○ 😊 ○ 😐 ◉ ☹	Makes me itch
Diabetes	○ 😊 ○ 😐 ◉ ☹	Makes me too sleepy

An MI Toolkit: “Drive-by MI”

READINESS RULERS

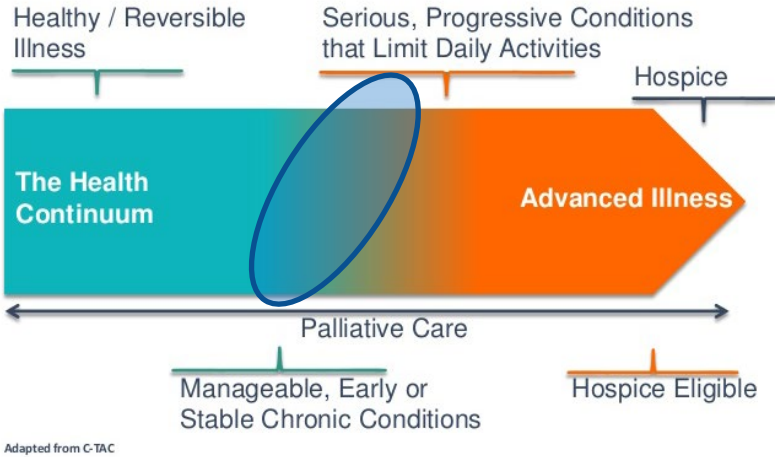
Readiness rulers are a tool designed to elicit change talk. Use them to explore the importance clients attach to changing, and their confidence and readiness to change (on a scale of 1 to 10). “On a scale of 1 through 10, how important is it for you to quit smoking?” “On the same scale, how confident are you feeling about your ability to quit?”

1	2	3	4	5	6	7	8	9	10

Low importance/confidence: **Extremely important/Confident**

Why I take this	How do I feel about it?	Notes
Anxiety	◉ 🙂 ○ 😐 ○ ☹	Helps me feel calmer

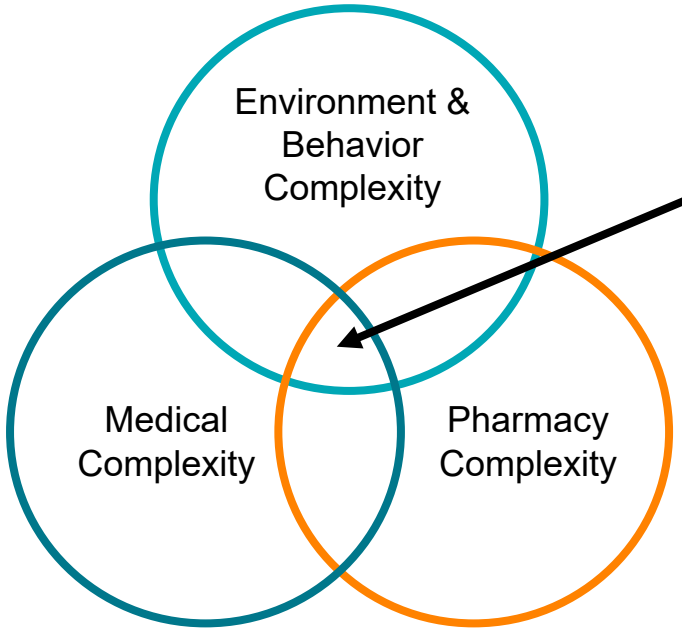
Where is the patient in Their Journey?



Goals of care defines amenable risk

Amenable – Gem

Social Worker
Behavioral Health Specialist

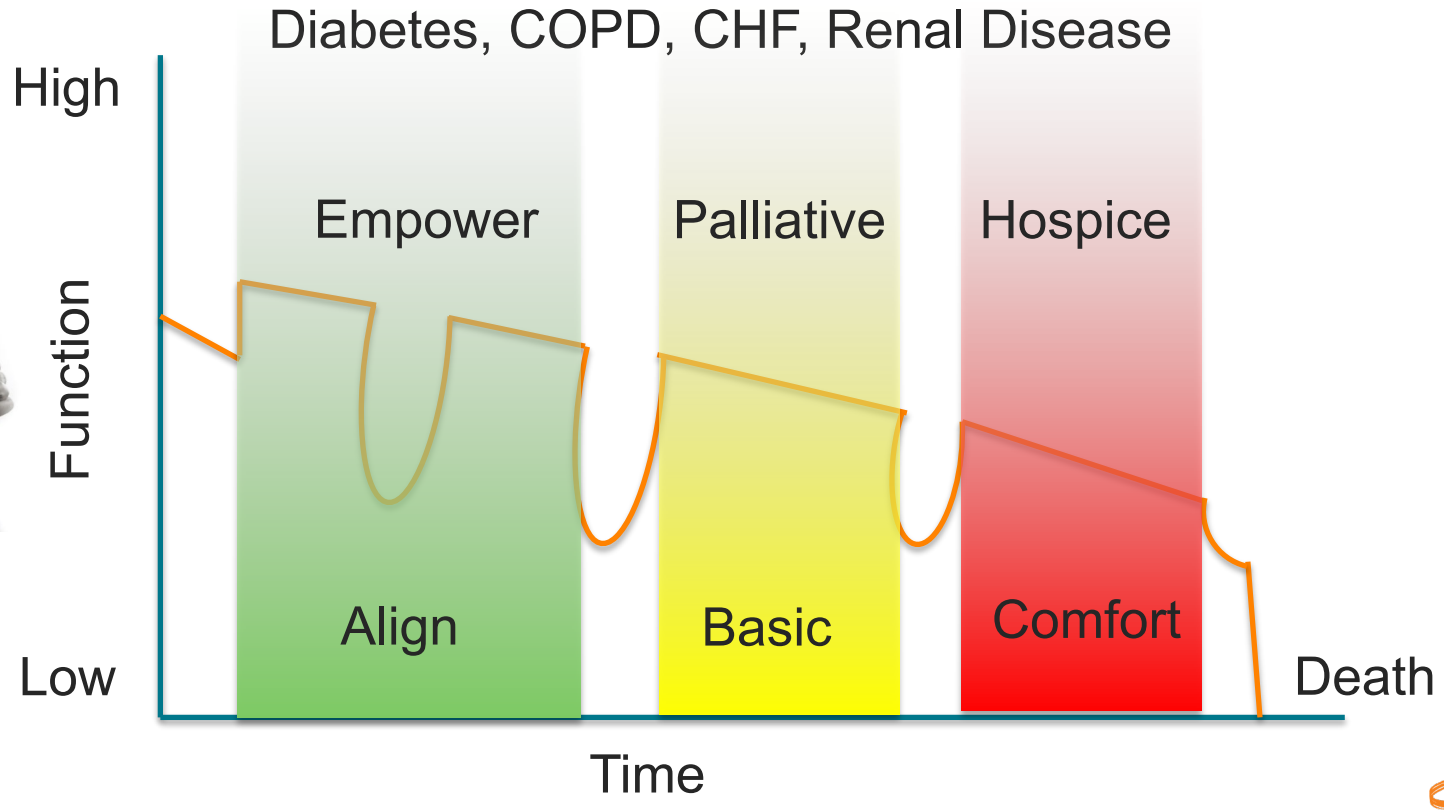


Goals of Care Alignment

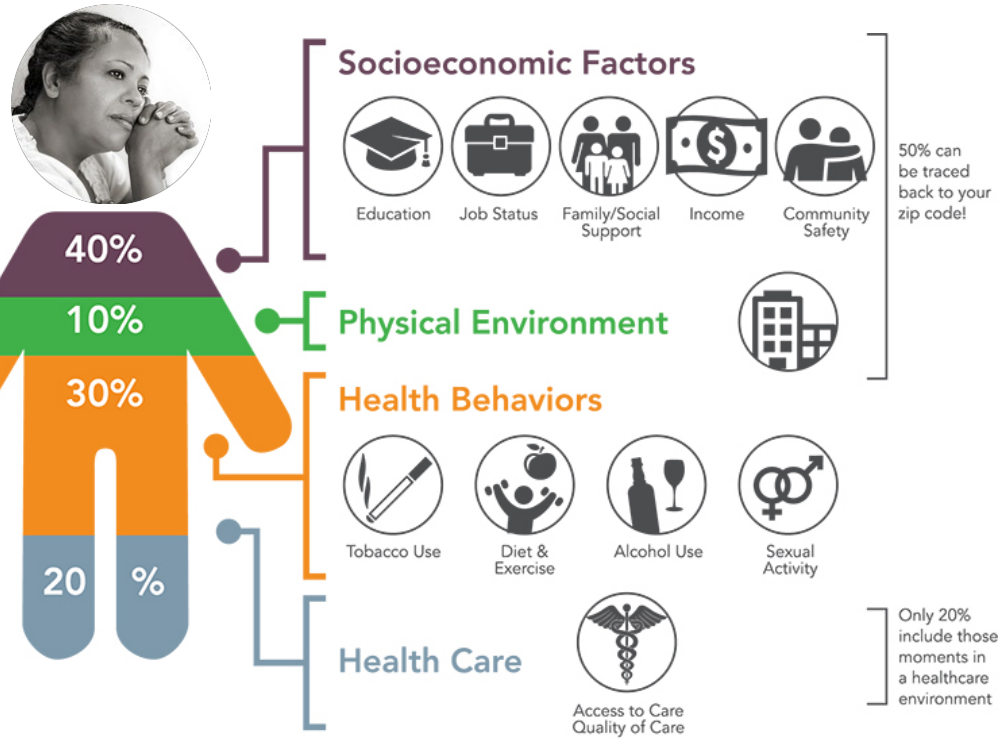
Nurse

Pharmacist

Supporting Serious Conditions



Remember The Whole Person



Source: Institute for Clinical Systems Improvement, Going Beyond Clinical Walls: Solving Complex Problems (October 2014)

Affirmation > Experience > Coordination > Compliance

Past

Affirmations

- I am an artist
- I quit smoking
- Worked as a lifeguard

Trauma

- Childhood abuse
- Death of Parent
- Overdose

Present

Medication Experience

- “This medication matters most to me.”
- “I hate this medication.”

Life Gaps

- “I cannot do this.”
- “I can do this.”
- “I wish I could do more of this.”

Future

Goals

(I would like to start…)

- Start painting again
- Plant a garden
- See my grandson

Goals

(I would like to stop…)

- Taking so many pills
- Drinking
- Feeling sad

Goals of Care Pearls

- Focusing on relationship first
- Provide adequate time to listen
- Seek patient point of view
- Allow patients to reveal their emotions
- Seek context (home visits, clinic visits, friend or caregiver input)
- Give the patient a sense of team support

MI helps resolve ambivalence…

…helping elicit a person's own motivation to change

Using MI is like giving water to the seed of motivation **The seed is already there**

- The only real water and sun is what the patient says and believes
- After they leave, the seed sprouts

A non-motivational, directive approach stamps dry dirt down over the seed, suffocating it

- Natural tendency to push back
- Status quo statements are believed

Traditional Counseling

- Advice given, patient expected to listen, follow instructions.
- Can increase resistance to change.
- Makes patient defensive.

Motivational Interviewing

- Patient does most of the talking.
- Help patient understand their own motivation for change.
- Patient is the expert on their personal circumstances.

Close-ended

- Do you have any questions about your medications today?
- Do you realize that smoking threatens your health?
- Do you think you can make this change?

Open-ended

- What questions can I answer for you about your medicine today?
- What do you think it would be like if you weren't a smoker anymore?
- Why do you think it might be time to quit?

