



2023

OPIOID ABATEMENT TOOLKIT



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PURPOSE OF THIS TOOLKIT

Contributed by: Erica Martin, MHA

Litigation against manufacturers, distributors and retailers alleged to have contributed to the ongoing opioid epidemic resulted in settlement funding for the abatement and mitigation of opioid misuse and abuse. These funds will become available to county governments in various amounts in the coming years.¹ This toolkit will facilitate collaboration between pharmacy personnel and county government personnel to address the opioid epidemic locally.

Pharmacy personnel can use this toolkit to begin the discussions with their respective county board of supervisors on potential projects and funding opportunities that address the needs of their shared communities concerning the abatement and mitigation of opioid misuse and abuse.

It should not be assumed that county governments will contact pharmacies about collaborations. The topics discussed in this toolkit should serve as a guide and empower pharmacy personnel to proactively identify opportunities to maximize the impact of these funds and determine how they may best serve their patients and communities.

This toolkit provides summaries on a variety of topics related to opioid use, mitigation of opioid misuse and abuse, stigma, substance use disorder, and medication assisted treatment. The primary audience for this toolkit is pharmacy personnel (pharmacists and pharmacy technicians) in any pharmacy setting. The secondary audience is county government officials.

Each section of the toolkit has a dedicated topic and seeks to briefly answer the following questions:

- What is a summary of this topic/service?
- **Abatement Strategies to Consider:** How could pharmacies offer this topic/service in their community to address the opioid epidemic?
- **Equity Considerations:** What should be considered in regards to equity related to this topic/service?
- **Resources and Funding Considerations:** What resources and funding would pharmacies need in order to implement or expand this topic/service? (This question is intended to provide general considerations on resources, and **not** intended to provide budget numbers or Full-Time Equivalent [FTE] recommendations).
- **Stories:** Occasionally, a story of why this service is needed or a success story related to this topic/service, may be included in a section to emphasize the importance of funding for opioid use disorder treatment and overdose prevention.

Disclaimer - The legislation at the federal and state levels related to the opioid epidemic is constantly evolving; therefore, this toolkit is current as of the date of publication. The digital version will periodically be updated to ensure it aligns with the contemporary legislative landscape, though take note of the publication date of the print version as it may not reflect the most recent updates.

1. Dose of Reality: Opioid Settlement Funds. Wisconsin DHS. Updated September 24th, 2022. Accessed December 5th, 2022. <https://www.dhs.wisconsin.gov/opioids/settlement-funds.htm>

BACKGROUND ON OPIOID SETTLEMENT FUNDS

Contributed by: Danielle M. Womack, MPH

On February 25, 2022, the Wisconsin Department of Justice announced the final approval of an agreement with the nation's three major pharmaceutical distributors (Cardinal, McKesson, and AmerisourceBergen) and Johnson & Johnson relating to their role in the opioid epidemic. The intent of these funds is for the prevention, treatment, and support of recovery from opioid use disorder (OUD). Starting in 2022, payments from the distributors will continue for 18 years, and payments from Johnson & Johnson will continue for nine years. Wisconsin is due to receive more than \$400 million in total funding. The 2021 Wisconsin Act 57 requires the Wisconsin Department of Health Services (DHS) to receive 30% of the state's total allotment while counties and municipalities that participated in the litigation will receive the remaining 70%. While additional settlements and distributions from other defendants in the litigation have been announced, the amounts associated with the settlements and distributions have not yet been finalized.



For more information on how WI DHS plans to use its fund allotment, click [here](#).

County governments that receive funds will be focused on the following [“core” abatement](#) strategies that are intended to integrate well with pharmacy services within their communities:

- **Naloxone or other FDA-approved drugs to reverse opioid overdoses**
 - » Expand training for first responders, schools, community support groups, and families.
 - » Increase distribution to individuals who are uninsured, whose insurance does not cover the needed service, or are unable to afford over-the-counter (OTC) naloxone.
- **Medication-assisted treatment (MAT) distribution and other opioid-related treatment**
 - » Increase distribution of MAT to individuals who are uninsured or whose insurance does not cover the needed service.
 - » Provide MAT education and awareness training to healthcare providers, emergency medical technicians, law enforcement, and other first responders.
- **Increase screening and access to medical care for pregnant & postpartum women**
 - » Expand Screening, Brief Intervention, and Referral to Treatment (SBIRT) services to non-Medicaid eligible or uninsured pregnant women.
 - » Expand comprehensive, evidence-based treatment and recovery services, including MAT, for women with co-occurring OUD and other Substance Use Disorder (SUD)/mental health disorders for uninsured individuals for up to 12 months postpartum.

- **Prevention programs**
 - » Funding for medical provider education and outreach regarding prescribing best practices for opioids that is consistent with the 2022 Centers for Disease Control and Prevention guidelines, including providers at hospitals with an emphasis on academic detailing.
 - » Funding for community drug disposal programs.
- **Expand syringe service programs**
 - » Provide syringe services programs with more comprehensive wrap-around services, including linkage to OUD treatment, access to sterile syringes, and care and treatment of infectious diseases.

With these focus areas in mind, PSW is working with the Wisconsin Counties Association to provide this pharmacy-facing toolkit to support community-based work on opioid abatement and mitigation efforts. While WCA appreciates and encourages collaboration among counties and other stakeholders relative to efforts to combat the opioid epidemic, WCA does not endorse any specific measures contained in this toolkit. Ultimately, it is up to each individual county to determine what measure will work best in combating the epidemic. Likewise, while WCA generally supports proposed legislation that will assist in addressing the epidemic, it must review any legislative proposal in detail through its platform process before expressing support for any particular proposal.

