Opioids in the community

Pharmacists educate patients, prescribers to fight misuse

Remington Drug Company in Remington, VA, is an Americana-lover's dream. Patients who come here to fill their prescriptions and receive medication counseling pass through the doors of a 105-year-old establishment that boasts soda fountains, swivel stools, glass-paned cherrywood cabinets, and a checkerboard floor. Vintage signs behind the marbletop counter announce the ice cream flavors of the day and invite visitors to take a break from their worries and enjoy a milkshake. Yet even here, in a pharmacy set in a bucolic town of only about 600 people, the nation's opioid crisis has reared its ugly head.

In his 11 years at the pharmacy and 3 years as a co-owner, Travis Hale, PharmD, has seen the crisis unfold from every angle: well-meaning patients becoming dependent on opioids prescribed by well-meaning physicians, prescribing patterns indicative of pill mills, drug-seeking behavior, and criminal diversion of medications.

"I had a patient whom we were told had been making drug transactions with medications dispensed in good faith by our pharmacy. While there was no way to prove this from our position in the pharmacy, it highlights the difficulty of the decisions we have to make given what information we have as pharmacists in the midst of this crisis," Hale said.

Then there are the unintended consequences of the nation's all-out war on opioids. In their haste to comply with CDC guidelines for opioid prescribing, some prescribers compound the issue and drive up demand for illicit opioids by cutting their patients' dosing, attempting to take patients off opioids with insufficient tapering, or simply refusing to treat chronic pain patients who have taken opioids long term. Some patients, unaware of their options and desperate for relief from both pain and opioid withdrawal, may turn to illegally obtained prescription drugs or street drugs.

It's a cycle that sends Hale to bat for chronic pain patients.

"My issue is that if we're going to cut opioid medications back on these folks, let's do it humanely. Unless a prescriber has inherited a patient [from a previous practice owner], they're the ones who put the patient on the medication, so let's work together to take them off," Hale said. "Their response is often that the guidelines said one thing one day, and another thing the next, and they're following the guidelines because to do otherwise would open them up to being sued."

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Travis Hale, PharmD, co-owner and pharmacist at Remington Drug Company, encourages pharmacists to be prepared to offer patients alternatives to opioids for pain relief.

As a result, community pharmacists are often caught between patients and prescribers, but by using their training, medication expertise, and the screening tools at their disposal, they can overcome the challenges the opioid crisis has set before them.

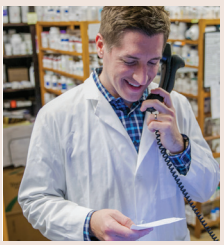
Quantify risk

Although checking the state prescription drug monitoring program (PDMP) can provide clues about inappropriate opioid prescribing and use, pharmacists can, and should, go beyond that, said Jeffrey Fudin, PharmD, FCCP, FASHP, CEO and chief medical officer of Remitigate and adjunct associate professor, at Albany College of Pharmacy and Health Sciences in New York.

"Looking at the PDMP and the patient's other prescriptions is not an adequate risk assessment. There are a number of validated tools pharmacists can use for assessing misuse and abuse," Fudin said. "Prescribers should be using them, but there is no reason pharmacists can't use them as well."

These tools are self-report assessments that patients can fill out or answer in the pharmacy and include the Opioid Risk Tool (ORT), which takes about a minute to complete and score; the Screener and Opioid Assessment for Patients with Pain—Revised, which has 24 questions designed to predict abnormal medication-related behaviors in patients with chronic pain; and the Current Opioid Misuse Measure, which has 17 questions that can measure risk for abnormal medication-related behavior in chronic pain patients who take opioids.

Fudin added that pharmacists should also screen for the risk of overdose or respiratory distress by using a tool like the Risk Index for Overdose or Serious Opioid-Induced Respiratory Depression (RIOSORD), which assigns point values to different conditions, medications, or events like emergency department visits to quantify risk. This opens the door for thorough patient counseling, Fudin added.



"The decisions we have to make [are difficult] given what information we have as pharmacists in the midst of this crisis."

Matthew C. Osterhaus, BSPharm, FASCP, FAPhA, owner of Osterhaus Pharmacy in Maquoketa, IA, and a former president of APhA, agrees. At Osterhaus Pharmacy, the pharmacists take the RIOSORD with them into the patient counseling booth.

