Role of Community Pharmacy in Improving Public Health

Janice L. Pringle, PhD
Professor, School of Pharmacy
Director, Program Evaluation and Research Unit
Objectives

1. Recognize potential roles of community pharmacists and pharmacies in improving community public health;

2. Identify reasons why community pharmacists and pharmacies are particularly suited for improving public health;

3. Describe the impact of the public health crisis emanating from opioid use disorders (OUD);

*Substance Abuse and Mental Health Services Administration*
Objectives

4. Describe what community pharmacists can do to address OUD and help prevent opioid overdoses;

5. Define and explain the utility of Screening, Brief Intervention and Referral to Treatment (SBIRT) within community pharmacy practice;

6. Describe specific opioid- and SBIRT-related initiatives occurring within community pharmacies in North Carolina, Pennsylvania and Virginia.

*Substance Abuse and Mental Health Services Administration*
Community pharmacy is increasingly being recognized as an untapped resource for improving public health (REF).
Community pharmacy has been supporting public health in a number of ways.

1. Immunizations
2. Universal Screening/Brief Intervention Programs (Pringle)
3. Public Health Communication Campaigns
4. Embedded Health Clinics
Why Pharmacists Are Particularly Suited for Improving Public Health:

1. Number of pharmacists
2. Accessibility of pharmacies
3. Public trust in pharmacy
4. Pharmacist clinical training
5. Evolving community pharmacy models
Opioid Use Disorder is a major public health crisis.
In 2015, 11.5 million persons reported misusing opioids while 1.9 million reported being addicted.¹

Rate of opioid overdose deaths increased 347 percent from 2000-2015 to 4,642 per 100,000 people.²

Rate of opioid overdose deaths in Pennsylvania increased 16 percent from 2015 to 2016.³

3. Copyright 2018, University of Pittsburgh. All Rights Reserved.
OUD as a Major Public Health Crisis: The Data

- 51 percent of those deaths were related to fentanyl-related substances;
- 45 percent were related to heroin;
- 25 percent were associated with prescription opioids.³
- Twenty out of 67 counties in Pennsylvania do not have MAT providers.⁴

⁴ DePasquale EA. Opioid Treatment Audits. 2017
What Can Pharmacists Do to Help Reduce OUD Prevalence?

1. PDMP
2. Predictive analytics
3. Collaborative care models
4. Passive identification (morphine equivalents)
5. SBIRT
What is SBIRT?

Screening  
Brief Intervention  
Referral to Treatment

SBIRT is a comprehensive, integrated public health approach to the delivery of early screening, intervention, and treatment services employing empirically-based and clinically useful practices to circumvent harmful consequences from substance use, including impeding the development of alcohol and other drug use disorders.
Traditional Approach
A Spectrum of Use

Looking for patterns of substance use that increase risk for harms in the population

Health impairment begins with substance use below diagnostic levels of severe substance use disorders… …it begins with hazardous and harmful use.
SBIRT

• An early intervention and prevention practice

• Reduces health and social harms and expenses

• Requires interprofessional collaboration

• Employs a widely applicable skill set
A process for **identifying** patients/clients whose substance use puts them at increased **risk for harm**.

<table>
<thead>
<tr>
<th>Instrument</th>
<th>What is Being Screened</th>
<th>Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>AUDIT</td>
<td>Alcohol</td>
<td>Adults</td>
</tr>
<tr>
<td>ASSIST</td>
<td>Alcohol, Tobacco, Drugs</td>
<td>Adults</td>
</tr>
<tr>
<td>MAST</td>
<td>Alcohol</td>
<td>General</td>
</tr>
<tr>
<td>DAST</td>
<td>Drugs</td>
<td>General</td>
</tr>
<tr>
<td>CRAFFT</td>
<td>Alcohol, Drugs</td>
<td>Adolescents</td>
</tr>
<tr>
<td>TWEAK</td>
<td>Alcohol</td>
<td>Pregnant Women</td>
</tr>
<tr>
<td>T-ACE</td>
<td>Alcohol</td>
<td>Pregnant Women</td>
</tr>
<tr>
<td>CAGE</td>
<td>Alcohol Dependence</td>
<td>General</td>
</tr>
</tbody>
</table>
SCREENING

Screening is the universal use of validated screening instruments to quickly assess a patient's substance use, consequences of substance use, and identify the appropriate level of intervention.
Initial Screens

Single-question screens can be used to determine if a patient requires further screening.

