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Clinical Pharmacist Led Suboxone Clinic: Management of Comorbid Pain and OUD

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Disclosure

Dr. Atkinson's Disclosures:

- Consulting Fee (e.g., Advisory Board): Purdue Pharma LP

Dr. Jorgenson's Disclosures:

- Nothing to disclose

Learning Objectives

- Review the rationale for integrating opioid use disorder (OUD) care into interprofessional pain management teams
- Summarize the roles of a pain management pharmacist practitioner in the delivery of OUD treatment as part of the interprofessional team
- Describe implementation of clinical pharmacy pain practitioner into the routine management of co-morbid OUD and pain
- Explain the impact of integrating the clinical pharmacy pain practitioner into OUD treatment

Clinical Pharmacy Pain & OUD: Integration, Implementation & Impact

Terri Jorgenson, RPH, BCPS

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Pain, OUD and Mental Health Connection

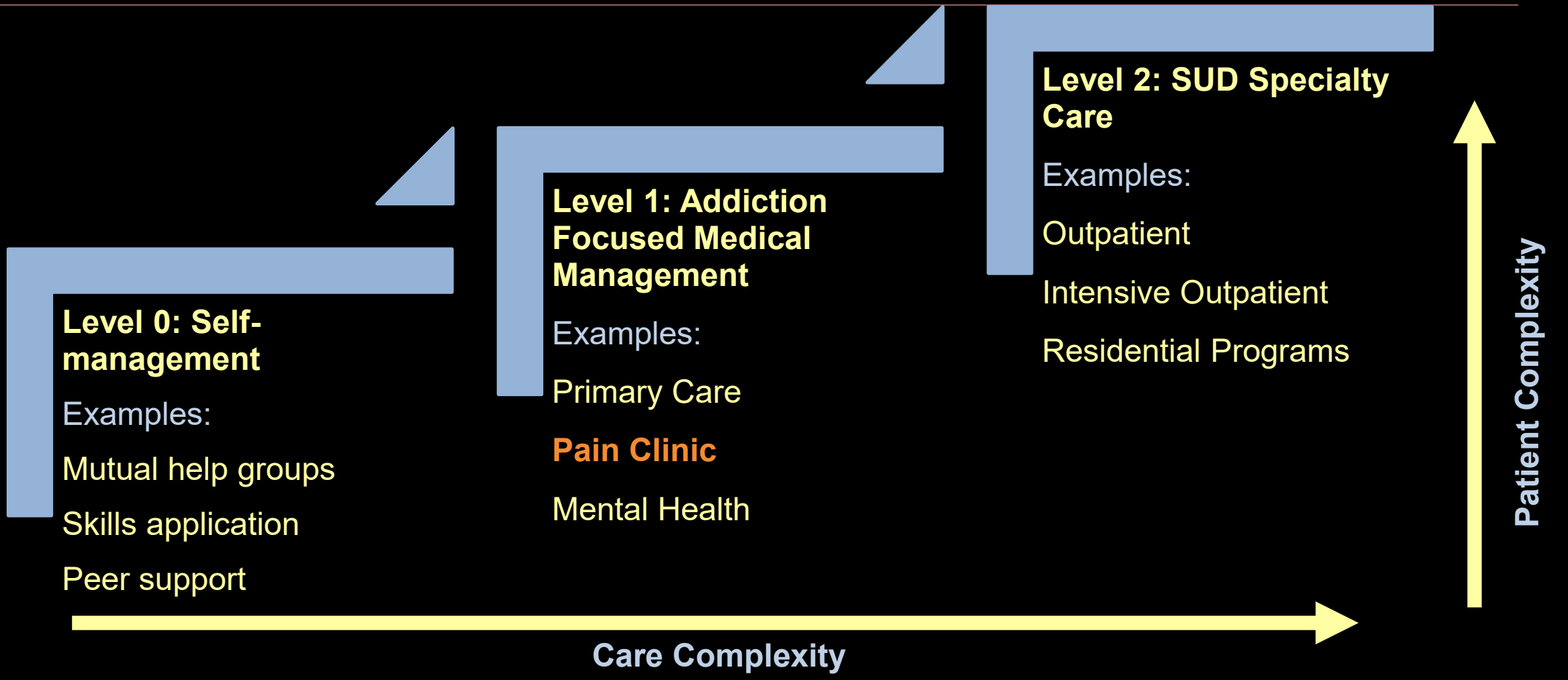
- 30% of patients in specialty pain care have concurrent SUD
- Adults with OUD - prevalence of co-occurring SUD / MH
  - Alcohol Use Disorder (AUD) - 26.4%
  - Methamphetamine - 10.6%
  - Past year / acute mental illness - 64.3%
  - Serious Mental illness - 26.9%
- Pain severity associated with poorer OUD treatment outcomes
  - Inability to access addiction treatment
  - Lower rates of OUD treatment sustainment
  - Higher rates of OUD relapse
- MOUD benefits: reduce illicit opioid use, increase treatment retention, reduce cravings, reduce death risk after overdose, lowers risk of death

2020 Observational VA Study (n = 1,394,102)

- Opioid discontinuation associated with increased risk of death from overdose or suicide (HR 1.67 to 6.77) with increased risk based on length of opioid use
- Highest risk in first 3 months after discontinuation; risk decreases over 3-12 months

Jones CM, McCance-Katz EF. Co-occurring substance use and mental disorders among adults with opioid use disorder. *Drug Alcohol Depend*. 2019 Apr; 197:78-82. doi: 10.1016/j.drugalcdep.2018.12.030. Worley MJ, Heinzerling KG, Shoptaw S, Ling W. Pain Volatility and Prescription Opioid Addiction Treatment Outcomes in Patients with Chronic Pain. Exp Clin Psychopharmacol. 2015 Dec: 23(6):428-435 doi:10.1037/pha0000039. Voon P, Wan L, Ekaterina N, et al. Greater Pain Severity is Associated with Inability to Access Addiction Treatment Among a Cohort of People Who Use Drugs. J Pain Res 2020:13:2443-2449. Morasco BJ, Corson K, Turk DC, Dobscha SK. Association between substance use disorder status and pain-related function following 12 months of treatment in primary care patients with musculoskeletal pain. *J Pain*. 2011 Mar; 12(3):352-359. doi: 10.1016/j.jpain.2010.07.010. Oliva EM, Bowe T, Manhapra A, et al. Associations between stopping prescriptions for opioids, length of opioid treatment, and overdose or suicide deaths in US veterans: observational evaluation. *BMJ*. 2020; 368:m283. doi: 10.1136/bmj.m283

Stepped Model of OUD Care: VA Adopted 2018



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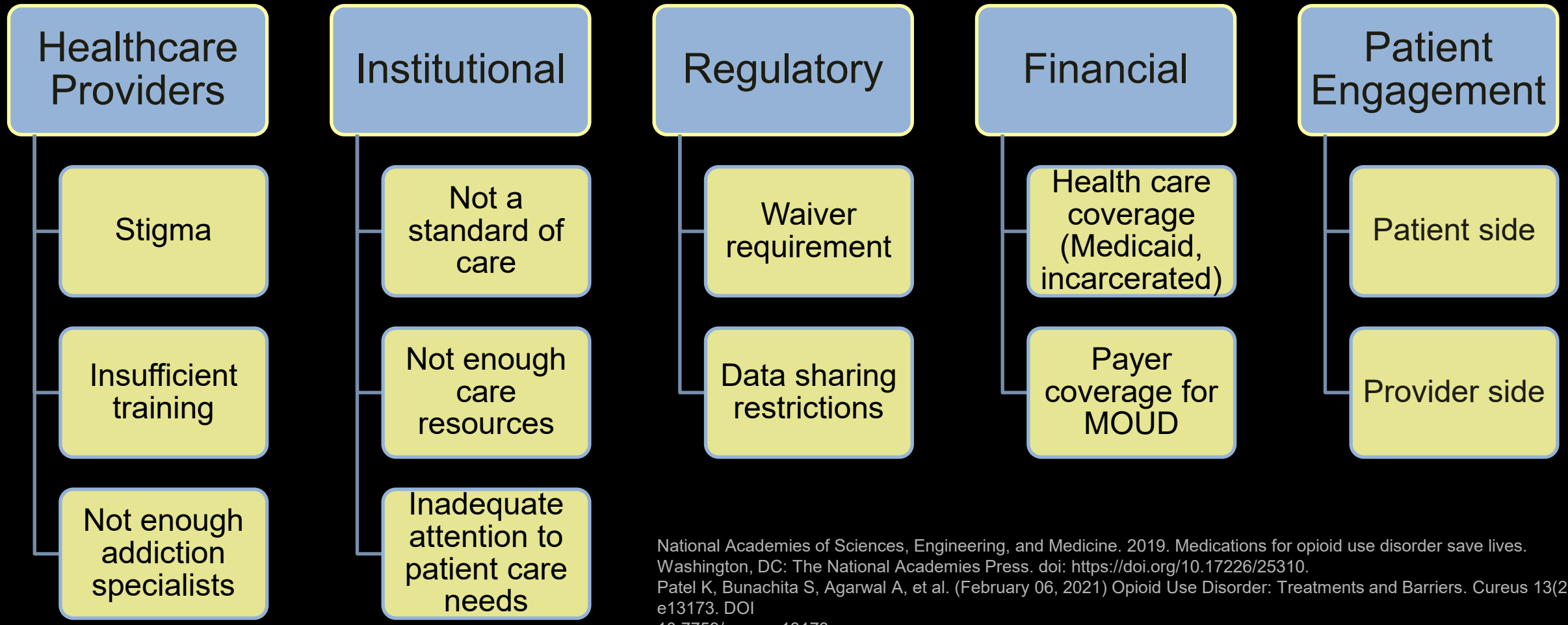
Gordon AJ, Drexler K, Hawkins EJ et.al. Stepped Care for Opioid Use Disorder Train the Trainer (SCOUTT) Initiative: expanding access to medication treatment for opioid use disorder within Veterans Health Administration Facilities. *Subst Abus*. 2020; 41(3):275-282.

