Integrating Behavioral Health into Medication Therapy Management
How Do We Help Our Patients Drink the Water?
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Objectives
- At the conclusion of this program, the participant should be able to:
  - Describe Medication Therapy Management (MTM)
  - Describe factors related to adherence
  - Discuss tools for activating and engaging patients
    • Patient Activation Measure® (PAM®)
    • Motivational Interviewing
    • Brief Action Planning
    • Health Literacy
  - State the importance of relationships in behavior modification

Financial Disclosure: I have no relevant financial relationships with commercial interests pertaining to the content presented in this program.

Medication Therapy Management
- Consensus definition adopted by pharmacy profession in 2004:
  - Medication therapy management (MTM) is service or group of services that optimize therapeutic outcomes for individual patients
  - Services include medication therapy reviews, pharmacotherapy consults, anticoagulation management, immunizations, health and wellness programs, and many other clinical services
  - Services designed to help patients get best benefits from medications by actively managing drug therapy and by identifying, preventing and resolving medication-related problems

Medication Therapy Management

Value-driven Health Care
- US health care moving away from fee-for-service (product) towards value-based purchasing
- Value is balance between quality and cost
  - Can optimize value by improving quality while reducing costs
  - Significant challenge in driving better quality is difficulty defining and measuring quality

Defining Quality
- Medical quality: “The degree to which health care systems, services and supplies for individuals and populations increase the likelihood for positive health outcomes and are consistent with current professional knowledge.”
  - American College of Medical Quality Policy 1
    - Adopted by Board of Trustees, 3/27/96
    - Amendments adopted by Board of Trustees, 2/10/04, 2/17/10

American College of Medical Quality was founded in Pennsylvania in 1973 as the American College of Utilization Review Physicians. In 1991 the name was changed to the American College of Medical Quality to reflect the evolving changes in the specialty.

http://www.acmq.org/policies/policies1and2.pdf
Medicare Star Ratings

• Five-Star Quality Ratings
  – Created by CMS in 2007 and included in Affordable Care Act (ACA) of 2010
  – Designed to help consumers, their families, and caregivers compare [goods and services] more easily
  – Help identify areas about which [consumers] may want to ask questions
  – One to five stars assigned based upon quality and performance

Centers for Medicare and Medicaid Services (CMS)

• Goal: To optimize health outcomes by improving clinical quality and transforming the health system
• Triple Aim Initiative:

Medicare Star Ratings

• 6 goals of CMS quality strategy:
  – Make care safer by reducing harm caused in delivery of care
  – Strengthen person and family engagement as partners in their care
  – Promote effective communication and coordination of care
  – Promote effective prevention and treatment of chronic disease
  – Work with communities to promote healthy living
  – Make care affordable

Triple-weighted Patient Safety Measures

1. High-risk medication (HRM)
2. Appropriate treatment of hypertension in persons with diabetes
3. Proportion of days covered (PDC) for oral diabetes medications
4. Proportion of days covered (PDC) for hypertension medications
5. Proportion of days covered (PDC) for cholesterol medications

Display Measures

• Measures posted on CMS website used for monitoring purposes or as “test” measures prior to becoming star rating measure:
  – Measures that may have reached high level of performance or do not have a lot of variability
  – Some are first-year measures
  – Some have small number of contracts for whom measure could be calculated
• Not included in annual ratings reported to members
  – But are included in CMS review
Display Measures

- 2013 patient safety display measures:
  - Drug-drug Interactions
  - Excessive doses of oral diabetes medications
  - Comprehensive Medication Reviews (CMRs)
  - Adherence to antiretroviral meds
    - Not an official display measure but currently tracked by CMS
    - Increases PDC (proportion of days covered) to 90%
- Star measures moved to display page for 2014:
  - Enrollment timeliness
  - Getting information from drug plans
  - Call center pharmacy hold times

