Meeting the Challenges of Opioids and PAIN

Opioids and Pharmacists
Thursday, May 16, 2019
A Provider Toolkit

**Meeting the Challenges of Opioids and PAIN:**

- **Patient Education on Pain and Opioid Prescriptions**
- **Addressing Opioid Prescription Practices**
- **Identifying Safe and Effective Pain Management Protocols**
- **Nonpharmacologic and Non-opioid Pharmacotherapy Alternatives**

[http://www.stratishealth.org/pip/opioids.html](http://www.stratishealth.org/pip/opioids.html)

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Meeting the Challenges of Opioids and Pain: How Pharmacists are Working to Address the Opioid Crisis

Erika Bower, PharmD, BCACP

Objectives

• Understand how guideline and regulatory changes have impacted pharmacy practice in multiple settings (community pharmacy, clinic settings, inpatient settings, etc.)

• Describe pharmacist-led initiatives that have occurred to address the opioid crisis
Opioid Epidemic

- More than 130 people die every day due to opioid overdose (illicit and prescription)
- Prescription opioid misuse contributes to economic burden of approximately $78.5 billion each year, which includes healthcare, lost productivity, addiction treatment, and criminal justice involvement
- 21-29% of patients prescribed opioids for chronic pain misuse them and 8-12% will develop an opioid use disorder
- Amount of opioid prescriptions has quadrupled from 1999-2014, however, there has not been an increase in the overall amount of pain that patients report

Opioid Epidemic - Minnesota

- Opioid Dashboard
- 422 Opioid overdose deaths in 2017
  - 195 involved prescription opioids
  - 111 involved heroin
  - 184 involved synthetic opioids (fentanyl, tramadol, etc.)
  - Continuing to rise

Opioid Epidemic Minnesota

- Racial Disparities
  - In 2016, African Americans were two times more likely to die of a drug overdose than whites
  - In 2016, American Indians were almost six times more likely to die of a drug overdose than whites

**Helpful Information**

- **Medication Therapy Management (MTM)**
  - Usually conducted by pharmacists
  - Variety of settings (Community, Ambulatory Care, Telehealth, etc.)
  - Assessment of all medications for appropriate indication, efficacy, safety, and convenience

- **Collaborative Practice Agreement (CPA)** agreement with prescriber to modify, initiate, or discontinue medication therapy on the behalf of the prescriber. Can also be initiated to order labs or other appropriate referrals

- **Naloxone** – opioid antagonist medication. Quickly reverses effects of opioids from the opioid receptor. Available in intranasal and injectable formulations

- **Morphine Milligram Equivalent (MME)** – value assigned to opioids to represent relative potencies
• Administered by the MN Board of Pharmacy
• State Board requires that pharmacists have access
• Collects prescription data on all schedules II-V controlled substances as well as butalbital and gabapentin
• Reported by pharmacies regardless of how prescription was paid for
• Intent to reduce diversion and detect abuse and misuse
• Can be accessed by pharmacists, prescribers, delegates of prescribers, medical examiners, MN Dept of Human Services Restricted Recipient Program staff and their delegates

http://pmp.pharmacy.state.mn.us/assets/files/2017%20Files/2017_FAQ_General%20ProgramIII.pdf

CDC Guidelines

• Intended for use by primary care physicians for chronic pain management in adults not related to palliative or active-cancer treatment
• Non-pharmacologic therapy and non-opioid pharmacologic therapy are preferred
• Consider opioid therapy only if benefits for pain and function are anticipated to outweigh risks. Should be in combination with other modalities
• Close monitoring for functional improvement and opioid use risk - Check prescription drug monitoring programs regularly and utilize urine drug testing at least annually

CDC Guidelines

- There is not a single dosage threshold for safe opioid use, however risk for overdose increases in dose-dependent manner
- Opioids should not be increased to > 90 MME/day without careful justification based on diagnosis and individualized assessment of benefits/risks
- Doses > 50 MME should have more frequent follow up and consideration of naloxone and overdose prevention
- Monitoring recommendations: at least every 3 months

ICSI Guidelines

- Institute for Clinical Systems Improvement – MN Collaborative of physicians and other representatives who work together to address major health topics
- Focus on continuous quality improvement and implementation of evidenced-based treatments to bring health service models in to practice
- Low Back Pain, Adult Acute and Subacute
- Pain; Assessment, Non-Opioid Treatment Approaches and Opioid Management
  - Many helpful pain management algorithms
  - Comprehensive care approach
ICSI Guidelines

• Address Acute or Acute on Chronic Pain
  – First opioid prescription should be lowest possible effective strength of short-acting opioid, not to exceed 100 MME total per prescription and < 3 day supply
  – Ongoing treatment to not exceed 100 MME per day (or 50 MME per day with concomitant benzodiazepine or hx of abuse)
• Avoidance of opioids for chronic pain if possible
• Functional and Risk Assessment
• Naloxone for high risk
• Monitoring considerations (UDS, Drug counts, Access PMP, etc)