OUD Treatment Barriers



National Academies of Sciences, Engineering, and Medicine. 2019. Medications for opioid use disorder save lives. Washington, DC: The National Academies Press. doi: https://doi.org/10.17226/25310.
Patel K, Bunachita S, Agarwal A, et al. (February 06, 2021) Opioid Use Disorder: Treatments and Barriers. Cureus 13(2): e13173. DOI 10.7759/cureus.13173
Madras, B. K., N. J. Ahmad, J. Wen, J. Sharfstein, and the Prevention, Treatment, and Recovery Working Group of the Action Collaborative on Countering the U.S. Opioid Epidemic. *NAM Perspectives.* Discussion Paper, Washington, DC. https://doi.org/10.31478/202004b

Beliefs about Opioid Use Disorder Treatment

Myths that Drive Stigma	Truths
⊗ Moral failing	√ Chronic, relapsing disease
⊗ Treatment trades one drug for another	√ Treatment saves lives
⊗ Increased diversion	√ Diversion to avoid withdrawals
⊗ Treatment is hard	√ Recovery easier with treatment
⊗ Patient said “no” to treatment	√ Patient not ready YET
⊗ Need wavier to play a role	√ Pharmacist improves access w/o waiver

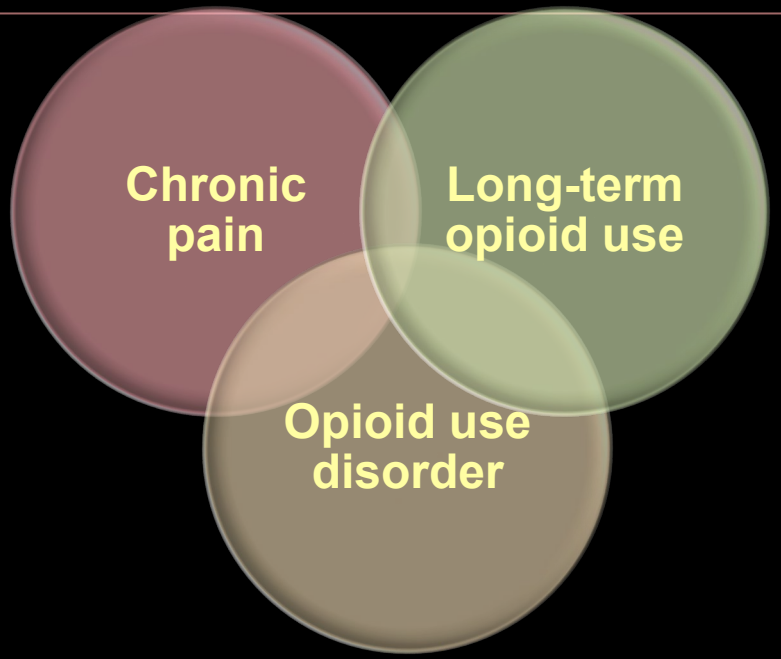
Madras, B. K., N. J. Ahmad, J. Wen, J. Sharfstein, and the Prevention, Treatment, and Recovery Working Group of the Action Collaborative on Countering the U.S. Opioid Epidemic. *NAM Perspectives.* Discussion Paper, Washington, DC. https://doi.org/10.31478/202004b

Words Matter

"If you want to care for something, you call it a flower; if you want to kill it, you call it a weed"

-Dan Coyhis

Target Population



Target population

- Access to chronic pain care and addiction
- Prescription opioid users (not current heroin users)
- Not able / willing to engage with specialty care services (“not an addict”)
- Moderate severity, single-substance disorder (not severe opioid + alcohol + ... use disorder)
- Medication for OUD (MOUD) home initiation feasible for many patients

Improving Access to Care: Pharmacist Practitioners

- Association of American Medical colleges (AAMC) projects up to 139,000 physician shortages by 2033
- Over 30 million people live in counties without a single prescriber for addiction treatment
- Pharmacists - Most easily and readily accessible, highly trusted health professional
- Evidence shows Pharmacist integration:
  - Improve opioid risk mitigation, sustained reductions in opioid doses with no change or improvement in pain control, improved access, reduce costs
  - Expands access and increases retention rates of MOUD

Image approved for use by VA

Association of American Medical Colleges. The Complexities of Physician Supply and Demand: Projections from 2018 to 2033. 2020 Jun. https://www.aamc.org/media/45976/download (accessed 2021 Apr 1). Bratburg J. Pharmacy: Addressing substance use in the 21st century. *Subst Abus*. 2019; 40(4):421-434. doi: 10.1080/08897077.2019.1694618. Dipaula BA, Menachery E. Physician-pharmacist collaborative care model for buprenorphine-maintained opioid-dependent patients. *J Am Pharm Assoc*. 2015 Mar-Apr; 55:187-192. doi: 10.1331/JAPhA.2015.14177. Larochelle MR, Bernson D, Land T et al. Medication for opioid use disorder after nonfatal opioid overdose and association with mortality: A cohort study. *Ann Intern Med*. 2018 Aug; 169(3):137-145. doi:10.7326/M17-3107. Wu LT, John WS, Ghitza UE et al. Buprenorphine physician–pharmacist collaboration in the management of patients with opioid use disorder: results from a multisite study of the National Drug Abuse Treatment Clinical Trials Network. *Addiction*. 2021 Jan 11. doi: 10.111/add.15353. Peckham AM, Ball J, Colvard MD et al. Leveraging pharmacists to maintain and extend buprenorphine supply for opioid use disorder amid COVID-19 pandemic. *Am J Health Syst Pharm*. 2021 Mar; 78(7):613-618. doi: 10.1093/ajhp/zxab003. Suzuki J, Matthews ML, Brick D et al. Implementation of a collaborative care management program with buprenorphine in primary care: A comparison between opioid-dependent patients and chronic pain patients using opioids non-medically. *J Opioid Manag*. 2014 May-Jun; 10(3):159-168. doi: 10.5055/jom.2014.0204. Harden P, Ahmed S, Ang K, Wiedemer N. Clinical Implications of Tapering Chronic Opioids in a Veteran Population. *Pain Med*. 2015 Oct; 16(10):1975-1981. doi: 10.1111/pme.12812. Jacobs SC, Son EK, Tat C et al. Implementing an opioid risk assessment telephone clinic: Outcomes from a pharmacist-led initiative in a large Veterans Health Administration primary care clinic, December 15, 2014-March 31, 2015. *Subst Abus*. 2016; 37(1):15-9. doi: 10.1080/08897077.2015.1129527. Westanmo A, Marshall P, Jones E, Burns K, Krebs EE. Opioid Dose Reduction in a VA Health Care System--Implementation of a Primary Care Population-Level Initiative. *Pain Med*. 2015 May; 16(5):1019-1026. doi: 10.1111/pme.12699

Pharmacist Collaborative Practice

- Formal practice relationship – pharmacist + collaborating prescriber
- Define and delegate patient care services to a pharmacist
- Outline pharmacist services to be provided outside of typical scope of practice
- Collaborative Drug Therapy Management (CDTM)
- Increase efficiency of team-based care delivery

NASPA. Collaborative Practice Agreements: Resources and More (accessed 2021 Apr 19).

Collaborative Practice Agreements

- State specific laws – 49 of 50 states, the District of Columbia legally authorize pharmacists to participate in CDTM
- Originated in 1963 – Indian Health Service
- CPA (e.g., CDTM) models:
  - Patient specific
  - Population specific
  - Statewide protocols
  - Class-specific prescribing
- State specific variations in CDTM components: add, modify, discontinue, order labs, controlled substances
- Comprehensive Medication Management approach

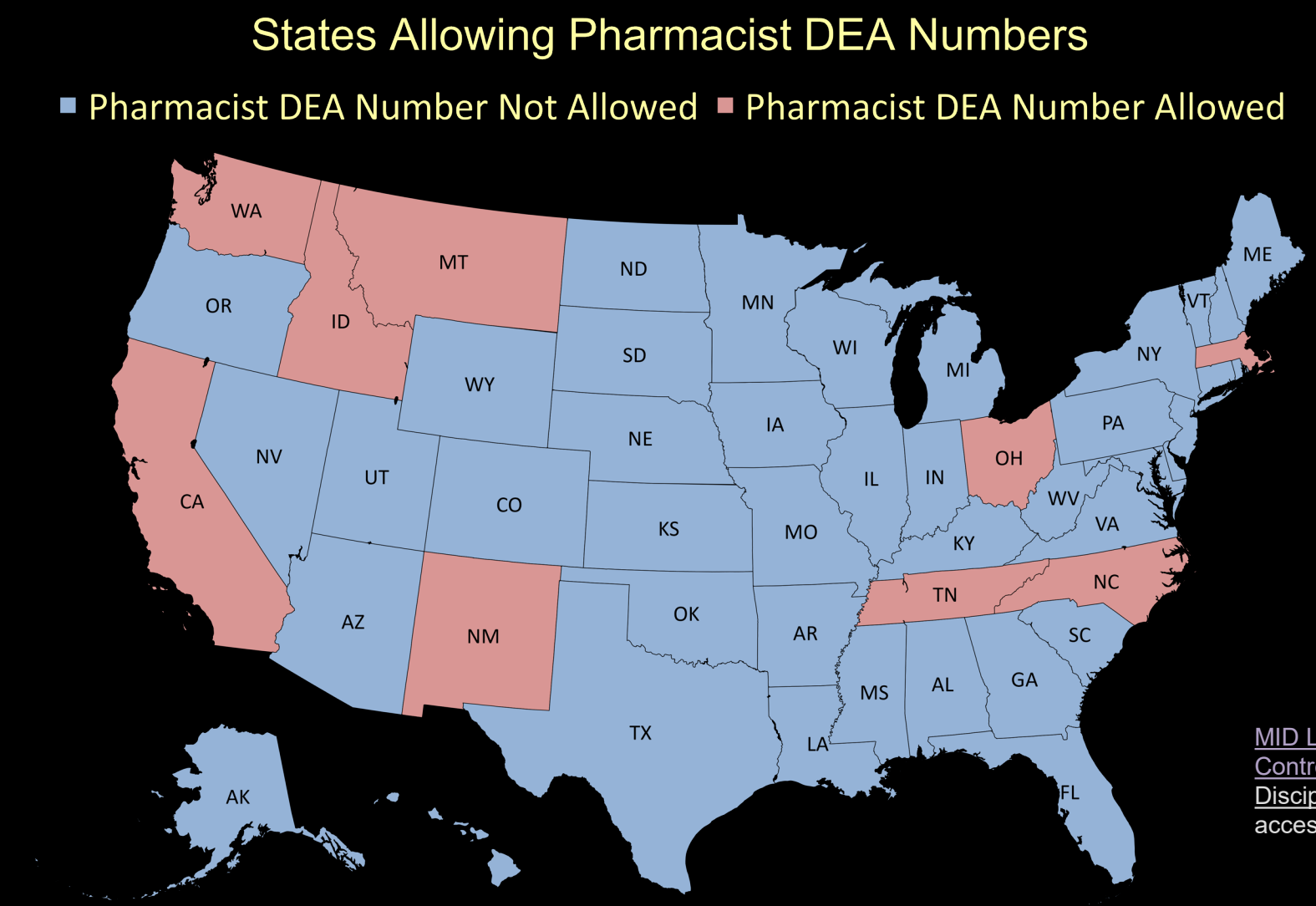
Sachdev G, Kliethermes MA, Vernon V, Leal S, Crabtree G. Current status of prescriptive authority of pharmacists in the United States. *J Am Coll Clin Pharm*. 2020; 3:807–817. doi: 10.1002/jac5.1245