What is Change Talk?

“I wish I could” **“I will”**

“I want to change” **“The reasons are…”**

“I can” **“It would solve so many problems if…”**

Evoking Change Talk

Any of these kinds of conversation or statements.

Speech that favors movement in the direction of change.

Discover Change Talk

When patients verbalize their own thoughts about change.

- **Desire** – “I wish I could exercise more often.”
- **Ability** – “I can walk around the block 2x/ day.”
- **Reasons** – “I know quitting smoking will lower my risk of getting cancer.”
- **Need** – “I need to quit smoking or my relationship with my kids will be ruined.”
- **Commitment** – “I **will** use a pillbox so I can make sure to take my meds twice a day.”
- **Taking Steps** –

  “I actually went out and…”

  “This week I started…”

  “I walked up the stairs today instead of taking the elevator.”

  “I went all last week without stopping by McDonalds.”

Develop Discrepancy

- Discrepancy helps people see the gap between where they are and where they want to be.

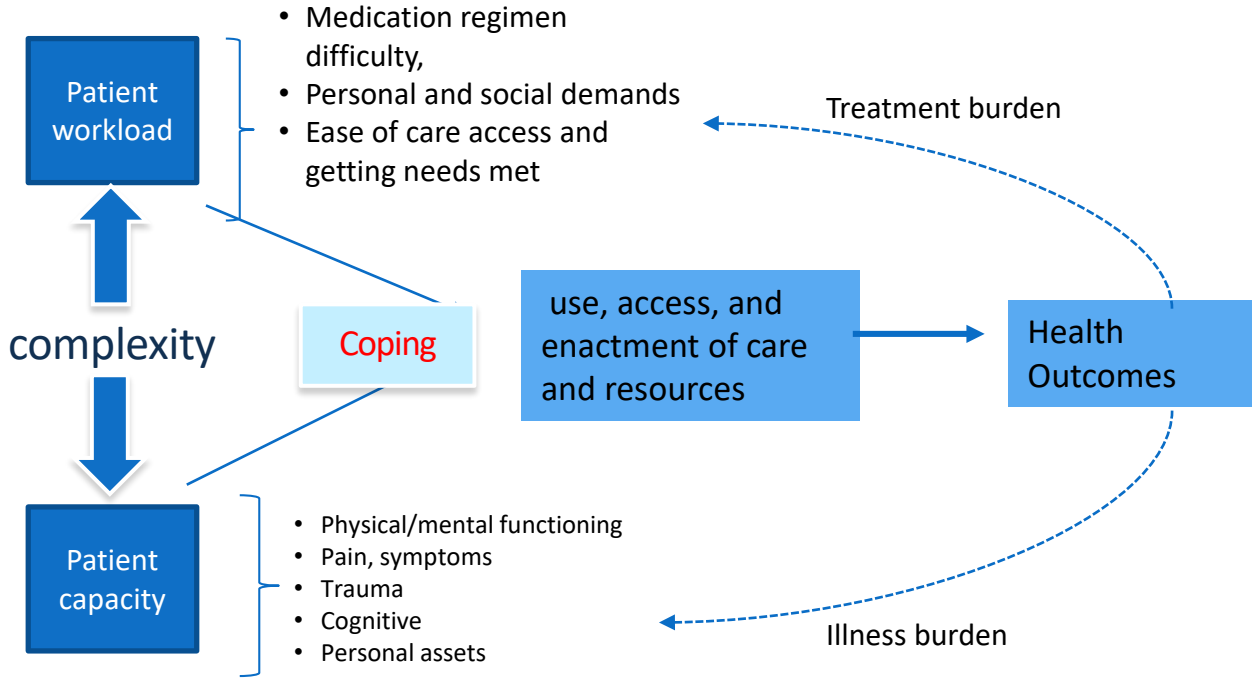
- Seeing a discrepancy between their values/beliefs and the reality of their current behavior, they are more likely to want to resolve that discrepancy.

Current Behavior

Values Beliefs

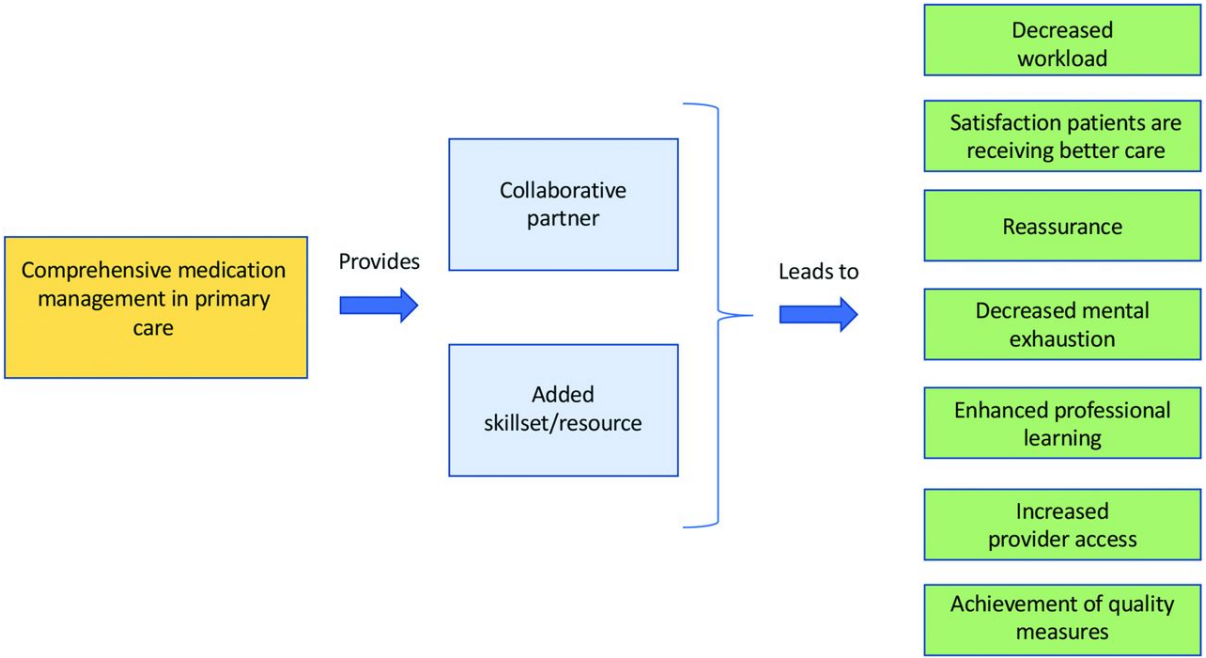
Who helps “amenability”?

Complexity Model



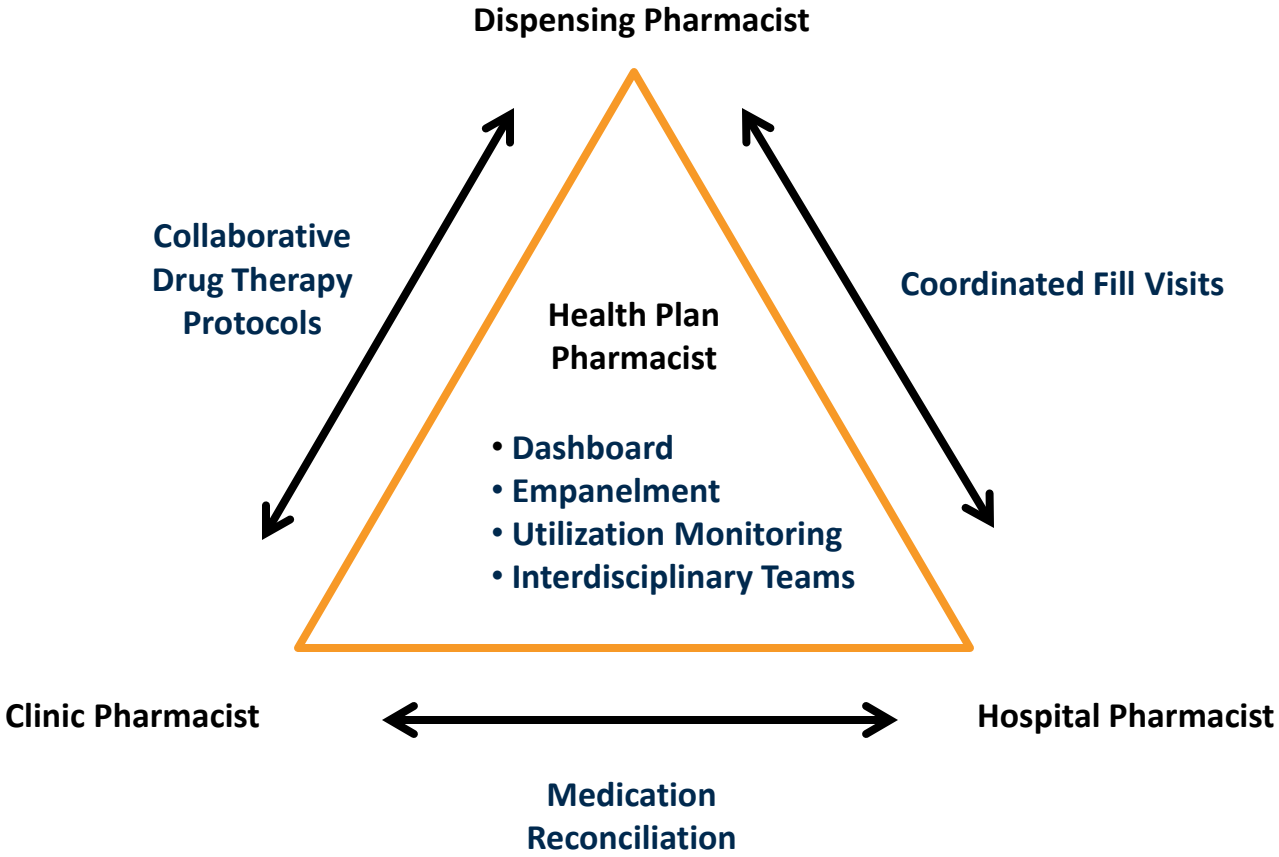
N.D. Shippee et al. / Journal of Clinical Epidemiology 65 (2012) 1041–1051