MN Opioid Prescribing Guidelines

• State of Minnesota and the Opioid Prescribing Workgroup
• Focus on period during acute pain and recovery from surgeries or injuries
  – Acute pain phase (Days 0-4 [or up to 7 for major surgery or trauma])
  – Post-Acute Pain Phase – up to 45 days after acute event
  – Chronic Pain - >45 days or beyond expected duration of recovery
  – Tapering
  – Women of Childbearing Age
MN Opioid Prescribing Guidelines

- Prescribed lowest effective dose and duration of opioids for acute pain
  - <100 MME per Rx or <3 day supply [200 MME for major trauma]
- Post-acute – no more than 50 MME/day
- Post-acute pain period is critical to halt progression to chronic use – offer tapers
- Evidence to support chronic opioid analgesic therapy for chronic pain is insufficient. Providers should avoid initiating chronic opioid therapy if possible
- Risk assessments (ORT, etc). Assessment of mental health
- Avoid combination benzodiazepines and opioids
- Check prescription monitoring program whenever prescribing opioids

CMS 2020 Policies & Final Call Letter

- Encourage health plans to offer flexibility and cost-sharing reductions/supplemental benefits for addiction treatment and part C services (chiropractic, acupuncture, etc)
- Encourage opioid reversal agents (naloxone) on lowest cost-sharing tiers
- New Part D STAR measures to display page
  - Use of Opioids at High Dosage in Persons without Cancer (OHD)
  - Use of Opioids from Multiple Providers in Persons without Cancer (OMP)
  - Use of Opioids at High Dosage and from Multiple Providers in Persons without Cancer (OHDMP)
  - Concurrent Use of Opioids and Benzodiazepines (COB)
- Previous Initiatives (2019):
  - Hard safety edits for acute pain, and opioid care coordination edit at 90 MME per day
  - Opioid Drug Management Program (DMP) – plans have ability to lock in to prescriber, pharmacy, or both based on CMS criteria
Pharmacist Unique Skills & Expertise

MME Conversions

- (Strength per Unit) * (Number of units/Day Supply) * (MME conversion factor) = MME per day
- Example: What is the MME of oxycodone 5 mg four times per day?
  - 5 mg * 4 = 20 mg total per day
  - 20 mg * 1.5 = 30 MME

Opioid Rotations and Tapering Plans

- **Opioid Rotations** – Changing from one opioid to another
  - Utilize MME
  - Adjust for cross tolerance (20-50%), pharmacokinetic factors, and impact from other concomitant medications

- **Opioid Tapering** – mix of art and science
  - Calculate MME
  - Taper speed dependent on medication involved, rationale for taper, and patient specific criteria
  - Can involve an initial opioid rotation
  - More challenging with mix of long and short acting formulations or patches
  - Patient education - withdrawal

Management of Unique Medications

- **Methadone**
  - Very long half-life
  - NMDA receptor antagonism
  - Accumulation effect – analgesic effect does not last as long as the metabolites remain in the system (increased risk for unintentional overdose)
  - As dose decreases you MUST recalculate MME due to accumulation effects

<table>
<thead>
<tr>
<th>Methadone (mg)</th>
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<tr>
<td>&gt;0, &lt;= 20</td>
<td>3</td>
</tr>
<tr>
<td>&gt;20, &lt;= 40</td>
<td>4</td>
</tr>
<tr>
<td>&gt;40, &lt;= 60</td>
<td>8</td>
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<tr>
<td>&gt;60</td>
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Management of Unique Medications

• **Buprenorphine**
  - Opioid receptor agonist/antagonist with high receptor affinity (displaces opioid) – challenging opioid rotations
  - Controlled Substance III – special DEA not needed
  - Ceiling effect – safest opioid for respiratory depression risk (not risk free)
  - Fewer side effects

<table>
<thead>
<tr>
<th>MME per day</th>
<th>Patch</th>
<th>Film</th>
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<tbody>
<tr>
<td>9</td>
<td>5 mcg/hr</td>
<td>150 mcg BID</td>
</tr>
<tr>
<td>18</td>
<td>10 mcg/hr</td>
<td>300 mcg BID</td>
</tr>
<tr>
<td>27</td>
<td>15 mcg/hr</td>
<td>450 mcg BID</td>
</tr>
<tr>
<td>36</td>
<td>20 mcg/hr</td>
<td>600 mcg BID</td>
</tr>
<tr>
<td>45</td>
<td>------</td>
<td>750 mcg BID</td>
</tr>
<tr>
<td>54</td>
<td>------</td>
<td>900 mcg BID</td>
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Other Topics

• Recognition and Management of Withdrawal
  - Recommendations for withdrawal medication

• Non-opioid management
  - Mental health medication
  - Non-opioid pain treatment alternatives
  - Assist with functional or risk assessments
What are Pharmacists Doing to Help?