The National Institute on Alcohol Abuse and Alcoholism (NIAAA) Single Question and National Institute on Drug Abuse (NIDA) Single Question are often used together, but can be used separately.
**National Institute on Alcohol Abuse and Alcoholism (NIAAA)**

How many times in the past year have you had more than (4 for men, 3 for women) drinks in a day?

A response of **1 or greater** is considered a positive screen that indicates further screening is needed.

Smith et al., 2009
National Institute on Drug Abuse (NIDA)

How many times in the past year have you used an illegal drug or used a prescription medication for non-medical reasons?

A response of 1 or greater is considered a positive screen that indicates further screening is needed.

Smith et al., 2010
# High-Risk Guidelines

## Alcohol: Consumption Limits

<table>
<thead>
<tr>
<th></th>
<th>Men (≤ 65)</th>
<th>Women, Men 65+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drinks per Week</td>
<td>&gt;14</td>
<td>&gt;7</td>
</tr>
<tr>
<td>Drinks per Occasion</td>
<td>&gt;4</td>
<td>&gt;3</td>
</tr>
</tbody>
</table>

![Images of glasses representing drinks per week and per occasion]
DAST-10

- Drug Abuse Screening Test
  - Contains 10 items completed by self report or via interview. Consists of screening questions for at-risk drug use that parallel the MAST (an alcohol screening instrument).
  - Developed by the Center for Addiction and Mental Health.
  - Yields a quantitative index of problems related to drug misuse.

- What are the strengths?
  - Sensitive screening tool for at-risk drug use.
  - Can be administered in five minutes.

- What are the weaknesses?
  - Does not include alcohol use.
  - Obvious question content may lead to specious responses.

Yudko et al., 2007; Skinner, 2982
Screening Results

• Scored Risk

• Assists in determining appropriate interventions

• Not Magic: Clinical judgment remains paramount

Recovery support
Referral to behavioral treatment
Brief Intervention
Education
Positive Reinforcement
Brief Intervention

- Brief conversation that explores consequences of substance use
- Strengthens motivations for change
- Goal is a commitment to an agreeable and specific behavior change
The Spirit of Motivational Interviewing

- Collaboration
- Compassion
- MI Spirit
- Acceptance
- Evocation
Referral to Treatment

- **Motivate** patients/clients to accept and commit to appropriate treatment
- **Actively link** patients/clients to treatment and recovery support
Pennsylvania is piloting SBIRT within pharmacy.
Vision

Develop a sustainable and replicable collaborative care model involving community pharmacists, primary care practices, and specialty treatment providers within Blair County, PA to:

1. **Screen** and **identify** patients for opioid use disorder (OUD) risk;
2. **Prevent** HepC, HepB, and HIV infection among high-risk patients; and
3. **Ensure** patients with OUD **receive** the appropriate specialty treatment necessary to achieve stable recovery and lower their risk for overdose.
Project Partners

University of Pittsburgh
School of Pharmacy

NACDS Foundation

Blair Drug and Alcohol Partnerships
Empowering Healthy Lifestyles
Approach

SBIRT

**SCREENING**
Universal administration of a validated instrument to quickly assess patient opioid use risk and select appropriate care

**BRIEF INTERVENTION**
Brief conversation (3-5 minutes) with patients to discuss their opioid use and increase motivation for behavior changes to reduce their risk

**REFERRAL TO TREATMENT**
Linking patients to appropriate SUD treatment and specialty care via warm-handoff
Approach

Prevention

• Provide vaccinations to patients using opioids for HepB.

• Provide screenings for HepC.

• Provide referrals for HIV screening through BDAP.