Comprehensive Medication Management (CMM) Approach

- Patient-centered approach to medication optimization delivered by a clinical pharmacist working with the patient, physicians, and other members of the healthcare team.
- Ensures medications are assessed for appropriateness, effectiveness, and safety given the patient's clinical status, comorbidities and other medications, as well as the patient's ability to take the medications as intended and adhere to the regimen.
- Quadruple Aim: better care, reduced healthcare costs, improved patient experience, and provider well-being

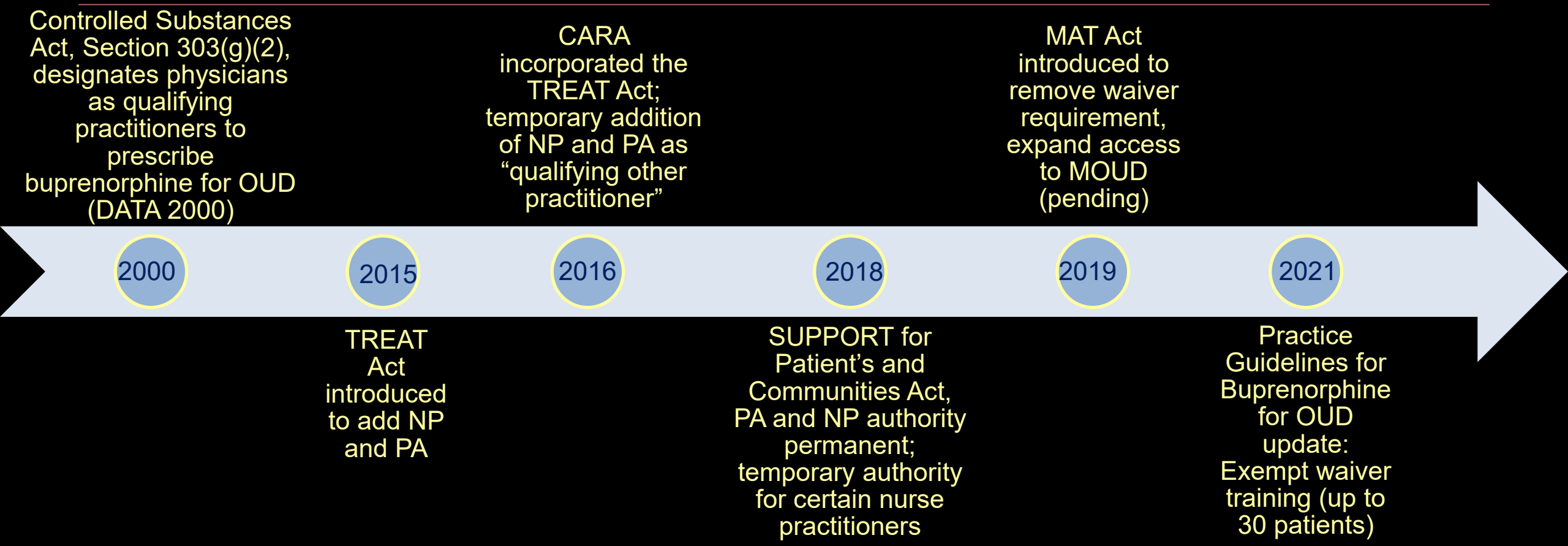
McFarland MS, Buck ML, Crannage E et al. Assessing the impact of comprehensive medication management on achievement of the quadruple aim. *Am J Medicine*. 2021 Jan; S0002-9343(20)31173-6. doi: 10.1016/j.amjmed.2020.12.008

Pharmacists: DEA Mid-Level Practitioners



MID LEVEL PRACTITIONERS - Controlled Substance Authority by Discipline within State (usdoj.gov) – accessed 7/9/2021

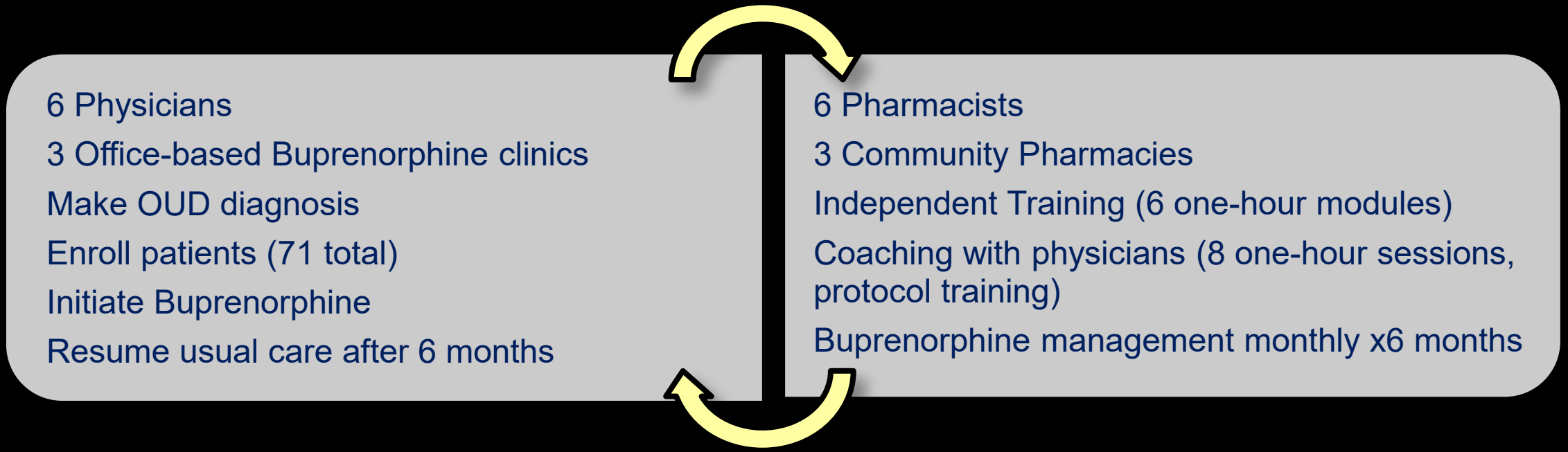
DATA-Waiver Legislation: Pharmacists NOT Currently a Qualifying Practitioner



Congress.gov. H.R.2634 – Drug Addiction Treatment Act of 2000. *106th Congress (1999-2000)*. https://www.congress.gov/bill/106th-congress/house-bill/2634 (accessed on 2021 Apr 1).
Congress.gov. S.1455 – TREAT Act. *114th Congress (2015-2016)*. https://www.congress.gov/bill/114th-congress/senate-bill/1455 (accessed on 2021 Apr 1).
Congress.gov. S.5424 – Comprehensive Addiction and Recovery Act of 2016. *114th Congress (2015-2016)*. https://www.congress.gov/bill/114th-congress/senate-bill/524/text (accessed on 2021 Apr 1).
Congress.gov. H.R.6 – SUPPORT for Patients and Communities Act. *115th Congress (2017-2018)*. https://www.congress.gov/bill/115th-congress/house-bill/6 (accessed on 2021 Apr 1).
Congress.gov. S.2074 – Mainstreaming Addiction Treatment Act of 2019. *116th Congress (2019-2020)*. https://www.congress.gov/bill/116th-congress/senate-bill/2074 (accessed on 2021 Apr 1).
Federal Register :: Practice Guidelines for the Administration of Buprenorphine for Treating Opioid Use Disorder

Physician-Pharmacist Community Collaboration: OUD Care

- Multi-site study, National Drug Abuse Treatment Clinical Trials Network



- Outcomes: 71 patients enrolled, 88.7% treatment retention at 6 months, 95.3% visit adherence, 100% medication adherence, high patient, pharmacist and physician satisfaction

Wu LT, John WS, Ghitza UE et al. Buprenorphine physician–pharmacist collaboration in the management of patients with opioid use disorder: results from a multisite study of the National Drug Abuse Treatment Clinical Trials Network. *Addiction*. 2021 Jan 11. doi: 10.111/add.15353

Collaborative Care Model with Pharmacist Practitioner

Pain / Addiction Specialty Practitioner(s)

- Medical history
- Assessment
- Diagnosis (Pain, OUD)
- Treatment plan
- Suicide Risk
- New care needs

Pharmacist Practitioner

- Medication Management
- OUD/Pain treatment
- Opioid tapers
- Overdose education, naloxone
- PDMP query
- Urine Drug Screen (UDS)
- Referrals
- Suicide Risk

Nurse Care Manager / Nursing

- Patient education
- Ensure labs, appts, screenings
- Visit triage
- Care Coordination
- Case management

Rehabilitation Medicine

- Physical, Occupational Therapy
- Other Multimodal
- Patient instructions

Behavioral Health

- Psychosocial assessment, plan
- Case management
- Psychotherapy
- Suicide Risk

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DeRonne BM, Wong KR, Schultz E, Jones E, Krebs EE. Implementation of a pharmacist care manager model to expand availability of medications for opioid use disorder. *Am J Health Syst Pharm*. 2021 Feb; 78:354-359.

