Taking Center Stage: *The All-Pharmacist team of Detailers*

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Disclosures

- The presenter of this content has NO financial disclosures or conflicts of interest with the material in this presentation.

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Introduction to ThedaCare

Who We Are:

- Integrated health system located in NorthEast Wisconsin
- **8** hospitals
- **39** Primary Care Clinics
- **2** Skilled nursing facilities
- Hospice facility
- Home health
- ACO with **140,000 +** lives

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OUR MISSION

To improve the health and well-being of our communities by empowering each person to live their unique, best life.

OUR VISION

We will reinvent health care by becoming a proactive partner in health – enriching the lives of all and creating value in everything we do.

I PROMISE to be a proactive partner in health by …

- Putting patients and families first
- Making health care easier
- Delivering high quality, affordable care

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Ambulatory Pharmacy Programs are Diverse

Understand **YOUR** program, **YOUR** role, **YOUR** patient population

–Here is OURS:

Pharmacists **embedded** in family medicine and internal medicine clinics who serve as:

- **Pharmacist providers** who see patients for scheduled appointments *(credentialed)*
- **Medication experts** who serve as a resource for the full clinic team
- **Partners in complex patient care management** & patients who are not meeting medication related goals
- **Educators** through formal presentations & **Academic Detailing**

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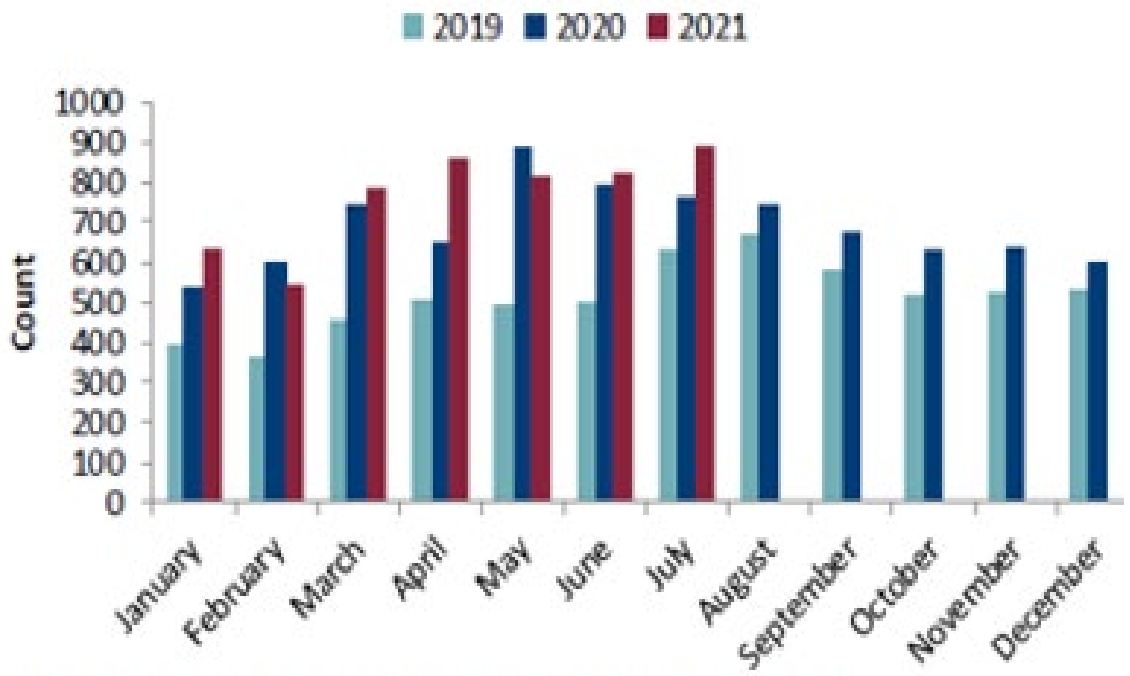
1st Step: Determine your "WHY?"