• Provide naloxone and education for all patients prescribed opioids.
# Project Phases

<table>
<thead>
<tr>
<th>Project Phase</th>
<th>Milestone</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Completed Milestones</strong></td>
<td>• Assemble Executive Committee and hold first weekly meeting by April 2018.</td>
</tr>
<tr>
<td></td>
<td>• Recruit 8 pharmacies within Blair County by June 2018.</td>
</tr>
<tr>
<td></td>
<td>• Conduct SBIRT training with 20 pharmacists by June 2018.</td>
</tr>
<tr>
<td><strong>Forthcoming Milestones</strong></td>
<td>• Implement SBIRT protocols at each pharmacy and begin data collection by July 2018.</td>
</tr>
<tr>
<td></td>
<td>• Conduct first monthly site visits by July 2018.</td>
</tr>
<tr>
<td></td>
<td>• Conduct data analyses and compile final report by December 2019.</td>
</tr>
<tr>
<td></td>
<td>• Develop recommendations and best practices for SBIRT dissemination within pharmacy settings by December 2019.</td>
</tr>
</tbody>
</table>
Objectives

• Screen 6,400 patients for OUD risk.

• Provide 1,280 brief interventions to patients at-risk for OUD.

• Connect 128 patients with the BDAP Care Manager for referrals to specialty treatment.

• Distribute naloxone and educational materials to 1,000 patients prescribed opioids.

• Vaccinate 200 patients using opioids for HepB.

• Provide 200 patients with testing for HepC and HIV.
PERU has recruited 9 pharmacies.

<table>
<thead>
<tr>
<th>First Wave Pharmacies</th>
<th>Site Champion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hollidaysburg Thompson</td>
<td>Luke Swintek</td>
</tr>
<tr>
<td>“In Town” Thompson</td>
<td>Jessa Saive &amp; Jeff Stiffler</td>
</tr>
<tr>
<td>Altoona Thompson</td>
<td>Pete Kreckel</td>
</tr>
<tr>
<td>Giant Eagle No. 71</td>
<td>Tom Jandora</td>
</tr>
<tr>
<td>Giant Eagle No. 79</td>
<td>Julie Evans</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Second Wave Pharmacies</th>
<th>Site Champions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community</td>
<td>Bill Faust</td>
</tr>
<tr>
<td>Duncansville</td>
<td>Ron Dick</td>
</tr>
<tr>
<td>Greenwood</td>
<td>John Jackson</td>
</tr>
<tr>
<td>Long-Term Thompson</td>
<td>John Ebersole</td>
</tr>
</tbody>
</table>

PERU has trained 17 pharmacists in person.

PERU has enrolled 24 pharmacists in online trainings.

PERU has conducted 5 site visits.

- Hollidaysburg Thompson Pharmacy
- “InTown” Thompson Pharmacy
- Altoona Thompson Pharmacy
- Giant Eagle Pharmacy No. 71
- Giant Eagle Pharmacy No. 79

PERU and pharmacies have scheduled dates to go live with SBIRT implementation.

- First Wave Roll-Out: 8/1/2018 – 8/7/2018
- Second Wave Roll-Out: 8/31/2018
How Can SBIRT Be Practically Applied?

1. Revenue models;
2. Standardized implementation approaches;
3. EHR applications.
How Can SBIRT Be Practically Applied?

4. Standardized training;

5. Professional learning networks;

6. Ongoing quality improvement and evaluation efforts.
Good News!

ALL of these things exist NOW.
Thank you!

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Community Pharmacy Intervention in the Opioid Crisis

Penny Shelton, PharmD, BCGP, FASCP
Executive Director
North Carolina Association of Pharmacists
My presentation will cover:

• Shenandoah University SBIRT training for health professions’ students, preceptors and practitioners

• Virginia Medicaid coverage of SBIRT provided by pharmacists

• North Carolina opioid-related initiatives involving pharmacists
SBIRT
SCREENING, BRIEF INTERVENTION, AND REFERRAL TO TREATMENT
Why SBIRT?

Historically--

SBIRT

Prevention  →  Specialty Treatment

Significant gap in service systems for at-risk populations.
Significant Barriers To Prevention and Care

- Stigma and misperceptions regarding patients with substance use disorders
  - “This is a choice/lifestyle they make/choose.”
  - “If I care enough to ask, they will just lie and say they don’t use / abuse....”