Collaborative Care Manager Models: Improved Access

Nurse Care Manager

- Frequent follow-up
- Case management
- Able to address
  - unexpected drug test results
  - insurance issues (prior authorizations)
  - prescription/pharmacy issues
- Concrete service support
  - Intensive treatment, legal/social issues, safety, housing
- Brief counseling, social support, navigation
- Support providers with large case loads

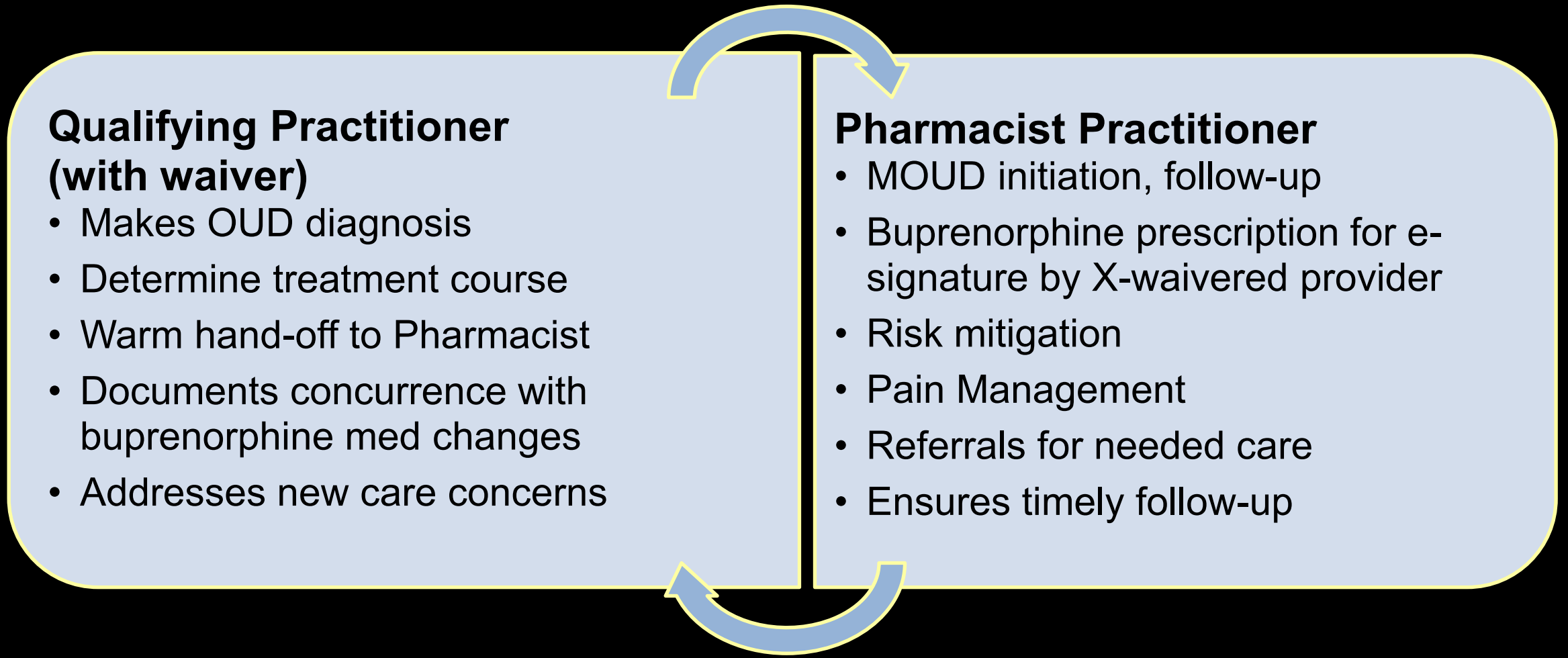
Pharmacist Care Manager

- Frequent follow-up
- Coordination of support services (legal/social, housing, triage care needs)
- Prescribe medications: Pain, withdrawal management, alcohol use disorder, naloxone
- Assess medication effectiveness and safety; adjust medications as needed
- Order and respond to Urine Drug Screen (UDS)
- Query and respond to PDMP
- Medication education
- Support providers with large case loads

Improved access to MOUD and close management of complex needs

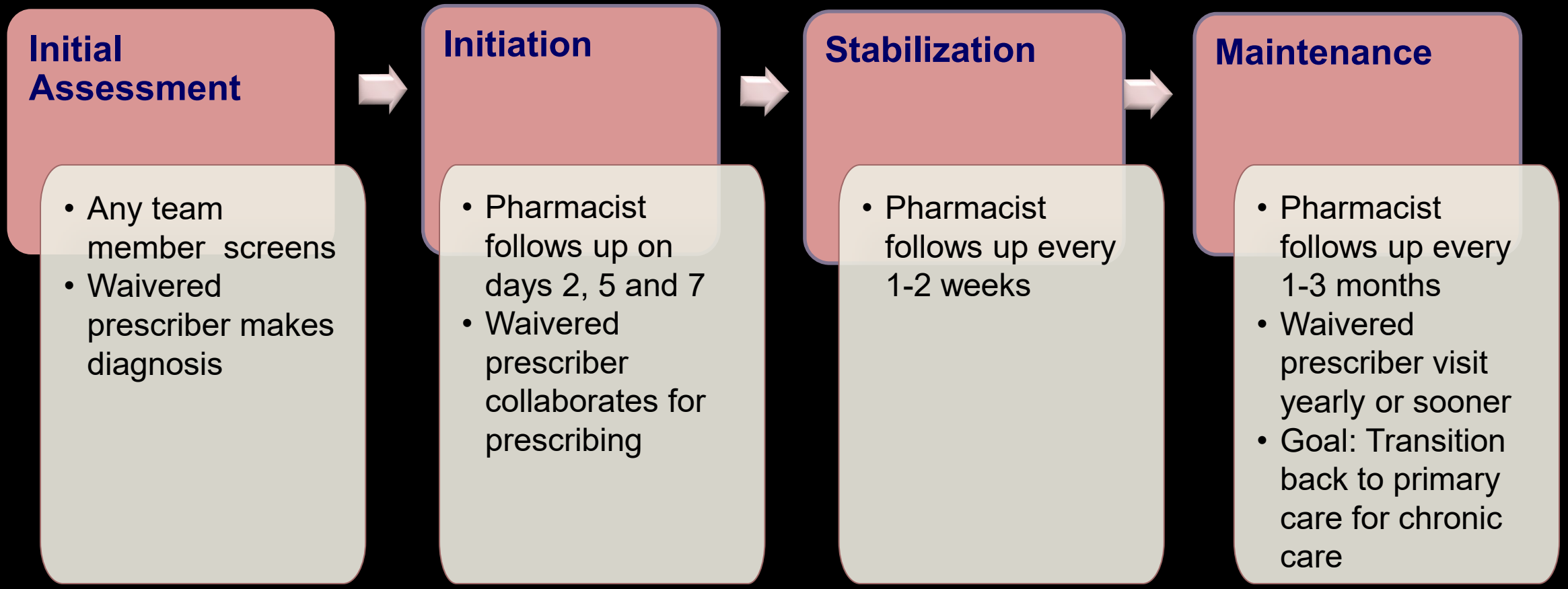
LaBelle CT, Han ST, Bergeron A, Samet JH. Office-Based Opioid Treatment with Buprenorphine (OBOT-B): Statewide Implementation of Massachusetts Collaborative Care Model in Community Health Centers. *J Subst Abuse Treat*. 2016; 60: 6-13. doi:10.1016/j.jsat.2015.0. Alford DP, LaBelle CT, Kretsch N, Bergeron A, Winter M, Botticelli M, Samet JH. Collaborative Care of Opioid-Addicted Patients in Primary Care Using Buprenorphine Five-Year Experience. *Arch Intern Med.* 2011;171:425-431. DeRonne BM, Wong KR, Schultz E, Jones E, Krebs EE. Implementation of a pharmacist care manager model to expand availability of medications for opioid use disorder. *Am J Health Syst Pharm*. 2021 Feb; 78:354-359.