Amenability Helps Providers

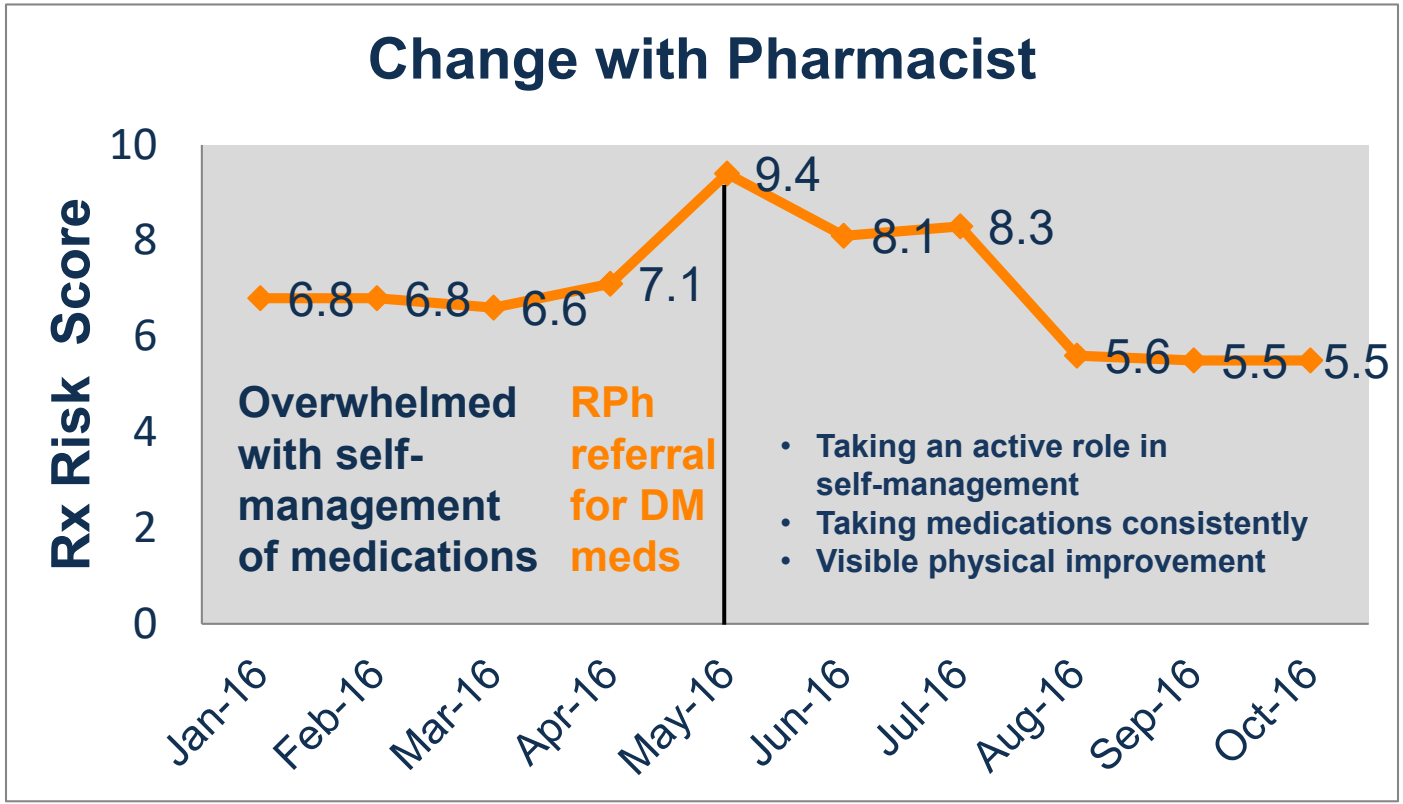


Source: https://www.jabfm.org/content/jabfp/32/4/462.full.pdf

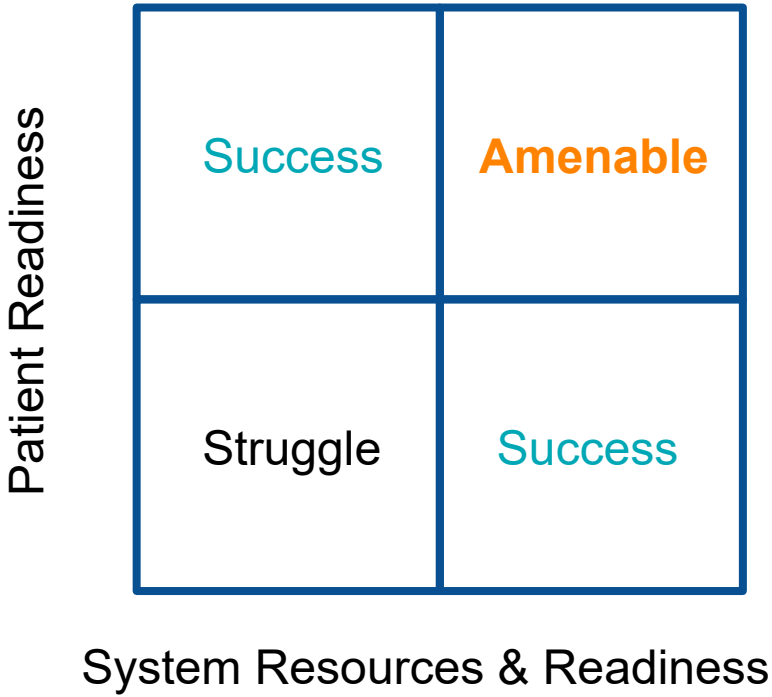
Who Helps “Amenability”



Medication Trauma Profile



Amenable – Triage



CareOregon Amenability Strategies

- Population
  - Segment to provide services in the right way
  - Work with people in “their context”
  - Find patterns ready for change
- Patient
  - Relationships to create dignity and belonging
  - Tools to engage and empower patients
  - Equity and Diversity
- Partnerships
  - Multidisciplinary
  - Regional specific
  - Create “Readiness-to-change” opportunities

Amenable – Pearls

- Avoid “medicated” a non-medical problem
- Healing is an experience of:
  - Hope
  - Belief
  - Trust
  - Relationship
  - Time
- Rx: Caring Conversations
- Deprescribe/Simplify
  - Less is more

Start with Empathy
End with Empowerment

- Build rapport and trust – best path to buy-in
- Listening is more powerful than fixing
- Find out “What Matters to Them?” to land on their goals of care
- Use the MEDS Chart to reveal how they feel about their medications
- Get trained in motivational interviewing
- Partner in their journey to “Hope & Healing”

The Power of Hope & Healing

The Nuts and Bolts of Deprescribing

Leah Goeres, PharmD., MPH, BCPS
Advanced Illness Care Pharmacist
CareOregon / Housecall Providers

Housecall Providers

So Many Steps!

Form Relationships

- Long medical histories
- Complex social situations
- Understanding their current care team (PCP, caregiver etc..)
- Ask about their pets! Seriously!

Miranda

birth: Tumultuous, violent relationship between parents, unstable housing

5 yo: Parents split, dad got "left behind"

11 yo: Lived with multiple caretakers in various locations

15 yo: First pregnancy/ birth. Stepbrother is father

18 yo: 3 children, still living in abusive household

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Moves back in with mom, daily sexual abuse from stepfather

Drops out of school

Begins heavy drug use and selling

Goes to prison on drug charges

Suicide attempt

Heavy alcohol use, drug relapses, cancer, car accidents

47 yo

Age 47 – 6 Children, ages 15-32

No GED/diploma, no employment

In recovery from severe substance use

Chronic pain, cancer, multiple surgeries; no teeth or dentures – Multiple psychiatric medications

Medication Beliefs or Healthcare Beliefs

- How is this different from Motivational Interviewing?
  - Consensus of reality
  - A change in medication vs. a change in behavior

Medication Beliefs or Healthcare Beliefs

Which medication/s are most important or helpful to you?

- Pain medicine
- Anxiolytic
- N/V medicine
- Oral chemotherapy
- Warfarin

Courtesy of:
Dr. Sean Jeffery, PharmD.

Medication Beliefs or Healthcare Beliefs

Which medication/s cause/s you the most trouble?

- Can’t identify
- Sometimes they list a medicine that’s not covered by insurance or have trouble getting
- Medications they perceive aren’t working
- Medications that upset their tummy

Courtesy of:
Dr. Sean Jeffery, PharmD.

Medication Beliefs or Healthcare Beliefs

Are you able to afford or obtain all your medications?

- Gain insight into how they manage regimen
- Gain insight into how “resourced” they are

Courtesy of:
Dr. Sean Jeffery, PharmD.

Medication Beliefs or Healthcare Beliefs

How do you feel about taking “X” number of medicines?

- Often met with ambivalence (pros = cons)
- Sometimes met with confidence -Assess self efficacy here-
- Occasionally they feel like they feel burdened

Courtesy of:
Dr. Sean Jeffery, PharmD.

Medication Beliefs or Healthcare Beliefs

What are your goals for your healthcare?

- Live as long as possible
- Housing/feel safe
- Stay out of hospital/ED
- Go to movies, spend time with friends
- Go to café with spouse

Courtesy of:
Dr. Sean Jeffery, PharmD.

So Many Steps!

- Form relationships
- Assess medication-beliefs
- Focus on goals
- Understand functionality and risk factors
- Review Medications

Focus on Goals

So, if I start working on one medication-problem today, which problem is most important to you?

- Pain
- Disease-altering medication
  (e.g. Daliresp; e.g. Kalydeco)

Pharmacy's Role in Palliative Care

- Form relationships
- Assess medication-beliefs
- Focus on goals
- Understand functionality and risk factors
- Review Medications

Functionality and Risk Factors

Risk Assessment

- ☐ Age ≥ 65 years
- ☐ Multiple prescribers
- ☐ ≥ 10 medications
- ☑ Cognitive impairment
- ☑ At risk for falling
- ☐ Tethers (O_2)
- ☐ Decreased renal function
- ☑ At risk for delirium
- ☑ Unstable home/social situation
- ☑Low health literacy
- ☑ Language Barrier
- ☑ Substance Use Disorder

Functionality and Risk Factors

Risk Assessment

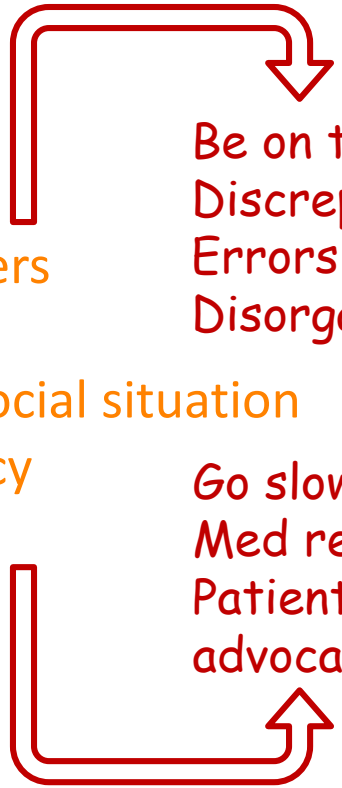
☑ Age ≥ 65 years

Be on the look out for:

- Cognitive decline
- Delirium
- Beer's list drugs
- Pain
- Declining physical function
- Falls
- Medical complexity
- Polypharmacy
- Unsafe home environment
- Isolation

Risk Assessment

- ☑ Multiple prescribers
- ☑ ≥ 10 medications
- ☑ Unstable home/social situation
- ☑ Low health literacy
- ☑ Language Barrier



Be on the look out for:
Discrepancies
Errors
Disorganization

Go slow
Med review will take longer
Patient may need an advocate or interpreter

Functionality and Risk Factors

Risk Assessment

- ☑ Age ≥ 65 years
- ☑ ≥ 10 medications
- ☑ Cognitive impairment
- ☑ Tethers (O_2, NG tube, etc…)
- ☑ Decreased renal function
- ☑ At risk for delirium

Delirium risk factors

Hx of delirium, CNS acting medicines, benzodiazipines

Functionality and Risk Factors

Risk Assessment

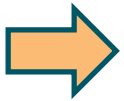
☑ At risk for falling
☑ Tethers (O_2)
☑ Unstable home/social situation

Risk factors for falls

Previous falls, medications that are sedating or affect balance, gait problems

Pharmacy's Role in Palliative Care

- Form relationships
- Assess medication-beliefs
- Focus on goals
- Understand functionality and risk factors



Review Medications

Review Medications

- Do you have a systematic approach?
- Describe you current process…..

