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June Quarterly Special Innovation Project Pacing Event

Tennille Daniels: Good afternoon and welcome to today's QIN-QIO special innovation projects quarterly pacing event before we get started we want to go over a few housekeeping announcements if you are listening to this webinar via the phone but are look at the slides via the platform please make sure to mute your computer speakers to avoid any feedback. There will be several opportunities for audience participation during today's webinar, so we encourage you to get into the queue when the operator gives those instructions or feel free to enter your questions and comments into the chatbox. At this time, I would like to turn it over to Kevin Frazier who will start today's event. Kevin?

Kevin Frazier: Thank you, very much and good afternoon, everyone. Thank you so much for joining us for today's second quarterly event. We have another exciting event planned today. Our featured topics for today's event is once again based on our ongoing continuous and assertive efforts to address the widespread opioid epidemic. As I last checked I believe that we had roughly 134 attendees that registered for this event. Perhaps even more as we speak. Which speak to the importance of this topic area. Today we have on the line with us the quality insights QIN as well as the health alliance QIN who will explain their results as part of the 2017 cohort. I'm quite pleased to share we have another well-respected and extremely knowledge opioids meet as a reactor for today's event. He is a good friend and colleague back when we worked on the hospital engagement network Dr. Dan Buffington. More will speak later. Before I turn the line over to our deputy group director who will set the stage for today's event.

I would like to thank each of our invited participants for their collaboration with us on today's piecing event. I would also like to thank our SIE team for all their continued efforts not just with the design and the planning of the pacing events but rather for all of the work that they do in support of our overall mission on a daily basis. With that being said at this time will turn the line over to Jeneen to set the stage for this afternoon's event. Jeneen, over to you now.

Jeneen Iwugo: Thank you so much Kevin, I had a chance to prepare the slides and I'm happy to see the work that is being presented today is right in the zone of the things that CMS and HHS are looking for in terms of things that we want to reinforce and then also things that we want to spread.

You're going to hear about efforts to reduce the use of opioids and also the misuse and this is really important because while there are patients that have chronic pain that needs opioids there are a lot of patients that have pain that can be addressed with opioids in combination with other treatments or with other treatments to begin with so you're going to hear a little bit about that as well as efforts to increase patient awareness of the risk of having an opioid. There are patients out there who receive prescriptions and they don't know that what they're getting is an opioid so that's really important to make sure that patients and advocates in the community are ensuring that people know the risk of the medication that's given to them and that they're making the connection between what they're hearing about the opioid crisis and

the prescription that they're filling. You're going to hear about the coordination of patients with behavioral health and opioid use disorder and also a huge effort that's going on across our networks to reinforce provider commitment to using, prescribing guidelines with the medication management and opioid clash. I will stop there, I don't want to do too much of a spoiler but I'm excited to hear today's presentations and to welcome everyone to the call. Thank you.

Kevin Frazier: Thanks so much Jeneen. I would like to turnover now to Charisse who will talk about today's event.

Charisse Coulombe: Thanks, Kevin and Jeneen for the great introduction to this really important topic. As we know opioids are a major focus of a lot of different groups across the country. Everyone including Congress and there are a few representatives who just introduced the Medicare beneficiary opioid addiction treatment act are looking for way to assist people in better understanding the prescriptions that they're getting.

But also finding ways to help people who have an opioid addiction. We know this epidemic is not limited to a particular age group and really impacts everybody. We know that there's a lot of need for coordination and education with both patients and families as well as their providers and we certainly appreciate the support and commitment of CMS and HHS to this important work as you will see today. As part of these two special innovation projects. As Kevin said earlier as part of this event we are pleased to have Dan buffing ton, the practice director of the pharmacology services and has many years' experience serving in schools across the U.S. His group provides practice-based training that focuses on the collaboration between patients, practitioners, and insurers to improve medication therapy management. So, we will be hearing from him after each of our speakers. And get his reaction and comments after each presentation. So, I would like to do now is introduce our first special innovation project, reducing opioid misuse and diversion. And I will turn the floor over to Smith who is our task lead from quality insight. The floor is yours.