Community Pharmacists

- Front lines – dispensing opioid prescriptions
- Access to prescription drug monitoring program
- Acceptance of E-Prescribing
- Training to identify drug seeking behaviors and resources to offer help
- Naloxone – Some pharmacies are entering into collaborative agreements with physicians to prescribe naloxone to high risk patients
- Collaboration with health-systems for post-discharge pain management

Community Pharmacists

- Minnesota Pharmacy Syringe/Needle Access Initiative – Pharmacy Voluntary
  - Persons are able to purchase up to 10 new syringes/needles without a prescription
- Medication Disposal Kiosks and education
- Pharmacists in medical cannabis dispensaries
- Medication Therapy Management (MTM)

Ambulatory Care Pharmacists

- Medication Therapy Management (MTM) Practitioners – comprehensive collaborative practice agreements
  - Family Practice/Internal Medicine initiatives
  - Several pharmacists practicing in comprehensive pain management clinics in the Twin Cities
    - Patient education
    - Opioid tapering
    - Opioid alternatives
    - Polypharmacy
    - Pharmacogenomic testing and counseling
    - Naloxone prescribing
    - Management of mental health medication and screening
Ambulatory Care Pharmacists

• Prescriber education
• Integration of guideline initiatives and strategies to improve EMR utilization for improved opioid prescribing
  – Alternative medications and dosing options
  – Integration of MME calculators
  – Integration of functional assessment tools
  – Auto-Prescription of Naloxone

Inpatient Pharmacists

• Education of prescribers – ED, surgical teams, etc
  – Guideline Review
  – Buprenorphine & Non-Opioids
• Emergency Department pharmacists
• Medication Safety Pharmacists
• Admission/Discharge medication reconciliation and patient education
• Medication Use Evaluations

Inpatient Pharmacists

- Enhancement of EMRs
  - Standardized opioid dosing to meet guideline recommendations
  - MME Calculators
- Inpatient Pain Teams
  - Team of pharmacists and nurse practitioners as a consult service
  - Acute on chronic pain management, post-surgical pain management, chronic pain + addiction, etc.
  - Transitions of care

Health Plans

- Utilization Management Strategies for Safety
  - Opioid-Naïve Patients: hard safety edit at the pharmacy which limits initial opioid fills for acute pain to no more than a 7-day supply. Subsequent fills not subject to this limit. CMS Rule.
  - Long Acting Opioids: a hard safety edit (prior authorization) may be implemented for all long-acting opioid medications to ensure safe prescribing
  - Quantity limits:
    - Non-Medicare: limit opioid prescriptions to an average daily morphine milligram equivalent (MME) of 90
    - Medicare: soft safety edit (i.e., can be overridden by the pharmacist) for an average daily MME of > 90. Hard safety edit (i.e., requires prior authorization) for an average daily MME of > 200.

Health Plans

- Quarterly opioid utilization monitoring program
  - Monitor high risk patients based on number of prescribers, pharmacies, and average daily MME
- Restricted recipient program
  - Lock in members to specific prescriber, pharmacy, or both
- Care coordinator education and resources
  - Deterra bags for safe medication disposal
- Promotion of safer alternatives through formulary choices (Buprenorphine, non-opioids, etc)

Other Initiatives

- Collaboration between state and national organizations, clinicians, and/or other stakeholders
  - Opioid Prescribing Improvement Program – Minnesota based workgroup
    - Continuing education, opioid prescribing guidelines, individual opioid prescribing reports (through MN-ITS)
  - AWARxE: Resource for pharmacists with education, medication disposal information, etc. [https://nabp.pharmacy/initiatives/awarxe/](https://nabp.pharmacy/initiatives/awarxe/)
  - Enhancing prescription drug monitoring programs (PDMP)
  - APhA Opioid Use and Misuse Resource Center
  - Center for Opioid Research and Education (CORE) - [https://www.solvethecrisis.org/](https://www.solvethecrisis.org/)
Other Initiatives

- Pharmaceutical Industry
  - Research and development of abuse deterrent drug formulations
  - Research and development of drugs with novel mechanisms of action
  - Software initiatives for the electronic medical record
- Technology
  - Prescribe Wellness App: App-based opioid risk assessment tool that can be used during MTM visit


Other Initiatives

- Academia
  - Targeted education for pharmacy students and enhanced curriculum
  - Community Education
- Pain Management and Palliative Care Pharmacy Residencies (PGY-2)
  - 25 Specialty Residencies in the USA
  - Continuing to expand
  - Minnesota: VA Hospital
Questions?