…use of structured guide: lead to a larger reduction in PIMs than non-structured activities (e.g. general review by pharmacist or physician)

Scott, I., Anderson, K., & Freeman, C. (2017). Review of structured guides for deprescribing. European Journal of Hospital Pharmacy. Science and Practice, 24(1), 51. http://dx.doi.org.libproxy.boisestate.edu/10.1136/ejhpharm-2015-000864

Review Medications – Tools – What to Stop

Beers Criteria - 2019 Update

- 70 changes from 2015 version

Removed

- H2 blockers

2019 additions

- Cipro and SMX-TMP
- Glimepiride
- Tramadol
- ASA for primary prevention if > 70
- Rivaroxaban

Review Medications – Tools – What to Stop

STOPP/START

- The European version of Beers.
- Includes indicators of possible under treatment.
- Prevalence of PIMs using STOPP/STAR T in primary care
- Potentially inappropriate prescribing (STOPP) 21.4%
- Potential prescribing omissions (START) 22%

Br J Clin Pharmacol. 2009 Dec;68(6):936-47

Good Palliative Geriatric Practice (GPGP)

- Study in older adults used tool to stop 58% of medications
- 2% of drugs needed to be restarted
- 88% of participants reported an improvement in global health

Arch Intern Med. 2010 Oct 11;170(18):1648-54

Review Medications – Tools – How to Stop

Deprescribing.org- Mobile App

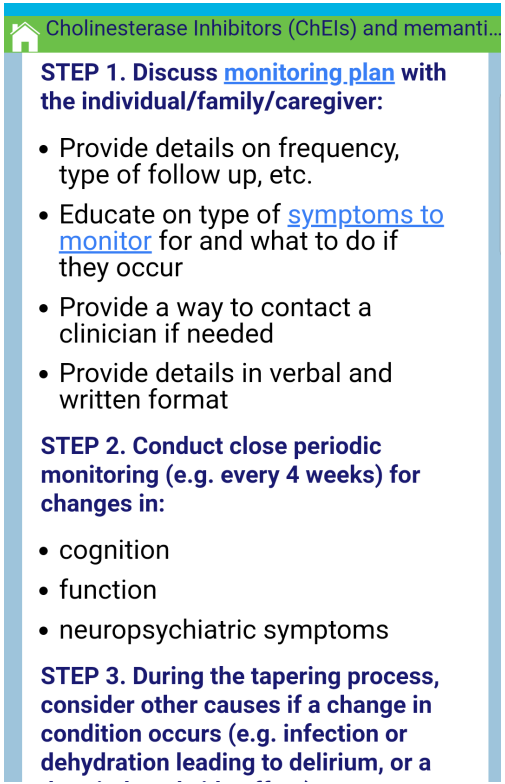
Four evidence-based deprescribing guidelines and algorithms

Produced through the leadership of the Bruyère Research Institute and the Ontario Pharmacy Evidence Network

Review Medications – Tools – How to Stop Deprescribing.org

Only select classes of medications

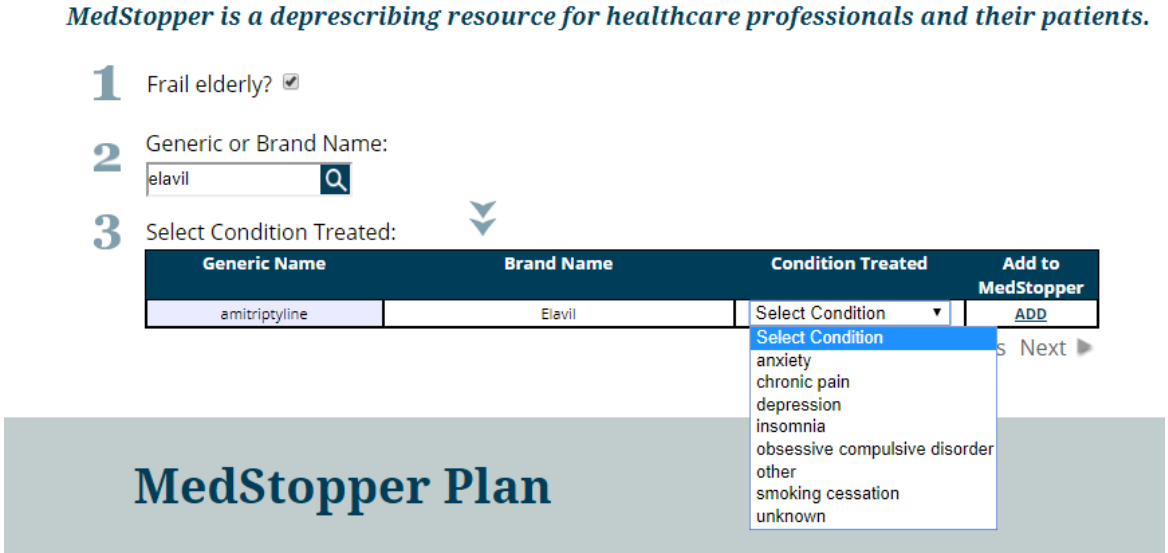
- Benzos
- PPI
- Antipsychotics
- Dementia drugs
- Antihyperglycemics



Review Medications – Tools – What/How

Medstopper.com

- Web-based tool developed in Canada
- Prioritizes meds for discontinuation
- Provides both Beers and STOPP/START justification for recommendations

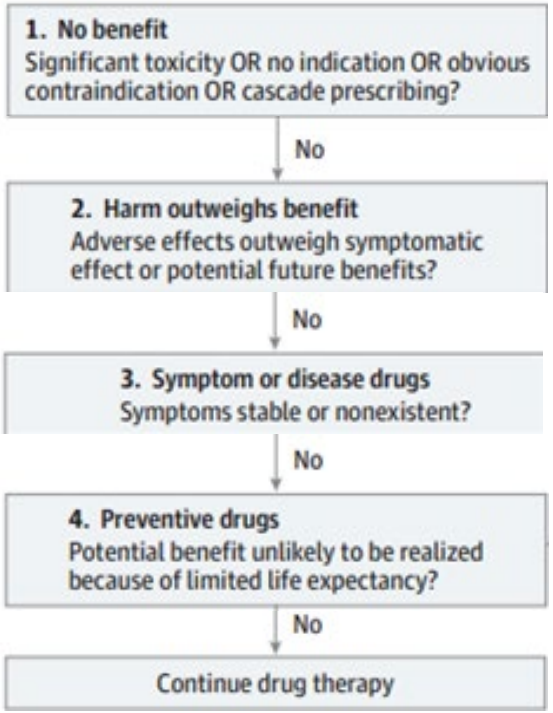


Review Medications – Tools – Medstopper.com

Stopping Priority RED=Highest GREEN=Lowest	Medication/ Category/ Condition	May Improve Symptoms?	May Reduce Risk for Future Illness?	May Cause Harm?	Suggested Taper Approach	Possible Symptoms when Stopping or Tapering	Beers/STOPP Criteria
	amitriptyline (Elavil) / Tricyclic antidepressant / **insomnia**				If used daily for more than 3-4 weeks. Reduce dose by 25% every week (i.e. week 1-75%, week 2-50%, week 3-25%) and this can be extended or decreased (10% dose reductions) if needed. If intolerable withdrawal symptoms occur (usually 1-3 days after a dose change), go back to the previously tolerated dose until symptoms resolve and plan for a more gradual taper with the patient. Dose reduction may need to slow down as one gets to smaller doses (i.e. 25% of the original dose). Overall, the rate of discontinuation needs to be controlled by the person taking the medication.	cramping, diarrhea, nausea, sweating, hot or cold flashes, headache, dizziness, flu-like symptoms, fatigue, anxiety, restlessness, trouble sleeping, vivid dreams, tremors, muscle aches, confusion, pounding heart (palpitations), unusual movements, mood changes	Details

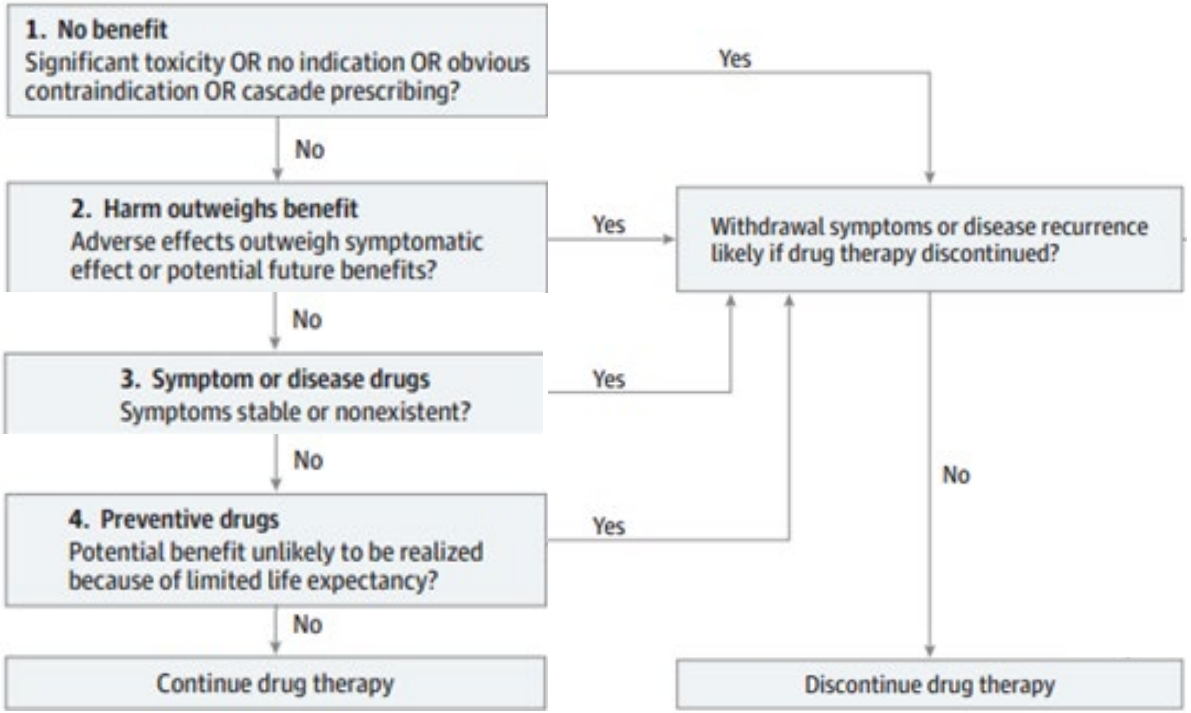
My Preferred Algorithm in Palliative Care…