HOW TO RESEARCH WHAT'S GOING ON IN YOUR COMMUNITY

Contributed by: Stephanie Tchen, PharmD, BCCCP

Since the introduction of extended-release oxycodone to the market in the late 1990s, the rate of opioid overdose deaths has more than quadrupled.^{1,2} In response to this crisis, the opioid epidemic was declared a public health emergency by the United States (US) Department of Health and Human Services (HHS) in 2017.¹ In 2019 alone, over 10 million people in the US misused opioids, and over 70,000 died from an opioid overdose. To combat the epidemic, numerous resources were released, including information about the effects of the opioid epidemic nationally, regionally, and locally.^{3,4}

The Centers for Disease Control and Prevention (CDC) adopted a guiding principle of “know your epidemic, know your response.”⁵ We are better prepared to confront, address, and prevent problems, such as the opioid epidemic, by having a thorough understanding of the causes and characteristics of the situation.^{4,5} Through reviewing data and statistics, we can increase awareness and better tailor and track responses at various levels, including at the community level. Studies have found that community-driven responses of evidence-based practices are vital for their implementation, sustainability, and influence.² As such, community dialog is an essential part in creating a truly effective strategy to reduce opioid harm.⁵

It is vital to understand the community and individuals served to reduce the burden of the opioid epidemic. Community-engaged research can accomplish this. Some examples of community-level resources include the State Department of Health Services (DHS) dashboards, local opioid stewardship coalitions, and overdose fatality review (OFR) boards.⁶ The DHS dashboards encompass multiple opioid-related topics such as deaths by count, adult and youth opioid usage, and treatment by county.^{6,7} They are regularly updated and compile opioid data in interactive visualizations. One DHS initiative is to evaluate data regarding opioids to identify and target communities that require additional support in preventing opioid harm.

It is vital to understand the community and individuals served to reduce the burden of the opioid epidemic

1. U.S. Department of Health and Human Services (HHS). What is the U.S. opioid epidemic? Accessed November 16, 2022. <https://www.hhs.gov/opioids/about-the-epidemic/index.html>.
2. El-Bassel N, Gilbert L, Hunt T, et al. Using community engagement to implement evidence-based practices for opioid use disorder: A data-driven paradigm & systems science approach. *Drug Alcohol Depend* 2021;222:108675. doi: 10.1016/j.drugalcdep.2021.108675.
3. Centers for Disease Control and Prevention (CDC). Understanding drug overdoses and deaths. Updated February 14, 2022. Accessed November 16, 2022. <https://www.cdc.gov/drugoverdose/epidemic/index.html>.
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6. Wisconsin Department of Health Services. Dose of reality: Opioids in Wisconsin. Updated November 22, 2022. Accessed November 23, 2022. <https://www.dhs.wisconsin.gov/opioids/index.htm>.
7. Wisconsin Department of Health Services. Dose of reality: Opioids data. Updated November 22, 2022. Accessed November 23, 2022. <https://www.dhs.wisconsin.gov/opioids/data-reports-studies.htm>.

Through these dashboards, the Wisconsin DHS has identified valuable information such as the rapidly rising rates of opioid-related Wisconsin deaths, which rose by nearly 50% from 2018 to 2020.⁸ Other resources that provide data on the national and state level include dashboards by the CDC or statistics by the National Center for Drug Abuse Statistics.^{4,9}

Opioid stewardship coalitions or programs involve stratagems such as promoting safe and rational opioid prescription, diversion prevention, and opioid harm prevention.^{10,11} Although hospital-associated programs remain scarce nationwide, institutions such as the University of Wisconsin-Madison School of Pharmacy have published toolkits to promote appropriate opioid stewardship. Examples of local community-based coalitions include the RISE Drug Free MKE (formerly known as MCSAP), Waukesha Drug Free Communities Coalition, and the 27th St. Drug Free Coalition.¹² These coalitions are commonly involved in events that benefit from pharmacist involvement, such as Drug Take Back Day. Pharmacists can also partner with local agencies such as Safe & Sound and Medication-Assisted Treatment (MAT) centers to educate and advocate for patients.^{13,14}

OFR boards are multidisciplinary groups, established on the state, city, or county level, to research the conditions surrounding fatal drug overdoses, identify gaps in care, and influence changes in law and policy.¹⁵ In Wisconsin, the OFR comprises 22 teams that cover 24 counties.^{16,17} Their goals include “recognizing and addressing gaps and barriers in services, identifying underlying causes of substance use disorders, determining prevention strategies targeting opioids and other substances, developing recommendations for policy and program changes at the local and state levels, and building a community of multi-disciplinary partners to collaborate across agencies.”^{16,17}

ABATEMENT STRATEGIES TO CONSIDER

Although there are a plethora of resources available to inform patients, pharmacists, and government officials about opioid data, knowledge of their existence is not universal. Pharmacists and pharmacies are well-positioned to impact public health and link patients with appropriate care and relevant resources due to their general accessibility.^{18,19} Pharmacies can disseminate information via several methods such as on-site advertisements of infographics or fliers/handouts in order to increase awareness of opioid-related resources available. With the