New Display Measures 2014

- Pharmacotherapy management of COPD exacerbations (PCE) for Part C for display in 2014 and inclusion in 2015 (deferred to 2016)
  - Percent of COPD exacerbations for members age 40 or older who had acute inpatient discharge or ER encounter
  - Dispensed systemic steroid within 14 days and
  - Dispensed bronchodilator within 30 days
- MTM Program completion rate for CMR for Part D
  - 2014 display measure
  - 2015 possible inclusion (deferred to 2016)

MTM Completion Rate for CMR

- Measures percentage of beneficiaries who met eligibility criteria for Medication Therapy Management (MTM) program and who received a CMR
  - Maintained as display measure for 2015
  - Will be Star measure in 2016
  - Will be weighted as process measure (1x)
  - Denominator is number of beneficiaries who were at least 18 years or older as of beginning of reporting period and who were enrolled in MTM program for at least 60 days during reporting period

Patient EH

- 50 year-old Caucasian male with type 2 diabetes x 10 years
  - PMH:
    - COPD (80 pack-year smoking history)
    - Diabetic neuropathy x 5 years
    - HF (EF ≈ 40%)
    - Chronic kidney disease, Stage 3
    - s/p partial left foot amputation
    - Sleep apnea
    - Super morbid obesity
    - Hyperlipidemia
    - Hypertension

- Discharge medication list:
  - Albuterol (Ventolin) 2 puff inhaled 3 times a day as needed
  - Alprazolam (Xanax) 1 mg 4 times a day as needed for anxiety
  - Amlodipine (Norvasc) 10 mg each night at bedtime
  - Asprin 81 mg each night at bedtime
  - Chloroquine (Mellaril) 1 tablet every day
  - Clindamycin (Cleocin) 300 mg 4 times a day
  - DolBuflodine (Cymbalta) 60 mg every day
  - Eeroxaril (Eyseta) 145 mg every day
  - Furosemide (Lasix) 2 times a day
  - Hydralazine (Apresoline) 25 mg every 8 hours
  - Insulin aspart (NovoLog) 30 units subcutaneous 3 times a day before meals plus sliding scale
  - Insulin detemir (Levemir) 50 units subcutaneous 2 times a day
  - Omeprazole (Prilosec) 20 mg before bedtime daily
  - Oxytodal (Periact) 10/325 every 6 hours as needed for pain
  - Pregabalin (Lyrica) 100 mg by mouth 3 times a day
  - Tizanidine (Zanaflex) 4 mg by mouth 3 times a day as needed for muscle spasm

- Labs: A1c
  - 10.4 8.5 7.2 7.6 8.0

- Disposition
  - Recently discharged from hospital following admission for right foot debridement
  - Referred to Diabetes Clinic for education
**Patient EH**

- 50 year-old Caucasian male with type 2 diabetes x 10 years
  - Clinic visit:
    - Shows up 35 minutes late for his first appointment
    - Rolled into clinic in wheelchair by sister and accompanied by mom
    - You walk into the reception area just in time to hear him say to the receptionist, "I'm just peachy, thank you very much, now get me the f_ _ _ outa here."
  - How would you respond?

**Adherence Problems in Diabetes**

- Non-adherence rates for chronic illness regimens and for lifestyle changes are ≈ 50%
- Patients with diabetes especially prone to regimen adherence problems
  - Research shows that diabetes regimens are multidimensional
    - Adherence to one regimen component may be unrelated to adherence in other regimen areas
    - Better adherence for medication use than for lifestyle change
    - Adherence rates of 65% reported for diet but only 19% for exercise
    - Two studies showed adherence to oral medications in patients with type 2 diabetes was 53 and 67% when measured by electronic monitoring

**Factors Related to Adherence**

- Demographic
- Psychological
- Social
- Health care provider
- Medical system
- Disease- and treatment-related

**Factors Related to Adherence**

- Demographic
  - Predictors of lower regimen adherence and greater diabetes-related morbidity:
    - Ethnic minority
    - Low socioeconomic status
    - Low levels of education
- Psychological
  - Appropriate health beliefs can predict better adherence
    - Perceived seriousness of diabetes
    - Vulnerability to complications
    - Efficacy of treatment
  - Higher levels of stress and mal-adaptive coping associated with adherence problems

