Transcript for Opioids and the Age-Friendly Health System Framework

Good afternoon and welcome to today's call.

I'm Victor Gonzalez, a quality improvement specialist with TMF. On behalf of my colleagues, who will be monitoring chat, we would like to welcome you to today's conversation, Community Coalition meeting covering Opioids and Age friendly Health Systems.

We have two wonderful guests with us today. It is my pleasure to introduce you to them. Before we get to that, I want to cover a few housekeeping issues that will hopefully make your time spent with us a little bit more comfortable.

Speaking of time, we certainly appreciate you sharing it with us today. We know that it is our greatest commodity, so we hope that you take away lots of good information that you can apply in your day to day activities.

There are a couple ways you can participate in today's conversation. You can request to speak by selecting the hand icon. You will find that in the bottom section of your WebEx meeting window. I want to warn you we have a jam packed session with a lot of information and if there is an opportunity, we would love to bring you into the conversation at the appropriate time, but we will ask that verbal questions be held to the end of the conversation.

Another way that you can communicate with us as the conversation is happening is to definitely check the chat often. If it's not included in your participant panel which is the right hand section of your WebEx meeting, go ahead and find it at the bottom right corner. You will see the little chat bubble. Click it. It will be added to the participant panel.

We will send you some good information there, including closed captioning. We do have closed captioning for today's call. We will drop that in today. Grace, if you would share that with our audience. If you want to follow along with closed captioning, that is fantastic.

The other reason we do closed captioning is because a copy and a transcript of this presentation will be available on our Learning and Action Network.

Here's one, we just talked about chat but let's go ahead and give it a try for those folks who paid the price of admission, which is free and always worth it. Go ahead and try it. We want to ask what is your organization currently doing to address opioid use disorder for the Medicare population? Keep your answer short. We do appreciate you participating in chat.

As we wait for those responses to come in, let's go ahead and move on and give you a little bit of overview of who we are as an organization. We have been rocking out since 1984. That year actually predates a lot of your high school graduations. We have been in the Quality Improvement Organization sector for CMS since that year, in the 1980s, focusing on promoting

quality health care. We have currently just been awarded a new five year contract that we are actually using to bring this information to you today.

We are in partnership with the Arkansas Foundation for Medical Care. If you came from Arkansas, we do appreciate it. I know it's standing room only but we will find you a comfortable place for you to put your feet up and let us know in chat if you are joining us from Arkansas.

Let's go ahead and jump right into it. As I said, we have two wonderful speakers today. Dr. Atanda is joining us as a PGY2 ambulatory care residency trade pharmacist who joined the UNT School of Pharmacy faculty in 2016. She serves as residency program director for the University of North Texas Science Center Ambulatory Care Pharmacy Residency and is responsible for course coordination of the musculoskeletal and connective tissue disorder IPT course and advanced diabetes care and post graduate preparatory elective courses.

As a Board certified ambulatory care specialist and certified diabetes educator, her practice interests include chronic disease state management and a focus on diabetes and sickle cell anemia management.

Additionally, she has an interest in team based learning, professional development and advancement of technology in the classroom. Dr. Atanda is faculty co adviser for the chapter of the Student College of Clinical Pharmacy and is a member of American College of Clinical Pharmacy Leadership Society, Texas Pharmacy Association, Texas Society of Health System Pharmacists and Alpha Zeta Omega fraternity.

She is joined by Dr. Sarah Ross, an alumni of the medical school, where she now works as faculty and completed her residency and fellowship training at John Peter Smith Hospital. She's Board certified in Family Medicine with additional certification in geriatrics and hospice and palliative medicine. Dr. Ross enjoys caring for patients and families through the stages of aging and in settings where they live. She believes that maintaining healthy habits and managing chronic disease is important for her patients of every age.

Discussion of goals for medical care and patients' attitudes towards health is a vital part of geriatric medicine. Dr. Ross serves as the course director for the geriatrics rotation and has also created content for electives of caring for older adults across the continuum of care. She has been involved in the work force enhancement program in the Center for Geriatrics at the University, focusing on Alzheimer's disease and education of medical professionals and caregivers.

Doctors, it is a pleasure to have you today. Welcome to today's call.

Dr. Ross, I will turn the controls over to you and we can go ahead and get started. It's a pleasure to have you both on.