- Discomfort on the part of healthcare professionals in knowing ...
  - How to start a conversation with a patient about drugs and alcohol use / misuse
  - What to say or what to do to help
SBIRT TRAINING GRANT
FALL 2015-FALL 2018
Didactic
Patient Counseling
Pharmacotherapy
Patient Assessment

OSCE
3rd Year

Experiential
APPE Skills Application
Checklist
AMERICAN SOCIETY OF ADDICTION MEDICINE (ASAM) LEVELS OF CARE

REFLECTING A CONTINUUM OF CARE

0.5  Early Intervention

Note: Within the five broad levels of care (0.5, 1, 2, 3, 4), decimal numbers are used to further express gradations of intensity of services. The decimals listed here represent benchmarks along a continuum, meaning patients can move up or down in terms of intensity without necessarily being placed in a new benchmark level of care.

SOURCE: https://www.asamcontinuum.org/knowledgebase/what-are-the-asam-levels-of-care/
Screening Brief Intervention and Referral to Treatment (ASAM Level 0.5) (99408 and 99409)

Early intervention (ASAM Level 0.5) settings for Screening, Brief Intervention, and Referral to Treatment (SBIRT) services shall include health care settings such as: local health departments, FQHCs, rural health clinics (RHCs), Community Services Boards (CSBs)/Behavioral Health Authorities (BHAs), health systems, emergency departments of hospitals, pharmacies, physician offices and private and group outpatient practices. Individual practitioners shall be licensed by DHP and either directly contracted by the MCOs, MMPs and the BHSA to perform this level of care, or employed by organizations that are contracted by the MCOs, MMPs and the BHSA.

Provider qualifications of SBIRT (ASAM Level 0.5) include: Physicians, pharmacists, and other credentialed addiction treatment professionals, within the scope of their practice, shall administer the evidence-based screening tool with the individual and provide the counseling and intervention. Licensed providers may delegate administration of the evidence-based screening tool to other clinical staff as allowed by their scope of practice, such as physicians delegating administration of the tool to a licensed registered nurse or licensed practical nurse, but the licensed provider shall review the tool with the individual and provide the counseling and intervention.

Note: Pharmacists are not allowed to delegate the approved screen, counseling or intervention.

Source: http://www.dmas.virginia.gov/#/arts
Required Process to Bill Virginia Medicaid for SBIRT

1. Use an approved/evidence based screen
   a. AUDIT, ASSIST, DAST

2. Documentation
   a. Which screen was used → Results
   b. Nature of Brief Intervention
   c. Patient’s response
   d. Any referrals made
   e. Outcome of referrals and any follow-up care

3. Determine billing code based on time spent

4. Keep documentation for 5 years

## Screening for Drug Misuse/Abuse

### Q1. In your **LIFETIME**, which of the following substances have you ever used?  

<table>
<thead>
<tr>
<th>Substance</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Cannabis (marijuana, pot, grass, hash, etc.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Cocaine (coke, crack, etc.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Prescription stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Methamphetamine (speed, crystal meth, ice, etc.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. Inhalants (nitrous oxide, glue, gas, paint thinner, etc.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. Sedatives or sleeping pills (Valium, Serpax, Ativan, Xanax, Librium, Rohypnol, GHB, etc.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>h. Street opioids (heroin, opium, etc.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>i. Prescription opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Please record <strong>nonmedical use only</strong>: Non-medical use refers to using a substance either not prescribed to the patient or used in ways or amounts not prescribed by their doctor.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>j. Other – specify:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

http://www.who.int/substance_abuse/activities/assist_v3_english.pdf?ua=1
<table>
<thead>
<tr>
<th>Question</th>
<th>Never</th>
<th>Once/Twice</th>
<th>Monthly</th>
<th>Weekly</th>
<th>Daily or almost daily</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. In the past 3 months how often have you used [drug name]?</td>
<td>0</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>3. In the past 3 months, how often have you had the strong desire or urge to use [drug name]?</td>
<td>0</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>4. In the past 3 months, how often has your use of [drug name] led to health, social, legal or financial problems?</td>
<td>0</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>5. In the past 3 months, how often have you failed to do what was normally expected of you because of your use of [drug name]?</td>
<td>0</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
</tr>
</tbody>
</table>

Skip to Question 6

http://www.who.int/substance_abuse/activities/assist_v3_english.pdf?ua=1
# ASSIST v. 3

For questions 6 and 7 ask about all substances ever used.

