MANAGING PERSISTENT PAIN IN AN OPIOID EPIDEMIC:
How ambulatory pharmacists can play a role

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Disclosure

- Amanda Locke has no actual or potential conflict of interest in relation to this program/presentation.
- I will not discuss off label use and/or investigational use in my presentation.

Objectives

At the completion of this program, the participant will be able to:
1. Describe two types of collaborative practice models involving pharmacists in the management of persistent pain
   1. Primary Care
   2. Pain Clinic
2. Review training for pharmacists to assist in the management of persistent pain and opioid medication
3. Identify opportunities across the continuum of care where pharmacists can contribute to management of persistent pain.
4. Discuss the barriers healthcare teams face when providing care to patients with persistent pain and on chronic opioid therapy.
Abbreviations

- Chronic opioid therapy (COT)
- Morphine equivalent dose (MED) vs morphine milligram equivalent (MME)
- MD = all providers: physician, nurse practitioner, and physician assistant

Virginia Mason is located in Washington State – these are the rules and regulations most familiar with…apologize for lack of details regarding other states and recognizes some aspects of the presentation may not be 100% applicable.

Who is in the room?

- Ambulatory …… Inpatient ……. Long-term Care Facility
- Currently have a pain service where you work?
  (inpatient or outpatient)
- Considering initiation of a pain service in the future?
- Here to learn and gather information!
What is Pain?

Pain: An unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage.

Pain is subjective, individualized, and at times unpredictable.

“State of severe distress associated with events that threaten the intactness of the person. The Obligation of the physician to relieve suffering goes back to antiquity.”

- E. Cassell MD

Clinical Review of Pain

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Acute Pain</th>
<th>Persistent Pain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cause</td>
<td>Generally Known</td>
<td>Often unknown, or behaving differently than expected</td>
</tr>
<tr>
<td>Duration</td>
<td>Short lived</td>
<td>Persists beyond time of expected healing &gt; 3 months</td>
</tr>
<tr>
<td>Treatment approach</td>
<td>Resolution of underlying cause results in improvement</td>
<td>Outcome is uncertain, pain control is the focus of treatment</td>
</tr>
</tbody>
</table>

Persistent Pain – how does it impact?

- Physical function
- Ability to perform ADL
- Work
- Recreation

Psychological Morbidity
- Depression
- Anxiety, anger
- Sleep disturbance
- Loss of self-esteem

Social Consequences
- Marital/family relations
- Intimacy/sexual activity
- Social isolation

Socioeconomic Consequences
- Healthcare costs
- Disability
- Lost workdays
Brief history on pain

- 360 BCE: Hippocrates recognizes analgesic properties.
- 1527: Paracelsus dissolves in alcohol.
- 1803: Friedrich Sertürner develops morphine, "God's own medicine.
- 1870–1880: Saw a three-fold rise in opiate use, which was multifactorial.

Brief history of opioids

- 1895: Bayer produces heroin.
- 1911: 1 in 400 Americans "addicted." This led to the passage, in 1915, of the Harrison Act which legitimized use of opium from licensed providers.
- 1978: Mexico and US spray opium fields with Agent Orange.
- Proliferation of 12-step, "abstinence only" programs.
- Harsh sentencing laws in the mid-1980s.
Brief history of opioids

- Historically underserved concern
- In 70’s and 80’s there was increased awareness and treatment of malignant pain
- Lead to movement to classify pain as 5th vital sign
- ’80s initial reports suggest COT may be a treatment strategy
- Prior to 1983 no scientific papers on COT for non-cancer pain
- Passage of Intractable pain acts created legal framework for prescribing
- 2000 – pain is the 5th vital sign

No ceiling for pain management….
“To write prescriptions is easy, but to come to an understanding with people is hard.”

-- Franz Kafka, “A Country Doctor”

WHAT IS THE LANDSCAPE NOW?

Where are we at today?

