MEDICATION ASSISTED THERAPY THROUGH A PHARMACIST-PROVIDER COLLABORATION AT A FEDERALLY QUALIFIED HEALTH CENTER

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Objectives

- Background
- Current practice site
- Pharmacology
- Pharmacist’s Role
- Progress
- Patient cases
Minnesota Community Care: Background / History

- Federally Qualified Health Center
  - Formerly West Side Community Health Center
- 36,338 total patients served annually
- 87% of patients are 200% of the FPL of less
- Culturally diverse population
Opioid Use Disorder

- 191 treated for OUD
  - 190 Buprenorphine / buprenorphine naloxone
  - 1 Naltrexone IM
- 1 provider and 1 RN
- Maintenance therapy only
  - Abstinence required for 72+ hours
Minnesota Community Care: Current

- Holistic interdisciplinary approach to caring for patients in our OBOT program
  - 6 providers: Nesvig, Graber, Meyers, Benish, Warford, Weinert
  - 2 clinics: ES and La Clinica
    - Plans for addition of HCH site
  - 1 LADC, LICSW: Mary Kelly English
  - Support: LaReesa, Neri
  - 2 care coordination nurses: Norma Decker and Lori Krumm
  - 1 pharmacist: Lauren Anderson

- Renewal Services
Opioid Use Disorder (OUD) Treatment

- Methadone
  - Full agonist
- Buprenorphine
  - Partial agonist
  - Ceiling effect
- Naltrexone
  - Antagonist
Pharmacology

EXHIBIT 3A.4. Intrinsic Activity of OUD Medications

- Full Agonist (Methadone)
- Partial Agonist (Buprenorphine)
- Antagonist (Naltrexone)
Pharmacology

- MOA: high affinity to the mu opioid receptors in the CNS which produces analgesia. This agonism plateaus at higher doses make it behave like an antagonist to other opioid agonists. Weak antagonism at the kappa receptor may have some role in reducing hyperalgesia and relieving withdrawal symptoms. It is coformulated with naloxone to deter IV injection.

- Indications
  - Moderate to severe OUD
  - Opioid dependence
  - Pain
Induction

- The initiation of buprenorphine
- Approximately 12-24 hours after last opioid use
  - May be longer or shorter depending on agent and patient specific factors
- Patients must be in moderate withdrawal
- If initiated too soon, will precipitate a full withdrawal
Role of the Pharmacist

- **Induction of Buprenorphine**
  - Provider barriers
    - TIME!
    - Induction can take upwards of 2 hours
      - Excluding prep time and f/ up
      - Clinical visits at MCC: 15-20 minutes

- **Plan: Utilize pharmacists to manage induction**

- **Additional Roles**
  - Comprehensive Medication Review
  - Management of acute pain or surgery
  - Opioid Tapers
Role of the Pharmacist: Process

- Patient is seen by primary MAT provider and is given a diagnosis
- Patient is then referred to LICSW to determine eligibility for the program or to PharmD for induction
- PharmD coordinates date of induction
- PharmD prescribes medication to outside or inhouse pharmacy
- PharmD calls patient for education and induction intake
- PharmD sees patient in clinic for induction
- PharmD follows patient in clinic or by phone until stable and then transfers care back to MAT PCP
- PharmD is then available as needed for consults, CMR, managing acute pain/ surgery, etc.
Why a Pharmacist?

- Clinical application of extensive pharmacology knowledge and ability to educate patients
- Knowledge of pharmacology of opioid agonists
- Knowledge of pertinent drug-drug interactions
- Medication Access
  - Knowledge of dispensing pharmacy experience
  - Knowledge of formulations and pricing
  - Knowledge of insurance coverage
  - Help patients navigate health care systems and learn to use a pharmacy
## Progress

<table>
<thead>
<tr>
<th>Description</th>
<th>Value</th>
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<tbody>
<tr>
<td>Number of patients seen for induction</td>
<td>20</td>
</tr>
<tr>
<td>Total number of patients still adherent</td>
<td>15</td>
</tr>
<tr>
<td>Percentage of patients still adherent</td>
<td>75%</td>
</tr>
<tr>
<td>Total number of patients seen</td>
<td>31</td>
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Patient Cases
Patient 1

34 y/o Female is referred to clinic for induction of buprenorphine. PMH significant for Crohn's Disease, chronic pain and multiple ear surgeries. She is recently divorced and has 2 young children. She was prescribed oxycodone and the dose has steadily increase. She has been trying to taper with her PCP, but is struggling with withdrawal. She is concerned about missed days at work as well as securing custody of her children.

She was induced in December 2018 and has been off all opioids since, with the exception of a 1 week course of oxycodone following an ear surgery in January during which she maintained on 8 mg of buprenorphine per day.

She currently has custody of her children, is doing well at work and reports a drastic increase in quality of life.
Patient 2

A 73 y/o female is referred to Renewal Services via warm hand off from her primary care provider. Began smoking opium with her husband when he was diagnosed with cancer. He passed away and upon stopping opium, she realized that she was dependent when she withdrew. Has tried and failed methadone.

Today she is stable on buprenorphine. She has not used any opium and feels that she has been given a new life.
Patient 3

49 y/o female who presented to clinic for an acute care appointment after losing her job. She is evaluated for a viral illness and discloses to her provider that she uses IV heroin daily. She has been to inpatient treatment 13 times. She is referred to Renewal Services and is induced on buprenorphine.

Today she is stable on buprenorphine and has not injected any substance in 5 months which is her longest period of time since commencing substance use.