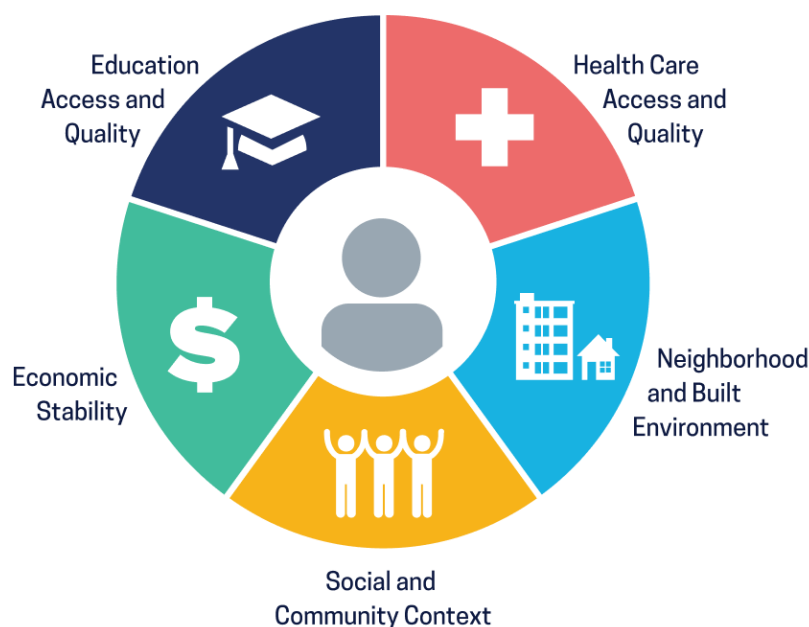
8. Wisconsin Department of Health Services. Dose of reality: Opioids data summary dashboard. Updated September 7, 2022. Accessed November 23, 2022. <https://www.dhs.wisconsin.gov/opioids/dashboards.htm>.
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rise of social media, digital resources, such as those provided by the DHS, can more easily be promoted online via posts and links to videos.⁷ Pharmacies can also provide opportunities for their pharmacists to become involved with local opioid related projects, such as opioid stewardship programs, MAT centers, and OFR groups. If available in facilities that allow medication safety reporting, pharmacists can also contribute to opioid data via reporting relevant information that may be utilized in local and community efforts.

EQUITY CONSIDERATIONS

The opioid epidemic can affect people regardless of age, race/ethnicity, or gender; however, research has found that health disparities and social determinants play a large role in driving the opioid epidemic.^{2,20,21} Social determinants, such as poverty, homelessness, and incarceration, can be grouped into domains such as economic stability, education access and quality, healthcare access and quality, neighborhood and built environment, and social and community context.^{2,22} Ethnic and racial minorities, such as Black individuals, face disproportionately higher rates of opioid-related overdose deaths, when compared to White

Social Determinants of Health



Social Determinants of Health
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Healthy People 2030

Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Retrieved [date graphic was accessed], from <https://health.gov/healthypeople/objectives-and-data/social-determinants-health>

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individuals.²¹ For example, in 2020 the rate of overdose deaths in elderly Black males was almost seven times higher than that of elderly non-Hispanic White males. These inequities were further aggravated in counties with larger gaps in wealth.

By leveraging and contributing to repositories of opioid data, pharmacists can promote equity and better tailor responses while placing emphasis on highly burdened areas.² Equity must be ingrained by focusing on community-driven responses, particularly in high risk communities, to reduce stigma and improve access to medications for opioid use disorder (MOUD).^{2,21} Similarly, community-derived responses also increase response equity. This can be accomplished with leadership that is representative of the community in which opioid reduction/prevention programs operate, as well as through community town hall meetings.²

Equity must be ingrained by focusing on community-driven responses, particularly in high risk communities, to reduce stigma and improve access to medications for opioid use disorder (MOUD).

RESOURCE AND FUNDING CONSIDERATIONS

To implement programs and to improve access to community-level opioid data, pharmacies may need additional resources and funding. For example, pharmacies may require financial assistance to compensate the pharmacists' time to produce new informational resources; however, through collaborating with other community organizations, local non-profits, and Schools of Pharmacy, pharmacies may be able to minimize costs. Student pharmacists offer a valuable resource in developing tools and outreach to patients, thus ensuring widespread dissemination of opioid data and available community resources.

THE ROLE OF STIGMA RELATED TO OPIOIDS

Contributed by: Katherine Rothbauer, PharmD

Stigma remains a pervasive problem and significant barrier among efforts to mitigate the opioid epidemic. The term stigma refers to negative, unsupportive, or discriminatory perceptions and attitudes toward a particular population or group, which result in decreased opportunities and quality of care for individuals in that group.^{1,2} This can be categorized into three types, including public stigma, self-stigma, and institutional stigma, all of which have clearly impacted the opioid crisis.¹ In the context of opioids, public- and self-stigma refer to the negative perceptions about opioid use or related treatment from other individuals or from oneself, respectively.¹ On the other hand, institutional stigma represents the larger systemic effect of these negative perceptions that result in overarching policies of governments and organizations that allocate resources away from supporting affected individuals.^{1,2}

Stigma: negative, unsupportive, or discriminatory perceptions and attitudes toward a particular population or group, which result in decreased opportunities and quality of care for individuals in that group