Okay. Thanks very much. I will get us started. We were asked to discuss the opioid topic as far as risk for opioid misuse or abuse among older adults and we want to apply it to the age

friendly health systems framework. If you have never heard of age friendly health systems, we will let you know what that's all about.

So objectives are listed here. We will define what age friendly health systems are as well as the framework, touch briefly upon medication assisted treatment or M.A.T. and also how we can use age friendly health systems to support patients and their families through a journey with regard to opioid challenges and use of Naloxone and how we as prescribers can utilize the prescription monitoring program as well.

So I will be doing the first half and Dr. Atanda will be covering the second half.

The first topic I wanted to talk about is what age friendly health systems are. This was something started in 2016 as a partnership between the Institute for Health Care Improvement and the Johnny Hartford Foundation as well as the American Hospital Association with a goal to measure impact on the health system as well as on older adults.

So an age friendly health system is a design that is meant to provide a framework to help give care to older adults that aligns with what matters to them as well as care that is focused on first doing no harm and that is evidence based. It's meant to be applied to every setting and every interaction, whether it be in a hospital out patient or other setting.

The purpose of it, again, is to improve health care outcomes, reduce cost and prevent harm to these older adult patients.

So here is the graphic for age friendly health systems. It outlines what the four Ms are. So this is meant to make complex care more manageable. So the four Ms are best practice interventions under these headings. It's a shift in how we provide care to older adults with the intent of incorporating these into the existing care, building upon what we already have, what we are already doing, and again, these are applicable to every patient at every encounter.

I want to mention that the what matters icon is at the top for an intentional reason. Really, the big focus and push on age friendly care is to provide a framework that's meant to support discussions about goals of care and priorities. So that's very applicable to pain management and use of high risk medications like opioids, so that whatever we're doing, that the care is aligned with the priorities of that patient and what's most important to them.

So age friendly health systems' four M framework is what matters, medication, mentation and mobility, again, a way for us to provide good care to older adult patients, and it's actually a designation that health care systems or offices can apply for through the Institute for Health Care Improvement so that designation comes from IHI, and in order to receive that designation, basically we make a plan to assess each of the four Ms and to act on that information. It's pretty simple.

There's two levels of designation. The first, level 1, is a participant which basically says that my practice is committed to working on this, to addressing what matters, medication, mentation and mobility for my patients.

Level 2 is called committed to care excellence. That age friendly health system designation is more involved with respect to actually submitting some data to show that you are measuring what matters, medication, mentation, mobility and then intervening as appropriate in those areas.

So this is the definition or the blurb on medication from the Johnny Hartford Foundation and the Johnny Hartford Foundation has forward basing materials for the lay population, and encouraging them to seek age friendly care and to be an advocate for themselves in these four Ms categories.

Under medications, patients are encouraged to ask your health care team if all of your medications are necessary, and check to ensure that your medications don't interfere with what matters, mentation, or mobility.

So just a quick example of again, the way the age friendly health system is set up is that we assess the area of importance and then we act upon it. So with regard to medication, you know, just applying for that age friendly designation could look like a procedure in your office that tracks that the medication reconciliation is going on, which it already should be, so for example, reconcile medications at each encounter and have a system in place to review for high risk medications could be the assessment piece, and acting upon that is potentially having discussions about de prescribing or kind of not roadblocks, but tools is what I'm thinking of, to help practitioners to be cautious with high risk medications or medications that are not in alignment with what that patient wants.

So with respect to the topic of opioids, it still is a quality improvement project related to assessing and acting upon the opioid specific topic. That could look like implementing a tool to gauge the risk of opioid use disorder among applicable patients or using the PEG scale which we will talk about later, which is for individuals already taking opioids to assess their effectiveness. The act could be, you know, related to the use of those opioids decreasing or discontinuing when appropriate, referring to M.A.T. if appropriate, that sort of thing.

The idea behind implementing age friendly health system using the four Ms framework is to intentionally assess areas of interest and act upon that information. It's about tracking measures for quality improvement and data and moving the needle, making positive changes.

So this is just a screen shot from the CDC. There's a lot of great resources that are available for more training, so we are glad you're here to get a little bit of flavor and insight on the topic of opioid use in your care settings, and if you want more, there's a lot more out there. The CDC has some great clinical tools and training available on their website, as you can see from that screen shot.

So this next slide is just definitions. I won't read it all, but the terms that are listed here are important to be aware of and distinguish. Opioid use disorder, we will talk more about here in a moment. Basically, the short definition is a problematic pattern of opioid use that leads to a clinically significant impairment and substance use disorder is the same definition, just more broad, to incorporate other substances.