<table>
<thead>
<tr>
<th>Question</th>
<th>No</th>
<th>Yes, but not in the last three months</th>
<th>Yes, in the past 3 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. Has a friend/relative/anyone else ever expressed concern about [drug name]?</td>
<td>0</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>7. Have you ever tried and failed to control, cut down or stop using [drug name]?</td>
<td>0</td>
<td>3</td>
<td>6</td>
</tr>
</tbody>
</table>

Ask Question 8 if patient mentions any drug that might be injected, including those in the other category (ie. steroids) Circle appropriate response.

<table>
<thead>
<tr>
<th>Question</th>
<th>No</th>
<th>Yes, but not in the last three months</th>
<th>Yes, in the past 3 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>8. Have you ever used any drug by injection?</td>
<td>Yes, but not in the last three months</td>
<td>Yes, in the past 3 months</td>
<td></td>
</tr>
<tr>
<td>- For non-medical use (including steroids)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Substance Involvement Score**

(Add numbers from 2-8)

https://www.drugabuse.gov/nmassist/

http://www.who.int/substance_abuse/activities/assist_v3_english.pdf?ua=1
Interpreting ASSIST Screen

Drug Risk Level

- High Risk (>26)
- Harmful Use (4-26)
- At-Risk Use (1-3)
- Abstainers (0)

Action

- High Risk: Referral to Treatment
- Moderate Risk: Referral or Brief Intervention
- Lower Risk: Brief Intervention

http://www.who.int/substance_abuse/activities/assist_v3_english.pdf?ua=1
Brief Intervention

Brief Negotiated Interview (BNI)

- Takes 5 – 15 min
- Base on Motivational Interviewing
- Evidence-based practice

Steps
1. Build rapport
2. Provide feedback
3. Build readiness to change
4. Negotiate a plan for change
Billing Codes for SBIRT Accepted by Virginia Medicaid

<table>
<thead>
<tr>
<th>Code</th>
<th>Service</th>
<th>Rate/Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>99408</td>
<td>SBIRT: 15-30 minutes</td>
<td>Ages&lt;br&gt;&lt;21=&amp;$25.83&lt;br&gt;&gt;20=&amp;$23.82</td>
</tr>
<tr>
<td>99409</td>
<td>SBIRT Greater than 30 minutes</td>
<td>Ages&lt;br&gt;&lt;21=&amp;$50.35&lt;br&gt;&gt;20=&amp;$46.45</td>
</tr>
</tbody>
</table>

Billing Virginia Medicaid for SBIRT

- Pharmacies, not pharmacists, are enrolled with DMAS

- Pharmacies can bill for SBIRT services
  - Fee-For-Service, approved billing codes
  - Bill using CMS 1500 Form (837P)
    - Direct data entry or
    - Paper claim
    - For MCO beneficiaries, pharmacy must contract and be credentialed with the individual health plan

- Pharmacist must document the required items and the pharmacy must maintain the documentation for the required time frame

Source: http://www.dmas.virginia.gov/#/arts
Peer Recovery Specialist Program

- Pharmacists as Peers
  - Certified as a peer recovery specialist through the Virginia Department of Behavioral Health and Developmental Services (DBHDS) Office of Recovery Services

- Peer services can be billed by the practitioner
  - Complex process and not yet being utilized

Source: http://www.dmas.virginia.gov/#/arts

Virginia DMAS ARTS
and
Considerations for other states
OPIOID ABusers ARE MORE LIkELY TO LIVE IN THE RURAL SOUTH.

22 out of the top 25 cities for opioid abuse rate are primarily rural and located in Southern states. Opioid abuse rates range from 11.6% of individuals in Wilmington, NC to 7.5% of individuals in Fort Smith, AR who received an opioid prescription. Alabama, Florida, North Carolina, Oklahoma, North Carolina, Tennessee, and Texas have multiple cities that are in the top 25 for opioid abuse rate. The three non-Southern cities in the top 25 are: Terre Haute, IN; Elmira, NY; and Jackson, MI.