- Social
  - Family relationships play important role in diabetes management
    - Studies show that low levels of conflict, high levels of cohesion and organization, and good communication patterns associated with better regimen adherence
    - Greater levels of social support, particularly diabetes-related support from spouses and other family members, associated with better regimen adherence
    - Social support buffers adverse effect of stress on diabetes management
Factors Related to Adherence

• Health care provider
  – Social support provided by nurse case managers shown to promote adherence to diet, medications, SMBG, and weight loss
  – Regular, frequent contact with patients by telephone promotes regimen adherence and achieved improvements in glycemic control
  • Also improved lipid and blood pressure levels
  – Support provided to patients by health care team was key element to success in achieving good glycemic control in Diabetes Control and Complications Trial (DCCT)

Factors Related to Adherence

• Health care provider
  – Quality of patient-doctor relationship very important determinant of regimen adherence
  • Patients who are satisfied with relationship with providers have better adherence to diabetes regimens
  • Patients who have a “dismissing attachment” style (discomfort trusting others [negative view of others] and greater self-reliance [positive view of self]) toward doctor and who rate their patient-provider communication as poor have been shown to have lower adherence rates to oral medications and SMBG

Factors Related to Adherence

• Medical system
  – Organizational factors that promote adherence:
    • Reminder post cards and phone calls about upcoming patient appointments
    • Appointments that begin on time

Factors Related to Adherence

• Disease- and treatment-related factors
  – Lower regimen adherence can be expected when:
    • Health condition is chronic
    • When course of symptoms varies or when symptoms are not apparent
    • When regimen is more complex
    • When treatment regimen requires lifestyle changes
  – Studies with diabetic patients indicate better adherence to medications than to prescribed lifestyle changes and better adherence to simpler regimens than to more complex ones

Adherence Statistics

• Non-adherence to medications estimated to cause 125,000 deaths annually
• Overall, about 20% to 50% of patients non-adherent to medical therapy
• People with chronic conditions only take about half of prescribed medicine
• Adherence to oral medications in patients with type 2 diabetes ≈ 50 and 70%

Proposed Solutions for Improving Medication Adherence

• Health Care Teams
  – Care teams comprised of nurses, care managers, pharmacists, and other clinicians
  – Increase number of touchpoints for patients, offering repeated checks on adherence as they move through system

• Patient Engagement and Education
  – Counseling by providers and pharmacists to ensure patients understand disease and role medication plays in improving condition

Proposed Solutions for Improving Medication Adherence

• Payment Reform
  – Realigning reimbursement incentives away from rewarding volume and towards rewarding good outcomes
  – Encourage providers to invest in resources such as counseling services to address adherence
• Leveraging Health Information Technologies
  – Ensure complete and accurate (and timely) medication data sharing among all key players


Patient EH

• Adherence Factors
  – Demographic
    • 50 yo Caucasian male on Medicaid x 5 years
    • Denied disability x 3
    • Completed high school and some technical college
    • Former hair stylist/bartender
  – Self-described former “life of the party”
    • “If they make a drug, I’ve tried it”

Patient EH

• Adherence Factors
  – Psychological
    • “My diabetes is going to kill me.”
    • “I’m sick and tired of being sick and tired.”
    • “What am I gonna do if I run outta my nerve/pain pills?”
    • “I’ve got to get outta this house and do what I’m gonna do cause I’m going to lose my license in 2 months and then I won’t be able to go anywhere.”
    • “Them people on that show, ‘My 600-lb Life’ get around better than I do.”