How it Works: VA Pharmacist Care Manager Model



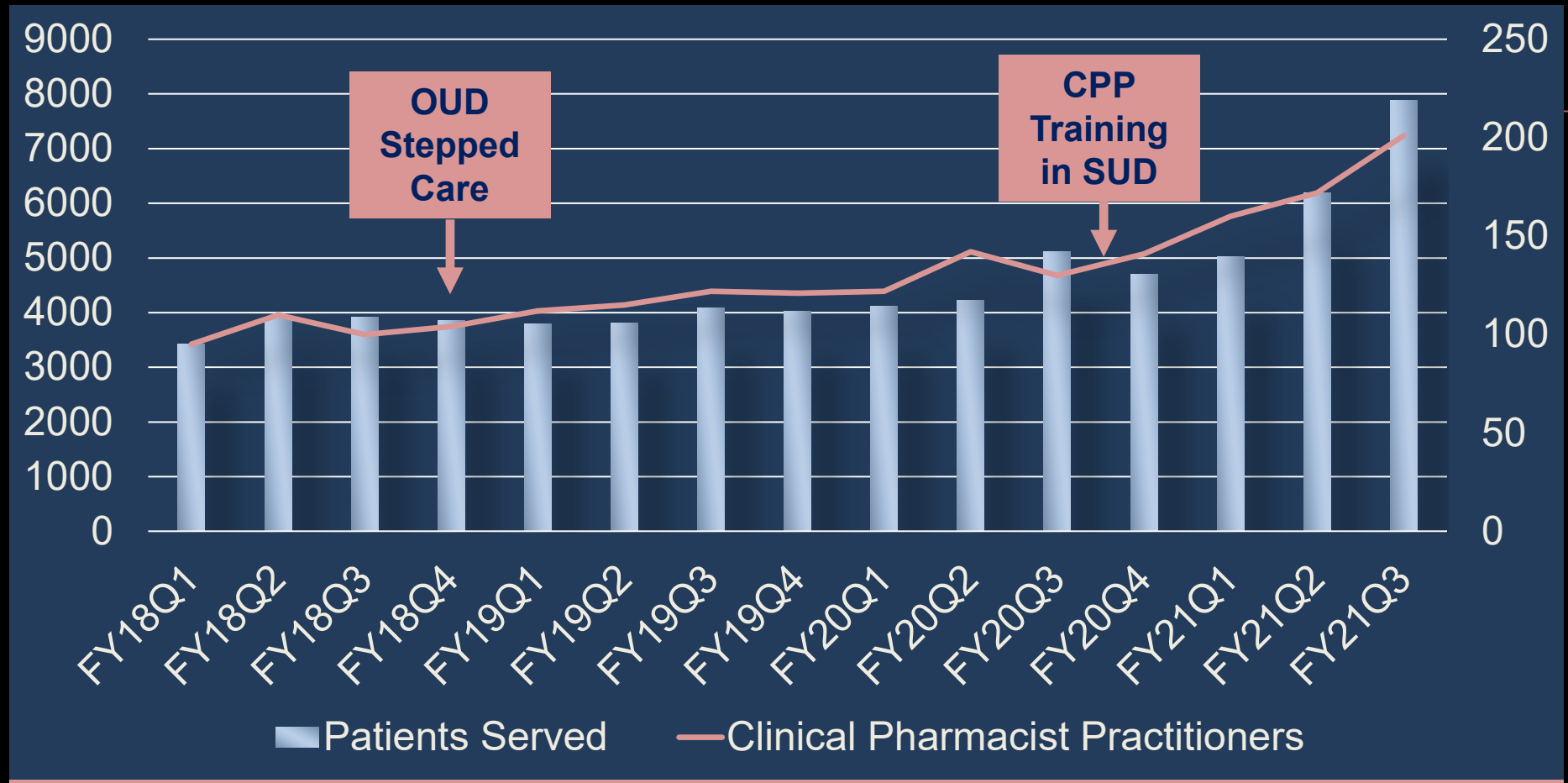
DeRonne BM, Wong KR, Schultz E, Jones E, Krebs EE. Implementation of a pharmacist care manager model to expand availability of medications for opioid use disorder. *Am J Health Syst Pharm*. 2021 Feb; 78:354-359.

VA Pharmacist Care Manager Model for MOUD: Medication Management Process Example



DeRonne BM, Wong KR, Schultz E, Jones E, Krebs EE. Implementation of a pharmacist care manager model to expand availability of medications for opioid use disorder. *Am J Health Syst Pharm*. 2021 Feb; 78:354-359.

Growth in VA Clinical Pharmacist Practitioners (CPP) Providing OUD Care



Fiscal Year 2021 (9 months):

14,500 Veterans provided OUD care by a CPP

33,000 Patient Care Encounters = 16,500 hours of OUD care

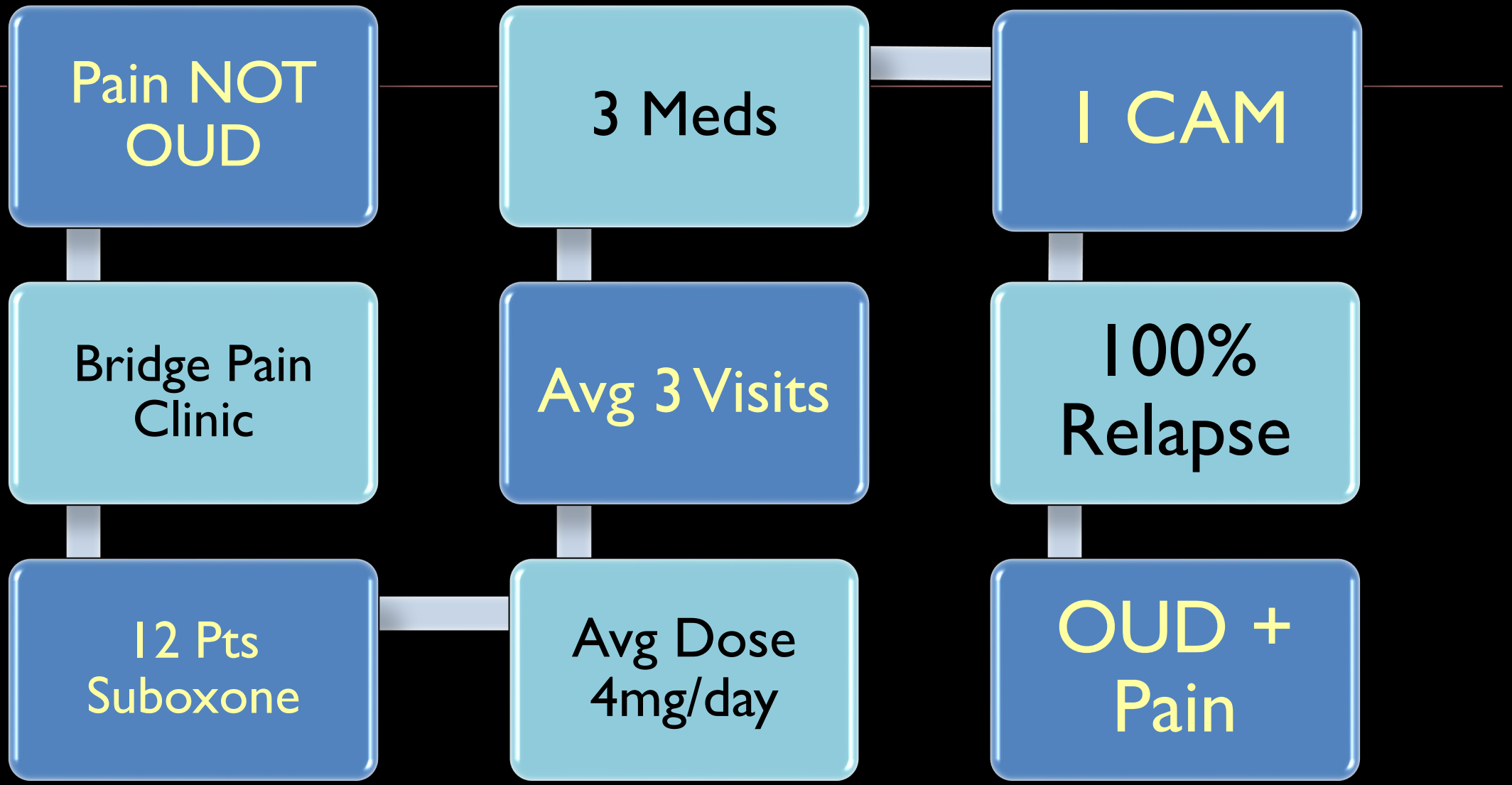
Since VA OUD Stepped Care Implementation:

- ✓ 35 CPPs hired specifically for rural OUD care
- ✓ ~20 Pharmacist Care Manager Models
- ✓ 93% growth in CPPs
- ✓ 104% growth in patients served by CPPs

From Pilot to Practice: 2017-2021

Timothy J Atkinson, PharmD, BCPS

Is it Really OUD if Patient has Pain?



2017-2021Pharmacist Led Comorbid OUD & Pain Buprenorphine Clinic

Demographic	Subgroup	Mean	N	Subgroup (%)	Total (%)
Age		58.6	**76**		100
Male			72	94.7	
Female			4	5.3	
		Hx MEDD			
Pain Clinic Transition		200	**39**		51.3
High Dose Taper			**21**	**53.8**	
	Taper Intolerance		13	33.3	
	Aberrant Behavior		6	15.4	
	Overdose		2	5.1	
Aberrant Behavior			**18**	**46.2**	
	Overuse		7	17.9	
	Hx OUD		7	17.9	
	Hx SUD		1	2.6	
	Other		3	7.8	
SATP Referral		124	**28**		36.9
Inpatient Detox			5	**17.9**	
	Suicidal Ideation/Pain		2	7.1	
	Opioid abuse		2	7.1	
	Opioid/BZD/Pain		1	3.7	
Outpatient SATP			**23**	**82.1**	
	Comorbid OUD/Pain		22	78.5	
	MVA/Pain		1	3.6	
Transition to VA		251	**9**		11.8
	OUD Clinic		7	9.2	
	Pain Clinic/Aberrant Behavior		2	2.6	

PainWeek

Meet Pete
(High Dose Taper)

57-year-old veteran with long history of rheumatoid arthritis and chronic low back pain s/p fusion 1999.