Aberrance, outside the boundaries of what that prescription was intended for or outside of the boundaries of the agreed upon and misused outside of the boundaries of why that was prescribed. Abuse by contrast, misuse with some consequences attached, diversion, we know is getting the medicine to where it's not supposed to be.

The two I wanted to be sure to compare and contrast is tolerance and addiction. Tolerance is, your patients have developed tolerance to opioids, may not show effects after use of a typical dose because they are more likely to be tolerant of that dose, therefore, are more likely to experience withdrawal if opioids are stopped abruptly. So tolerance and withdrawal are part of the diagnostic criteria for an opioid use disorder but they are not the only criteria. Tolerance and withdrawal do not equal an opioid use disorder or an addiction.

So the definition for addiction that I pulled came from the American Society of Addiction Medicine or ASAM and says people with addictions suffer from problematic pattern of substance use and compulsive behaviors that will often continue despite the harm or the physical consequences.

As I mentioned, there's a lot of resources through the Centers for Disease Control and they published guidelines in 2016 that are available on their website, and I will be touching on some of the points with those guidelines in the next slides.

So part of the guidelines are things PCPs already know and have been taught is we try other things first, right? We utilize non opioid therapies when possible and that could be instead of or in combination with opioids, so considerations would be timed Tylenol. For many, not all, but for many of my older adults with chronic osteoarthritis pain, just getting them on the arthritis strength extended release Tylenol on a schedule is often very effective at pain management for them.

Other adjuncts with this here, the serotonin norepinephrine reuptake inhibitors for help with pain management, anti convulsants, analgesics, tricyclic antidepressants might be appropriate. Typically in the older adult population we are real cautious with those, but otherwise can be good choices.

And the other non pharmacological things. Behavioral therapy, counseling, cognitive behavioral therapy procedures such as corticosteroid injections for joint pain, physical therapy, weight loss, aquatherapy. Lot of different even heat/cold. There's a lot of different non prescription pain management options that can be recommended and tried.

So with regard to using opioids, this is just a little bit from the CDC guidelines on choosing opioid therapy and the recommendations for dosage, duration, et cetera. This is acute pain. It's meant to be for a short period of time, three to seven days, with an instant relief option. If it's chronic non malignant pain, still the instant release options are recommended. I kind of use the cut off that we have there with regard to the total morphine milligram equivalents as a general guide for PCP opposed to probably going to need specialist intervention. For less than 50 morphine milligram equivalents per day, there's a little risk for overdose. I would hope that most physicians have some comfort level with those lower daily doses of opioid prescribing. Getting above 100 is a much greater risk of opioid overdose. So those are folks that definitely need to be managed by folks that do this every day and have some specialty experience and training.

And morphine follow up is very much important, initially every few weeks, then at least every three months.

Here's a little more from these guidelines. The importance, touching on the importance of assessing for risk and assessing for harm. So if they are in a high risk category for potential overdose, prescribing Naloxone is available, Dr. Atanda will provide more details on that, and the PDP is available, that is a good aid for tracking prescribing or filling habits to make sure that we're not abusing and filling it multiple places or more frequently and things of that nature.

One thing in older adults that we have to be real cautious with is mixing opioids with other high risk medications like benzodiazepines and then for those who may be having signs or risks of opioid use disorder, the medication assisted treatment programs are an appropriate referral.

There is a paper here that talks about assessing the risk of opioid misuse and they basically boiled it down to six patient characteristics that have been identified as predictors for increased risk of inappropriate use. They are listed here.

A patient that focuses on the opioid, the specific medication or prescription itself, its overuse, there may be other substance abuse, low functional status, unclear etiology of pain and exaggeration of pain.

There's numerous tools available as far as a formal tool to assess for risk potential.

So I really like the PEG scale. This is a way to assess where we are for someone who is on therapy with opioids, that's a way to assess whether they are effective. The P stands for pain, E for enjoyment and G for general. Each of those questions is scored on a 0 10 scale with 0 being nothing at all and 10 being the worst imaginable.

So what is your pain score in the last week, what is or what number describes how the pain has interfered with your enjoyment of life in the last week. Then last in general, what number from 1 10 describes how the pain has interfered with your general activity.

