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Responding to the Opioid Crisis:

Success of a Pharmacist-Led Pain Management Clinic at the Indian Health Service

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The Institute of Medicine states that approximately 100 million people live with chronic pain in the United States[1]. Between 1999 and 2008, non-medical use of prescription pain killers in the American Indian and Alaska Native population was double to triple the frequency than in white or black population, respectively. In 2013, 249,000,000 prescriptions for opioids were written, equivalent to about one prescription per adult living in America[2]. This helps create an environment conducive for opioid overdose. Per the Centers for Disease Control and Prevention, 1 in 4 people on chronic opioid therapy struggle with addiction and over 14,000 people died from overdoses involving prescription opioids in 2014 in the United States[3]. In response to these staggering statistics, various federal and clinical agencies have introduced bills and initiatives to better manage opioid misuse and abuse.

In May 2013, the House of Representatives approved a bill package designed to develop prescription drug monitoring programs and a task force to create optimal pain treatment practices[4]. The American Pharmacists Association is a huge proponent of this package, citing pharmacists are an underutilized resource while having valuable clinical knowledge in the initiation, monitoring, and discontinuation of opioids. Pharmacists are also able to refer patients to non-pharmacologic forms of pain management as well as educate about and dispense naloxone to all those who are prescribed chronic opioids.

On a national level, the Surgeon General Vivek Murthy has developed the Turn the Tide Rx campaign to curb and reverse the opioid crisis in the United States[2]. The initiative was launched via an easy to use website with a variety of facts, figures, and educational materials about the initiative. This website offers a simple and clear pledge for clinicians who agree to be educated about pain management and safe and effective use of opioids, endorsing prescribers to talk with other prescribers about this issues and how to jointly address it. It contains a plethora of guideline-based pocket guides and toolkits on assessing pain and addiction risk, appropriate opioid prescribing, and how to manage opioid overdose. As required by law for prescribers in most states, there are also instructions on how to obtain a login for and analyze opioid usage via the prescription drug monitoring programs. Finally, it provides patients and the public with fact sheets about opioid treatments, safe disposal of medications, and helpline options.

There is evidence for use of opioids in acute pain lasting 12 weeks or less, but contradictory to common knowledge, strong studies to analyze the benefit and safety of long-term opioid therapy are not yet available[5]. In accordance, the Pain

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Management Clinic (PMC) at Gallup Indian Medical Center (GIMC) was started in the 2000s at the Gallup Service Unit under a collaborative practice agreement in order to assess, treat, and control non-cancer chronic pain while improving quality of care to patients. Outcomes were to improve functionality, improve pain scores, and reduce emergency and urgent care visits. The GIMC pharmacy resident from 2010-11, Dr. Aimee Reinhard, PharmD, NCPS, became PMC Coordinator in 2012. Subsequently, a dramatic expansion of PMC services began. Currently Dr. Reinhard dedicates approximately 20 hours per week managing pain patients in various capacities, while other pain pharmacists support PMC activities for 5 to 10 hours per week depending on other obligations.

The impact of the PMC has been significant and very evident throughout the hospital system since Dr. Reinhard became PMC Coordinator and the Pain Committee was established. There have been fewer drug seekers visiting the facility requesting primarily narcotic medications from emergency room physicians, urgent care clinic providers, primary care providers, and the outpatient pharmacy. Additionally, in approximately six to 12 months, the Pharmacy PMC will merge with the Palliative Care/Non-Cancer Pain Clinic run by family medicine providers. This position will finally supply GIMC with a full time pain pharmacist, allowing more dedicated follow-up for the numerous patients on waiting lists for ongoing appointments while expanding responsibilities of the pharmacist to palliative care as well.

The Pain Committee is a very flexible entity. It includes the following core members: medical director, PMC coordinator, pain pharmacists, palliative care providers, and primary care providers. The medical director is a silent member, and the success of the PMC is partly due in part to the support of the medical director for emphasis on proper pain management. The Pain Committee conducts meetings as needed to review guideline updates, performs internal review of prescribing patterns, and completes consultations and patient reviews. Policy changes that have been implemented include 28-day supply only over 30-day supply fills for chronic opioids to avoid refill requests on weekends, limited opioid prescribing from emergency room and urgent care departments, maintenance of pain agreements and opioid consent forms, increased use of the New Mexico Prescription Monitoring Program (PMP), and increased use of urine drug screens (UDS).