Previous Medical History

- Hypertension
- Hyperlipidemia
- GERD
- Depression
- PTSD
- Insomnia

Pain Medication Regimen

- Naproxen 500mg bid
- Cyclobenzaprine 10mg tid
- Morphine SA 120mg qid
- Hydrocodone 10mg/APAP qid prn

Patient Case “Pete”

- Pete was referred to PharmD Pain Service for assistance with tapering in 2016.
  - Over 18 months he tapered to morphine SA 60mg tid
  - He was resistant and struggling with taper
  - An opioid rotation failed/restarted morphine SA 60mg bid & Hydrocodone 10mg/APAP bid prn
- Veteran discloses that he is drinking due to pain
  - He agrees to stop but does not stating he has reduced intake
  - At follow-up visit, he reports quitting completely but ethyl glucuronide test indicates recent problematic alcohol intake
- Rapid taper was initiated and veteran de-stabilized
  - Pain Team agreed to slow taper restarting at morphine SA 30mg tid but veteran keeps asking for morphine SA 60mg tid
- Pete is seen in comprehensive pain clinic (MD, PharmD, PsyD)
  - Problematic opioid use and alcohol was discussed
  - Veteran is highly focused on opioid therapy to physically function

Patient Case “Pete”

- Reviewed criteria for opioid use disorder (OUD)
  - Veteran identifies with criteria and agrees to treatment
  - Adamant that pain drives opioid use (and alcohol use)
- Initiated suboxone 4mg/1mg bid
  - 1 week later he reports morphine worked better and withdrawal symptoms bothered him for two days
  - 2 weeks later he is engaged with whole health and more active and requests to remain on same dose, denies increase
  - Today, nearly a year later he remains on the same dose with pain controlled and enormous improvements in pain & function

Clinical Summary:

- High dose opioid therapy (520 MEDD)
- Long taper-destabilized during taper
- Started using alcohol to supplement
- Combative and resistant to taper at times
- Alcohol testing contradicts reports of abstinence

VA TVHS Stepped Pain Care Model

Comorbidities

RISK

Treatment Refractory

Complexity

Comprehensive Pain Clinic

STEP 3

Pain Physician (BC Pain/Addiction)
Pain Psychologist
Pain Pharmacist Practitioner
Chiropractor
Physical Therapist

TVHS Pain Clinic

STEP 2

5 Pain Physicians & 3 NPs

- Review/Accept Consults
- Comprehensive Assessment
- Physical Exam
- Interventional Procedures

Refer to Pain Pharmacist High Risk Clinic If:

- High Dose Opioid Therapy
- History of Addiction
- Dangerous Combination Therapy
- Multiple Medication Failures
- Medication for OUD/Pain

Primary Care Pain Pharmacist Clinic at Each Hub

STEP 1

- Joint Assessment with PCMHI at Initial Visit
- Collaborate with PCP for moderate-risk patients
- Triage Higher Risk Patients for Pain Clinic

Services Include:

- Non-opioid Pharmacotherapy
- Opioid Taper
- Opioid Risk Re-evaluation
- Urine Drug Testing
- Pain Care Coordination

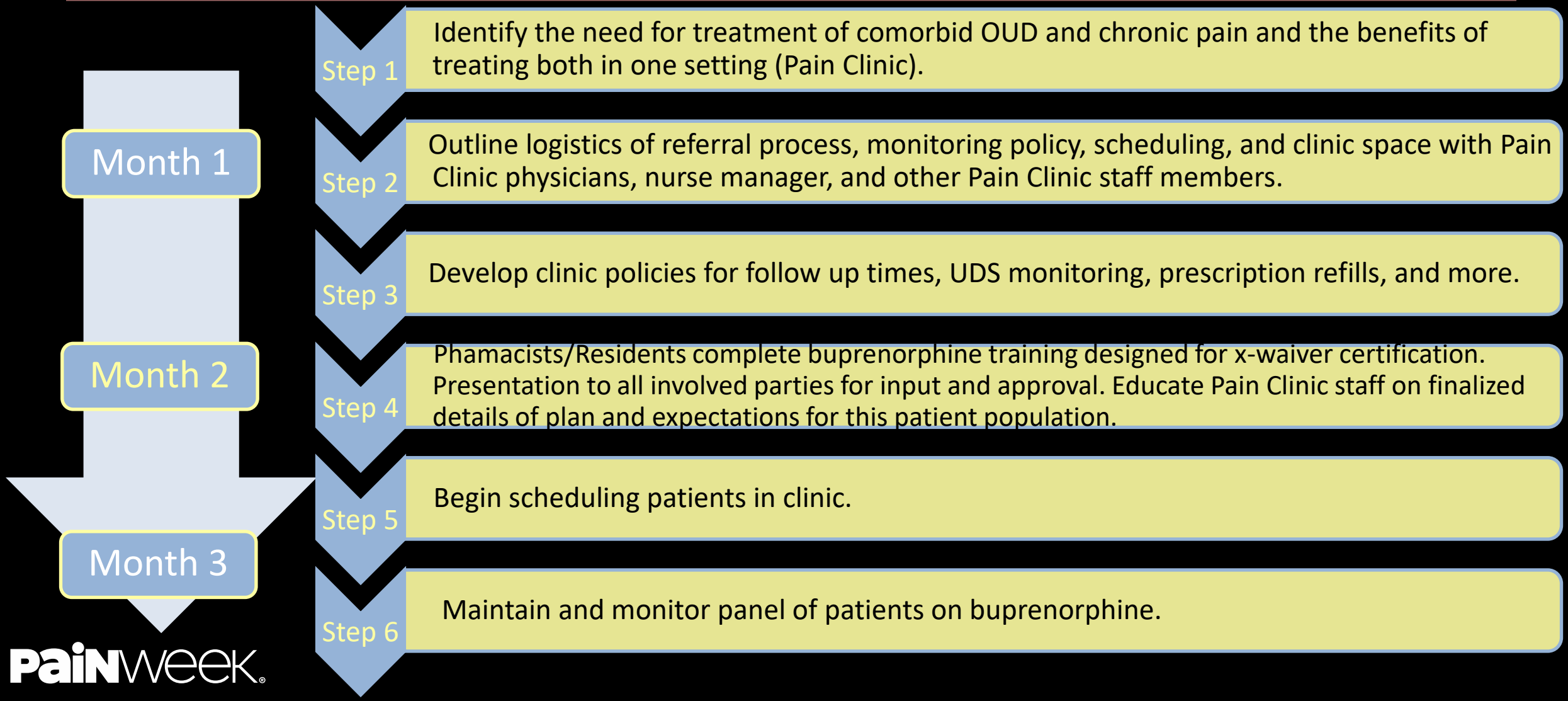
Whole Health Clinic at Each Hub

- Chiropractic
- Physical Therapy
- Acupuncture
- Nutrition
- Health Coaches

Tennessee Valley VA: CPP Led Plan for OUD

- Population Health showed patients with OUD lost to follow-up
- One x-waivered provider in pain clinic, access issue
- Early 2018, Pain Physician asked Pain Pharmacist to take over follow-up visits and monitoring.
- 2018 - Pain Pharmacist run medication for OUD (MOUD) clinic ½ day per week inside pain clinic, collaboration with Pain Physician
- Established care coordination plan with substance use treatment program (SATP) and Mental Health services
- PGY-2 Pain Pharmacy Resident longitudinal experience
- Clinic now runs 1 full day/week, pharmacist providing MOUD induction and stabilization, addressing pain management needs

Implementation of a Pharmacist-Led Buprenorphine Clinic - Overview



Meet Matt
(Aberrant Behavior)

39-Year-Old veteran with long history of chronic low back pain. Multiple surgeries most recently L2-L5 fusion with hardware 1 year ago

Previous Medical History

- Hypertension
- Hyperlipidemia
- Anxiety
- Depression
- PTSD
- Insomnia

Pain Medication Regimen

- Gabapentin 600mg tid
- Duloxetine 60mg daily
- Lidocaine 5% patch 1 daily prn
- Oxycodone CR 30mg tid
- Oxycodone IR 15mg qid prn

Patient Case “Matt”

- Matt has been requesting medication renewal two weeks early for months but simply states he is following directions for med renewal
- Matt often has ED visits related to pain but states he is considering another surgery due to pain
- Matt recently reported his prescription lost/stolen and provided a police report

At today’s visit:

- Matt denies any misuse/abuse of his medications and states he wishes he didn’t need them for his pain.
- UDS results:
  - + opiates
  - + oxycodone
  - + benzodiazepines

Patient Case "Matt"

- Matt's history is concerning for multiple red flags for misuse/abuse
  - Monitoring was increased including random urine drug screen (UDS) and pill counts
- UDS results: (confirmation)
  - Opiates → hydromorphone → unprescribed
  - Benzodiazepines → alprazolam → unprescribed
- Lost/Stolen meds reported ONLY after being contacted for required pill count

Clinical Summary:

- High dose opioid therapy (225 MEDD)
- ED visits for pain
- Lost/stolen meds
- UDS + unprescribed medications
- Failed pill count

Patient Case "Matt" Resolution

- Discussed case with collaborating pain provider
  - Agreed – opioid therapy inappropriate
    - Discussed alternatives for veteran – Ketamine, Buprenorphine/Naloxone, and/or non-opioid therapies
- Patient Discussion:
  - Express concern for red flags noted
    - Inform UDS results
  - Emphasize that treatment must change
    - Review DSM-V criteria for OUD to see if veteran identifies or agrees to OUD treatment
    - Evaluate readiness to change and initiate treatment
    - Discuss benefits and risks to medication for co-morbid OUD/Pain
  - Present menu of treatment options/alternatives
  - Allow veteran to choose from appropriately selected options

- Matt agreed- opioids become a problem
- Adamant- behavior driven by pain
- Expressed relief- pain treated differently
  - Addressed with Suboxone

Retrospective Cohort Review

Primary:

- Average follow-up time with Pain Pharmacist Practitioner compared with average patient follow-up time prior to clinic opening
  - Assessed at month 6, 12, then annually

Secondary:

- Loss to follow up (current vs. prior)
  - Assessed at month 6, 12, 18, 24, then bi-annually
- Mortality rates (current vs. prior)
  - Assessed at month 6, 12, 24
- May consider others such as no-show rate, follow-up telephone encounters

TVHS Retrospective Cohort Review

Physician Alone

2017

- 29 patients on MOUD
- 1 Pain Physician
- 15 lost to follow-up
- 3 deaths within 6-8 months of ceasing participation

Pharmacist/Physician Collaboration

2018

- 16 patients on MOUD
- 2 Pain Physician prescribers
- Pain Pharmacist Practitioner follows
- 0 Lost to follow-up
- 0 deaths
- More frequent follow-up and outreach efforts to promote engagement with treatment recovery

The "Pharmacist Led Buprenorphine Clinic" won the VA CPPO Best Practice Award in the MH/Pain/OUD in the 2018-2019 national competition

Why Use Specialized Pharmacists?