I think this can be very telling. I actually have an older adult with pretty severe arthritis pain that had really not had any benefit from Tylenol. She had some significant side effects from Tramadol and we started on hydrocodone at 2.5 milligrams 2 3 times a day and her PEG score in just one week went from 9 to 4, if I remember correctly. So it's very helpful to kind of gather that data and show that this is of a benefit.

Conversely, if there's no change, we have some data to support making that argument of decreasing or discontinuing or finding other alternative options for their pain management.

This is a snapshot from the website through the mental health organization. They provide some good education about medication assisted treatment. I just wanted to acknowledge them as a reference for your information as far as learning more about medication assisted treatment. The next few slides provide some information on M.A.T.

So it's an approach to treat opioid use disorder or substance use disorder, and a support to sustain that recovery, to prevent overdose. We haven't talked too much about the numbers, I believe Dr. Atanda has something on that, but it's a significant problem, and that's why we are here to provide some information on how we can try to identify and help reduce that risk of overdose and identify folks that could be at risk.

So in M.A.T., medications are used in combination with counseling and behavioral therapies and it's a treatment approach for opioid and heroin and other substance abuse addictions. The aim is to help folks kind of get back on an even keel, so they're using these medications inappropriately and using them for some of the euphoric effects as well as cravings, so trying to normalize things to help reduce those cravings and effects.

I won't read all of these but this is the DSM V criteria for opioid use disorder. It has specific criteria for the presence of physical dependence on that opioid as well as two of the criteria listed below within the last 12 months, and as far as your ICD 10 codes, you have mild, moderate and severe level where you have 2 3 for mild, 4 5 for moderate and 6 or more for severe level of opioid use disorder.

So this next slide is really the easier kind of quick and dirty way to diagnose or look for a problem with opioid use and the four Cs. Impaired control, compulsive use in spite of harm, continued use despite physical, social or emotional difficulties, and craving for non pain relief.

So that is like I said, a real quick way to encompass the effects or the criteria for kind of identifying if this is a problem. There are specific medications that are approved for treating opioid dependency or opioid use disorder. Methadone, Naltrexone, they are used to help treat the disorder with things like heroin, morphine or codeine as well as oxycodone and hydrocodone. Those are the medications that would be prescribed to help, again, kind of get things on an even keel for folks using these medications inappropriately.

The next slide, I really liked this information that I found through one of the CDC training modules and this is just some communication strategies. This topic may be hard to bring up, or

maybe awkward potentially, so I really liked the kind of suggestions for ways to approach or talk to patients, to kind of generalize and normalize if some medications cause problems, they can't participate and all kinds of people can have problems with opioids, and our motivation as care providers is to help you get to the healthiest version of you in the long term, and getting help for this is like getting help for other chronic medical problems, and we want to give you the best care possible. There's a lot of treatment options, let's figure out how we can get you some treatment and work together to find the treatment that works.

So the last thing I wanted to mention is just the availability of M.A.T. programs. I wasn't sure how accessible it would be, and I know that that has been a criticism or a barrier as far as a barrier to individuals with opioid use disorder finding good treatment options that are paid for. In some cases, treatments may not be easily accessible or may not be covered by insurance, and stigma is also a significant barrier.

So I think the starting point with regard to us as providers is developing competence in identifying patients who need this support, because that can definitely be a challenge if we don't identify and we can't get them the treatment that they need.

So again, there's a lot of trainings available through the CDC and there's programs available and the first link is providing a search with regard to finding treatment options.

So we will transition to Dr. Atanda, clinical pharmacist, with regard to strategies to help address and prevent opioid misuse and abuse so I will pass the baton to her.

Thank you so much, Dr. Ross.

I hear a little bit of an echo.

I wanted to go ahead and speak about strategy to address specific opioid disuse or abuse. Dr. Ross did a great job of giving an overview of the concern and why we need to approach this issue with our age friendly systems and that way we can join forces.

Some overviews or specifics. We did see [Indiscernible] have some form of chronic pain and within that population, we do see a significant amount, over 50%, being in an older population or older patients of 65 years and older.

Also, another study looked at prescribing habits and looking at opioid prescriptions in particular, and noticed that opioid prescribing was highest in patients who are 65 years and older as well. We do have a significant need for awareness and appropriate strategies to manage opioid therapy in our older population.

In terms of specifics as it relates to overdose, the statistics provided by the National Institute on Drug Abuse, unfortunately we are seeing an increase in the national overdose deaths related to any opioid. This is not specific to opioid prescriptions. We can see the trend going from 1999 to 2020.