As it relates to opioids, stigma prevents accurate understanding of the factors that contribute to opioid use disorder (OUD) and often promotes the idea that OUD is a downstream effect of poor personal choices. It has been shown that nearly three quarters of Americans believe that people with OUD lack self-discipline or that the individuals themselves are to blame.³ With these attitudes, individuals and groups are less likely to support large-scale resources that could help people who use opioids, such as treatment programs, syringe service programs, or overdose prevention tools like naloxone. Stigma also limits accessibility to effective treatments for OUD. A recent survey demonstrated that less than half of Americans believe that effective long-term treatments for OUD exist, despite evidence that FDA-approved medications for OUD not only exist, but are effective and save lives.⁴

Stigma also impacts opioid risk mitigation efforts among patients who take opioids as prescribed (i.e., appropriately) for pain management. For example, stigma that identifies naloxone as a tool only for “addicts” limits widespread naloxone distribution and decreases the willingness of community members or individuals prescribed opioids to carry naloxone.⁵ Not only the public, but healthcare providers and workers too, may also intentionally or unintentionally uphold stigmatizing ideas about patients who use opioids, resulting in further discouraging individuals from seeking treatment or accepting resources to reduce harm.⁶

1. Boronstein J. Stigma, Prejudice and Discrimination Against People with Mental Illness. American Psychiatric Association. Published August 2020. Accessed October 31, 2022. <https://www.psychiatry.org/patients-families/stigma-and-discrimination>.
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ABATEMENT STRATEGIES TO CONSIDER

On the frontlines of healthcare, pharmacies have a responsibility to apply certain guiding principles to all professional activities to reduce the stigma surrounding opioids. Pharmacists, technicians, and other healthcare workers can start by using person-centered language and avoiding stigmatizing terms such as “addict,” “drug abuser,” or “drug problem.” Instead, language that is person first, such as “person with opioid use disorder” or “harmful use” frames the discussion more neutrally and reduces the likelihood of an immediate negative perception.^{2,7,8} Table 1 outlines evidence-based language recommended when discussing substance use and, specifically, opioid use. Pharmacies can begin by training staff about this specific language and the stigma it can portray, not only when interacting directly with patients, but also in discussions between staff members.

It has also been demonstrated that sympathetic narratives, or personal stories, humanize individuals with OUD. This can reduce stigma and increase public acceptance of life-saving resources such as naloxone.^{2,9} When offering naloxone to patients, pharmacies could consider sharing printed materials that include a narrative about an anonymous, real-life experience with opioids or overdose, in addition to providing information about naloxone administration and overdose response.

TABLE 1. Evidence-Based Language to Reduce Stigma of Opioids and Substance Use.^{2,7,8}

<i>Stigmatizing Language to Avoid</i>	<i>Language to Use</i>
Addict	Person with substance use disorder
Drug problem/opioid problem	Substance use disorder/opioid use disorder
Opioid abuse	Harmful use of opioids
Clean screen	Testing negative for substance use
Dirty screen	Testing positive for substance use
Former addict	Person in recovery
Opioid replacement	Medication treatment

Pharmacies can also emphasize that effective treatments exist for OUD by increasing accessibility to treatments, thereby normalizing treatment for individuals who could benefit. Pharmacies are more likely to be access points for patients than the locations of opioid treatment programs, particularly for those living in rural areas.¹⁰ While pharmacists can dispense methadone without limitation for pain management, stricter federal limitations exist on the prescribing and/or dispensing of methadone for OUD. These differences in requirements depending on indication impose a barrier to treatment and further stigmatize the use of these medications for OUD treatment. Thankfully, some of these barriers to buprenorphine have been removed due to recent changes in federal regulation. Currently, pharmacists can ensure buprenorphine products are available in community pharmacies for dispensing. Further, they can advocate for policy changes that advance practice by expanding the ability of pharmacists to provide medication treatment.¹⁰

While current policy precludes provision of medication treatment for OUD in pharmacy settings beyond dispensing buprenorphine according to prescription, pharmacists can also reduce

- Ashford RD, Brown AM, Curtis B. Substance use, recovery, and linguistics: the impact of word choice on explicit and implicit bias. *Drug Alcohol Depend.* 2018;189:131-138. doi:10.1016/j.drugalcdep.2018.05.005
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stigma by providing compassionate care and normalizing screening for opioid diversion or harmful use. Pharmacists may employ screening, brief intervention (SBI) with or without referral to treatment (SBIRT) models in community pharmacies as part of the dispensing process for opioid medications, which includes nonjudgmentally providing standard opioid safety education on safe disposal, overdose prevention, and naloxone use. Information on community resources for treatment can also be provided, such as through the SAMHSA Treatment Services Locator: <http://www.samhsa.gov/find-treatment>.¹¹

EQUITY CONSIDERATIONS

Awareness of the intersectionality between opioid-related stigma and other forms of bias should inform efforts toward reducing the stigma of opioids. It has been demonstrated that the degree of opioid-related stigma expressed toward an individual or group may vary depending on factors including but not limited to socioeconomic status, race, and gender.¹²⁻¹⁴ People with

opioid or other substance use disorders who also hold other marginalized identities are more likely to experience stronger expressions of stigma and harsher treatment.¹⁴ With regard to socioeconomic status, working-class individuals have been shown more likely to be viewed with harsh negative attitudes related to opioid use than middle- or upper-class individuals.¹² Implicit bias association tests have shown that people are more likely to view Latinx individuals with substance use disorders as more deserving of punishment than White individuals, demonstrating the role of race and ethnicity in the degree to which stigma is expressed and experienced.¹⁴ There have been less conclusive findings regarding the intersection of opioid stigma and gender, though ongoing research is warranted to better understand how different gender identities experience opioid stigma.^{12,14}

People with opioid or other substance use disorders who also hold other marginalized identities are more likely to experience stronger expressions of stigma and harsher treatment.