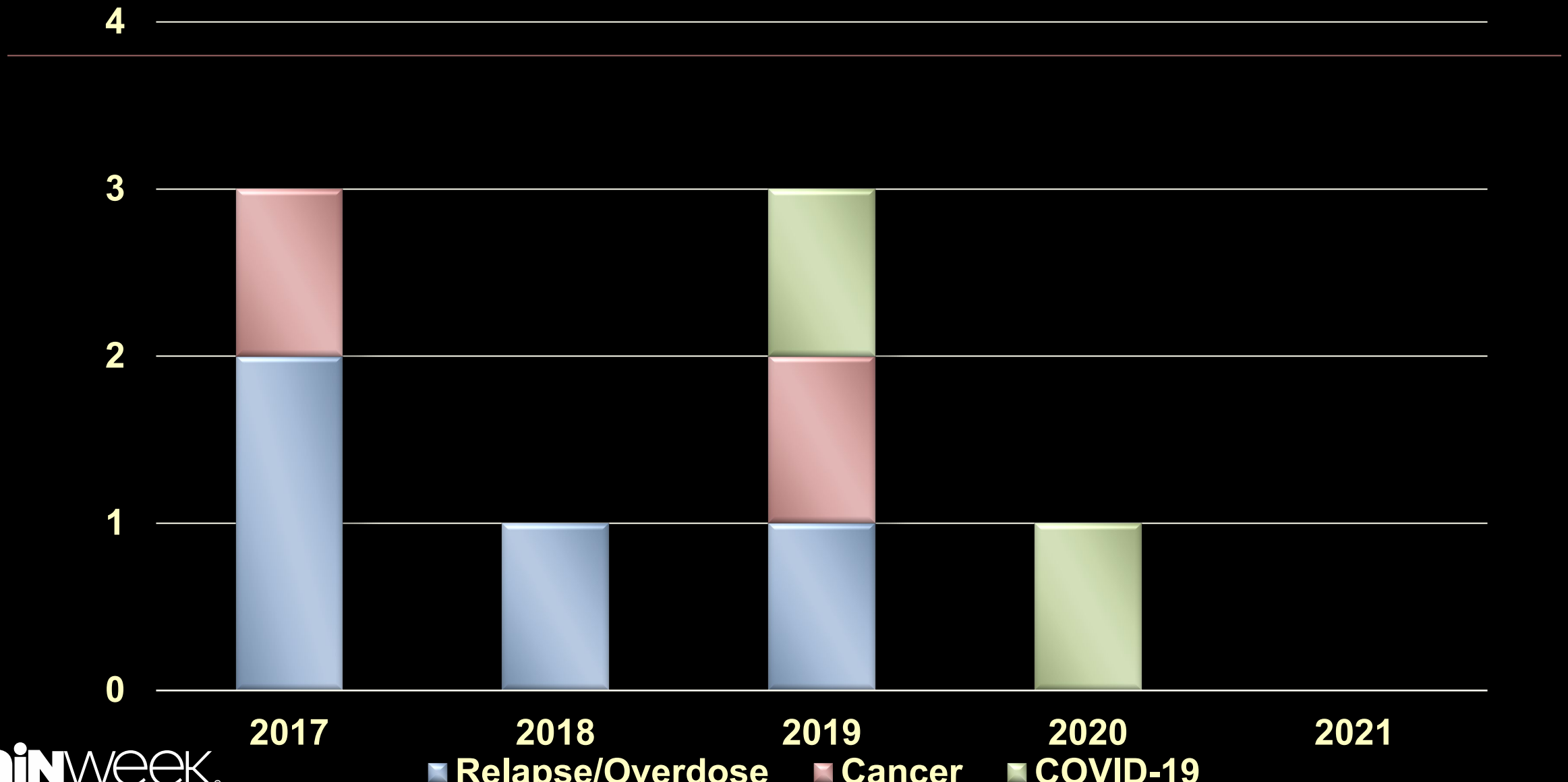
Expertise in Pain Pharmacotherapy

- Pharmacokinetics, pharmacodynamics, pharmacology, pharmacogenetics
- Develop evidence-based effective, least toxic, most economical treatment regimens

Collaborative Drug Therapy Management (CDTM)

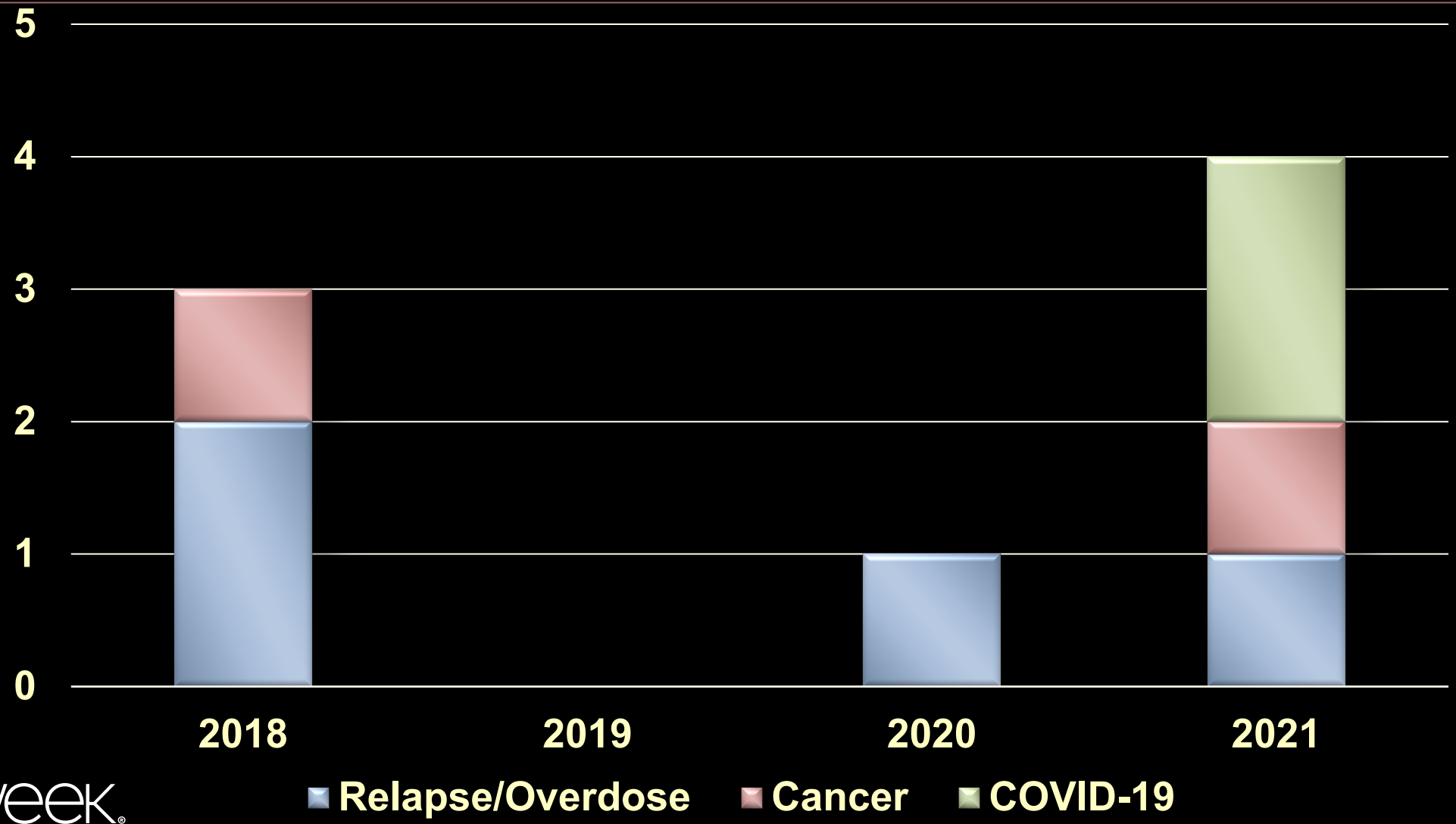
- Counseling to improve adherence, treat side effects, titrate to effect
- Monitor for misuse/abuse, detect aberrant behavior, decrease risk of pharmacotherapy
- Curbside & electronic consult services, coordination of care