Review Medications



JAMA Intern Med. 2015 May;175(5):827-34

Review Medications



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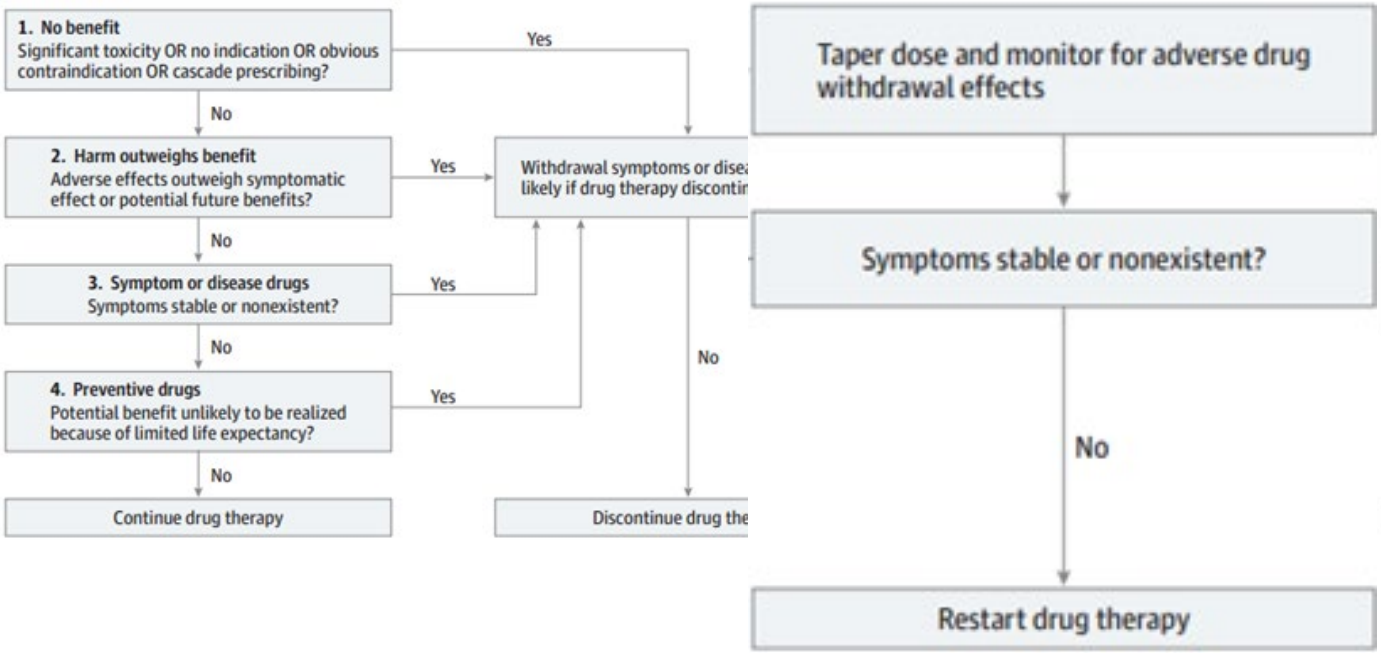

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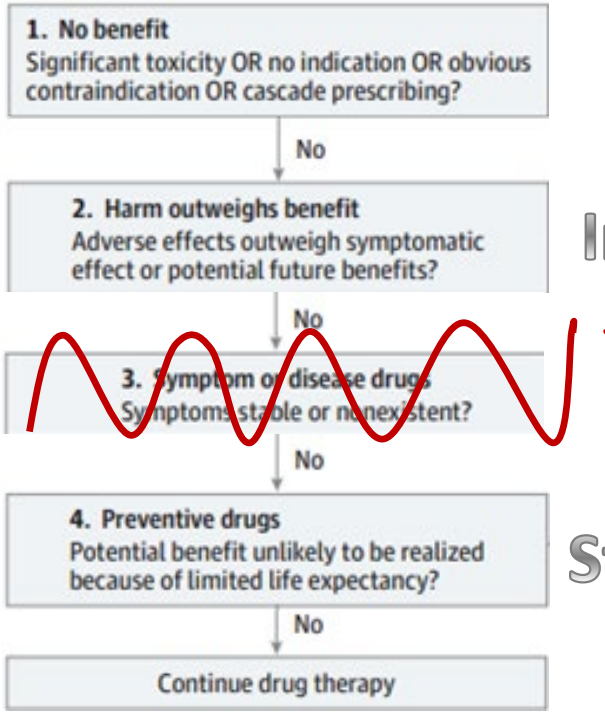
Review Medications



Insulin, Donepezil

Symptoms/disease not stable

Statins, Bisphosphonates

CDC Guideline for Prescribing Opioids for Chronic Pain 2016

Intended for: primary care clinicians treating chronic pain for patients 18 and older

Not intended for:

- patients in active cancer treatment
- patients experiencing acute sickle cell crises
- patients experiencing post-surgical pain
- Patient using/needing MAT

CDC Guideline for Prescribing Opioids for Chronic Pain 2016

- The recommendation statement does not suggest discontinuation of opioids already prescribed at higher dosages.
- The Guideline does not support abrupt tapering or sudden discontinuation of opioids.
- The Guideline strongly recommends offering medication-assisted treatment for patients with opioid use disorder.

N Engl J Med 2019; 380:2285-2287

Why is Deprescribing So Difficult?

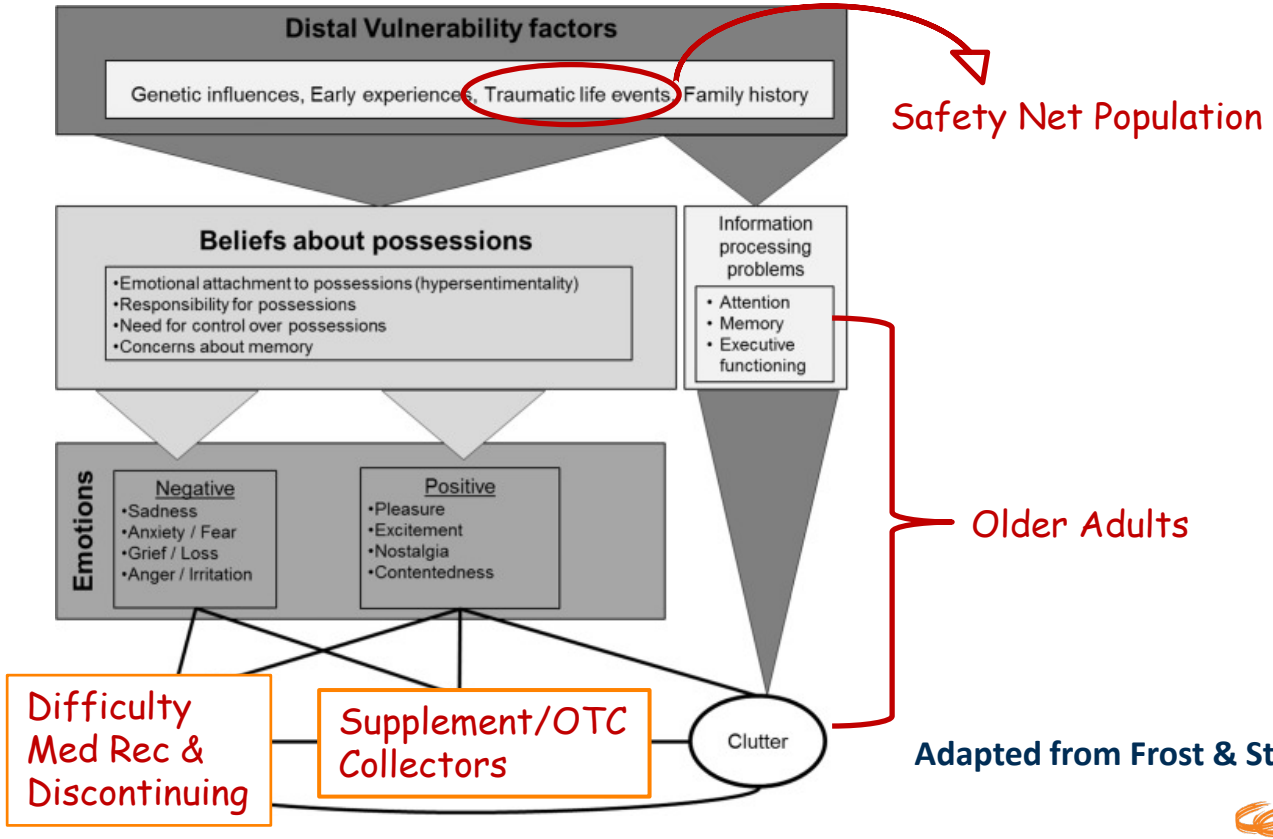
careoregon.org

Distal Vulnerability factors

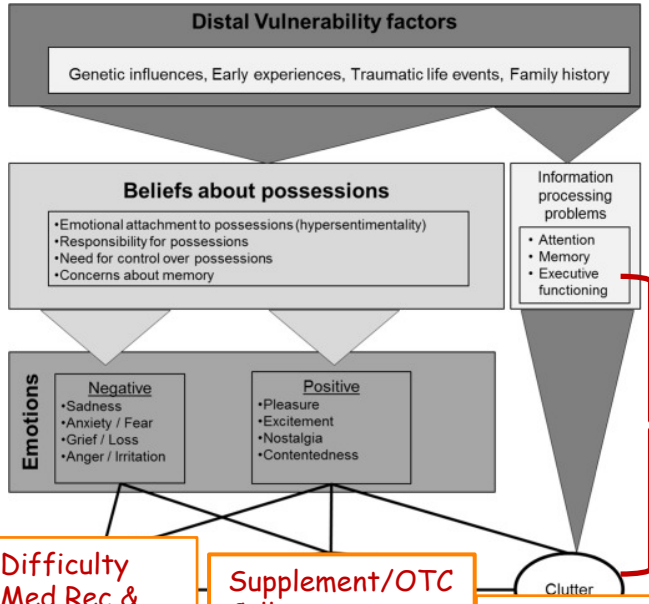
Genetic influences, Early experiences, Traumatic life events, Family history

Adapted from Frost & Steketee

Understanding Hoarding Behaviors



Intervening on Hoarding Behaviors



♦Build Trust
♦ Get buy-in
♦ Reinforce locus of control

Older Adults

Difficulty Med Rec & Discontinuing

Supplement/OTC Collectors

♦ Organize
♦ Educate
♦ Sequester
♦ Label

♦Focus on safety measures
♦Falls -> clear path
♦LTC pharmacy
♦Higher level of care (ALF)

Limitations of Hoarding Model

- Opioid dependence
- Benzodiazepine dependence
- Certain amount of reasoned action (adapting to a low resource environment)

Take-aways

- Don’t expect much palliative care to happen without first establishing a relationship
- Target questions to find out what is important to patient, then use that to tailor therapy
- Use a systematic approach to reviewing or stopping medications
- Expect that deprescribing will be very difficult in certain patients
  -patients have autonomy and you don’t need to feel guilty about it


35
Break

Population Health and Care Management Strategies

Leveraging Data, Technology and a Multi-Pronged Approach to Target Care Coordination Efforts

Karissa Smith, LPC, CADC I
Director of Care Coordination
Population Health Partnerships
CareOregon

Home of the Regional Care Teams

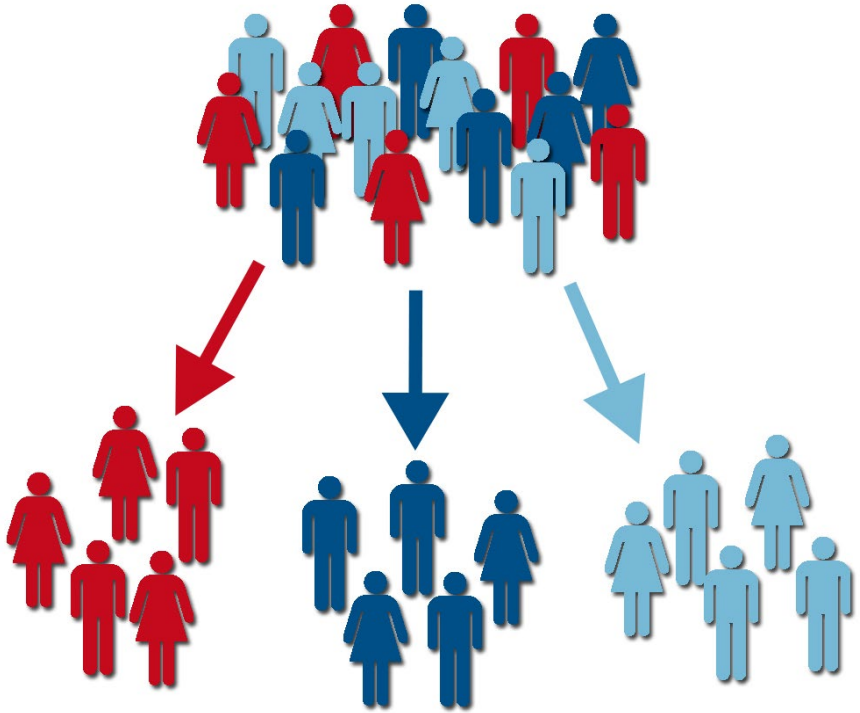
Supporting Regional Leadership			Direct Member Support/ RCT		
Health System & Community	Delivery System	Population Health Management	Telephonic	Hospital	Clinic/Home
CBO Support / Partnership Bldg	Cost & Utilization	Population Segmentation	HCC ENCC RN Triage Coord	TCO Specialist	HRS TCO RN Housing CM
SDOH / Comm. Equity	Clinical / Comm. Partnership	Identified sub pop. work	RCP, RCT, SNF, BH referrals	Transitions post discharge	Social Determinant PCP align
Sys Lvl Involvement	Inform Strategies	Quality	Community Partners referrals	PCP collaboration	Pharm Med Rec