"We talk about things that put the patient at higher risk, things they don't think about, like other illnesses, concomitant use of benzodiazepines, and things that may not have anything to do with addiction or drug-seeking, but that make it a good place to start the discussion," Osterhaus said. "As the discussion develops with the patient, sometimes we get to a score that helps us decide that a patient should have naloxone in their home."

Part of the discussion should focus on how patients take, or will take, their opioid medications, because what happens in "real life" doesn't always match up with the directions for opioid use, but the conversation should be couched in terms of education, said Fudin.

"Patients may think nothing of taking an extra dose and then telling me later, as though they did something

Hale and Remington Drug Company co-owner Al Roberts, RPh, bought the 105-year-old pharmacy in 2015.

wrong and are asking for forgiveness, or they will drink alcohol or operate heavy equipment while taking the drug," Fudin said. "They can feel invincible, and that's how people get into trouble."

Such counseling should not be a one-and-done discussion, and pharmacists should lay the groundwork for a good rapport with patients, said Amanda Schroepfer, PharmD, clinical and residency director at Goodrich Pharmacies in the northern suburbs of Minneapolis.

"When you have a good relationship with your patients, they will tell you a lot of information about themselves they are not always willing to share with [health professionals] they don't know as well. But they have to know you are willing to spend a few minutes with them every time they come in," Schroepfer said.

Set expectations

Patients whose health providers have decided to taper them off opioids will often turn to pharmacists for help. Setting expectations for pain management can be challenging as both providers and patients alike adapt to the "new normal" in pain management, said Hale.

"Twenty years ago, patients were getting large quantities of opioids with the goal of eliminating their pain entirely, but now the goal of pain management is to reduce pain by 30% or 40%," Hale said.

Sometimes Hale is not entirely comfortable with the discussion, but he forges ahead so patients know what to expect. "Who are we to decide [how much pain should be acceptable], though? That's not necessarily my place, so I just tell them not to have the expectation that they will be pain-free. I tell them it's more about knocking the edge off so they can do their daily activities."

Hale encourages pharmacists to be prepared to recommend options for pain relief.

"Talk about what they're currently being treated for, and look at their history. Do they have something you can manage with OTC products, or are they going to have to see someone for pain management?" Hale said. "To truly manage pain, medication can't be the only thing. There usually has to be some physical component, like physical therapy."

Work with prescribers

There will inevitably be times when, in executing their corresponding responsibility, pharmacists are compelled to seek clarification from prescribers. This is especially true when something in the PDMP suggests a potential problem, said Steve Simenson, BPharm, president and managing partner of Goodrich Pharmacies in Minnesota and a former president of APhA.

"Physicians don't always look in the PDMP, even though they are required by law [in some states] to do so. For HIPAA reasons, they have to log out of the electronic medical record [EMR] before logging into the PDMP. It's another step, and because there's no penalty for not looking in the PDMP, they don't always check it," Simenson said.

In other words, the physician may not be aware the patient has multiple prescriptions for opioids written by different prescribers or that the patient is taking medications prescribed by another provider that could interact with the opioid. Making matters worse, pharmacists don't always have access to the EMR themselves, leaving them with a dearth of information on which to base a recommendation. The only thing left to do, then, is call the prescriber—a potentially sticky situation if the pharmacist doesn't approach the provider the right way.

"It's not what you say, it's how you say it," said Fudin. "Approach the prescriber as a team member: not lower than, or higher than, the prescriber, but as an equal. Present the information and your concerns, and let the prescriber know that it would be helpful if you could obtain additional information to verify the legitimacy of the prescription. Maybe the prescriber has records you don't have, or maybe you'll be more comfortable with filling the prescription if you knew the prescriber's side of the story."

Osterhaus agrees. "Don't make it a set of demands or a knee-jerk response," said Osterhaus. "You may have a very limited data set, and that puts you in the position where it's important to give the prescriber a chance to share his or her logic about why the prescription was written."

Other times, it may seem like the prescription is not born of evidence-based medicine. Here is where screening for opioid risks with tools like the ORT and RIOSORD can be extra helpful. That can prepare pharmacists for having a discussion based on quantifiable risk, but the message has to be delivered nonjudgmentally, said Felicity Homsted, PharmD, BCPS, chief pharmacy officer of Penobscot Community Health Care in Maine.