Patient EH

• Adherence Factors
  – Social
    • Lives in grandmother’s trailer
    – Grandmother was “as close to God on earth as I’ve ever seen.”
    – Trailer between sister’s and mother’s trailers
    • Sister has 3 children (ages 3, 6, and 9) and is currently separated from husband (restraining order pending)
    – Husband is African-American
    – EH is primary “babysitter”

Patient EH

• Adherence Factors
  – Social (continued)
    • Parents divorced
      – Dad works
      – Asks to borrow car and/or money weekly
      – Mom works
      – Is the “force to be reckoned with”
      – Is remarried to “satan”
    • Parents do not approve of homosexual lifestyle
      – “I tried everything to get my daddy’s attention growing up. Telling him I was gay finally got it!”
    • Many, many, many past boyfriends
      – Some still call/text
      – “God is calling me outta homosexuality, so I do not want to talk to them no more.”
Patient EH

• Adherence Factors
  – Health care provider
  • One primary care provider x 5 years
    – PCP recently changed employers
    – Recently saw Physician Assistant at former clinic until PCP could get established with new employer
  • Cardiologist
    – Chinese ethnicity who speaks very broken English
  • Nephrologist
    – Pakistan ethnicity who speaks very broken English
  • Endocrinologist
    – Indian ethnicity

• Adherence Factors (continued)
  – Health care provider
  • Surgeon at wound center
    – Travels to neighboring county because does not like surgeon at wound center in home county
  • Ophthalmologist
    – Treats ocular edema and diabetic retinopathy
  • Home health nurse
    – Comes to redress foot wound
  • Pharmacist-owner at independent retail pharmacy
  • Primary Nurse Care Manager provided by Medicaid (CCNC)
  • Pharmacist that works with Care Manager (CCNC)

Patient EH

• Adherence Factors
  – Medical system
    • Medicaid insurance…..NCTracks (need I say more?)
    – “My insurance won’t pay for me to get fat surgery.”
    • Refuses to go to hospital in home county
  – Disease- and treatment-related
    • PMH as listed on first slide
    • 7 past surgeries for necrotizing fasciitis
      – “Dr. _________ butchered all my man-parts.”
      – “5 of the surgeries were to fix what Dr. _________ screwed up.”
      – “Dr. _________ one of the surgeons at wound center in home county
      – “If I ever see Dr. _________ out in public, I WILL shoot him.”

“People actively involved in their health and health care tend to have better outcomes – and some evidence suggests, lower costs.”
-Health Policy Brief
HealthAffairs
February 14, 2013

Tools for Engagement

• Empower patients to take the lead
  – Patient Activation Measure (PAM)
  – Motivational Interviewing
• Equip patients to succeed
  – Brief Action Planning (BAP)
• Educate patients when there’s a need
  – Health Literacy
  – Teach Back
• Encourage patients to believe
  – Power of relationships

“People actively involved in their health and health care tend to have better outcomes – and some evidence suggests, lower costs.”
-Health Policy Brief
HealthAffairs
February 14, 2013

You can lead a horse to water, but you can’t make him drink
–John Heywood (c. 1497 - 1580) or Old English Homilies, 1175
"You can lead a horse to water, but you can't make him drink"

- John Heywood (c. 1497 - 1580) or Old English Homilies, 1175

“Coercion thru threats of dire outcomes from poor control of the disorder are doubly unethical: it does not work and high anxiety patients withdraw from care when threatened.”

Haynes RB, McDonald HP, Garg AX
Helping Patients Follow Prescribed Treatment

Stages of Change

Figure: http://johnnyholland.org/2011/01/the-a-b-c-of-behaviour/
Concept: Prochaska JO, Velicer WF. The transtheoretical model of health behavior change.

Patient Activation Measure (PAM)

- Commercial assessment tool that gauges knowledge, skills and confidence essential to managing one’s own health and healthcare
- 10- or 13-question scale developed by Judith Hibbard, DrPH and Bill Mahoney, PhD and colleagues at University of Oregon
- Predictive guidance helps to identify realistic and achievable opportunities to change behaviors and treatment that can move individual towards increasing activation
- Segments patients into one of four activation levels along empirically derived continuum

Patient Activation Measure® (PAM®)

Level 1 - Uninformed and overwhelmed
- Individuals have little knowledge and lack confidence. Knowledge is low, motivation is low, and adherence is poor. Their perspective: “My doctor is in charge of my health.”

Level 2 - Beginner
- Individuals have some knowledge, but large gaps remain. They believe health is largely out of their control, but can set simple goals. Their perspective: “I’m part of my health care team.”