Based on Abuse Rate

**TOP 25 CITIES**

1. Wilmington, NC  >11.6%
2. Anniston, AL    11.6%
3. Panama City, FL 11.5%
4. Enid, OK        10.2%
5. Hickory, NC     9.9%
6. Pensacola, FL   9.8%
7. Gadsden, AL     9.1%
8. Montgomery, AL  8.8%
9. Johnson City- Bristol, TN-VA 8.6%
10. Texarkana, TX-AR 8.5%
11. Tuscaloosa, AL 8.2%
12. Jacksonville, NC 8.2%
13. Amarillo, TX  8.1%
14. Terre Haute, IN 8.1%
15. Odessa, TX     8.0%
16. Oklahoma City, OK 8.0%
17. Longview, TX   8.0%
18. Fayetteville, NC 7.9%
19. Evansville- Henderson, IN-KY 7.8%
20. Chattanooga, TN 7.7%
21. Elmira, NY     7.7%
22. Jackson, TN   7.7%
23. Baton Rouge, LA 7.7%
24. Jackson, MI   7.5%
25. Fort Smith, AR 7.5%

Source: https://www.pqcnc.org/node/13873
North Carolina’s Opioid Addiction Plan 2017-2021

Given that the opioid epidemic is complex, we plan to implement comprehensive strategies in the following focus areas to reduce opioid addiction and overdose death:

1. Create a coordinated infrastructure
2. Reduce oversupply of prescription opioids
3. Reduce diversion of prescription drugs and flow of illicit drugs
4. Increase community awareness and prevention
5. Make naloxone widely available and link overdose survivors to care
6. Expand treatment and recovery oriented systems of care
7. Measure our impact and revise strategies based on results

Source: https://www.ncdhhs.gov/north-carolinas-opioid-action-plan
NCAP Opioid Educational Initiatives

Fundamental Modules

1. Naloxone Eligible Candidates
2. Chronic Pain & Addiction
3. CDC Guidelines
4. CSRS & Pharmacist’s Responsibility
5. Safety, Disposal & Syringe Exchange
6. Treatment of opioid substance use disorders
ADVANCED OPIOID WORKSHOP:
TRANSFORMING PRACTICE TO SAVE LIVES

Elevating the Role of the Pharmacist

Four dynamic modules of content will be covered:

1. Pain management topics and best practices.
2. Harm reduction topics and service concepts.
3. Use of SBIRT (screening, brief intervention and referral for treatment) in practice.
NCAP Opioid Educational Initiatives—Certificate Level Trainings

Addiction & Recovery Training

MAT Training
Medication Assisted Treatment
Physician-Pharmacist Collaboration

- Buprenorphine Physician-Pharmacist Collaboration in the Management of Patients with Opioid Use Disorder

- Exploring the feasibility of transitioning the care of adult patients with opioid use disorder, who receive office-based buprenorphine treatment, from physicians to pharmacists
  - Physicians induce and stabilize
  - Pharmacists manage ongoing MAT and monthly visits
North Carolina Association of Pharmacists
Advancing Pharmacy. Improving Health.
Medicaid Gross Drug Expenditure for Hep C
North Carolina, SFY 2011–16

- Medicaid treatment expenditures for Hep C increased from $3.8M in 2011 to $85.6M in 2016.
- Increases are from new medications on the market and increased cases.

*Does not account for drug rebates
Endocarditis & Sepsis Among People Likely Using Drugs, North Carolina, 2010–2015

Heart valve infections associated with injection drug use increased **13.5 times**

Sepsis (bloodstream infections) increased **4 times**

Source: NC Division of Public Health, Epidemiology Section, NC EDSS, 2010-2015
Opioid Epidemic: My Stump Speech

• Complex, multi-faceted problem for which no one solution will solve the problem. Instead we have to tackle the problem, in concert, but through various methodologies.

• When it comes to pharmacy we have to look at pharmacists as a well-educated yet highly underutilized resource.
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