Figure 2. Wisconsin Suspected Opioid Overdoses by Month, YTD



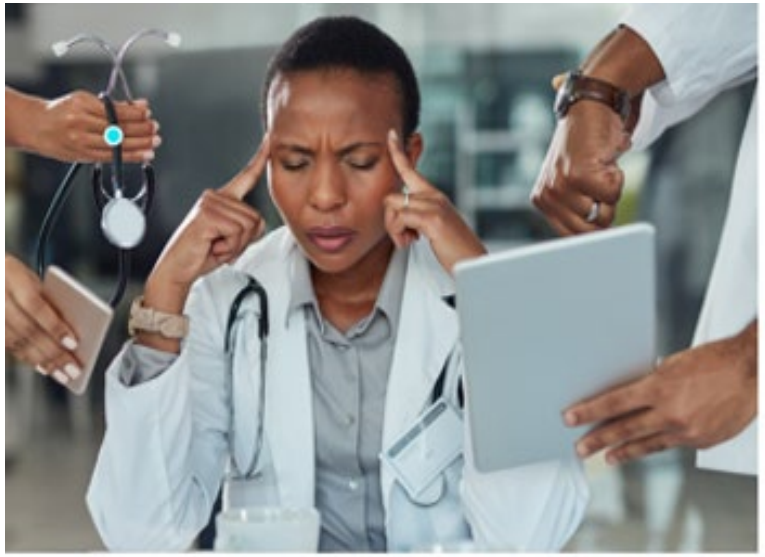
Source: Office of Health Informatics, Wisconsin Department of Health Services
Data: Wisconsin Ambulance Run Data System (WARDS)

THE PROBLEM

The U.S. spends as much money correcting the problems caused by medications as we do on the drugs themselves.

ONE SOLUTION

Pharmacists in ambulatory care.



Physician burnout

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What value does a pharmacist add to a family medicine clinic?

Key Performance Indicators (KPI)

- Quality
  - Change in prescribing practice
  - Academic Detailing visits

- Accepted appointments
  - For target patient populations

- Volume
  - Referrals, appts, patient panel
- Revenue

- ACO Payer performance

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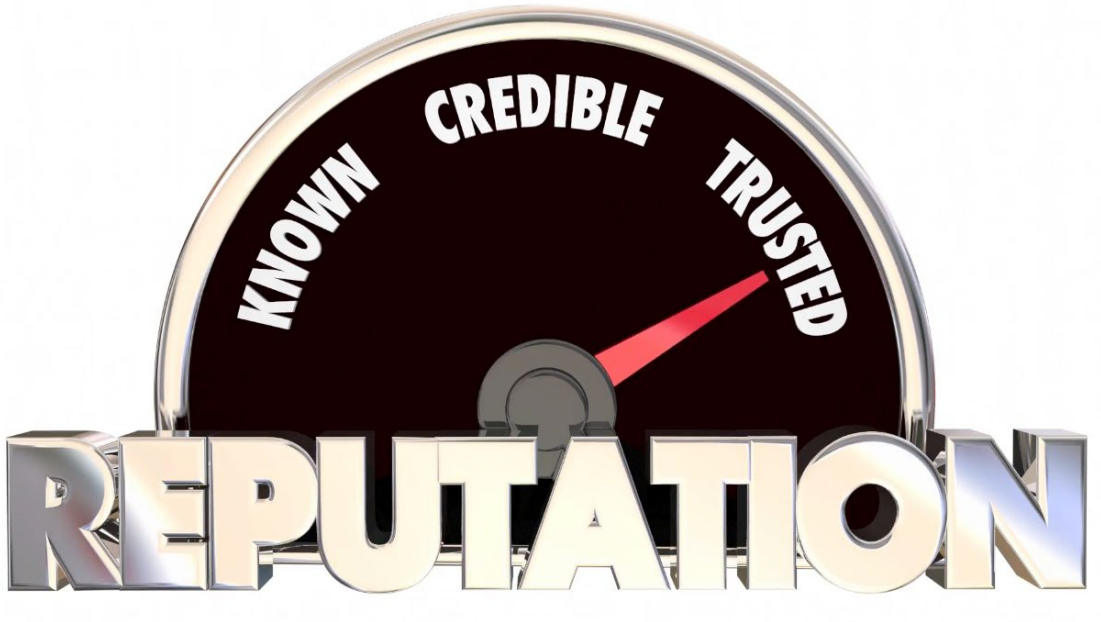
Comprehensive Medication Management

- **Standard of practice**
- Distinguishing **feature of our service** & important to note in benchmarking
- “Ongoing accountability to the care of the **WHOLE patient**”
- Makes us **unique** amongst the clinician care teams
- **Provides a service** that others are unable or unwilling to do
- Can **justify the decision** to place a pharmacist as the clinician in the program of interest
- **Supporting** (and **growing**!) literature