One example of how this intersection of biases impacts efforts at reducing stigma is in the printed materials some pharmacies may offer with information about opioid overdose and naloxone. As previously discussed, using printed materials to convey narratives or personal stories of anonymized individuals impacted by opioid use can be a powerful tool to reduce stigma. However, it is important to depict individuals that represent the identities of the various patient populations served and avoid overrepresentation of non-marginalized, majority groups, as this may actually promote ongoing opioid-related stigmas toward marginalized, highly burdened groups.¹⁵ Ongoing examination of the biases that intersect with opioid stigma will be essential in policy-level efforts to increase access to treatment for OUD.

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RESOURCE AND FUNDING CONSIDERATIONS

To reduce stigma related to opioids through implementing the educational practices and patient care services described above, additional resources for pharmacies would likely be necessary.

One important resource would be dedicated time for the provision of education on the evidence-based language that reduces opioid- and other substance use-related stigma. Committing to providing this education not only to pharmacists, but to all pharmacy staff members, as well as emphasizing the importance of using non-stigmatizing language in all discussions whether directly with patients or not, would require additional time and access to educational materials.

Another resource consideration in reducing opioid stigma would be ensuring adequate private counseling space for opioid overdose education, counseling on naloxone, and completing SBI or SBIRT discussions when appropriate. While this information should be readily available to all patients who express interest, it is important to offer this information in an environment where the patient feels comfortable and not judged by either pharmacy staff or other individuals nearby. Having these discussions can be normalized by offering printed materials to all patients who are interested, that emphasize not only the factual points about opioid safety and naloxone use, but also depict personal narratives of people impacted by opioid use, humanizing this experience and reducing the strong negative connotation carried by stigma.

TALKING WITH PATIENTS ABOUT OPIOIDS: MOTIVATIONAL INTERVIEWING

Contributed by: Theresa Frey, PharmD, BCPP

Given the prevalent stigma related to both opioid use disorder (OUD) and chronic opioid pain medication use, it is essential that healthcare providers approach patients tactfully and collaboratively when inviting them to engage in discussions about opioid safety related treatment enhancements.¹ Trust and open communication are paramount to optimal patient care outcomes, including overdose prevention.² Motivational Interviewing (MI) is one method of communication which can be utilized to enhance patient and provider communication surrounding opioid safety.

MI is a style of communication used to collaboratively work toward mutually agreed upon goals and can be utilized by pharmacists to engage patients in a variety of opioid related health interventions that involve behavioral change, including, but not limited to, the following³:

- Comprehensive therapeutic pain management plans that enhance opioid safety
 - » Opioid rotation to agents with an improved safety profile (buprenorphine)
 - » Opioid tapering or dose reduction
 - » Sedating polypharmacy reduction
 - » Acceptance of multi-modal pain care
- OUD treatment engagement
 - » Medications for opioid use disorder (MOUD)
 - » Harm reduction interventions such as sterile syringe programs, pre-exposure prophylaxis, and fentanyl test strips
- Naloxone Distribution
 - » Acceptance of naloxone in patients prescribed opioids, patients with opioid misuse or OUD, and community members with at risk contacts
- Safe Medication Storage and Disposal

The MI communication style is utilized to engage patients when there is ambivalence about making a change. MI helps to highlight the discrepancy between a patient's own values and their current behavior. It provides a framework of open and interactive conversation which can be used to draw out a patient's own motivations for change and ideas about how best to implement changes in their life.⁴ It also provides a viable avenue for sharing information about

1. McCracken MD, Vasileva D, Orchanian-Cheff A, Buchman DZ. Ambiguous identities of drugs and people: A scoping review of opioid-related stigma. *Int J Drug Policy*. 2019;74:205-215. doi:10.1016/j.drugpo.2019.10.005

2. Mueller SR, Glanz JM, Nguyen AP, et al. Restrictive opioid prescribing policies and evolving risk environments: A qualitative study of the perspectives of patients who experienced an accidental opioid overdose. *Int J Drug Policy*. 2021;92:103077. doi:10.1016/j.drugpo.2020.103077

3. Miller WR, Rollnick S. *Motivational Interviewing: Helping People Change*, 3rd Edition. Guilford Press; 2013:xii, 482.

4. Understanding Motivational Interviewing | Motivational Interviewing Network of Trainers (MINT). Accessed October 29, 2022. <https://motivationalinterviewing.org/understanding-motivational-interviewing>

therapeutic opportunities to optimize treatment for pain conditions and enhance safety. MI has been utilized for substance use historically, but the idea of using it for opioid tapering or reduction is a newer concept.⁵ However, there is literature to support using MI for this purpose.^{6,7} A 2020 prospective, randomized controlled pilot study demonstrated benefit of MI in combination with guided opioid tapering via weekly to monthly physician calls after total knee or hip arthroplasty.⁶ The primary endpoint, rate of return to baseline opioid use, was 62% faster in the intervention group than usual care (HR 1.62; 95% CI 1.06-2.46; p=0.03). Additionally, the MI-guided opioid tapering intervention showed a non-statistically significant trend toward decreased time in post-operative pain and promotion of surgical recovery.