Population Data, Health Equity, Trauma Informed

How Care Coordination and Population Health Strategies may Impact Miranda

Using Data to Segment our Population

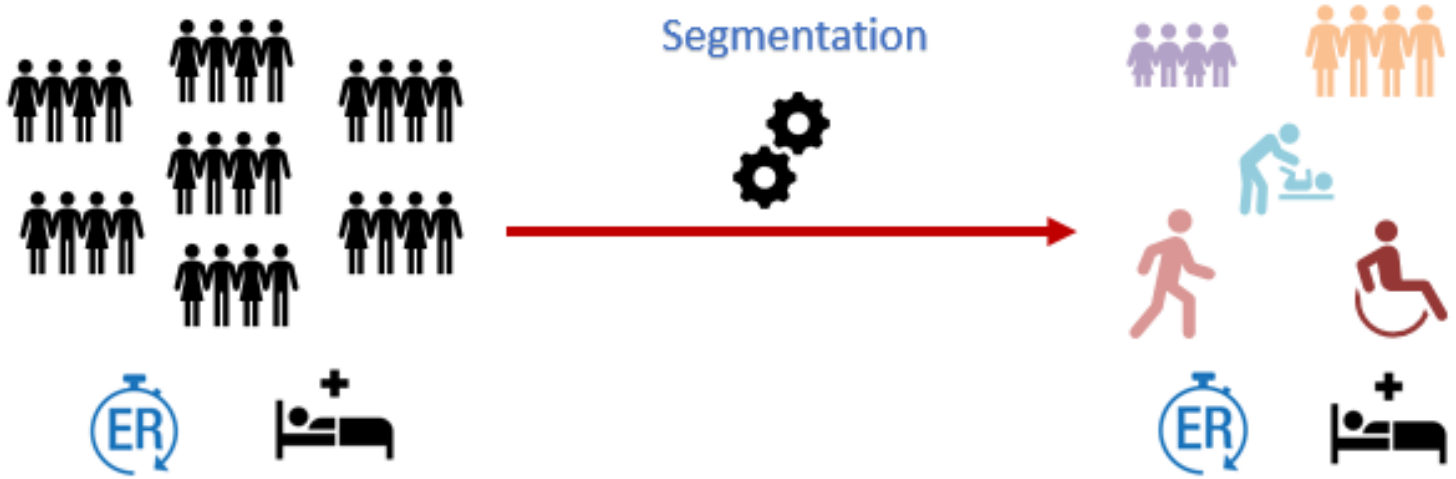
What is Segmentation?



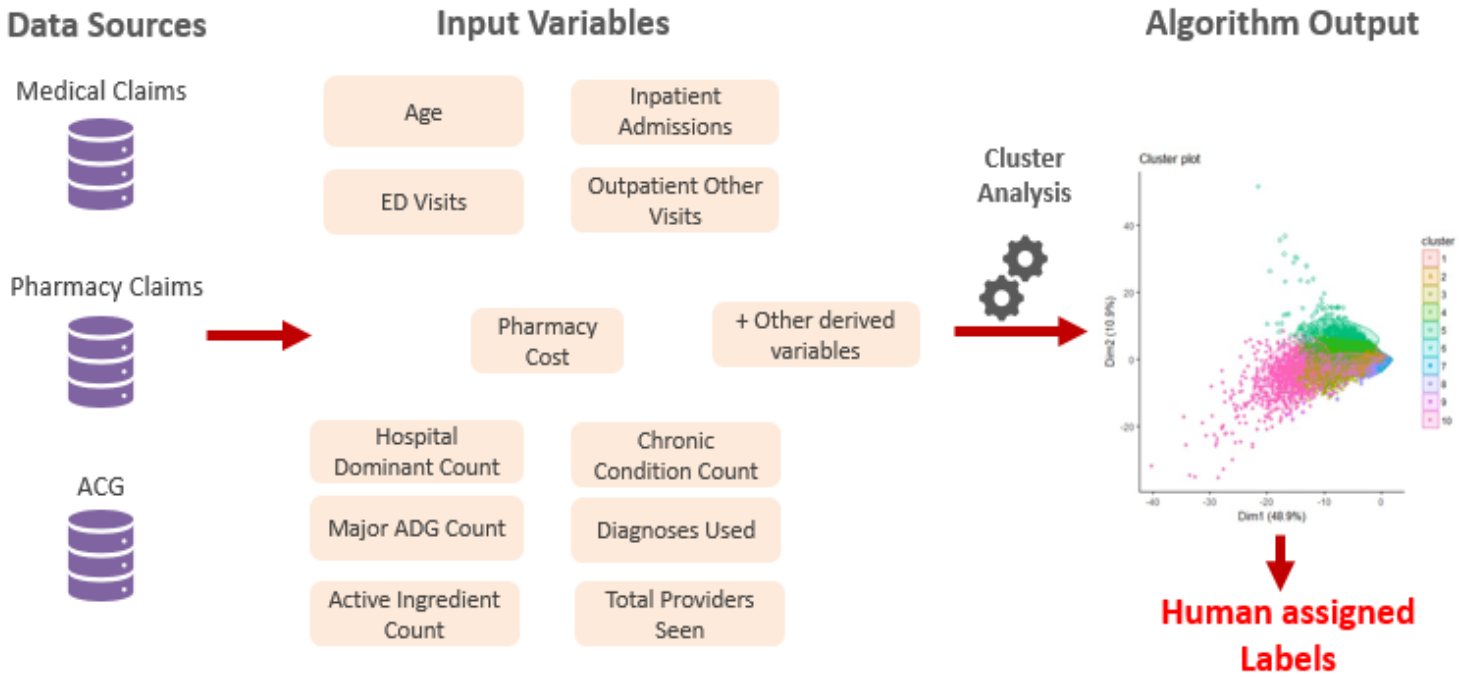
Why Segment Your Population?

- Understanding our population based on specific patterns/behaviors/needs
- Inform resource allocation to address those specific needs
- Observe population level trends over time (are members collectively getting more healthy, more sick, etc.)
- Identify member-level trends by provider/clinic to inform opportunities for quality improvement and support
- Proactively outreach our at-risk members to improve health outcomes

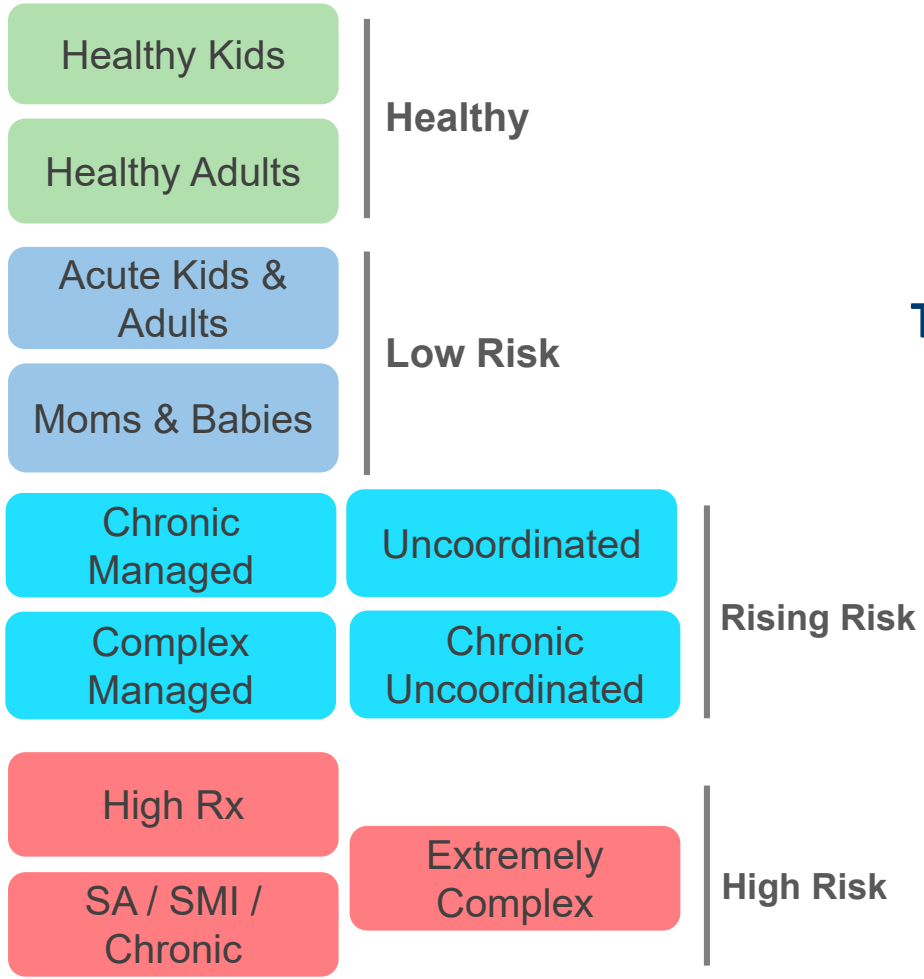
Why Segment Your Population?



Development of Our Segmentation



Segments



Total CareOregon Population

Understanding the Segments: Healthy

Healthy Kids

- No pattern of conditions
- Minimal Healthcare Utilization
- $ 219
- Focus on well visits and prevention

Healthy Adults

- 31 years
- Minimal Healthcare Utilization
- $ 1,000
- Focus on well visits and prevention

Understanding the Segments: Low Risk

Acute Kids and Adults

- Acute Medical issue, not long term in nature
- May go to ED and/or PCP for acute issue
- $ 1,600
- Short term care coordination from clinic or plan to ensure they have what they need post acute issue

Moms and Babies

- Pregnancy and Birth
- Delivery and newborn admissions
- $ 8,300
- Care coordination from clinic/plan to ensure mom/baby have follow up appointments with PCP.

Understanding the Segments: Rising Risk

Chronic Managed

At least 4 chronic conditions, 20% have severe mental health issues, have one hospital dominant condition, prevalent conditions are diabetes, hypertension, low back pain, and asthma

Engagement with PCP/Specialists and OP care, no significant ED/IP use

$ 8,600

1) Member may need to connect with BH specialist at clinic and/or need referral to specialty MH
2) Make sure member's conditions/medications are reviewed

Complex Managed

Has multiple medical conditions

Have high engagement with PCP/Specialists (on average 30+ OP visits), few IP/ED visits

$ 45,000

1) Clinic does review of patient on a regular cadence to ensure medical issues are addressed

Highest rate of specialist visits than any other segment

Highest prevalence of Cancer & Rheumatoid Arthritis compared to other segments

Understanding the Segments: Rising Risk

Uncoordinated

Mostly in their 30's with no chronic conditions, 30%-40% have SUD and half use tobacco.