Our Purpose with Academic Detailing

- To **drive improvements** in prescribing practice
- To **establish and build** professional, collaborative **relationships** with our providers
- To discuss **patient scenarios**
- To **identify patients for partnership** with the ambulatory pharmacist
- Focus area **alignment** with **organizational priorities**



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OPIOID EPIDEMIC IN WISCONSIN

Opioid deaths in Wisconsin are rising and have exceeded the annual average of ~350 automobile crash fatalities every year.[1,2] In 2017, 362 Wisconsin residents died of prescription opioid overdose and 880 people died of a heroin or synthetic opioid overdose. Southern Wisconsin counties have the highest rates of opioid fatalities, Dane County included. Kenosha, Florence, and Menominee Counties have the worst fatality rates, in excess of 20% per 100,000 residents.

Figure 1. Rate of drug overdose deaths involving opioids by county of residence - 2019 data.

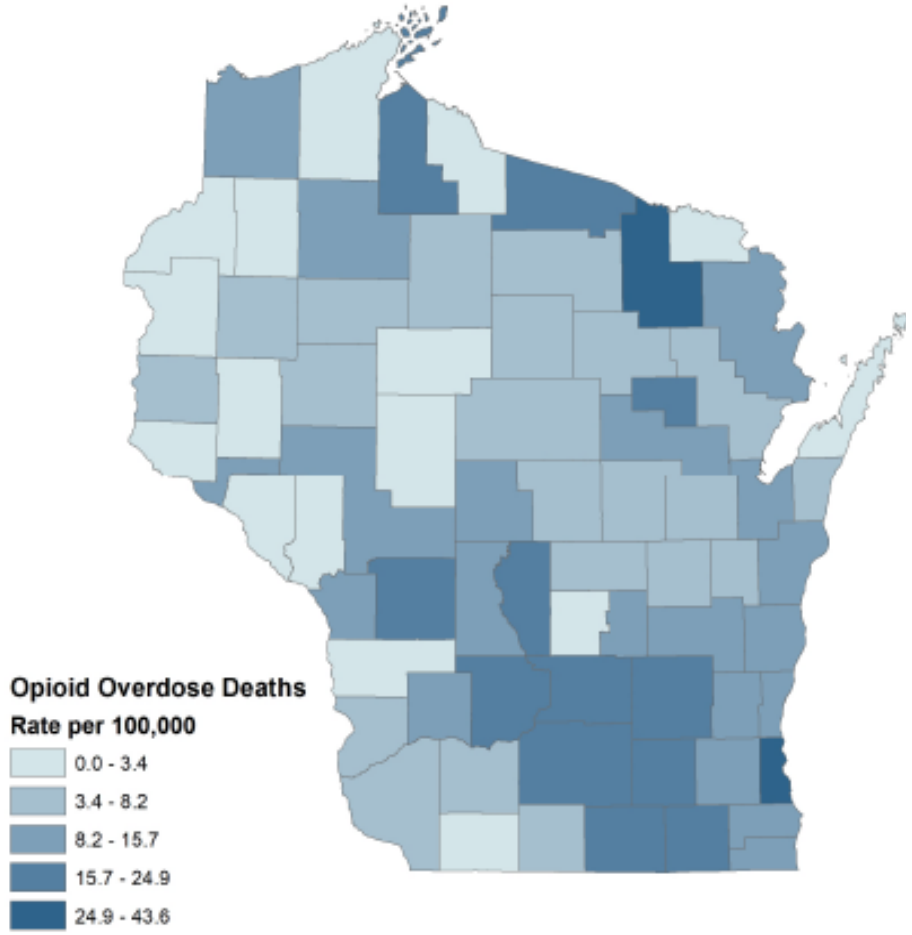

Table 1. ThedaCare Market Area - 2014 - 2019 Deaths by Opioids

County	Total Deaths	Rate/100 K
Outagamie	77	7.0
Waupaca	21	6.7
Shawano	14	5.6
Winnebago	112	11
Waushara	10	6.8
Green Lake	10	8.8
Marquette	19	20.6
Dodge	93	17.4
	356	**10.5 / 100 K**

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HOW NALOXONE CAN HELP

Naloxone Products Currently Available[3-4]

1. Narcan® 4 mg/0.1 mL Nasal Spray for most insurers is a preferred brand name copay
2. Naloxone 0.4 mg/mL unit dose vial x2 for most insurers is a generic copay (requires 2 IM syringes with attached needles).