Level 3 - Maintaining behaviors and pushing further
- Individuals have few barriers, but may struggle at times. They make changes with support. Their perspective: “I’m my own advocate.”

Level 4 - Lifting the bar
- Individuals have few barriers, and are driven by knowledge. They strive for best practice behaviors and are goal-oriented. Their perspective: “I’m part of my health care team.”

Motivational Interviewing (MI)

Motivational Interviewing

• First described in 1983
• Initially developed as brief intervention for problem drinking
• Tested with other health problems in 1990’s
  – Focus in chronic diseases
• Works by activating patients’ own motivation for change and adherence to treatment

“Spirit” of MI

• Foundational way of interacting with patients
  – Collaboration
    • Focus on mutual understanding
  – Acceptance
    • Patient makes decisions. We are guides.
  – Evocation
    • Evoke patient’s own motivation and resources for change
  – Compassion
    • Understand and validate their reality

Patient JK

• 72-year-old African-American widowed male with h/o MI x 2, HF, DM x 15 years (A1c = 12.3% in February 2014)
  – Current Medications

<table>
<thead>
<tr>
<th>Medication</th>
<th>Adherence Index</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aspirin 325 mg daily</td>
<td>-</td>
</tr>
<tr>
<td>Furosemide 40 mg daily</td>
<td>0.60</td>
</tr>
<tr>
<td>Glipizide 10 mg BID</td>
<td>0.40</td>
</tr>
<tr>
<td>Lisinopril 40 mg daily</td>
<td>0.40</td>
</tr>
<tr>
<td>Metformin 2 gm BID</td>
<td>0.40</td>
</tr>
<tr>
<td>Omeprazole 20 mg daily</td>
<td>0.60</td>
</tr>
<tr>
<td>Sitagliptin 100 mg daily</td>
<td>No fills</td>
</tr>
</tbody>
</table>

– Diagnosis: Non-adherence

Patient JK

• 72-year-old African-American widowed male with h/o MI x 2, HF, DM x 15 years (A1c = 12.3% in February 2014)
  – Treatment plan
    • What factors are important to consider when working with JK?
      » Demographic
      » Psychological
      » Social
      » Health care provider
      » Medical system
      » Disease- and treatment-related
Patient JK

- 72-year-old African-American widowed male with h/o MI x 2, HF, DM x 15 years (A1c = 12.3% in February 2014)
- After several visits with JK, you discover that:
  - Wife died 6 months ago
    - Married for 55 years
    - “Ma’ did everything for me”
    - He found her dead in recliner one morning after seeing her give herself a shot for “sugar” before bed
  - 3 sons and 2 daughters
    - 2 sons have passed away, 1 son in prison
    - Daughters live in other states
    - Seldom visit

Desired Action

<table>
<thead>
<tr>
<th>Desired Action</th>
<th>De-motivational Interrogating</th>
<th>Motivational Interviewing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lower A1c</td>
<td>“Your A1c is too high. Needs to be lower.”</td>
<td>“How have you been feeling lately?”</td>
</tr>
<tr>
<td>Improve medication adherence</td>
<td>“Why are you not taking your medicines?”</td>
<td>“Which medications seem to be helping you right now?”</td>
</tr>
</tbody>
</table>

Patient JK

- **Prescription:**
  - Come to Pharmacy lunch counter qAM to take medications
  - Stop omeprazole, glipizide, and sitagliptin
  - Start insulin glargine 15 units qAM

Take-aways to Use Today

- **Collaborate with your patients**
  - See patient as expert on themselves
- **Evoke patient’s own motivation and resources for change**
  - Avoid the “expert” trap
- **Respect patient autonomy**
  - Inform and encourage choices without judgment
- **Demonstrate genuine compassion**
  - Understand and validate their struggle
  - Honor reality

Closing MI Thoughts

- “Everybody’s motivated about something.”
- “If your consultation time is limited, you are better off asking patients why they would want to make a change and how they might do it rather than telling them that they should.”
  - William R Miller, PhD
  - Stephen Rollnick, PhD
  - Christopher Butler, MD

There is no guarantee that using MI techniques in your conversations with your difficult patients will get you the outcomes you want, but it will most certainly help you understand why you are not.