Realistically, these policy changes are very evident. Adherence to scope of practice is stronger now and has resulted in less erratic opioid prescribing. More providers are becoming increasingly wary of prescribing opioids, either initiation of opioid treatment altogether or provision of large quantities. For example, the emergency room is more a silo for addressing acute pain, whereas chronic pain issues (of patients who have been on approximately daily opioid therapy for at least 90 consecutive days) are referred appropriately to primary care providers. In accordance with NM law, providers are using the PMP more universally.

We have expanded pain management resources by adding interventional services as well. Two physicians in the family medicine department provide twice weekly pain/palliative care clinic visits. These physicians typically perform trigger point injections with lidocaine to get muscles to relax and to remove tight knots which may be disrupting nerve fibers as well. This ideally reduces the use of opioids, non-steroidal anti-inflammatory drugs, steroids, and epidurals. A total of three acupuncturists have also been brought on board, really reducing the bottleneck and wait time for patients to return for follow-up, especially in a treatment modality requiring frequent visits for effectiveness. These providers are observing large amounts of relief of migraine pain, Meniere's disease, and increases in activities of daily living.

PMC hasn't been the answer to every difficult pain question, but it has shown clinical success beyond simply curbing inappropriate prescribing. Simple investigative work such as initiating the right drug for the pain level or defining twice daily dosing as every 12 hours and not necessary any two times per day has improved pain and function greatly. Importantly, many cases of hyperalgesia have been reduced by careful reductions in daily opioid doses. PMC has had no shortage of interesting and creative appointments, medication therapies, and patient personalities.

The PMC delivers the major output for the Pain Committee. Pharmacists are vetted to conduct visits based on interest and competency. Qualifications to work as a pain pharmacist at GIMC include completion of on the job training with annual competency, six hours of annual continuing education in pain management and National Clinical Pharmacy Specialist qualification obtained within a year of practice as a pain pharmacist, Pain Week conference participation every two years, New Mexico naloxone training webinar completion, and pharmacist clinician training class completion for physical assessment capability. Likewise, pain providers attend trainings sponsored by the state of New Mexico, the Indian Health Service, Pain Week conference, and other entities.

Patients are admitted into the PMC via consults from primary care providers only. The consultations received generally involve difficult to manage patients and therapies. Pain pharmacists then conduct PMC visits, are available during business hours for pain consultations from any internal hospital system department, and report PMC activities to the Pharmacy and Therapeutics Committee annually.

The patient population of the PMC is fluid. About 450 total patients are tracked, 50 of which are actively seen in the PMC. When patients are deemed clinically stable, their care is released back to the primary care provider. PMC visits are generally from 1 to 4 PM on Wednesdays and are occasionally expanding to full days due to workload. The initial two PMC appointments are one hour long, followed by 30 minute visits scheduled at weekly to multiple month intervals based on pain levels and titrations. At this time, show rates have varied based on pharmacist scheduled in the PMC and patient provider preference. Telephone consults can be received during business hours Monday through Friday.

The PMC electronic health record template and interview process are consistent with the "universal precautions" approach to unified pain management[6]. Many of the questionnaires, tools, and lab tests are repeated periodically based on policy and patient-specific need. A controlled substance pain agreement, a consent for chronic opioid therapy, a Current Opioid Misuse Measure (COMM) for risk assessment, and a Patient Health Questionnaire (PHQ-9) to assess for concurrent depression are explained to all new patients and signed. Patient goals are also discussed with regards to realistic changes, the level of control that would satisfy the patient, what activities of daily living or hobbies the patient would like to retain, what relationships the patient would like to improve, and more.

New patients are required to complete urine drug tests (UDS), which can be performed in house or sent out if specific drug levels are required. If a UDS shows positive for illegal substances, a discussion with the patient on toxicity and risks will ensue allowing them to choose if they want to continue to use other substances for pain or use only the pain medication(s) appropriately prescribed by GIMC providers. Patients can be deemed ineligible for PMC if they do not discontinue the use of illegal substances. If the patient's PMP shows negative for prescribed opioids or positive for non-prescribed substances, the providers will conduct more research. This has helped uncover a caregiver who was diverting opioids from patients under her care while she was drugging her patients and claiming multiple incidences of stolen opioids.