Academic detailing, an outreach education technique focused on sharing evidence-based clinical practices, has been utilized to promote MI to support opioid tapering in Canada.^{7,8} Example scripts from this Canadian outreach effort can serve as a resource for utilizing MI in opioid tapering efforts but may also be extrapolated for use in situations regarding initiating medications for opioid use disorders (MOUD).⁷

When MI is used to support reducing or tapering off opioids, patient collaboration in the process is critical; if patients are tapered too quickly, they may experience withdrawal symptoms or increased pain and be at risk for prescription opioid misuse, opioid use from non-prescription channels, and overdose.² Opioid tapering or dose reductions should be considered as only one element of a comprehensive treatment plan to optimize patient safety and health outcomes and should not be implemented in isolation.

Opioid tapering or dose reductions should be considered as only one element of a comprehensive treatment plan to optimize patient safety and health outcomes and should not be implemented in isolation.

In summary, MI is an evidence-based tool that appropriately trained pharmacists can utilize to support communication with patients about a variety of opioid safety related treatment enhancements where ambivalence about making this change exists, as part of a comprehensive treatment plan.

ABATEMENT STRATEGIES TO CONSIDER

Screening, brief interventions and referral to treatment (SBIRT), a health approach which uses MI skills to highlight care enhancement opportunities, can be implemented by inpatient, community, emergency room, and ambulatory care pharmacists to improve opioid safety and engage patients in opioid use disorder treatment when indicated.⁹ The SBIRT approach can be used to offer interventions directly available in pharmacies (such as over-the-counter (OTC) naloxone or fentanyl test strips) or to refer to alternate healthcare services when needed. It is also imperative that any conscious or unconscious bias pharmacists have as it relates to substance use disorders are addressed to eliminate discouraging individuals from seeking treatment or accepting resources to reduce harm.

5. Smedslund G, Berg RC, Hammerstrøm KT, et al. Motivational interviewing for substance abuse. *Cochrane Database Syst Rev*. 2011;2011(5):CD008063. doi:10.1002/14651858.CD008063.pub2
6. Hah JM, Trafton JA, Narasimhan B, et al. Efficacy of motivational-interviewing and guided opioid tapering support for patients undergoing orthopedic surgery (MI-Opioid Taper): A prospective, assessor-blind, randomized controlled pilot trial. *eClinicalMedicine*. 2020;28. doi:10.1016/j.eclinm.2020.100596
7. Crawley A, Murphy L, Regier L, McKee N. Tapering opioids using motivational interviewing. *Can Fam Physician*. 2018;64(8):584-587.
8. Yeh JS, Van Hoof TJ, Fischer MA. Key Features of Academic Detailing: Development of an Expert Consensus Using the Delphi Method. *Am Health Drug Benefits*. 2016;9(1):42-50.
9. Screening, Brief Intervention, and Referral to Treatment (SBIRT). Published April 3, 2014. Accessed June 4, 2023. <https://www.samhsa.gov/sbirt>



Adequately trained pharmacists can also provide Comprehensive Medication Management pain and opioid use services that utilize MI and have more time dedicated to direct patient care. These services could be provided in the ambulatory care setting either in person, via telehealth or via phone, though must follow state, federal, and Drug Enforcement Administration (DEA) regulations regarding controlled substance prescribing. Pharmacists can participate in pain care optimization as part of an interdisciplinary team and practice in advanced prescribing roles via collaborative practice agreements (CPAs).

Although this is not the current status in Wisconsin, future legislation to allow for pharmacists to obtain a DEA registration would also aid in pain care and opioid safety optimization efforts. This would allow pharmacists to directly implement opioid taper prescriptions or buprenorphine for OUD, after diagnosis established by a qualified provider, via CPAs and/or pharmacist provider status to provide timely receipt of medications, improve care efficiency, and enhance the patient care experience. This is particularly relevant in consideration of recent X-waiver removal, where pharmacists could provide an additional access point for buprenorphine formulations, both for pain and OUD, via CPAs. Pharmacists in the Veterans Affairs (VA) healthcare system have demonstrated the utility of pharmacist controlled substance prescriptive authority for increasing patient access.¹⁰ Pharmacy Residency training for comprehensive medication management in pain and substance use disorders practice areas would support pharmacist readiness for advanced practice models.

Training of pharmacists in MI could be completed through in person or virtual workshops. The addition of longitudinal coaching/support networks would also aid in MI skill retention and

10. Baum SG, Kominek C, Jorgenson T, Brooks A, Rose K. DEA-registered clinical pharmacist practitioners: Progressing practice to increase patient care access. *Am J Health-Syst Pharm AJHP Off J Am Soc Health-Syst Pharm*. Published online May 9, 2023:zxad101. doi:10.1093/ajhp/zxad101

fidelity. A train-the-trainer approach could also be implemented for a more wide-spread reach. Training and resources regarding comprehensive pain management would also be valuable for using MI skills to share evidence-based pain medication recommendations.

Training regarding stigma related to chronic opioid use and OUD including persons with lived experiences is recommended to increase provider understanding and empathy.¹¹ Having persons with lived experiences provide input into service development and patient care materials is likely to enhance the acceptability of the services.¹²

EQUITY CONSIDERATIONS

Historically marginalized groups are more likely to experience stigma related to opioid use due to multiple layers of social disadvantage. Stigma itself can also contribute to chronic stress, thus negatively impacting health outcomes.¹ To achieve health equity for the potential target population for service utilization, careful review of barriers related to intersecting identities, such as race, ethnicity, and socioeconomic status is valuable.