Kandi Givner: Good afternoon everyone, I am the project lead for aligned health solution improving care outcomes for Medicare beneficiaries with mental health and opioid use special innovations project. Just to let you all know we were awarded this project back in September 2017. So roughly we're about nine months in and our project primarily focus on Medicare beneficiary who is are experiencing the comorbidity of mental illness and chronic opioid use through our interventions we are very confident that not only were our beneficiaries benefit from our efforts, yet the communities' families, friends and other health care providers will also see a long-term result from our project. Next slide, please.

Now just to give a little bit of background about our project and how it was developed, after we research Medicare claims of prescription opioids and have a mental health illness we learned of the national averages which is reflective on the bullets towards the bottom of the slide there. And after we learned of the high use of opioid users of 60 days or more and these with a mental health illness we did our own data for the regions we support, North Carolina and Georgia. And there were two communities that popped out to us which was northwest Georgia and the Wilmington, North Carolina area that you see in the charts.

That focused our attention in these areas and we realized there was an evident need for us to reach out to those communities and, you know, and put our project use there. So that's where we began leading our recruitment efforts. Next slide, please. Now our target population once again it does focus on the Medicare beneficiaries with the dual diagnosis with mental health diagnosis and an opioid long-term use but we also were targeting the emergency departments itself. So the ED staff, behavioral health staff all of those within the ED and once we share with them our project goals of reducing unnecessary opioid prescribing in the ED and also decreasing the emergency room presentations and hospitalizations of that population by 25%, they were on board.

We were successfully able to recruit our goal of two hospitals in northwest Georgia and we reached our goal of recruiting seven hospitals in the North Carolina expanded territory of Wilmington as well. Next slide. Part of our project goal we expressed in we also let them know our key intentions. We had an advisory board. We meet with them quarterly to discuss the projects, the updates, where we are, where are some of the challenges that we are facing and their insight and knowledge on the matters. We also have a website for individuals to go look at information about our project. We share our learning and action network information there as well. We meet with our communities and recruit hospitals and we have a huge focus on peer support specialist in the northwest Georgia area.

Our LANs like I mentioned we do this monthly, probably the second week of each month but we have topics ranging from identifying mental health, identifying mental health or a mental illness, we have topics about pain management, how to deal with that with a mental health patient with a patient who has a chronic illness. So we come together as a team to put these topics together and we have guest speakers and we have a patient or family experience at the beginning of that call that really drive our audience to participate and learning from one another. So along with those interventions we will have a -- we will provide education to ED prescribers as well as providing the whole health action management training. But those are year two interventions, so we haven't quite got there yet but that is on our list of interventions.

Next slide, please. Now how effective have we been? Nine months in we are fully recruited. Our sessions have begun. We have had about 85% in attendance of our recruited participants so that's roughly about 23-24 individuals on our LAN call. We had one that finished around 3:00. So, I had to jump off early, but we had 20 in attendance there. We had hoops that we had to deal with HR and policies and procedures. We are still working through those. So, we have two hospitals, one hospital is a little bit more successful than the other as far as getting that peer in there. There's not too many hoops. And now that we have our baseline data. We did receive our baseline data for all our recruited participants. It's provide our hospitalization rates; the observation stays so we have a foundation now where now we can start to really monitor our 25% goal in the reductions there. Next slide, please. Now our return on investment. The return on investment was developed after completing a literature review and from that review we projected what results we could anticipate and what the cost would be expected in the areas as far as our ED visits, the hospitalizations and the prescriptions, the prescribing opioids. Now we are able to use our own Medicare data now that we have the baseline. So, we know who is at risk, how many people, how many people are being readmitted and the impact long-term. This slide here shows the estimates or the

best guess at the time. Now we are, you know, in the process of monitoring our own data so we can keep track of the ROI targets that we did put out there. So overall, our project, we're reaching that target of mental illness of long-term opioid users. We have our hospitals recruited. We know the impact that the specialists have. We're conducting learning sessions, providing educational tools. We have our website up. We have our baseline data now available to us. But we still have some questions for the audience after going through that. Next slide, please. And we wanted to know of the other QIOs on line has anyone had any similar issues with the onboarding issue of a peer support specialist and anyone doing any similar work that can provide some insight of what they're currently experiencing as well and that's all I have. Thank you.

Daniel Buffington: Great, this is Dan, I wanted to make couple observations. Your presentation highlighted a really critical point and that's the pain and mental illness are often comorbid factors that make treatment a greater challenge but also give bad outcomes. The measures understood that there's different point of root causes from the access to opioids in different settings. How patients are managed. Do patients understand acute versus chronic pain and engaged all those different parties and I would underscore the word collaboration. You demonstrated the effect and success of collaboration across the community.