Product Comparison[4]
https://prescribetoprevent.org/pharmacists/formulations/

DO NOT RECOMMEND:

1. Off-label use of the parenteral product for nasal use is not recommended due to assembly and administration.
2. Naloxone products manufactured for via Carpuject® administration due to complex administration and requires availability and use of a Carpuject® device.
3. Do not dispense multi-dose vials or ampules of naloxone for injection.

Table 2. Algorithm for Naloxone Co-prescribing by Opioid Dose +/- Risk Factor

	Lowest Dose <20 MEDD[1]	Lower Dose 20-49 MEDD increase risk for overdose 1.3 to 1.9 times the risk of <20 MEDD[3]	Moderate Dose 50-89 MEDD increase risk for overdose 1.9 to 4.6 times the risk of <20 MEDD[3]	High Dose ≥90 MEDD increase risk for overdose 2.0 to 8.9 times the risk of <20 MEDD[3]
Morphine	≤19 mg	20-49 mg	50-89 mg	≥90 mg
HYDROcodone	≤19 mg	20-49 mg	50-89 mg	≥90 mg
OxyCODONE	≤12.5 mg	13-32 mg	33-59 mg	≥60 mg
hydroMORphone	≤4 mg	5-12 mg	13-22 mg	≥23 mg
OxymorPHONE	≤6 mg	4-16 mg	17-29 mg	≥30 mg
Fentanyl products	–	12 mcg/h	≥25 mcg/h	≥25 mcg/h
Methadone[2]	–	–	2.5-5 mg	≥6 mg
	Opioid dose and risk of overdose is low. if NO concomitantmedications or risk factor(s) then Naloxone is not needed.		**Opioid dose alone results in unacceptable risk of opioid overdose and additional medications/risk factor not needed.**	

Risk of overdose increases

≥1 Concomitant Sedating Medication(s)[3]	• barbiturates • benzodiazepines • zolpidem, eszopiclone, zaleplon (z-drugs) • muscle relaxants • tricyclic antidepressants (TCAs)	**OR**	**Any 1 High Risk Condition (Risk Factors)**
			• children or other-at-risk household contacts • depression • any lung disease: current or history of tobacco use, sleep apnea, asthma, COPD, emphysema • kidney impairment: AKI, CKD III or worse, GFR or CrCl < 60mL/min, delayed graft function in solid organ transplant • liver impairment: cirrhosis, hepatic encephalopathy, LFT abnormalities, s/p liver transplant • memory impairing condition: dementia, Alzheimer's, Lewy Body Dementia

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How To Discuss Naloxone with Patients

Refer to the "How to Give Naloxone" patient handout
https://www.dhs.wisconsin.gov/publications/p01576.pdf

Instead of using the word "overdose," consider using language like "accidental overdose," "bad reaction" or "opioid safety." You may also consider saying:

- Opioids could slow or stop your breathing.
- Naloxone is for an opioid emergency — to be used only if there is a bad reaction where you are unable to awaken.
- Naloxone is for opioid medications similar to how someone with severe allergies carries an EpiPen®.
- Naloxone is an emergency medication if a child, grandchild, teenager, or young adult were to ingest any opioids.
- Naloxone is like a fire extinguisher – it's there in case of an emergency and hopefully you never need it.

Other Resources About Naloxone or Opioid Harm Prevention

Refer to the following URLs to find other resources that can be shared with the patient and/or their caregivers.

- WI State Naloxone Standing Order : https://www.dhs.wisconsin.gov/opioids/standing-order.htm
- Prescribe to Prevent: https://prescribetoprevent.org/
- Dose of Reality: https://doseofrealitywi.gov/

References

1. Wisconsin Department of Health Services https://www.dhs.wisconsin.gov/publications/p01690.pdf
2. NIH Drug Abuse https://www.drugabuse.gov/opioid-summaries-by-state/wisconsin-opioid-summar
3. Prescribe to Prevent: https://prescribetoprevent.org/
4. Lexi-Comp Online, Lexi-Drugs Online, [internet database]. Hudson, OH: Lexi-Comp, Inc.; 2012. Accessed August 2019.