Opioid Overdose Deaths Hit Record High

Figure 4. Opioid Prescriptions Dispensed by US Retail Pharmacies
Overdose Deaths:
- Rates were highest among people age 25 to 54 years.
- Rates were highest among non-Hispanic whites and American Indian or Alaska Natives, compared to non-Hispanic Blacks and Hispanics.
- Men more likely to die from overdose, however this gap is closing.
Statistics

- 50% of Americans experience chronic or recurrent pain
- ClI would rank pain behind only heart disease and cancer
- Costs more disability than heart disease or cancer
- $60,000-80,000/year in US healthcare and disability

Population-based, prospective cohort:
- N=1843 workers with acute low back injury and at least 4 days lost time
- What doubled the risk of disability after 1 year?
  - >150 mg MED
  - Receipt of opioids for > 7 days
  - Received at least two prescriptions

Early opioids and disability in WA WC. Spine 2008; 33: 199-204
Martin et al 2011 Gen Int Med 2011;26:450-7

Tools to help

Center for Disease Control Guidelines
- Focused on Primary Care Providers
- No safe dose of opioids – 90mg MED risk cut off
- Risk begins after 7 sequential days of use

State initiated best practice guidelines
- AMDG in Washington State – 120mg MED risk cut off
- Oregon Opioid Prescribing Guidelines

Laws, regulations, standards
- Understand state level regulations “shall” vs. “should”
- Organizational best practices beyond state requirements
Risk of fatal overdose seems directly related to the maximum prescribed daily opioid dose.

- Doses (MSO4 equivalents) 50-99 mg/d had a 3.7-fold increase in overdose risk.
- Doses >100 mg/d had an 8.9-fold increase in overdose risk.

Washington State Changes

Begun with development of Best Practice Guidelines and changing state laws and regulations - 2010

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PAIN MANAGEMENT

265-919-950 Pain management—intent,
265-919-951 Exclusions,
265-919-952 Definitions,
265-919-953 Patient evaluation,
265-919-954 Treatment plan,
265-919-955 Informed consent,
265-919-956 Written agreement for treatment,
265-919-957 Periodic review,
265-919-958 Long-acting opioids, including methadone,
265-919-959 Epidural care,
265-919-960 Consultation—Recommendations and requirements,
265-919-961 Consultation—Deviations for exigent and special circumstances.
265-919-962 Consultation—Deviations for the physician,
265-919-963 Pain management specialists.
Should vs. Shall

Washington State Law

Should
- Patient history: review of PMP if available, relevant information from pharmacist for physician
- Physical examination: available diagnostics, available consultations
- Long acting opioids and methadone prescribing education if using
- Episodic care: treatment and management

Shall
- Patient history: current and past tx for pain, comorbidities, any substance abuse
- Physical examination: nature and intensity of pain, history of addiction, psychiatric conditions, effect of pain on function, history of overdose and/or naloxone administration, other medical conditions, family medical history, and risk factors
- Treatment plan
- Informed consent
- Written Agreement
- Periodic Review
- Consider and document the consideration of consultation for pain management
- MUST consult a pain specialist for patients with an MED >120mg

Opportunity for pharmacist in patient care

Physician MUST do
- Diagnosis
- Physical Examination

Physician or pharmacist CAN do
- Patient History
- Review of risk assessment
- Review of PMP and other tools
- Periodic assessment of function and pain
- Review informed consent / patient agreement
- Consideration of consultation to other specialists
- Develop treatment plan in conjunction with physician

Unintentional Opioid Overdose Deaths
Washington State—1995 - 2013

Number of deaths
- Heroin and/or Opioid Unspecified
- Prescription Opioids

279% increase from 2000
What is the MED, high-risk cut off by the CDC?
- 50mg
- 90mg
- 100mg
- 120mg

What is the MED, high-risk cut off by AMDG (Washington State)?
- 50mg
- 90mg
- 100mg
- 120mg
Audience Engagement

What is the MED, high-risk cut off by AMDG (Washington State)?
- 50mg
- 90mg
- 100mg
- 120mg

Audience Engagement

More individuals die from opioid overdose in the United States every year than from ______?
- Car accidents
- Cardiovascular disease
- Cancer
- Natural Causes