Your team's metrics for reducing clinical problems or cost are impressive so the exact issue that many times gets lost and is difficult to digest or understand in a large project that involves so many people is does your effort make a difference? So, for the time and effort that goes into identifying those problems, those root causes, putting measures in place to address them and while there's obviously a need to improve patient care and protect lives does it result in a cost savings and I think the answer's clear that your results show a strong ROI statement that is derived from attacking the numerous moving parts. Let's see what questions come in?

Kandi Givner: Okay. Thank you.

Charisse Coulombe: I think one of the things pointed out is it's not just point of care prescribing in a primary office but looping in that emergency department. Into that total community wide communications loop and pharmacies and if your state and area has a PDMP, a prescription drug monitoring program that can also be an electronic in the moment point of care reference point for finding various issues from doctor shopping to overlapping prescriptions in many cases those may be appropriate prescriptions but still represent a dashboard for a lack of a better term of seeing for -- foreseeing potential controlled substance complications from a pharmacology perspective.

Charisse Coulombe: Dan we have one question in the chat that looks like it's for the whole group. Linda is asking do any of the HINs share successes with the use of peers in this area? Do people want to type in or chat in so people can respond, that will be great.
Daniel Buffington: I know while it may not be success -- an issue of medication of opioids in the early phases and in continuing various HINs have tracked adverse drug events and put measures in place. I think that this is, where we're at now collectively is a broader perspective of looking at opioids as a major adverse drug event category. So there's going to be plenty of prior early examples of successes on opioid controls and safety measures.

Charisse Coulombe: Absolutely and certainly it is one of the, I would say one of the umbrella topics that CMS is looking at in multiple arenas including the HINs as well as the QINs. Looks like Todd might be typing a question. I will wait a few seconds before saying thank you so much, Kandi, that you and your team are doing in this arena. We know the importance of this work and providing beneficiaries that have mental illness with better outcomes as they utilize opioids in their community so we appreciate this, Kandi, we appreciate your team's work and this time I will turn it over to Smith who is over in quality insights and her team have worked on reducing opioid misuse and diversion and their special innovation projects have been going since 2016 so the floor is yours.

Biddy Smith: Okay. Great. Hello, thank you for having me here this afternoon. I am the network lead for special projects for quality insight. I will talk about our opioid misuse and diversion next slide.

A little bit of background. Primary care physicians provide the majority of the acute and chronic management. Prescriptions for opioid pain relievers have quadrupled since 1999. The greatest rates have been in internal medicine, family practice and general medicine. In March 2016 the CDC estimated that 20% of patients received prescriptions for opioids therefore it's not surprising that opioid analgesics today are the most commonly prescribed class of medications in the United States. Next slide. For our target population, we did a cross test work and targeted 2000 participating clinicians. We also worked to have statewide impact with collaborating with physicians and work.

Our key interventions and designs engage clinicians and their practices. We created tools and guides to create awareness. We also developed a crosswalk between improving opioid prescribing practices and pain management for the quality program. We encouraged patients and families to take an active role in their pain management plan and stress the risks of opioid misuse. Following we recently developed the clinician opioid prescribing report which prepares the practices to their peers and opportunities for improvement. We are currently working on variety of way to share these reports with providers throughout each of our QIN state. Through collaboration with state opioid coalitions, senior Medicare patrol groups, state office managers association we have reached providers as well as beneficiaries.

We continue to work and collaborate with state agencies. In Delaware we have successfully worked with their website. Next slide. Effectiveness. This slide shows rates of opioid use, opioid prescriptions for multiple providers, and overlapping opioid prescription. These all decrease from project start in 2016 Q3 to the most current quarter available, 2017 quarter three. In the first year in the project's implication, the states within our network achieved a reduction in opioid use.
At the start of the project 4056. Then it was decreased to three thousand. This equate to 39,977 less patients using opioids. Additionally, over the same time we achieved a reduction in opioid prescriptions. A total of 5,000 patients received less prescriptions. And, less patients received an overlapping opioid prescription. Next slide. From quarter three 2016-17 we saw a reduction of opioid use by 39,977 beneficiaries QIN-wide this equate to a reduction of 3.4 million dollars in Medicare opioid prescription costs. Outside of opioid use we are unable to equate a dollar amount to the other two measures. I believe the decrease in multiple

prescribers and overlapping prescriptions can be equated to increases in patient safety and well-being through less opioid use therefore decreasing the risk of misuse and diversion.