Brief Action Planning (BAP)
Brief Action Planning (BAP)

- Highly structured, stepped-care, self-management support technique grounded in principles and practice of Motivational Interviewing
- Structured way of interacting with individuals interested in making a concrete action plan for some aspect of their health
- Use when patients are ready to start change process

http://www.centremi.ca/learn/brief-action-planning/

Brief Action Planning (BAP)

- Structured around 3 core questions:
  - “Is there anything you would like to do for your health in the next week or two?”
  - “I wonder how sure you feel about carrying out your plan. Considering a scale of 0 to 10, where ‘0’ means you are not at all sure and ‘10’ means you are very confident or very sure, how sure are you about completing your plan?”
  - “Would it be useful to set up a check on how it is going with your plan?”

http://www.centremi.ca/learn/brief-action-planning/

Health Literacy

The degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.

Institute of Medicine Report

http://nnlm.gov/outreach/consumer/hlthlit.html

More than half of US adults (90 million) find it difficult to understand and act on health information

Health Literacy

US Department of Health and Human Services

Goals to Improve Health Literacy

1. Develop and disseminate health and safety information that is accurate, accessible and actionable
2. Promote changes in health care system that improve health information, communication, informed decision-making and access to health services
3. Incorporate accurate, standards-based and developmentally appropriate health and science information and curricula in child care and education through university level

http://nces.ed.gov/naal/health.asp

http://www.health.gov/communication/hlactionplan/
Goals to Improve Health Literacy

4. Support and expand local efforts to provide adult education, English language instruction and culturally and linguistically appropriate health information services in community
5. Build partnerships, develop guidance and change policies
6. Increase basic research and development, implementation, and evaluation of practices and interventions to improve health literacy
7. Increase dissemination and use of evidence-based health literacy practices and interventions

Health Literacy

Three Things to Do Now

- Use tools currently available
  - Health Literacy Universal Precautions Toolkit
  - AHRQ Pharmacy Health Literacy Assessment Tool and User’s Guide
- Use teach-back method of communication
- Help change systems of care
  - Make health literacy a priority in your work environment

Literacy Summary

- Low health literacy more common than you think
  - And very hard to identify
- Low health literacy related to worse health outcomes in variety of settings
- Strategies exist to help provide better care for patients with low health literacy
- Programs and services need to be designed with health literacy in mind

“Eschew Oblfuscation”

What Does This Sign Say?

Please remember to bring all of your medicines, vitamins, and supplements in their original containers with you to every office visit.

Teach Back
Teach Back

- 40 – 80% of medical information forgotten immediately
- Nearly half of information retained is incorrect
- Teach back is a way to confirm that you have explained what patient needs to know in a manner that they understand
- Helps staff understand how to communicate with patient

AHRQ Health Literacy Universal Precautions Toolkit

Power of Relationships

"The problem with communication is the illusion that it has occurred."

-- George Bernard Shaw

Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

World Health Organization


The Definition has not been amended since 1948.
http://www.who.int/about/definition/en/print.html

Relationships Matter

- Family and social support important aspects of adherence to diabetes management
- Numerous correlational studies have shown positive and significant relationship between social support and adherence to diabetes treatment

Diabetes, Metabolic Syndrome and Obesity: Targets and Therapy 2013;6:421–426

Provider Effect

• **Study:** Examine influence of patient and physician psychosocial, sociodemographic, and disease-related factors on diabetes medication adherence

• **Methods:** Data collected from 41 Geisinger Clinic primary care physicians and 608 patients with type 2 diabetes
  - Adherence to oral hypoglycemic medications calculated using medication possession ratio based on physician orders in electronic health records (MPREHR)
  - MPREHR: Proportion of total time in 2 years prior to study enrollment that patient was in possession of oral hypoglycemic medications

  [Diab Educator 2012;38(3):397-408]