A 2019 analysis of US National Vital Statistics System indicated that substantial disparities exist in drug overdoses, related mortality, pain management, and treatment outcomes according to social determinants.¹³ Notably, ethnic-minority patients were significantly less likely than white patients to receive acute overdose reversal agents, such as naloxone, when treated in the emergency department. Racial and ethnic disparities have also been noted in pain medication prescriptions and OUD treatments.^{14,15} Though beyond the scope of this toolkit, the analysis also recommended that efforts should be directed at upstream factors such as: education, economic opportunity, social cohesion, racial and ethnic disadvantage, geographic isolation, and life satisfaction.¹³

RESOURCE AND FUNDING CONSIDERATIONS

Pharmacies would need accessible educational programming to train pharmacists in MI skills, SBIRT, responsible opioid tapering, and provision of evidence-based pain care for pain management, harm reduction, and OUD. Pharmacists would benefit from a network of support and collaboration in provision of this service, both with peers providing this service and with non-pharmacist pain and OUD specialists. Virtual community of practice calls with participating pharmacists and collaborating providers could offer a network for strong practice and educational resource sharing. Funds to develop and maintain up-to-date marketing materials for the service (virtual and printed) and educational handouts would be beneficial. Comprehensive pain or OUD services with follow-up medication management work best with an active CPA with a physician partner who has a DEA license and controlled substance prescribing authority

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11. Livingston JD, Milne T, Fang ML, Amari E. The effectiveness of interventions for reducing stigma related to substance use disorders: a systematic review. *Addict Abingdon Engl.* 2012;107(1):39-50. doi:10.1111/j.1360-0443.2011.03601.x
 12. Harm Reduction Principles. National Harm Reduction Coalition. Accessed June 1, 2023. <https://harmreduction.org/about-us/principles-of-harm-reduction/>
 13. Singh GK, Kim IE, Girmay M, et al. Opioid Epidemic in the United States: Empirical Trends, and A Literature Review of Social Determinants and Epidemiological, Pain Management, and Treatment Patterns. *Int J Matern Child Health AIDS.* 2019;8(2):89-100. doi:10.21106/ijma.284
 14. Rambachan A, Fang MC, Prasad P, Iverson N. Racial and Ethnic Disparities in Discharge Opioid Prescribing From a Hospital Medicine Service. *J Hosp Med.* 2021;16(10):589-595. doi:10.12788/jhm.3667
 15. Chang JE, Franz B, Cronin CE, Lindenfeld Z, Lai AY, Pagán JA. Racial/ethnic disparities in the availability of hospital based opioid use disorder treatment. *J Subst Abuse Treat.* 2022;138:108719. doi:10.1016/j.jsat.2022.108719

at this time. If legislation were enacted to allow a pharmacist to obtain their own DEA license, this would decrease the prescribing burden for collaborating physicians for pain and OUD medication management services.

Providing adequate compensation for pharmacies providing this service to support pharmacist time preparing for and providing care is essential. Pharmacists would benefit from protected time to provide comprehensive medication management services that include opioid tapering preparation and support.

Site infrastructure that supports private telephone, video, or in-person visits is important to create an ideal environment for provision of care and a safe space for conversation about potentially stigmatized content.

Providing adequate compensation for pharmacies providing this service to support pharmacist time preparing for and providing care is essential

STORIES

As a pharmacist practitioner who often utilizes MI skills to discuss treatment enhancement opportunities in the treatment of mental health and substance use disorders, I have found it helpful for garnering engagement in many types of medication changes, including controlled substance medication tapering or reduction. I find that using MI helps me to build trust and mutual respect, so that we can work together to meet the patient's health goals and enhance safety. I have had patients tell me that they had not felt heard or felt judged in other settings and I believe that using MI helped them feel more open to share their potentially stigmatizing health information with me and stay engaged in their care plan. As a pharmacist provider, I also feel that using MI techniques helps to reduce my sense of burnout because it allows me to meet the patient where they are at, and the MI philosophy involves a shared sense of responsibility for treatment progress with the patient.

RACIAL DISPARITIES IN PAIN MANAGEMENT

Contributed by: Diane Johnson, PharmD, BCPS

With special thanks to Anna Marceau, PharmD and William Peppard, PharmD, BCPS, FCCM

Chronic pain affects nearly one hundred million Americans and costs the United States about \$365 billion annually. However, the burden of chronic pain is not equally distributed across racial and ethnic groups, with non-White groups being disproportionately affected. While it is also notable that most published literature focuses on Black, Hispanic and non-Hispanic White individuals, unfortunately harmful stereotypes persist in which non-White patients are thought of as experiencing less severe pain. The consequence is that non-White individuals are less likely to receive a comprehensive diagnostic and treatment approach to managing pain.¹

This and other historical falsehoods have contributed to on-going disparities in pain management. In the 19th century, Black individuals were thought to be more tolerant to pain and were therefore not provided with the same amount of anesthetics or analgesics prior to treatment, if offered at all. Other examples of the century include World War II in which Black soldiers were used for chemical testing, and the Tuskegee Institute's study of untreated syphilis in Black men even after treatment was discovered.²

Considerations for disparities should be included across the assessment, treatment, and management of pain in any clinical setting, not only within the emergency room or peri-operative care. As previously mentioned, non-White patients are less likely to receive analgesics, let alone opioids, and they are also less likely to be admitted following an emergency room visit.¹ For example, one study found that Black children were only one-fifth as likely to receive opioids as White children following emergency appendectomies.³ Other studies have shown that prescriptions for opioid analgesics are more likely to be given to White patients than Black patients.⁴

Considerations for disparities should be included across the assessment, treatment, and management of pain in ANY clinical setting

ABATEMENT STRATEGIES TO CONSIDER

It is important to recognize the factors that can contribute to racial and ethnic disparities in pain management. Recognizing these factors will enable pharmacists to shape responses that do not unintentionally perpetuate harm, as well as to identify when stereotypes may be preventing a patient from receiving equitable care.