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PSW Pharmacy Society of Wisconsin

How to Prescribe Naloxone to Your Patients

1. Determine the naloxone formulation you wish to prescribe for your patient. Narcan® nasal spray is preferred for ease of use, however, there may be affordability issues depending on insurance coverage.
   a. Preferred prescription comments: "RPh may substitute a similar brand or generic naloxone based on insurance coverage, product availability and/or patient preference"
2. Consult your ambulatory pharmacist for partnership on naloxone. Pharmacists are able to:
   - Educate your patient on the role of and use of naloxone
   - Confirm insurance coverage and confirm affordability
   - Connect them to a free naloxone resource if needed

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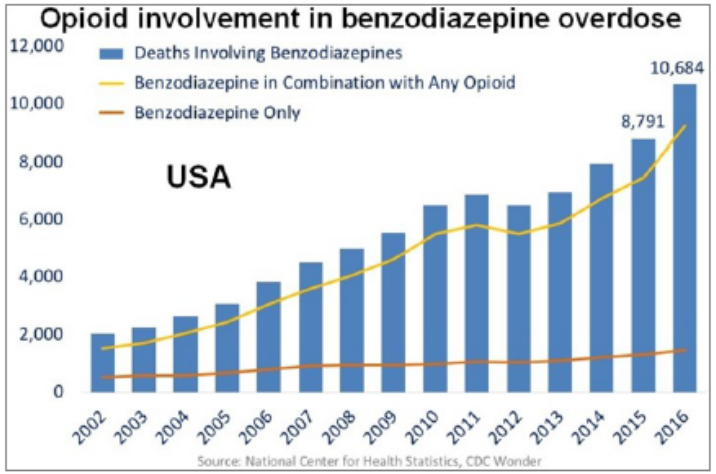
Opioids + Benzodiazepines

10x
risk of death from overdose

A cohort study in North Carolina found that the overdose death rate among patients receiving both types of medications was 10 times higher than among those only receiving opioids.



U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

AVOID CONCURRENT PRESCRIBING

Avoid prescribing opioids and benzodiazepines concurrently whenever possible
(Recommendation #11)

Medicare

5x
risk of opioid-related overdose

Patients

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Monitoring Opioids

CDC Guideline Recommendations

2 **ESTABLISH GOALS FOR PAIN AND FUNCTION**

Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how opioid therapy will be discontinued if benefits do not outweigh risks. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.

7 **EVALUATE BENEFITS AND HARMS FREQUENTLY**

Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently. If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.

Partner with patients to provide safer, more effective pain management.

Learn more | www.cdc.gov/drugoverdose

CDC

Clinically

30%

improvement in pain and function scores

Meaningful

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Monitoring Opioids

CDC Guideline Recommendations

3 **DISCUSS RISKS AND BENEFITS**

Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy.

PRESCRIPTION OPIOIDS HAVE BENEFITS AND RISKS

Many Americans suffer from chronic pain. These patients deserve safe and effective pain management. Prescription opioids can help manage some types of pain in the short term. However, we don't have enough information about the benefits of opioids long term, and we know that there are serious risks of opioid use disorder and overdose—particularly with high dosages and long-term use.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

As many as **1 in 4** PEOPLE receiving prescription opioids long term in a primary care setting struggles with **addiction**.

ThedaCare Policy—TCP-20
Management of Chronic Opioid Therapy (COT) and Chronic therapy with Controlled Substances

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Opioid Bold Aim Metrics

- **Within 6 months** of clinic establishment, **100% of providers** will receive an **Academic Detailing visit with the ambulatory pharmacist**
  - **132 AD visits** with **98.5%** acceptance

- **Within 6 months, no more than 20% of patients with MEDD ≥50** will not be co-prescribed naloxone
  - As a program, **we achieved 28%,** with **adjusted rate of 14%**

Pharmacist Embedded Clinics	Jun-22	Adjusted
Pharmacist Embedded Clinics		
	101	51
	361	361
	28.0%	14.1%

- **Within 1 year,** we will **reduce the number of chronic opioid patients co-prescribed benzodiazepines by 15%**
  - Achieved this within **4-9 months** *(rolling go lives)*
  - We have **144 fewer patients on opioids and benzodiazepines!** *(136 of those from pharmacist embedded clinics)*
  - Received **142 taper referrals**