• **Results:**
  - Factors associated with better adherence to oral hypoglycemic medications:
    - Satisfaction with physician’s patient education skills
    - Patient beliefs about need for medications
    - Lower diabetes-related knowledge
  - Patient knowledge may not be directly related to self-management behaviors
  - Shorter duration of time with diabetes
  - Taking only oral hypoglycemic medications
  - Association between shared decision making and medication adherence significantly modified by patients’ level of social support

  [Diab Educator 2012;38(3):397-408]

Effect modification of the relationship between perceived involvement in care and medication adherence by level of social support

[Diab Educator 2012;38(3):397-408]

Provider Effect

• **Study:** 60 people having wisdom teeth removed
  - Told they would receive either:
    - Placebo (which might reduce pain of having tooth removed, or might do nothing) OR
    - Naloxone (which might increase pain, or do nothing) OR
    - Fentanyl (which might reduce pain, or do nothing) OR
    - No treatment at all
  - **First phase:** Clinicians (not patients) were told fentanyl was not yet a possibility because of administrative problems with study protocol (PN Group)
  - **Second phase (week later):** Clinicians told that problems had been resolved, and now patients might indeed receive fentanyl (PNF Group)


• **Results:** Pain after placebo administration in PNF Group significantly less than pain after placebo in PN Group at 60 minutes

**Emotional Bank Accounts**

- Metaphor for amount of trust that exists in relationships
  - Both personal and professional
- Deposits build and repair trust
- Withdrawals break down and lessen trust
- Everyone is an accountant
- We track deposits and withdrawals others make with us

Emotional Bank Accounts

- Deposits
  - Seeking first to understand
  - Showing kindness, courtesy, and respect
  - Keeping promises and commitments
  - Being loyal to the absent
  - Setting clear expectations
  - Apologizing when you make a withdrawal
  - Forgiving others

- Withdrawals
  - Assuming you understand
  - Showing unkindness, discourtesy, or disrespect
  - Breaking promises or commitments
  - Being disloyal or bad-mouthing others
  - Creating unclear expectations
  - Being proud or arrogant
  - Holding grudges

**Epidemiology of Multimorbidity and Implications for Health Care, Research, and Medical Education**

- Methods
  - Cross-sectional study on 40 morbidities from database of 1,751,841 people registered with 314 medical practices in Scotland
- Findings
  - 42.2% of all patients had one or more morbidities
  - 23.2% were multimorbid (presence of ≥ 2 disorders)
  - Onset of multi-morbidity occurred 10–15 years earlier in people living in most deprived areas compared with most affluent
  - Presence of mental health disorder increased as number of physical morbidities increased and was much greater in more deprived than in less deprived people
- Interpretation
  - Complementary strategy needed, supporting generalist clinicians to provide personalized, comprehensive continuity of care, especially in socioeconomically deprived areas

**Prevalence of Multimorbidity by Age and Socioeconomic Status**
Physical and Mental Health Comorbidity and the Association with Socioeconomic Status

![Graph showing physical and mental health comorbidity with socioeconomic status]


Behavioral Health Screenings

- Patient Health Questionnaire (PHQ-9)
  - Most common screening tool to identify depression
  - Abbreviated version available: PHQ-2
- CAGE AID
  - 4-question tool used to screen for drug and alcohol use
- Screening, Brief Intervention, and Referral to Treatment (SBIRT)
  - Evidence-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs

Selected Comorbidities in People with Four Common, Important Disorders in the Most Affluent and Most Deprived Deciles

- Poor patients with diabetes more likely to have painful condition, depression, and anxiety

Screening, Brief Intervention, and Referral to Treatment (SBIRT)

- Consists of three major components:
  - Screening: Healthcare professional assesses patient for risky substance use behaviors using standardized screening tools
  - Brief Intervention: Healthcare professional engages patient showing risky substance use behaviors in a short conversation, providing feedback and advice
  - Referral to Treatment: Healthcare professional provides referral to brief therapy or additional treatment to patients who screen in need of additional services
- Service is billable under certain conditions

Motivation to Change

- Two things that help one move out of poverty:
  - Education
  - Relationships
- Four reasons one leaves poverty:
  - It’s too painful to stay
  - A vision or goal
  - Special talent or skill
  - Key relationship