Audience Engagement

More individuals die from opioid overdose in WA State every year than from ______?
- Car accidents
- Cardiovascular disease
- Cancer
- Natural Causes
IMPLEMENTATION OF PHARMACISTS IN PAIN MANAGEMENT

Getting Started

1. Determine the ask of each team
2. Understand team dynamics
3. Review current state of pharmacist on team (or not on the team)
4. Assess readiness of pharmacist(s)
5. Plan measures for success and ongoing improvement

PRIMARY CARE
Ask

Assist Primary Care Providers in the management of chronic opioid therapy patients by:
1. Ensuring all safety assessments are completed (per regulatory and internal requirements)
2. Review treatment options from a holistic approach (consider comorbid issues and drug interactions)
3. Recommend non-opioid treatment
4. Assist in taper planning and management

Current State Team Dynamics

- Focused improvement the year prior, but standard implementation was not completed
- All responsibility was on the prescribing provider
- No standard coverage plan specific for controlled substances
- No standard process for risk assessment and review
  - Standard template with triggers/reminders, however often ignored or deleted

MED range from low to high per provider 2015

![Graph showing MED range from low to high per provider 2015]
<table>
<thead>
<tr>
<th>Provider</th>
<th>Q 1 month</th>
<th>Q 3 months</th>
<th>Q 6 months</th>
<th>Q 12 months</th>
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<tbody>
<tr>
<td>Provider 1</td>
<td>5</td>
<td>11</td>
<td>11</td>
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<tr>
<td>Total</td>
<td>14</td>
<td>17</td>
<td>70</td>
<td>27</td>
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</table>

**Pharmacist Current State on Team & Readiness**

- Already integrated onto the team
- Managing other chronic disease states (e.g., cardiovascular disease, smoking cessation, anemia)
- Solo visits, few shared medical appointments
- Minimal MA support
- No involvement in pain management

**Stages of Implementation**

1. Identify pharmacist champion(s)
2. Set up training
3. PDSA with COT Champion
4. Roll out to all providers and sites
5. Maintenance
**Team Member Roles**

**MD, DO, ARNP, PA**
- Diagnosis and treatment
- Oversight of complicated problems
- Minor surgical and diagnostic procedures
- Mentor and coach for team-based care

**Pharmacist**
- Medication management
- Medication review/polypharmacy
- Assessment of individualized patient risk

**Medical Assistant**
- Review health maintenance module
- Shared documentation
- Coordination provider "flow"

**Specialist**
- Consult
- Defer management of chronic non-cancer opioid regmt. to PCP

**COT Champion**
- Teach best practices for chronic non-cancer opioid regmt.
- Promote responsible cross-coverage for COT patients
- Responsible for implementation metrics and ongoing success review

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**Linked Visit: Pre-Visit Work Up**

- Ensure patient packet for risk assessment ready at check-in desk
- Pull Prescription Monitoring Program (PMP) information
- Review past risk scores
- Review current medication regimen and PMP
- Determine need for monitoring (urine screen, ECG, etc.)
- Inform pharmacist of pre-determined care plan if applicable

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**Linked Visit: Visit Flow**

- Standard rooming
- Obtain urine screen
- Discuss all medications for pain management
- Establish pain and functional goals with patient
- Review controlled medication agreement with patient
- Recommend/start non-opioid pain management treatment options
- Review risk profile
- Review functional improvements
- Refill medications
- Determine final care plan and follow up
Outcomes / Success

- Improved provider satisfaction in providing care to complex patients
- Pharmacist role expanded into other comorbid disease states
- Continuity among providers + improved standardization
- Improved documentation and overall patient care

Outcomes / Success: Adherence to Guidelines

Determine what your team, or organization, would like to focus on.