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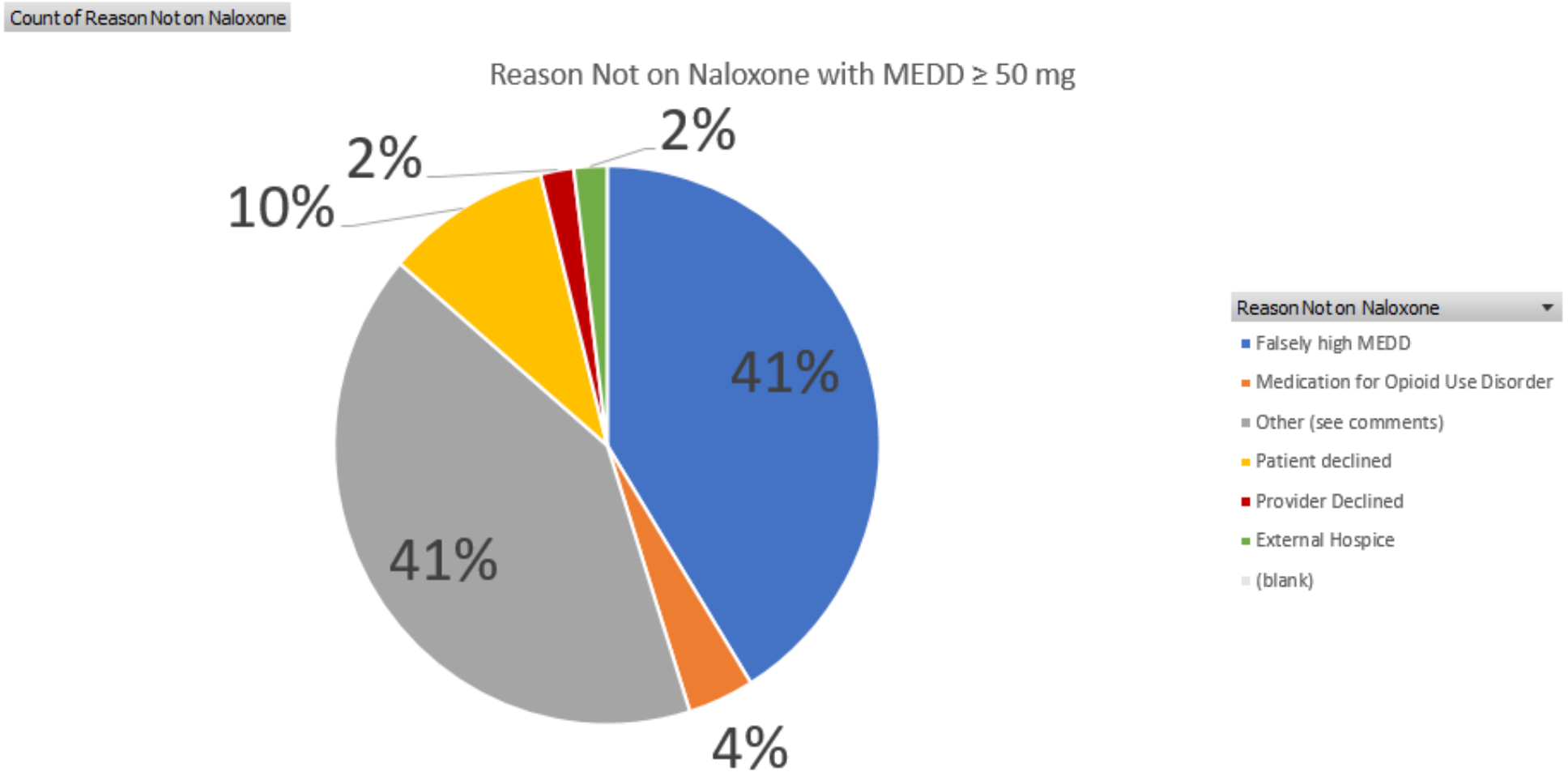
Deeper Dives & Lessons learned

- **Understand**, **challenge**, and **question** your data
- Then adjust your database rules as needed
- Reasons for **no naloxone**
- **Fewer is better**



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Ambulatory Pharmacy Diabetes Initiatives

1 ACO Cost Savings

Generate $372,000 in annual savings through elimination of DPP4 and GLP1 coprescription (duplicate mechanisms)*

*62 patients across our ACO are on a DPP4 and a GLP1

2 Academic Detailing

Every provider receives a one on one session with a pharmacist to discuss pharmacotherapy for diabetes in depth

3 Pharmacist impact on A1c

Tracking new referrals to ambulatory pharmacy for diabetes medication management to measure change in A1c from time of referral to 12 months later

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Use GLP-1 and SGLT-2 in Patients with Compelling Indications Even if Their A1c is at Goal

There are compelling indications related to ASCVD (diagnosis or high risk), heart failure, and renal effects that have led to the recommendation to utilize corresponding GLP1s or SGLT2 even if A1c is already at goal.