Pharmacists’ Opportunity

<table>
<thead>
<tr>
<th>CCNC Enrollees with total medical cost &gt; $50,000</th>
<th>CCNC Enrollees</th>
<th>CCNC Enrollees on TC Priority list</th>
<th>CCNC Enrollees on Medication Management Priority list</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of members</td>
<td>1,348,029</td>
<td>122,529</td>
<td>17,751</td>
</tr>
<tr>
<td>Total medical cost</td>
<td>$4,078</td>
<td>$27,527</td>
<td>$23,813</td>
</tr>
<tr>
<td># of Inpatient visits</td>
<td>0.11</td>
<td>0.52</td>
<td>1.41</td>
</tr>
<tr>
<td>Inpatient costs</td>
<td>$369</td>
<td>$3,464</td>
<td>$5,337</td>
</tr>
<tr>
<td># of mental health inpatient visits</td>
<td>0.01</td>
<td>0.04</td>
<td>0.04</td>
</tr>
<tr>
<td>ED visits</td>
<td>0.67</td>
<td>1.65</td>
<td>2.94</td>
</tr>
<tr>
<td>Outpatient visits</td>
<td>2.09</td>
<td>2.91</td>
<td>2.53</td>
</tr>
<tr>
<td>Pharmacy visits</td>
<td>4.97</td>
<td>19.63</td>
<td>16.95</td>
</tr>
<tr>
<td>Pharmacy costs (Pre Rebate)</td>
<td>$721</td>
<td>$5,177</td>
<td>$3,342</td>
</tr>
</tbody>
</table>

Patient’s make more visits to pharmacy per year than primary care providers (PCP) or mental health provider(s)

Data on file Community Care of NC

http://www.integration.samhsa.gov/clinical-practice/sbirt

A Framework for Understanding Poverty
Ruby K. Payne, PhD

Patient EH
• Home visit
Patient EH: Rewind….

• 50 year-old Caucasian male with type 2 diabetes x 10 years
  – Clinic visit:
    • Shows up 35 minutes late for his first appointment
    • Rolled into clinic in wheelchair by sister and accompanied by mom
    • You walk into the reception area just in time to hear him say to the receptionist, “I’m just peachy, thank you very much, now get me the f _ _ _ outta here.”
  – Knowing what you know now about EH, how would you respond?

“There is no medicine like hope, no incentive so great, and no tonic so powerful as expectation of something tomorrow.”
- Orison Swett Marden, MD

Telling the frustrated, overwhelmed, ambivalent person with a chronic disease they need to take better care of themselves is akin to telling the person stuck in quicksand they need to get out as soon as possible.

We then who are strong ought to bear with the scruples of the weak, and not to please ourselves. Let each of us please his neighbor for his good, leading to edification. For even Christ did not please Himself; but as it is written, “The reproaches of those who reproached You fell on Me.” For whatever things were written before were written for our learning, that we through the patience and comfort of the Scriptures might have hope.
- Romans 15:1-4

Closing Thoughts

• Patients often need encouragement more than education
• We tend to operate from the perspective that everyone wants to live a long life
  – That is not always the case
• There are no guarantees in medicine
  – Following guidelines and recommendations does not guarantee positive outcomes
  – Research data help us recommend options that reduce risk…..not guarantee results
“The good physician treats the disease; the great physician treats the patient who has the disease”
- Sir William Osler

Key Principle to Remember

“People don’t care how much you know until they know how much you care.”
- Theodore Roosevelt

Contact Information

- Community Care of North Carolina (CCNC)
  - State-contracted, public-private partnership made up of regional networks
  - Manages approximately 80% of state’s Medicaid program
  - Provides cooperative, coordinated care for patients through Medical Home model
- Carolina Community Health Partnership (CCHP)
  - One of fourteen networks across the state
  - Serves Cleveland and Rutherford counties
  - Purpose: Provide care that is patient-focused, provider-driven, community-based, and cost-effective
- More information available at www.communitycarenc.org
  - MI resource manual: https://www.communitycarenc.org/population-management/motivational-interviewing/

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