We are also seeing an overdose trend as it relates to prescriptions with opioids, so we do see another trend in increase from 1999 to 2020 with total overdose deaths as they involve prescription opioids. Thankfully, we are seeing a downtrend, however, in prescription opioids specifically without any other synthetic choice co administration. It seems to be on a downtrend but unfortunately, overall opioid use, including synthetic opioids, is increasing in terms of the overdose deaths we are seeing nationally.

So what are some common signs of opioid overdose we need to be aware of? As clinicians with patients who may be using opioid therapies, classic signs would be [Indiscernible], altered mentation, so if they are confused or very somnolent and can't be woken up, you can see difficulty breathing as well because of reduction in respiratory drive and the pinpoint pupil, something we do see in an overdose situation. It's important for us to know those signs so we can intervene or at least inform our patients and family members so they know if that was to occur.

When it comes to Naloxone, it is an available kind of counteragent for opioid overdose. It is an opiate antagonist that will help with the partial reversal of opioid depression induced by natural or synthetic opioids. Thankfully, it comes in various formulations from nasal sprays to injections and different forms of the injection route. This makes it easier not only for health care providers to administer Naloxone, but for patients to do that as well and their caregivers and family members, in an event of an overdose.

When it comes to Naloxone dispensing in Texas, [Indiscernible] it will increase access to a life saving intervention like Naloxone and is available in pharmacies to be dispensed without a prescription as far as they are under a standing physician order. There is a pharmacy organization in Texas that has standing physician orders available for anyone to be able to use.

There are two exceptions when it comes to dispensing, whether that be intramuscular Naloxone is available to dispense without a prescription, but we are not able to do the auto injector. Also, the intra nasal Naloxone formulation in an atomization device or as Narcan are available to be dispensed without a prescription.

This might be a little small to read but we do have access to the full article that will be provided to you as well. But it just gives an overview of what are the Naloxone dispensing habits in Texas as it relates to our retail or chain pharmacies. What we are able to see, it was a great study published in JAMA, pharmacists are willing and are dispensing Naloxone without a prescription, especially if they are aware of the standing order and have that on stock.

So when you are informing your patients, it's also important to have this conversation about where they could get Naloxone. Of course, a prescription can be provided but if they are in a pinch or a bind, they can also get it without a prescription.

Bringing it back to our age friendly health systems, going back to the four Ms framework I think is a great way to approach conversations as it relates to opioid misuse or abuse. So a quick overview, we focus on what matters, of course medication use as well, mentation and mobility.

So how do we approach Naloxone discussion with patients and their family members? I think one of the first things you can do whenever you are prescribing an opioid therapy or if someone is coming to your care already established on opioid therapy, is to discuss the symptoms of an opioid overdose. And really focusing on the mentation and mobility symptoms, especially as it relates to older adults, which has more severe consequences.

It's also important to introduce Naloxone therapy to the conversation when a patient is taking high opioid doses, so thinking of having a regimen with 60 morphine milligram equivalents or higher or if you have a history of opioid intoxication in the past or are taking extended release or long acting medication formulations. This is important to help reduce the risk of having a problem.

When you are framing these conversations it's important to not use accusatory approaches. Trying to use terms like accidental overdose instead of opioid abuse or misuse, because some patients will have an overdose situation that is unintentional and focus on opioid emergency instead of using those terms as well to help reduce any kind of resistance or friction to your patient/provider relationship as it relates to this conversation.

Have an open conversation, are there any concerns they have about opiate therapy that is being prescribed or provided, or Naloxone use as well, so educating them as to how to use it, how to get it and let everyone know it's just a preventive strategy in case of opioid overdose was to happen.

The other part I wanted to highlight in this part of the presentation is our prescription drug monitoring program. Thankfully, the data base is available to track the controlled substance prescribing and dispensing in the state and it's available across the nation. Texas has its own that is now mandated for prescribers and also pharmacies to utilize.

So the Texas State PDMP should be reviewed before any opiate therapy is started, periodically through the prescribing relationship or if there was to be a new prescription, and if you have any concerns, that's also a good time to review the prescribing and also dispensing habits with the patient.

So what kind of data is collected in the Texas PDMP? Number one thing we see of course is scheduled medications, schedule II, III, IV and V. Pharmacies are required to report the data from dispensing of these medications at least by the next day of dispensing. That is available to prescribers who are using the PDMP as well so you can look at patterns of use and identify any misuse or abuse potential.