"The way to approach it is: 'Here is the patient. Here is the medical history. Here is the evidence for what the safety concerns are for using this medication in this population or not. Here are the risks for their conditions or interactions with their other medications,'" Homsted said. "Approach the prescriber in a nonbiased, educational, meaningful way."

Hale discusses naloxone with clerk Cheryl Crowder, left, and pharmacy technician Debbie Grzech, CPhT.

Engage in the teachable moment

There may be cases in which a pharmacist thinks it's a no-brainer that a patient has been prescribed an opioid inappropriately. But pharmacists should keep in mind that they likely have a greater understanding of the risks of opioids than the prescriber, unless the prescriber is a pain specialist, said Homsted.

"So little of medical training focuses on medications, and in general, the portion on pain is even smaller. Pharmacists have a greater focus on the medications used in pain management, specifically their pharmacology and pharmacokinetics, which need to be considered when tapering effectively," Homsted said, noting that in many communities patients don't have access to pain specialists, and the decisions about opioid prescribing often fall to primary care physicians.

Homsted noted that some prescribers may be set in their ways or slow to adapt to new ways of thinking about pain.

"There are those who have difficulty in accepting the need for a change in their opioid prescribing practices. In their minds, if they change their view of it, then they are compelled to acknowledge that what they were doing before was causing harm," Homsted said.

"I explain that what we know now is different than what we knew before. We thought viewing pain as a fifth vital sign and prescribing these medications [in vast quantities] would help, but then later evidence showed that it was actually causing more harm than good. You have to let them go through the learning process in a way that helps them realize what we previously believed was all wrong, not that they were doing something wrong intentionally."

At the other end of the spectrum are prescribers who cut dosing or prescriptions without appropriate tapering, often to avoid the perceived threat of DEA scrutiny. That presents an opportunity for pharmacists to step up for patients, said Nicholas Hagemeier, PharmD, PhD, associate professor at Bill Gatton College of Pharmacy at East Tennessee State University in Johnson City.

"In situations like that, most don't seem to think of the unintended downstream consequences of decisions that are made right now, like if they are really precipitating illicit drug use," Hagemeier said. "Advocate in an evidence-based manner. Say, 'I see where we're going to be tapering [the patient] off her opioid. Based on the prescription I received, it looks like we're planning to cut her dose in half. What are your thoughts about tapering by X% instead, which evidence suggests improves patient success with tapering?'"

Simenson said that pharmacists may need to suggest something other than targeting the opioid. "There are often other things that make it difficult for a patient to get off an opioid if they've been on it for a long time. A lot of people who have opioid use disorders also have problems with benzodiazepines. You might have to work on the benzodiazepines first, and that can take months."

Hale keeps the conversation focused on the patient.

"Some conversations may start off a little uncomfortably, but we make it clear that we're trying to make it easy on the patient, and that opens the door," Hale said. "The patients are the main priority, and we'll do whatever we can to help them out."

Terri D'Arrigo, reporter

Opioid resources

- APhA Opioid Use, Abuse, and Misuse Resource Center: www.pharmacist.com/opioid-use-abuse-and-misuse-resource-center
- APhA2018 Pain Institute: Innovative Approaches to Chronic Pain: http://elearning.pharmacist.com/products/4870/apha-2018-pain-institute-innovative-approaches-to-chronic-pain
- APhA Pain, Palliative Care, and Addiction Special Interest Group: www.pharmacist.com/pain-palliative-care-and-addiction-sig-1
- CDC Guideline for Prescribing Opioids for Chronic Pain: www.cdc.gov/drugoverdose/prescribing/guideline.html
- Opioid Risk Tool (ORT): www.drugabuse.gov/sites/default/files/files/OpioidRiskTool.pdf
- Pharmacists: On the Front Lines: Addressing Prescription Opioid Abuse and Overdose (CDC brochure): www.cdc.gov/drugoverdose/pdf/pharmacists_brochure-a.pdf
- Risk Index for Overdose or Serious Opioid-Induced Respiratory Depression (RIOSORD): http://paindr.com/wp-content/uploads/2015/09/RIOSORD-tool.pdf