Some Examples:
- Urine screens
- Morphine equivalent dose
- Documentation standards
- Consultations completed
- Patient education delivered
- Risk assessment tools completed
- Patient agreement/consent documented

Outcomes / Success for one section

Assuming the following were not completed outside COT Annual appointment:
- Regulatory requirements documented
- Patient agreement reviewed
- Calculation of MED for consultation
Provider buy-in
- Have a Provider Champion!!!!!
- Start with a small, engaged group – then spread to the rest of the team
- Have a timeline for follow up
- Tie outcome/success metrics to providers

Barriers to implementation

- Provider buy-in
- Patient identification
- This is tough....
- Utilize the EMR
  - Diagnosis codes
  - Medication list
  - Flags in the chart
Barriers to implementation

- Provider buy-in
- Patient identification
- Patient buy-in
  - Have a long history with provider
  - May not have completed risk assessments before
  - May not have worked with a pharmacist in clinic setting before
  - If lead with “regulatory” discussion may make them feel defensive

- Tracking metrics (manual completion if no discrete data fields in EHR)
  - Critical for share and spread
    - Morphine Equivalent Dose (MED)
    - Transparency between providers to identify best practice
    - Adherence to completion of risk assessment tools (e.g., ORT, urine screens)
    - Adherence to department guidelines (e.g., no early refills, consultation)

Audience

Shared Success or Learnings?
Ask

Assist Psychiatrists in the management of chronic opioid therapy patients by:

1. Ensuring all safety assessments are completed (per regulatory and internal requirements)
2. Review treatment options from a holistic approach (consider comorbid issues and drug interactions)
3. Assist in taper planning and management
4. Help improve access by managing patients long term

Team Dynamics

- No coverage standards
- Minimal practice standards in place
- All responsibility was on the prescribing provider
- No standard process for risk assessment and review
- Two providers conducted shared medical appointments every other month to complete "annual" appointment
Pharmacist Current State on Team & Readiness

- No presence on the team
- No providers had ever worked with a pharmacist

Stages of Implementation

1. Identify pharmacist champion(s)
2. Set up training
3. PDSA with COT Champion
4. Roll out to all providers
5. Maintenance

Pharmacist Role on the Team

- 2013 to 2015
  - MD Quarterly
  - RX Quarterly
  - MD Annual
- 2016 to 2017
  - MD Quarterly
  - RX Quarterly
  - MD Quarterly

Pharmacist obtained DEA license Feb 2014
Barriers to implementation

- Patient buy-in
  - Have a long history with provider
  - May not have completed risk assessments before
  - May not have worked with a pharmacist in clinic setting before
  - If lead with "regulatory" discussion may make them feel defensive

- Scoping the work
  - Define clearly with the team and the pharmacist(s)
  - When to refer to PCP or other specialists
  - Understand scope and role with opioid-use dependence

- Tracking metrics (manually as not discrete data fields in EHR)
  - New having a pharmacist on the team…looking to understand value
  - Ensure value-added metrics are agreed upon and discussed
  - By provider, by patient, by pharmacist
Barriers to implementation

- Patient buy-in
- Scoping the work
- Tracking metrics (manually as not discrete data fields in EHR)
- Team scripting when explaining why scheduled with pharmacist
  - Scheduling over the phone
  - Scheduling for next visit in clinic
  - Provider out of office cancelations

Will only be useful if providers are having the same conversations!!

Audience

Value-added metrics?

TRAIN THE TROOPS
Approaches to training

- Utilize current training method at your organization if this works well
- Identify a pharmacist champion and physician champion
- Work closely with other providers
- Follow through

Example Training

3-4 months

- CE
- Lectures
- Case review
- Shadow
  - MD champion
  - Rx Champion
- Didactics

Example Training

3-4 months

- CE
- Lectures
- Case review
- Shadow
  - MD champion
  - Rx Champion
- Solo visits
  - Stable patients
  - Clear criteria
- Joint visits
- MD next
- Rx begins visit

2 months
Example Training

- CE Lectures
- Case review

Joint visits
- Shadow
  - MD champion
  - Rx Champion
- Rx begins visit
  - MD next

Solo visits
- Stable patients
  - Clear criteria
- Rx champ
  - MD feedback

3-4 months

2 months

Didactic Learning Set-up

- Pharmacist Champion and Physician Champion
  - Review of physician standards and guidelines
  - Define physician “ask”
  - Identify areas for learning
- Pharmacist Champion
  - Identify CE opportunities
  - Review learnings prior to team engagement
  - Coordinate, and/or lead, team learning sessions
  - Set up review with specialists (behavioral health, physical therapy, physiatrists/anesthesiologists)