There are some exceptions to reporting or utilization of the PDMP. For example, if a prescriber is unable to access the PDMP and needs to provide therapy, you can have that happen in good

faith as long as there is adequate documentation of an attempt to use the PDMP before the prescription's provided.

It's also important to note that patient [Indiscernible] is not required to utilize the PDMP. You can utilize that information as part of your daily practice and best care recommendation. However, the data that is included in our PDMP is protected by HIPAA laws, so it should only be accessed if there is an established patient/provider relationship and also note that patients have a right to and access to get a list of everyone who has checked their PDMP records. It's really important, it should only be used for actual patient care related abuses versus non patient care related abuses. That is a mandated check in Texas. Providers should be utilizing PDMP any time there is a new prescription or refill or change in relationship, and there should be adequate documentation in the health record.

Also, the Texas PDMP has some great tools I will highlight shortly that can help providers identify utilization patterns that might be at risk for misuse or abuse. Also to figure out what a patient's risk factors or odds ratio of having an overdose happen.

So NarxCare provides two different scores. The first is a Narx score. That provides utilization data and they also have an overdose risk score that provides the odds ratio of a patient having an overdose happen.

To give you a quick overview as to how this works, whenever you walk in, you look at your patient's chart, you see for the Narx score there will be one for [Indiscernible] stimulant medication and the third, the last digit in the series, will be the number of client dispensations for each of those medications. This patient will currently have four prescriptions that are active and one that is inactive.

There is an overdose risk score and those scores range from 0 999. It will help you depending on what the patient's score is, be able to categorize what their risk is or what their behavior patterns are as it relates to use of opioid medications.

So for our Narx score, as far as 0 999, you see lower exposure, lower risk, and that's majority of the patient population. 200 499 is moderate complexity so there are probably multiple medications, there might be multiple pharmacies involved. A score above 500 is definitely indicative of multiple prescribers, pharmacies and potential concerns for overlapping prescriptions.

Here are some recommendations as to how you can use that data. If someone has a score that is 0, that's a good time to have a discussion about risks and benefits of controlled substances and at really a low risk of misuse or abuse, or inappropriate dispensing behaviors.

If someone has a score between 10 and about 650, that's a good time for you to start to review usage of any unsafe patterns you're seeing and make sure you discuss those concerns with the patient. Any score above 650, of course, you can use any of the items above by discussing concerns with the patient, but if possible, you should also reach out to the prescriber and the

pharmacy to see what's going on with the dispensing and to make sure, you know, people might not be aware this is what the patient's doing and to share that information with other prescribers is very helpful.

Then for overdose score, again, 0 999, this is a chart including the odds ratio that's linked to the score range. You can see with the higher score, it's indicative of the higher odds ratio that there will be an overdose. This is an unintentional overdose with an opiate medication.

So a score of less than 450 for overdose score is usually a lower risk, so you just want to look at other risk factors beyond what is provided in the PDMP. A score between 450 650 will be a good time for you to consider prescribing or dispensing Naloxone because it is a higher risk for an overdose based on the patient's profile.

A score above 650 is when you really want to consider prescribing Naloxone and also reviewing their usage patterns and discussing with the patient. If they are also really high morphine milligram equivalents, that might be a good time to look at their current regimen and see if you can consider tapering or providing alternate pain medications as well to supplement their pain regimen.

You can also consider referral for either in patient or out patient management if there is a concern for substance abuse disorder.

So I wanted to provide additional references that go over the age friendly health systems and our guidelines for opiate prescribing, a general summary as to approach the conversation about opioid misuse and abuse in a patient friendly manner and making sure you also provide Naloxone as an agent that can be used for an accidental overdose to your patients, and let them know that is available in Texas without a prescription.

That was the end of this section of the presentation. Thank you for your attendance and attention. Thank you, Dr. Atanda and Dr. Ross, for sharing your expertise and your experiences with our audience today. That was a lot of information in a very short period of time. Lots of good links and resources there. We have been busy putting a few of those in chat. Not to worry, we are going to follow up with you and make sure that you have access to those.

That does give us a little bit of wiggle room to invite our audience to raise their hand which they will find there at the bottom of their WebEx meeting window. You will see a hand icon there. You can certainly join our conversation by raising your hand. You also find it to the right of your name, if you have joined through computer audio.