All Cause Mortality Enrollment



PAINWEEK

All Cause Mortality Within 1 Year of Discharge



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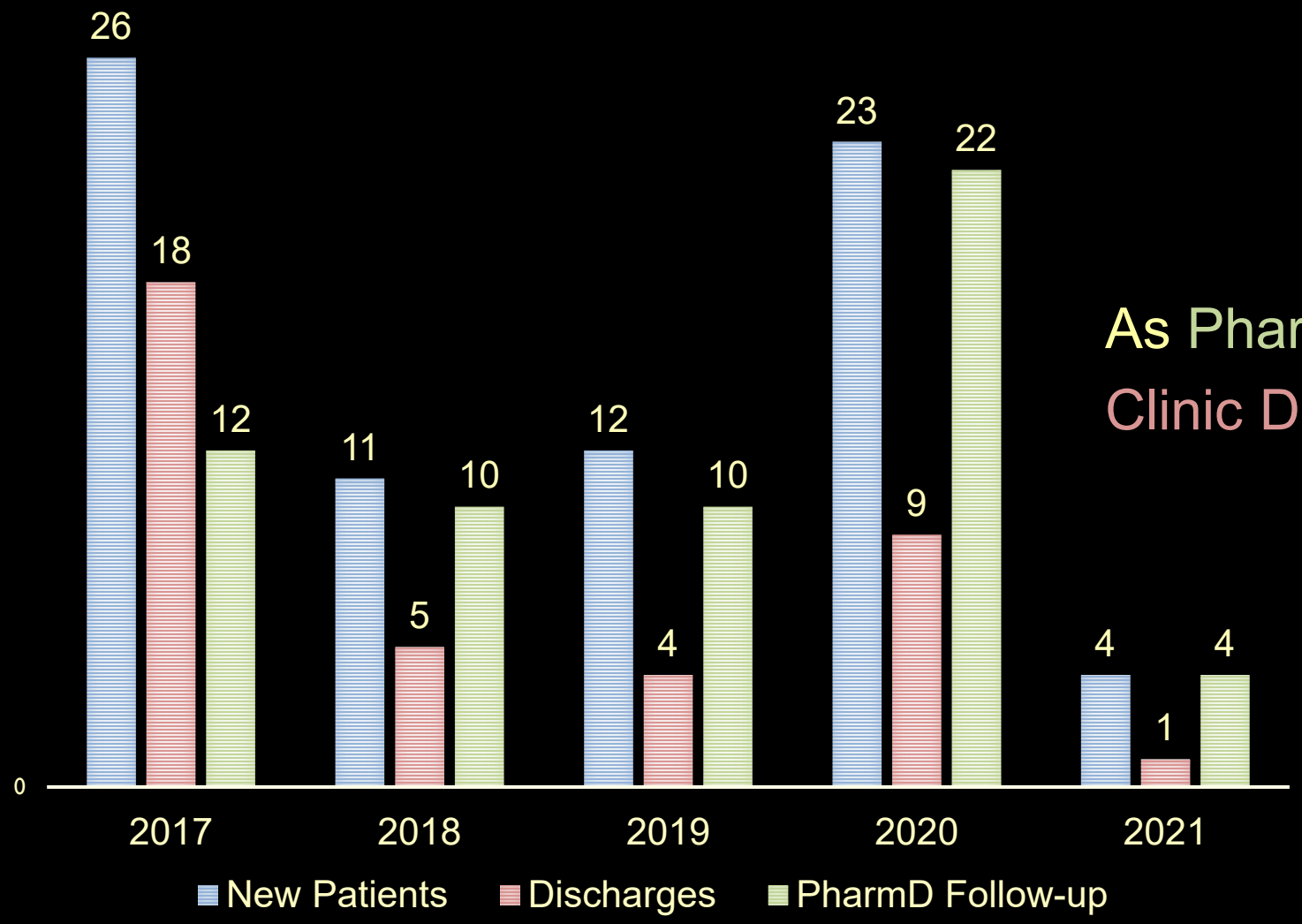
Pharmacist Led Suboxone Clinic

CLINIC ENGAGEMENT



As PharmD Follow-up ↑

Clinic Discharges ↓

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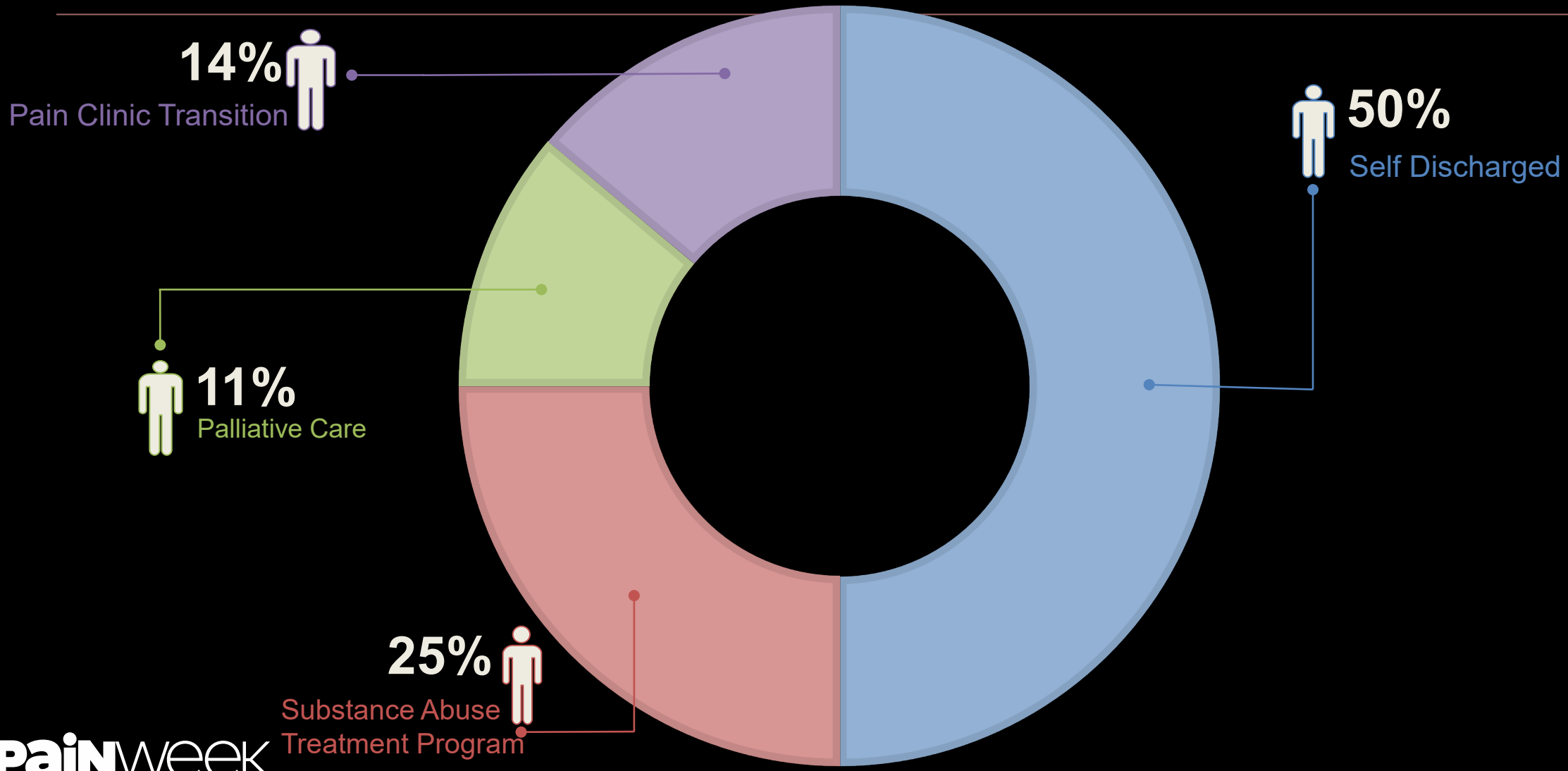
CLINIC DISCHARGE SUMMARY 2017-2021



PainWeek®

Meet Ben
(Substance Abuse Treatment Program Referral)

PMH: Opioid dependence, alcohol dependence, C5-C6 cervical fusion w/ hardware, s/p L2-S1 lumbar fusion, lumbar stenosis and radiculopathy, seizure disorder, depression, and HLD

SUD history:

- RRTP admission for AUD and OUD one year ago
- Referred to **Interdisciplinary Pain Clinic**, psych assessment reveals pain motivated alcohol and opioid abuse
- Adherence concerns: starts and stops buprenorphine/naloxone multiple times over the last 18 months.
- 1 incarceration for 30 days within the past 6 months
- Multiple hospitalizations for alcohol detox in the past 12 months

Patient Case “Ben”

Case Discussion:

Mr. Ben has been referred to you for treatment, what concerns would you have?

What changes would you make to promote adherence and mitigate risk?

Is this the right setting for treatment? Addressing the right care needs?

Patient Case “Ben”

Treatment Concerns:

- Continued use of alcohol
  - Is buprenorphine appropriate if alcohol dependence is predominant?
- Poor adherence to meds and follow-up
- Multiple treatment failures

Barriers Identified:

- Transportation to visits
- Economic hardship
- Unwillingness to do group therapy or addiction counseling
- Blames everyone else for events

Patient Case “Ben”

9 months ago: No-show to visit, follow-up call: “Veteran tired of being treated like a child or that he’s being punished”

- He requests to come off suboxone “been on it too long anyway”
- Taper schedule provided

8 months ago: ex-wife found him on the floor after alcohol relapse

- Discharge diagnosis: Rhabdomyolysis, AKI, AUD, and aspiration pneumonia

7 months ago: Seen in buprenorphine clinic. “Veteran upset about being cut-off his medications, forced to use alcohol for pain when ran out of meds.”

- Argumentative and tangential throughout visit
- Verbal de-escalation skills used to decrease stress and resolve concerns
- Veteran asserts that pain drives abuse and he needs the suboxone to stay sober

Patient Case “Ben”

Case Discussion:

Would you restart Ben’s Suboxone? Why or why not?

How many second chances does he get?

Why should we believe it will be successful this time?

At what point should we refer him to a more intensive treatment program?

Patient Case "Ben"

5 months ago: After two cancellations for car accident, Veteran is admitted for alcohol detox. Veteran blamed providers for relapse claiming he ran out of meds "What was I supposed to do?"

- Suboxone restarted with weekly meetings/follow-up required
- Poor insight into frequent follow-up and feeling "picked on"

3 months ago: Veteran reports increase to suboxone 8-4-8 has been helpful for both pain and cravings. Denies alcohol. Attends meetings

- Appears more stable and healthy than ever

Last month: Veteran admitted for alcohol detox. Referred to Intensive alcohol rehab program. Discharged from buprenorphine clinic.

11 months after discharge from buprenorphine clinic, Ben died of suspected relapse/overdose

Moving into the Future

Expand Pain Pharmacist Practitioner Services for OUD:

- 4 Pain Pharmacist Practitioners currently practicing at facility hubs
  - Only 1 incorporating OUD into practice
- Encourage stable management at facility hubs with Pain or Primary Care Pharmacist Practitioners

Virtual Visits to Decrease Travel Burden:

- Video visits available if progressing toward recovery
- Virtual visits available every other visit

Streamline Inpatient to Outpatient Transitions of Care:

- TVHS Taskforce on High Risk Opioid Inpatient Services
  - Brings inpatient psychiatry and pain clinic providers to discuss improved collaboration
  - Aims to improve care for those admitted for detox

Clinical Pharmacist Led Suboxone Clinic for Managing Comorbid Pain & OUD

Questions?

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