CE Programs that may be helpful
Example Didactic Learning

- Clinical Pearls
- Patient cases
- Small groups
- Entire team
- Individual completion
- Time line given to team members
- Via email
- Via standing team meetings or special team meetings

Shadow

One-by-one all pharmacists spent time with the MD champion shadowing patients and discussing cases. Purpose:

1) Relationship building
2) Confidence and understanding
3) Start to generate rapport with patients

One-by-one all pharmacist shadow 2-3 visits with the pharmacist champion completing the rx-portion

1) Learn by example
2) Learn together by discussing the patient case
3) Ensure standardization among the team members

Pharmacist Shadow

- Shadow 2-3 visits
- Complete 2 months of solo visits
- Complete one visit with(rx) champ shadow
Follow up

Encourage assessment of provider and pharmacist feedback.
- Recommend using a general survey that can be at specified times after go-live
- Dynamic surveys based on individual needs
- Tie in to individual performance review if needed

ORGANIZATIONAL ASSESSMENT

Who is involved in Pain Management?
Understand Prescribing Habits

1. Who is prescribing within the enterprise?
   - ED
   - Urgent care
   - Primary care
   - Surgery teams
   - Hospitalists upon discharge
   - Ambulatory specialties (rheum, neuro, GI, sleep)

2. What standards are already in place?
   - Patient agreements
   - Risk assessment tools
   - Coverage policy among providers
   - Standards followed by the team (e.g., dispense only 14-days post op)

3. When does patient care cross between departments and providers?
   - ED
   - Procedures
   - Inpatient discharge
Understand Prescribing Habits

1. Who is prescribing within the enterprise?
2. What standards are already in place?
3. When does patient care cross between departments and providers?
4. Pharmacists prescribe controlled substances?
   - Know state laws
   - Understand the ask, or role, the pharmacist will have

Organizational Alignment

- Department policy
- Department standards
- Organizational accountability

Organizational Alignment

- Department policy
- Department standards
- Organizational accountability
Multi-Department Alignment within Organization

Opportunities

- Do all providers use the same risk assessment tools?
- Training process for new providers and/or residents standard?
- Do all surgeons follow the same guidelines for dispensing post-op?
- What is the process of handoff post-op back to the ambulatory providers?

- Do all inpatient RNs follow the same guidelines for consulting?
- Who within the organization have buprenorphine training and certification?
- Is there a process in place to consult psychiatry or social work if opioid use disorder is suspected?

Gap Analysis

Assess gaps in care from an organizational and department level

- Prescribing habits
  Example: day-supply, MED
Gap Analysis

Assess gaps in care from an organizational and department level

- Prescribing habits
  Example: day-supply, MED

- Department coverage
  Example: early refills, scripts without a visit

- Risk assessment completed
  Example: urine screen, PMP, opioid risk tool

Measure Success

SUCCESS
Potential Measures of Success

- Prescribing standards followed
- Documentation standards followed
- Utilization of risk assessment tools
- Frequency of visits for pain management
- Audits of state regulations “shall” documented
- Patient and provider feedback regarding process change
- Average Morphine Equivalent Dose (per provider or department)
- Utilization of resources (e.g., pharmacist, social work, pain consult)

Barriers = Opportunities

- Consensus
- Communication
- Patient care handoffs
- Provider leadership + operational leadership
- Training and continuing education
- PATIENTS and caregivers
  - Understanding
  - Communication
  - Education

Audience

Who has pharmacists involved in committees focused on pain management?

Key learnings and/or opportunities
Key Take Away

- Collaborate, educate and inform your patient
- Have a team
  - MD, Pain Psychologist, MSW, RN, PT, OT, Pharmacist, Health Coach
- Use all available resources
- Have consistent follow up and engagement

DISCUSSION & QUESTIONS

Empathy is
Seeing with the eyes of another
Listening with the ears of another
Feeling with the heart of another

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