You can also ask questions in chat and I know we have had some activity there. So I want to invite my colleagues Grace and Cindy to offer up any questions our audience might have for Dr. Ross and Dr. Atanda.

So in addition to providing Narcan, does that include teaching the client on how to use the Narcan?

Yes, that's a good one. It definitely includes a demonstration, especially because the intra nasal Narcan formulation is the most accessible for patients and easiest to use, so you can either have a handout that kind of explains how to use it to provide while you're also prescribing that. Also, pharmacies have that information available in case they were to go directly to a pharmacy and get that. It's always important to use that teach back method to ensure they understand how to use it appropriately.

Thank you for your question. Thank you for that response, Doctor. I think it's important to have the education go along with it, for sure. There's a lot of resources related to that.

Any other questions?

Also, there's another comment, actually, that says I like to teach the skill for long term management patients. Mostly to summarize it, she was saying chronic pain patients have to figure out what to say in terms of the scale of 1 10 in order to get their pain meds managed and then using the PEG scale allows the provider to get a better understanding about how the pain is affecting the client, and the client cannot automatically say, you know, 8, 9 or 10 or whatever it is, especially with those with increased dependency.

What do you think about that?

I had read that comment and appreciate that. It's really, it comes down to function because we are not going to get the pain level down to 0 for these patients that are having very chronic ongoing pain challenges, and so for some patients, living at a pain scale of 4, 5, 6 may be tolerable and their function is a lower score, so getting those kind of scores for function, for how this is affecting your day to day emotionally and functionally is definitely an important piece of the puzzle for assessing if the medications are warranted and are helping.

Well, thank you for that. As we are waiting for other comments in chat and maybe some questions, by raising your hand, I wanted to bring your attention to the poll that I have just opened up on the right hand side of your screen. You might see the word Polling added to your participant panel.

If you can't see the poll, just click to the left of any of the sections of your participant panel to expand that. Just to the left of the word Polling you will see a little chevron, that icon people refer to as a carat, greater than sign, click on it and you will be able to see the rest of the poll so you will be able to answer that. It's important to get your feedback.

And scroll down, you will see not only are we asking whether you are satisfied with the content, but we also are allowing you an opportunity to ask additional questions that we might have to take back and answer, if we can't do it today, or if you would like, if you are the shy type and just want to sneak it in there, we can certainly address it later. It also gives you the opportunity for assistance.

So if you are hooked up with one of our quality improvement people doing this work in the community coalitions, we congratulate you for doing that. Of course, all of the services that we provide are free of charge.

If you are working with Cindy and Grace, you are especially blessed to be working with two of our top consultants. We have many, many other folks who are equally talented, ready to provide some additional services.

With that, Grace, Cindy, do we have any other questions or comments in chat? If we don't, I certainly want to throw up a couple of discussion questions that might provoke some questions or maybe get those juices flowing. Hopefully we will get a few more before the end of the conversation and utilize Dr. Ross's and Dr. Atanda's time most effectively.

A couple things we have got here are what excites you the most about information presented today. You can definitely drop it in chat. Raise your hand, go off mute and talk to us.

Also, for those of you working on addressing opioid use with your Medicare patients, what would you like to put in place based on what you have learned today, and what actions are you interested in taking as a result of today's presentation? We would love to hear from you on that and certainly if we have any others that are popping up in chat, we would like to hear those as well. Grace or Cindy?

Kimberly Duncan asked something with COVID but I wasn't sure what she was asking. Kim, can you unmute yourself and ask your question? Not sure if she's still on.

She just unmuted. Kimberly, can you go ahead, please? We're not hearing. You might be double muted. That happens sometimes. She's trying. I see you. I see that mute icon flashing. You might have to drop it in chat, just to give us a little bit of clarification. That's the reality of doing some remote calls, is sometimes technology gets in the way of communicating, but we have always got more ways to definitely get the message across. If you want to use chat, we would love to hear that. If not, I'm sorry you're having some challenges there.

We will wait. Hopefully Kimberly will be able to give us a little more clarification. We know chat is working for sure. But as we're waiting, let me also address the fact that we do have some information here on joining our TMF Learning and Action Network. This is important, it is definitely, as I said, free to join. Be sure to check that out. There's a lot of resources, event recordings, what we just did today will be up there.

If you haven't already, we encourage you to do that. Join the Community Coalitions section of our network and be sure to sign up to receive those notifications, as new resources are being added.