So, some of the questions we kind of struggled with is there a different way to calculate return on investment. What are some other methods to demonstrate the impact of the educational campaign beyond traditional ROI calculations and what are some of the other way to demonstrate a reduction in utilization is there an industry standard.

Daniel Buffington: This is Dan again, the shocking part of this entire today's session is we get the title opioid crisis like it's one thing. When really it represents a wide array of issues from inappropriate prescribing, the problems with severe side effects, treatment complications, even if it's prescribed appropriately. Drug interactions, misuse, addiction, overdose and it's reached an all time high. It's clear from your presentation and your network results that you guys also looked at it from a diversity of problems that worsen the outcome for patients and families as well as the challenges. The key part of your presentation is to get results it starts with change and the change starts with education.

And most importantly to each of the parties that are involved and critical messages that opioid prescribing should be and you guys emphasized it not only with how you approached it but the power of your results is that when you streamline the number of prescribers and practitioners who are making these medical decisions and tracking the outcomes, you directly get people, you get folks actively communicating on that patient's personalized care and it doesn't become just a prescription that's being processed so you get to see both the positive and negative results. In addition to that, regardless of how you describe it whether it's a financial cost of the educational material that you outlined here. Time spent distributing those, it is a positive return and, again, both presentations have done an excellent job and that's often a target for a payer but also for everyone touching the health care system. These questions that you listed are really key. Is there a different way to calculate a return on investment? When you start to look at traditional ways, the way you set up your metrics for that equation, so they could involve clinical outcomes.

It could just be financial, it could be quality of life metrics. You could make that on claims data but maybe what's obvious and maybe what's not so obvious. The obvious is reduction in opioid use but you could look at secondary measures for these therapies so there is that impact. Pain, rehab. And reductions in the identification of addiction and treatment and overdose complications. The -- what are some of the other methods that demonstrate these change? Utilization. Increased utilization of nonpharmacology intervention. Patient safety. There are some standards out there that you can look to the pain societies but also the American pharmacies -- pharmacist association developed a series of support material to look at this as well at reducing opioid utilization and improving health outcomes but those factors again, could be reducing the duration of treatment, defined by prescription quantity, by number of refills. Conversion from opiate to non-opiate. Data review or looking at reduced rehab or the impact of rehab and getting folks to return to daily activities or return to work. Great job.

Biddy Smith: Thank you. Thank you for your insight.

Charisse Coulombe: We would greatly appreciate if anyone can help on her work. Todd had a question and this applies to both presentations for today. His comment was related to peer support specialists are growing as a sector of the health care workforce. Lib experience is valuable. I don't know, Dan, if you have experience with working with peer support specialists in your work.

Daniel Buffington: We provide consultations on an inpatient and outpatient basis and it is but/for collaboration. And I will also add that maybe a little bit of a side track and it could also be its own symposium is there's changes happening even when we look at practice point of care delivery and some of the pressure points. And what I will say is that I sit on the AMA CPT panel. Current procedural terminology and that's where a foundation for how we code services and I just want to emphasize that there is a radical transition taking place in the broadening in the interpretation of the codes to be interprofessional.

They're historically chronic pain or chronic care coordination and transitional care. Two things that are critical right now as innovative transitions. Is a transformation from an old school concept of service delivery and documentation of being a date, a time, a place, a patient, a practitioner and in the moment. And those two categories, chronic care coordination which directly apply to this and transition s of care which also directly apply to this are descriptors that are interdisciplinary peer group support coordination and are over a period of time so they're helping to identify those patients at transitions and across not just a date of service visit at an office but across a period of time and that's just a fundamental change that's promoting the way we would approach these types of coordinated care.

Charisse Coulombe: Dan, as you said earlier this is a very sophisticated, complex topic to address. It sounds like the AMA group is certainly on the right track. Just as a reminder you can ask your question via the phone line using star pound but Jacqueline has a question. I think this is directed to you, Biddy. If you can tell us what data, you have on that.

Biddy Smith: We don't have data right now but that is something we're exploring. We just recently started wrapping up for that Q3 quarter 2017. So now we're starting to look back and look at different things we can capture and see what the impact was and what changes of practice there may have been. And Dan's comments will be helpful with directing us for some of that as well.