GLP-1 agonist

There are FDA approved medications for CVD benefit as well as evidence for renal benefit.

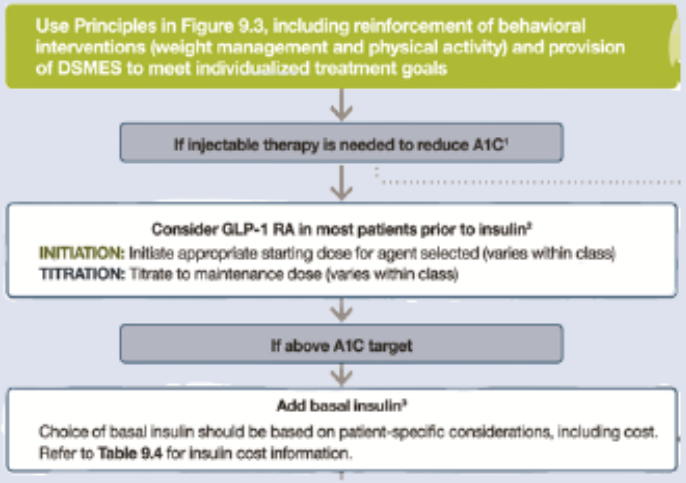
SGLT-2 inhibitors

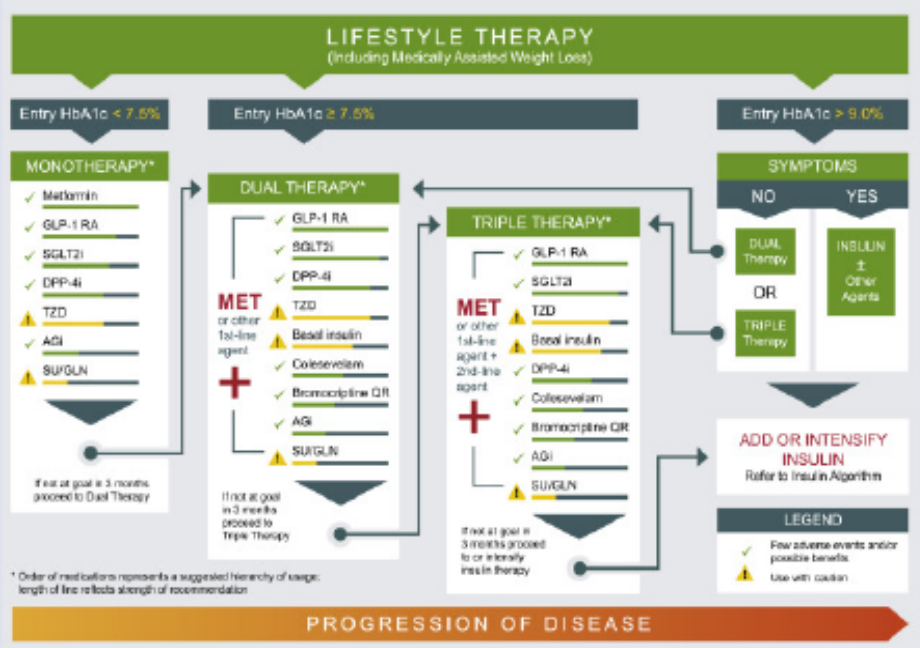
There are medications that have received FDA approval for CVD benefit, HF benefit and renal benefit. Even in those that haven't yet received FDA approval for these other indications, some studies have still shown heart failure and renal benefits.

Utilizing Ambulatory Pharmacists to Optimize Guideline Directed Therapy

Review of Current Therapies and Consideration of Newer Agents

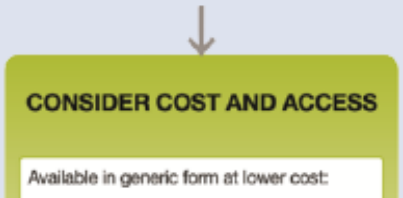
Many of the newer therapies have shown benefit for multiple indications and are generally recommended over therapies such as sulfonylureas and TZDs in the guidelines.





Cost Concerns

Based upon the guidelines, it may seem like there are not many options for patients for whom cost is a major concern. Ambulatory



Examples of Patient Assistance Programs:

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