On average has 5+ ED visits, less likely to engage with PCP

$ 7,000

1) Work with member on getting connected to SUD treatment and/or PCP
2) Connection to community resources that are age appropriate

Chronic Uncoordinated

Has at least 4 chronic conditions and 2 hospital dominant conditions, and on average takes medications with over 20 ingredients

Has had at least one unplanned IP stay, a couple ED Visits

50% of members in Chronic Uncoordinated segment are frail & 50% of them also use Ambulance (~n=1,800)

$ 25,000

1) Ensure member is attending appointments and has support as needed to make sure they get needs met
2) Focus on ED/Obs/IP transitions to ensure member has f/u appointment with PCP and med rec happens

Understanding the Segments: High Risk

High RX

Most likely have HIV, Rheumatoid arthritis, cancer

On expensive medications, little to no IP/ED use, engages with PCP/Specialist

$80,000

Pharmacy Med Review

Understanding the Segments: High Risk

SA/SMI/Chronic

Has severe and persistent mental illness and/or substance use disorders and is likely to be frail

Significant use of the ED (average is 20+ visits) PCP visits from different PCPs

$ 40,000

53 active ingredients

85% of members in this segment use Ambulance

1) Focused on working with CHOICE and/or Specialty MH/SUD providers
2) Getting members on MAT/MH treatment
3) SDOH Interventions

Extremely Complex

At least 4 hospital dominant conditions, multiple conditions, frail, and have septicemia

77% of members have chronic renal failure

Significant IP use, ICU admission, and ED visits

$ 217,354

51 active ingredients

1) Clinic looks at palliative care interventions
2) Goals of Care Conversations/POLST
3) Referral to AICU Summit and Housecall

What About Miranda?