Charisse Coulombe: Absolutely. I completely agree. Maria put a comment in about cross-sectional growth curves if you don't have those friends they are looking at designs that look at cohorts. Could be a great way to look at the impact of educational components if they have clear start dates for those types of campaigns. I believe that's a response to demonstrate the impact. Jacqueline says is there a collaboration with organizations like the VA and the Department of Defense? Both government entities that have issues with opioid misuse. I think that question really is for anybody that would like to answer that. Biddy or Dan or Kandi.

Biddy Smith: We have used some of the VA and the DOD's resources as part of our practice Change Package that we developed. So, some of the tools and things they have created we have used as well. I would underscore those are large organizations and bodies that have a large approach and they have been successful and some of the resources have demonstrated

the success rate and utility in terms of positive impact on health outcomes in pain on the use of alternative therapy so anything that reduces in the term that I use in point of care is anything that reduces the opiate burden, the quantity, the intensity of the product selected or the duration of exposure is positive. So various types of nonpharmacologic and alternative therapies are significant components to reducing the opiate crisis.

Charisse Coulombe: Great, thanks, Dan and Biddy for those insights. This shows the sophistication of this type of crisis and certainly I have seen great collaboration with CMS, the VA and the DOD especially at the CMS quality conference this past February I was able to sit in on a session where the VA and DOD spoke about the opioid crisis and what they were doing to address this in their communities. So great example of great collaboration across government entities. I know, it looks like we don't have anybody in the queue. It looks like we just got another comment in about the 2016 CDC opioid guidelines. And the work that the CDC is doing and Biddy is putting up her project page for reference. Thank you, Biddy for that. I don't know, Dan, if you have any comments about Coleman's chat response or questions about that?

Daniel Buffington: I'm reading it as we speak. Clearly part of this may be the concerns, the effectiveness of NSAIDs but also an equal balance of concern in an alternative to opiates. But I'm trying to see the rest here yeah he points out there are many other factors that are equally as critical from diet to weight loss and exercise that these are part of that methods that point of care has to change from how we're viewed today, what hurts, how can I treat it and has to take a more holistic approach because all of these are variables on health, wellness and ability to cope and manage pain syndromes.

Charisse Coulombe: Right. Absolutely. Absolutely.

Daniel Buffington: Yeah. Coleman adds another point that the opioids themselves don't increase function or reduce chronic pain. It's an academic or a paradigm change that we have country.

Charisse Coulombe: Jacqueline asked another question to probably the whole group or perhaps Dan you can start us off about addressing the growing fears among prescribing clinicians to work with patients with chronic pain because they are being monitored and how can that issue be addressed. We know there are people with, you know, sickle cell disease or other chronic illness that, you know, they do need an opioid but that the physicians and clinicians are shying away from prescribing. Any comments about that patient population.

Daniel Buffington: Or practitioner population. Yeah, the way the question's phrased is something that I try to address at a national level as well and that's the fact that the struggle and the burden within a point of care practice and that's not just for physicians but for other types of professionals as well is that chronic pain patient is a high intensity patient population to manage. Add to that PDMP, state boards and other types of bodies that are paying far more attention to this but we're seeing some medical practices throw their hands in the air saying I'm not going to prescribe the controlled substance at all. That's a pendulum swing in the other direction of who gets hurt? The patient. We need to have a balance discussion in the middle and I will say this, openly, is that part of the people that need to be at that balanced

discussion need to be the regulatory bodies as well. Many of those, well, they're not clinical in nature.

So, it's important that practitioners' voices and patient and family advocate voices are heard in that mix as well and that we see taking place at a state and national level in terms of either aggressive fully seen or regulating now there's a whole series of lawsuits happening around the United States. We must make sure that people don't get over sensitized and turn their back on the topic out of fear of the ripple or the burden it creates on their point of care practice of decision-making. It creates a concentric ring of this discussion point and is equally important. And I've seen not only primary care, but pain management practices say they're not going to prescribe any opiates and while obviously judicious and safe and effective use is imperative, no use is beyond comprehension as well.

Charisse Coulombe: Certainly, a lot of different lenses to look at this issue with. We do have one phone question in the queue, so we will go to that question at this time.