Providers also complete a review of the patient's PMP. Over time, increased utilization of the PMP has helped to identify and prevent further drug diversion. For example, patients have been found drug and doctor shopping under maiden and married names, under multiple birthdays, in other states, or under a different sex altogether. Some patients have been selling immense amounts of opioids and others taking immense amounts.

PMC or physician initiated random pill counts for any of the hundreds of tracked patients has also been incorporated into the policy. These pill counts can be requested regardless of clinic appointment dates. Pill counts not only show if patients are taking too many pills or diverting pills, but also may show that the patient may not need as many tablets per fill if they consistently have more than expected based on dosing frequency. Additionally, if a patient has adhered to prescribing rules, he may be allowed an early refill of the chronic opioid to cover them during a vacation. On the other hand, if the pill counts are inconsistent with instructions, then prescribing may be reduced to 5-, 7-, or 14-days fills only. If the patient doesn't show for pill count within 24 hours of the request, they can have their opioid use privileges revoked. Other reasons for PMC discharge include any violation of pain agreement, including but not limited to drug diversion, doctor shopping, and more. Proper storage and security of opioid therapy at home is also explained to the patient, and funding for lock boxes is in the pipeline. Lost or stolen opioids are not replaced.

As mentioned previously, there is also opportunity to recommend a multitude of non-pharmacologic treatments like slushy ice bags, rice socks, an anti-inflammatory diet, tennis ball massage for muscle tension and pinched nerves, chair exercises, prescriptions for aquatic therapy, and distraction therapy. Finally, pain pharmacists have the option to enter consults for and coordinate interventional therapies for physical therapy; occupational therapy; acupuncture; trigger point injections; podiatry; orthopedic; ear, nose, and throat; nutrition; diabetes; and for patient who need to obtain a new primary care provider.

Outside of the PMC, an annual pain evaluation is performed for all pain patients. This provides both a holistic description of the patient's pain, a second opinion, and review of the safety and efficacy of treatment thus far. It has served to reassess risk versus benefit of current opioids, toxicities and adverse effects, to identify what services are available for the patient now, perform pill counts, perform physical assessments, reconcile the course of treatment with current pain characteristics or levels, coordinate tapering schedules, and more. Some issues that have been found include many incidences of opioid-induced hyperalgesia and a patient filling opioids medication regularly but not taking them because she did not want to tell the provider the medication did not work.

In order to ensure maximum safety and life-saving methods in the realm of opioid therapy, naloxone overdose prevention training and dispensing has been critical. Providers, patients, and rescue buddies are trained in the indication for, the administration of, and follow-up of naloxone use. Naloxone can be administered by anyone in NM due to Good Samaritan laws. Naloxone training has reached 75% of patients tracked in the past year. Few people have requested refills on the naloxone kits other than for

replacement of expired product. Based on experience, many patients and rescue buddies have inquired why they didn't know of opioid-related risks earlier and stated that if they had naloxone available at home earlier, they could have saved a life. In addition and in collaboration with a local prevention of suicide and substance abuse network, a couple of pain pharmacists have created "Pills Can Kill" booklets for general dispersion to patients in waiting rooms, offices, schools, and throughout the county.

MedSafe™ receptacles for collection of all unused or unwanted medications, including controlled substances, are now available at all three of our pharmacy waiting rooms to get meds out of community without charging patients. Therefore, the local biannual DEA take back days can be sponsored at other drop locations to reach farther into the community.

Most importantly, the PMC and partners will continue to evolve now that the opioid crisis is so exposed in the media and in the Public Health Service. The truth is that opioids are merely band-aids, and the Pain Committee's goal is to uncover the band-aids, identify the solutions, and execute appropriate coordination of treatment. Overall, these services will distribute fewer opioids, reduce overdose risk in the community, and improve patient functionality and quality of life. The pain management services at GIMC have spurred the public hospital in town to try to mirror our policies for consistent community actions toward pain management.

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