- Healthy Kids
- Healthy Adults

Healthy

- Acute Kids & Adults
- Moms & Babies

Low Risk

- Chronic Managed
- Complex Managed
- Uncoordinated
- Chronic Uncoordinated

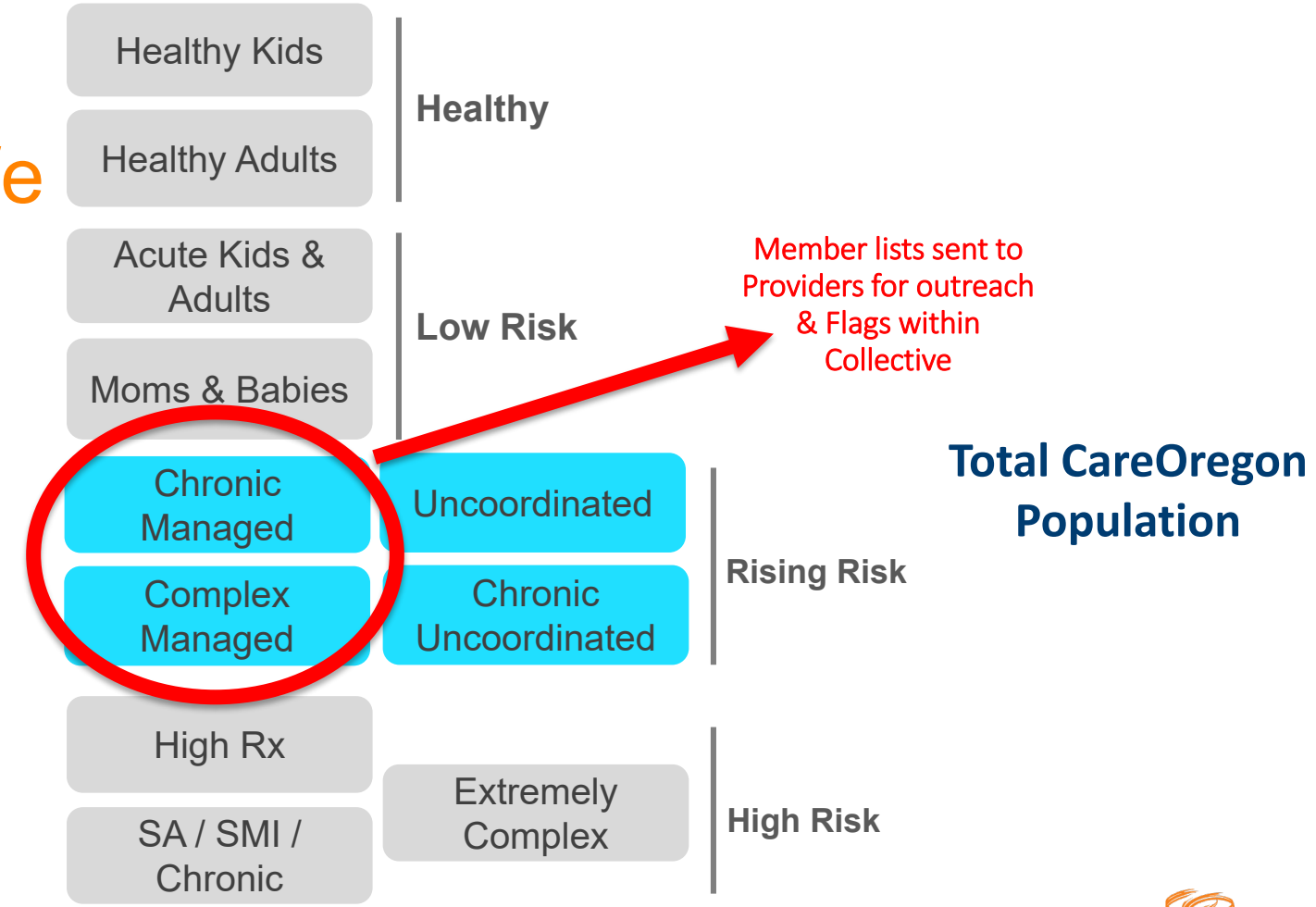
Rising Risk

- High Rx
- SA / SMI / Chronic
- Extremely Complex

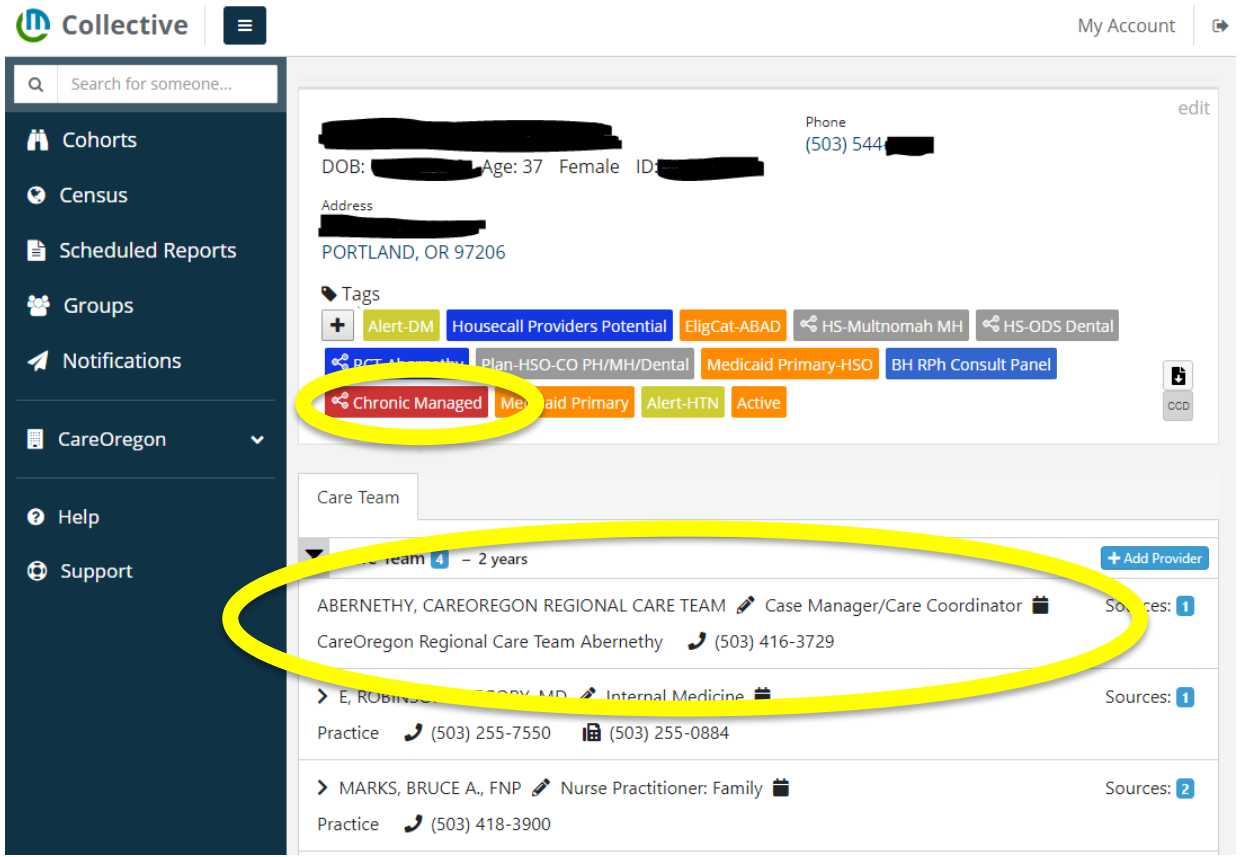
High Risk

Total CareOregon Population

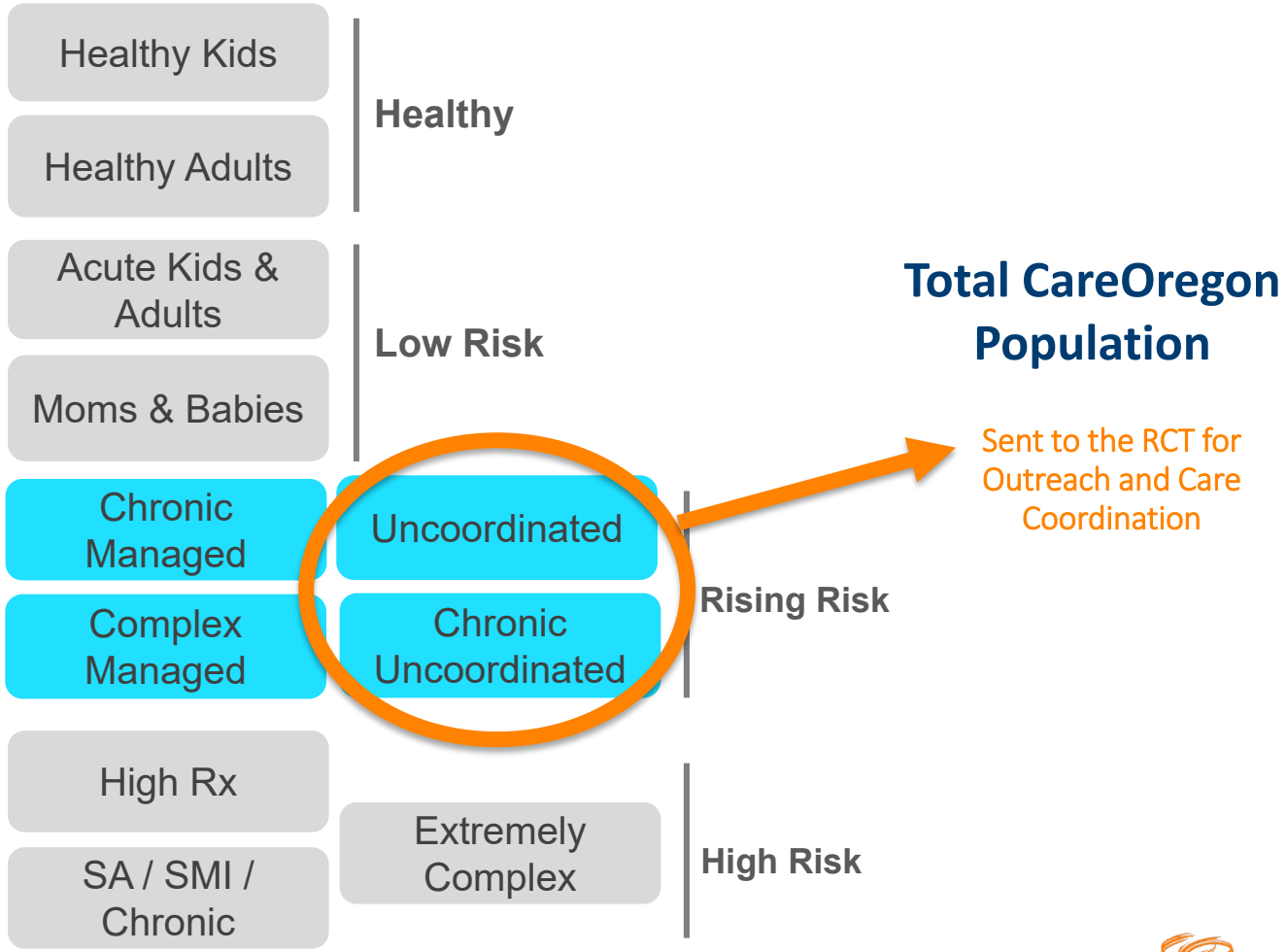
What Do We Do with the Rising Risk Cohort?



Tags in Collective



What Do We Do with the Rising Risk Cohort?



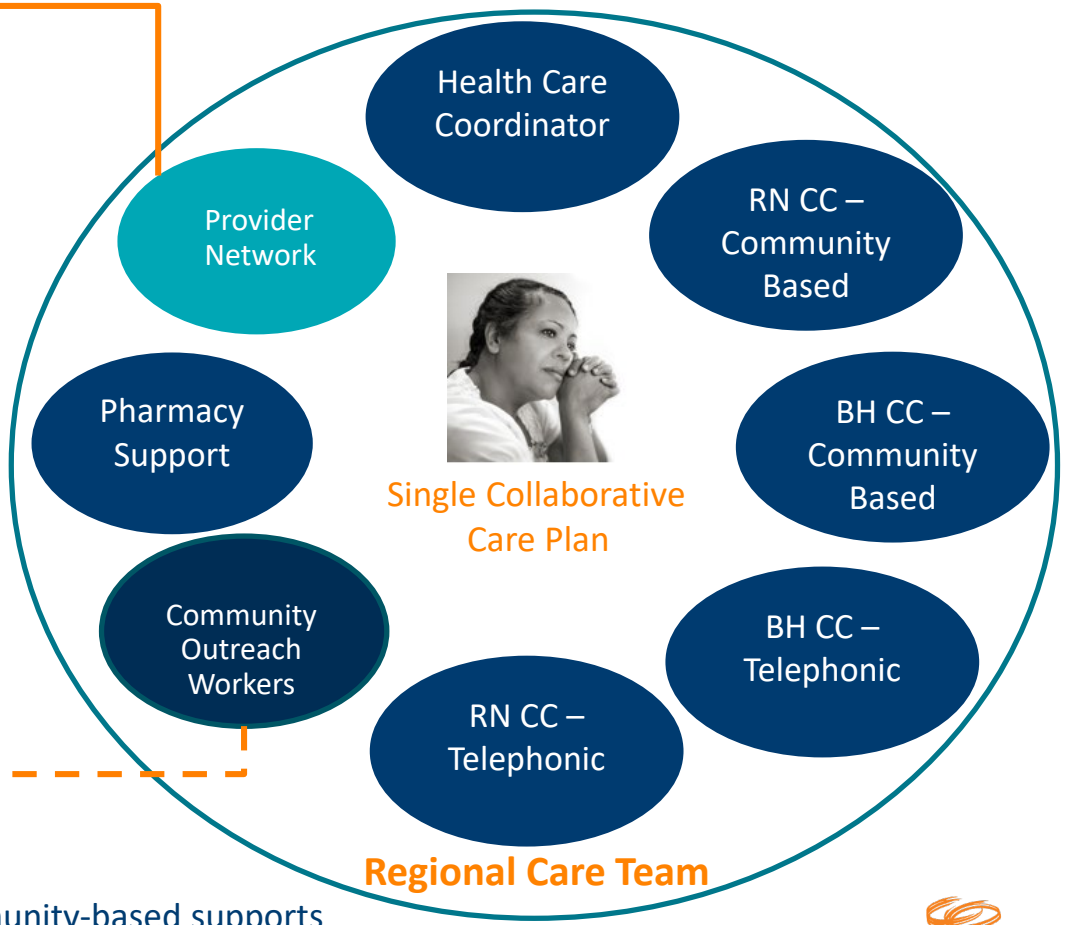
So, What is Care Coordination & What are the Regional Care Teams?

What is a Regional Care Team?

Patient-focused multidisciplinary team, dedicated to working with clinical partners to **coordinate services and resources** for patients and providers.

Primary Care, Specialty, & Community Mental Health:

- ✓ Case managers
- ✓ Clinic Care coordinators
- ✓ Social workers
- ✓ Nursing/MA team
- ✓ Transitions care coordinator
- ✓ Peer mentors
- ✓ Clinic manager
- ✓ Engagement specialist



*Care Oregon community-based supports

What is Care Coordination?

- Coordination of a Member's health care services, resources, and support activities
- Involves a team-based approach focused on the needs and strengths of the individual Member
- Addresses interrelated medical, social, cultural, developmental, behavioral, educational, spiritual and financial needs
- Ensures that individuals involved in a Member's care facilitate the appropriate delivery of health care services and supports
- Successful Care Coordination requires the exchange of information, collaboration, and communication between all involved

Care Coordination from a Regulatory Perspective

1. Provide Access to Care Coordination
2. Connect Members to Services
3. Provide Transition Planning and Follow Up
4. Assess for Care Coordination & Other Needs
5. Develop and Implement Individualized Care Plans
6. Prioritize Specific Populations and Specific Levels of Care

Care Coordination from a Regulatory Perspective

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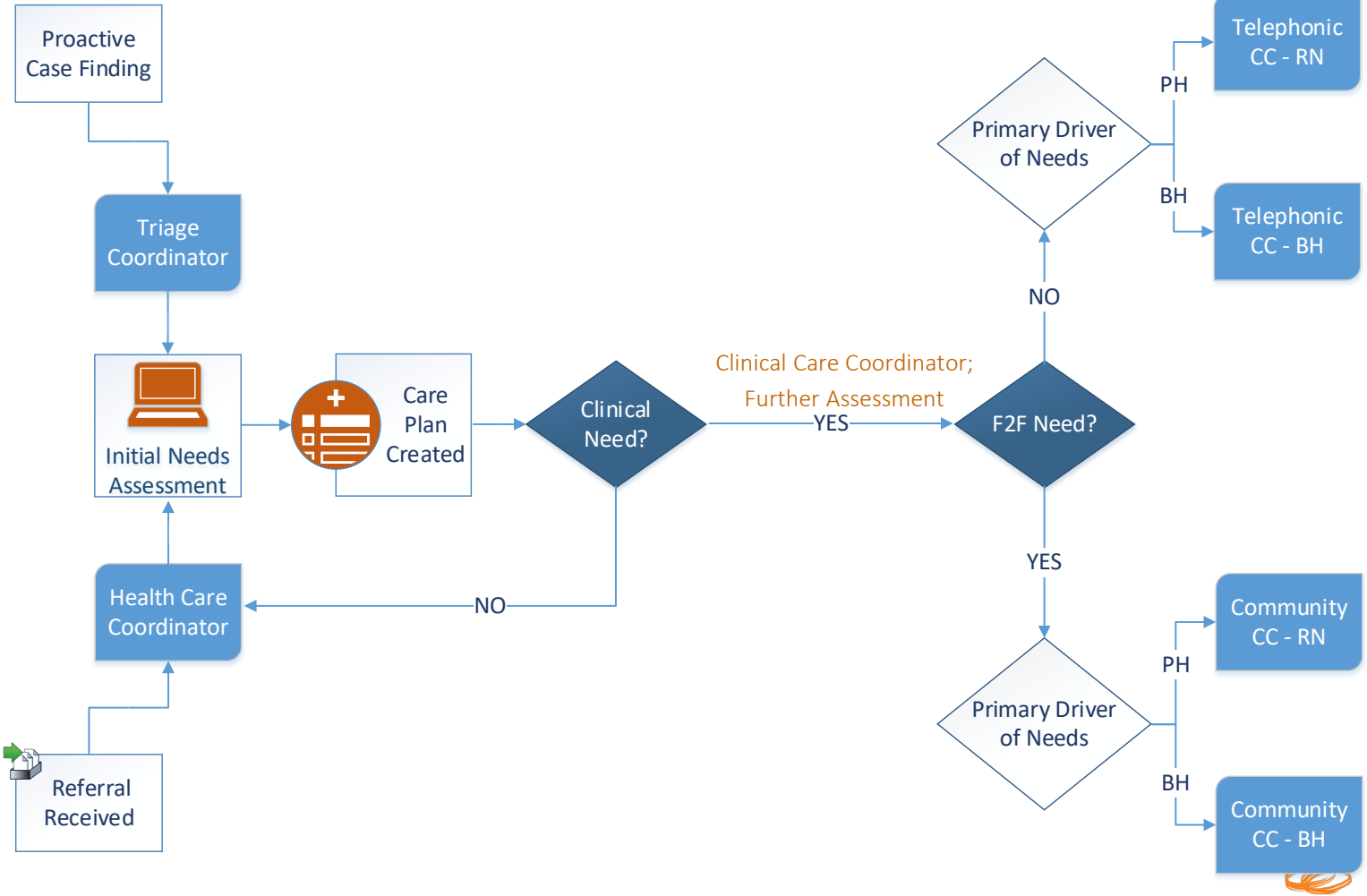
5. Develop and Implement **Individualized Care Plans**
6. Prioritize Specific Populations and Specific Levels of Care

Care Plan Drives the Workflow



So, How Do Reach Us?

Centralized Referral Process:
ccreferral@careoregon.org

Referral form found on our website

https://careoregon.org/docs/default-source/providers/forms-and-policies/complex-care-case-management-referral-ohp-medicare.pdf?sfvrsn=dde33d3e_4

Or Call Customer Service to be connected to your Regional Care Team

Thank you

Now, please fill out the **AFTER** section of your self-assessment sheet!

POST-Seminar Self-Assessment (please do not complete until AFTER session)

1. How do you rate your **new** knowledge of the positive impact that focusing on goals of care can make on patient outcomes? **From 1 (lowest) to 10 (highest)**

1 2 3 4 5 6 7 8 9 10

Panel Questions & Answers

CareOregon

Join Our Upcoming Session!

Trauma-Informed Care and SUD
December 13th

Thank you!

CareOregon

Panel Questions & Answers

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