Kim was asking if the opioid abuse has increased during COVID.

Great question.

The short answer is yes. I'm afraid I don't have the exact numbers but both alcohol and opioid use and abuse has increased during the pandemic. I don't know if Dr. Atanda has additional input on that.

Yes. I'm looking at preliminary data suggesting there has been a spike in opioid overdose and unfortunately, deaths as well from opioid overdose. Part of that is an intersection with patients having COVID symptoms, having respiratory symptoms already, and also thinking of social factors that could lead to opioid misuse and how that could be affected by the opioid epidemic. We are seeing some of that spike information that is trending now.

Grace, thank you for the response, Dr. Atanda. I appreciate that. There is always a little bit of lag when collecting data but definitely something that our providers are seeing or have seen an increase in their practices and in their patient population.

I was going to ask, Grace, if you might drop into TMFnetworks.org for folks before they leave today. There are resources available for those without an account. We certainly encourage you to set up your free account, to get the zone tools, teach back cards, recorded events, all that is going to be accessible to you and will look like this after you join.

There's a couple blue buttons there on the bottom right hand of the slide that I'm sharing with you. You will be able to kind of navigate through that. Very easy, user friendly approach to downloading these resources and hopefully putting these best practices in place. Thanks, Grace. I see that.

Here is some additional information. That timing was perfect. Be sure to do that. There's our E mail, our group E mail, if you wanted to reach out to us. Make note of that E mail. We will be happy to address any of your questions or concerns you might have there.

Also, be sure to check us out on Facebook at TMF Community Coalitions, follow us on Twitter and of course, we have some additional information in here as well and some E mails for Grace, Cindy. And if you are working with Frank on any of this, he collaborates with our team as well and is responsible for a big chunk of Texas and doing some fantastic work in his communities.

I believe he's on the call today, too. I do appreciate that.

Just a few more minutes. I know we have a hard stop. Dr. Ross and Dr. Atanda will be back in clinic and we want to be sure we are respectful of their time, as well as our attendees. We do appreciate you sharing your time with us this afternoon.

Dr. Ross, and Dr. Atanda, I had a question for y'all. With regard to the age friendly health systems in the primary care setting, have y'all been able to implement that at y'all's practice?

Yes, we have the designation at our center for older adults here at the Health Science Center in Ft. Worth and when we applied, the progress was slightly different. Now they have the level 1 and level 2 designation, and the level 1 is pretty straightforward. You are basically just filling out an application that says yes, kind of attesting that you are already doing some of those things

and it can be as simple as doing a Medicare annual wellness visit for having a designated time to track medication reconciliation, discussion of advanced care planning for what matters, doing a dementia screen, doing a depression screen, and doing a fall risk screen. So just having a way to attest that you are doing those things for level 1.

And then for level 2, actually submitting some data showing that you are doing those things.

Thank you for that information. I was just curious what the buy in was for the practice to initiate that.

Oh, that's a really good question. I have had that conversation with others. We are an academic institution and definitely wanted to lead the way, so to speak, in making sure we were doing that and getting the designation and I mean, hopefully as time progresses, it will be there will be more weight placed on that, so to speak. There's not any specific financial incentive to answer a question that wasn't asked, but maybe is being thought about. There's not a specific reimbursement model for becoming age friendly or assuring you are doing those things but there's obviously measures that are connected with some of the age friendly metrics so it can kind of dovetail with things that do have financial incentives.

But really, it's those bragging rights and the ability to say that you are an age friendly health system. It's first implemented in hospitals and hospitals are really big on having those labels, we are an age friendly system, we are a top trauma center, whatever the label might be, and I know that's maybe less of a draw for private practices and whatnot, but that's I guess my two cents on that topic, if that helps.

I appreciate that.

I certainly appreciate it as well. I'm sure our audience does as well. We appreciate your time, Dr. Ross, Dr. Atanda. We did have a hard stop. I want to honor that and be sure that we get you out of here and back in clinic and in front of patients. We thank you so much for joining our call today and sharing your insightful information and phenomenal experience.

We thank our audience for sharing their time with us today as well. Cindy and Grace, for coordinating this call and putting it all together. We hope to host you again, Dr. Ross, Dr. Atanda and we hope to host our audience at our next event.

Thank you so much for joining. That does conclude our call for today. You may now all disconnect. Have a wonderful rest of your week. Thank you.

[End of webinar]