>> Hi. This is Lindsey Alley. I first want to say thank you to both organizations and great presentations. I have to apologize before my questions because I was on the phone not seeing the screen for most of the call so if I say anything that was shown I apologize. But I have a couple of questions for Biddy. One is about your data reports. You say there's peer to peer comparison. The evidence base for effectiveness of those is not strong. For the peer-to-peer comparison component and there's a lot of recommendations are to have some kind of gauge to go with the comparison because it doesn't promote change compared to somebody else who has worse behaviors or similar behaviors so having some kind of marker and then for what the goal is. I am wondering how you can start that if you were thinking about that in the process.

Biddy Smith: We definitely did. That is why it took us a little longer to get those reports formulated because that was the real challenge. Julie is on the call, she is our data analyst and really was kind of the creator of these reports. I don't know if you can unmute her line and maybe she can speak a little more to that? Is that possibly? Julie was the line?

>> I have a second question too. As long as we're waiting for a list. But it looked like the data you were presenting on your change data was all big data, epidemiology outcomes, is that right?

Biddy Smith: That's correct.

>> I'm wondering if you had any plans or if you had already done any kind of a survey or qualitative data collection that can hide those results to your intervention specifically and see what direct change you had?

Biddy Smith: We haven't. We started exploring those kinds of things just here recently because this was wrote more as a campaign and now we're looking at ways to maybe more quantify our efforts.

Charisse Coulombe: I think we might have Julie on the line now. Okay, there's a few more

questions in the queue. Is there plans to collaborate with health plans, insurance companies to work with their PBMs to identify and flag patients with multiple prescribers before the pharmacist suspends the opioid work? Dan I think that question might be directed to you.

Daniel Buffington: Well it likely is and I've been staring at that one a minute because I can answer that from a couple different direction. Has there been collaborations between them to identify high risk patients, yes. I've worked with several on creating specialty or specific claims review metrics or queries to do that. The interesting part about this question though is that it says "before" the pharmacist dispenses and I'm not sure short of the PDMP, that's one of the core goals of the PDMP although from state to state they vary in the duration or aging of the data so some states and medical practices have to populate it within a week. Florida has moved it within a day. Other states vary so the accuracy or the robustness of the data in the prescription drug monitoring program can vary but it would be nice to see plans go from retrospective claims reviews to some type of an enhanced proactive flag that could do that and I know of a few folks that do plan to query to see if there's an interest in that and that in of itself sounds like, Tonya if you want to connect after, might be a great additional innovation project to look at here that we can look at for that would directly affect patients all across the country but it would require a proactive flag and a learning system for the pharmacist.

Charisse Coulombe: Great. Thanks, Dan. So thanks, everyone for great conversations related to these two special innovation projects. We also have Sarah Philips on the line with us from HealthInsight. And we gave her a little bit of time on this webinar to talk about CMS's medication management and opioid pledge. Again, another tool in the opioid crisis toolbox that people can utilize. So Sara, the floor is yours.

Sara Phillips: My name is Sara Philips I work here in Utah with the HealthInsight HIIN and I'm really impressed with all of the work that this group is doing and the projects that we've heard about today that are really designed to reduce the opioid adverse events in our country. And I'd like to take just a minute to talk to you about another initiative that we're working with CMS on. I was assigned recently to work with the MMO medication management of opioids affinity group.
It consists of membership from CMS, ESRD, TCTI, QIN-QIO and HIIN and it's focused primarily on identifying best practices surrounding opioid prescribing, management, treatment, and that will inform the development of a Change Package but there is a second initiative and that surrounds the medication management of opioids pledge that is now on the healthcare community's website.

So, you might ask why a pledge? Well, I, we're not going to be tracking this. This is not something that we're going to go back to individuals who sign it and say are you actually doing what you said you would but I believe individuals who sign a pledge really we want them to commit to this. And if you look at what the dictionary says about a pledge it says it's a solemn promise or agreement to refrain from or do something. Webster, it's a binding promise. And that's what we're hoping individuals who commit, via their signature on the pledge, will be doing, committing and promising to put into place initiatives that will help to reduce adverse events related to opioids. There's three goals to improve health outcomes, reduce unnecessary utilization and generate cost savings for public and private payers.

And we just heard about some of these initiatives that are really doing just that. Next slide, please. The target audience for this is -- our clinicians, practices, improvement networks, organizations and the goal is to have them be in action to work on elements that will reduce the current crisis in our country. Now right now the pledge is opened to all clinicians or anyone else that want to sign it but it is being revised because right now when you click on it, it asks for a provider name and we felt that that was a little confusing. So they're going to be adding additional care team members so it's very clear that this pledge apply to all of us in the health care community. So let's go through a couple of the elements of the pledge. There are four commitments and under each of them there are additional bullets that explain what's being asked of those signing the pledge. The first is that we educate ourselves and our team.

So that we refer patients to appropriate resources and implement in into our practice the use of evidence-based guidelines. That we will treat pain safely and effectively. And that we will identify, treat and refer persons with a substance abuse problem to the appropriate resources. And that might mean that we actually create some of those opportunities for using substance use screenings and referrals. Next slide, please. The next two bullets involve partnering with our pharmacies and community based organizations that are currently offering naloxone dispensing and education and those that provide medication assistant treatment. And coordinating with medication therapy management services. To assist with prescribing patient education, risk stratification, and medication monitoring. Next slide, please. The second bullet of the pledge talks about ensuring persons with opioid use disorder are treated in a respectful person-centered manner and that means that we're going to increase patient protections by using better risk benefit information regarding opioid medications that we're going to refer, create, expand services and connection to these services for the individual and their families that have experienced an overdose.

It also means that we're going to identify connections within the behavior health and pharmacy systems as resources to maximize the individuals and the families engagement in those community support services and that we're going to develop some accountability contracts including that the patient or the individual will utilize only one pharmacy and one provider. We talked about that just a little bit ago.

The third element of the pledge involves leveraging and aligning with existing programs as appropriate to combat opioid misuse. And that involves working with the national and state laws, the regulations that are in your state, and the initiatives that are ongoing within your state. And also working with those prescription drug monitoring programs. I actually looked on the website and it looks like 47 states as of 2016 had these programs in place. My guess is that all of our states do at this point. And then the last element is who we just heard about on this call. That we identify and we report these successes and the best practices that we're hearing about in our communities and that we spread them within our networks. I did want to mention that the pledge does probably involve some elements that not all care team members do. When you commit to this, you are committing to only those elements that are within your scope and control. So if you're not a prescriber that would not be something that they would -- there would be an expectation that you would be working in that area. The link to the website is here on the slide and I think we can probably put it into the chatbox also. And I would ask if anyone has questions and Dan, I would ask if you have anything that you

would like to add.

Daniel Buffington: I am thankful and grateful that CMS and other health care agencies are recognizing the magnitude of the crisis issues and making it agency wide focus. It's something that is going to take all of our efforts collectively and like you just stated that pledge to sharing and when you look at rapid cycle improvement, it is built but for the -- that sharing of successes and it doesn't stop at just publishing them. We heard it on today's call. It's the willingness to show what worked for you and help the other entity implement those like efforts as well and it's -- today was a great webinar. Thank you.

Charisse Coulombe: Thanks, Sara and Dan for that and we hope that all you've on the call take this pledge to your hospitals and colleagues and clinicians and encourage them to take a look at it and to sign it. We can go to the next slide. I know throughout the entire presentation today we've actually had a lot of requests and offers that have and do continue to be made in the chat. A lot of resource links that have been offered out there and people, you know, making comments about the usefulness of the tool that have been created.

I would encourage people to have open dialogue, make additional requests and offers that don't need to wait for a social webinar for that to occur. Reach out to your colleagues. You know, and I know people have put their e-mail addresses in the chat as well. And with that I'm going to turn it over to Kevin for any last words from CMS today.

Kevin Frazier: Thank you so much. And I just want to say thanks so much to Biddy and Kandi for the wonderful presentations today. And to you, Dan, for the really great work serving as a reactor today. Thanks also to the attendees for all of the great questions that were raised during the course of today's event. I do have a simple ask of those in attendance today and I did log these in the chatbox. Before exiting this session, if you would be so kind as to respond to the following two questions, it would really assist us in increasing the quality of these events and please, just feel free to submit your responses directly in the chatbox. So question one, what did you like best about today's pacing event? And question number two, is your next quarterly pacing event will occur in September. How do you feel we could improve upon our current approach to the design and delivery of these events. If you could respond to those two questions it would be greatly appreciated and that's all that I have. Have a great afternoon, everyone and thanks for joining us today.