1. Meints SM, Cortes A, Morais CA, Edwards RR. Racial and ethnic differences in the experience and treatment of noncancer pain. *Pain Manag.* 2019;9(3):317-334.
2. Hoffman KM, Trawalter S, Axt JR, et al. Racial bias in pain assessment and treatment recommendations, and false beliefs about biological differences between blacks and whites. *PNAS.* 2016, 113(16):4296-4301.
3. Mende-Siedlecki, P, Qu-Lee J, Backer R, et al. Perceptual contributions to racial bias in pain recognition. *J. Exp. Psychol. Gen.* 2019;148(5):863-889.
4. Morden NE, Chyn D, Wood A, et al. Racial inequality in prescription opioid receipt – role of individual health systems. *N Engl J Med.* 2021;385:342-51.

Pharmacies can identify when a patient may be experiencing biased treatment and advocate as appropriate for needed resources. Patient factors to consider might include: patient coping skills and catastrophizing, stoicism, patient preferences/expectations, and health literacy.¹ Staff can ensure that the patient has received the appropriate work-up and that the medications and treatments that are accessible and offered in alignment with appropriate guidelines and patient preferences. Then, staff ought to identify if there are social determinants of health that need to be improved to enhance treatment fidelity, as this in turn helps pain management outcomes. This could involve referral to community organizations and resources for access to healthy food, medical interpreters, patient advocates, or transportation. Due to the greater risk for non-White patients to be non- or under-insured, pharmacy staff ought to be cognizant to offer alternate treatment options that are more affordable or better connect with the patient, when needed.

More generally, all healthcare providers need to be aware of their current implicit and explicit biases. Ensure that false beliefs regarding pain or medication use are not perpetuated and are appropriately corrected. If patients feel that they are not believed regarding their pain experience, or if their pain is not recognized by the healthcare team, they will be left undertreated.^{2,3,5}

Pharmacies need to ensure appropriate access to (i.e., supply for) analgesics and harm reduction materials. It has been reported that only 25% of pharmacies in predominately non-White neighborhoods had sufficient opioids in stock, compared with 72% in White neighborhoods.¹

In summary, pharmacies and health systems should ensure that diversity, equity, and inclusion are a prominent part of their strategic plan. At the individual-level, promoting training for staff with regards to decreasing bias and understanding cultural differences is one effective strategy. Another is recognizing biases and disparities in treatment in order to identify additional resources that may be needed to support related social determinants of health and that the treatment planned is accessible and affordable. At the pharmacy-level, individual sites can review their prescription information to identify differences between racial and ethnic groups, ensuring to account for confounding variables such as comorbidities. They can also look for gaps in care with various painful disease states and consider specific outreach to local high burden, minority communities. Finally, yet importantly, promoting diverse employee recruitment ensures more groups are adequately represented in a given practice setting.

RESOURCE AND FUNDING CONSIDERATIONS

Many resources to increase cultural awareness and understanding biases are free of charge, such as [Test Your Implicit Bias - Implicit Association Test \(IAT\) - Loyola Marymount University \(lmu.edu\)](https://www.lmu.edu/~psych/implicit/). This can be used to help start discussions and allow individuals to recognize where they need to make personal improvements. A cost consideration would be to allow staff time to attend cultural awareness and bias trainings or bring in experts to provide staff trainings. Free content exists online on various platforms, such as YouTube, Ted Talks, and podcasts. Local experts exist who may be willing to come to lead a group discussion or presentation on this topic. Potential speakers include physicians, clinical and public health researchers,

5. Todd KH, Deaton C, D'Adamo AP, et al. Ethnicity and analgesic practice. *Ann Emerg Med.* 2000;35(1):11–16.

6. Peppard WJ, Sheldon H, Endrizzi S, et al. Racial equity in opioid prescribing: a pharmacist-Led multidisciplinary health system assessment. *J Am Coll Clin Pharm.* 2022;5:959–973.

nurses, community organizations focused on opioid misuse prevention and intervention, health department officials, fire departments, etc. Note that there could be a cost associated with conducting research in your own institution regarding pain management disparities and implementation of strategies to improve these.

STORIES

A recent publication suggested inequity in opioid prescription rates for Black and White patients among 310 large and racially diverse health systems, including Froedtert & the Medical College of Wisconsin (F&MCW).⁴ This prompted F&MCW to further investigate its own opioid prescription data.⁶ Pharmacists have led similar investigations to evaluate racial inequities in health care, and are well positioned to assess opioid prescribing. The racial differences in opioid prescribing observed in unadjusted and partially adjusted analyses were primarily due to higher rates of key comorbidities in non-Hispanic Black patients rather than race. While this analysis demonstrates the importance of adjusting for relevant confounding variables before drawing conclusions for differences in care between patient populations, it did raise additional questions and identified opportunities for further investigation. This serves as a model for how pharmacists can use their position and skill set to take a leading role in such assessments.



HARM REDUCTION

Contributed by: Matthew Stanton, PharmD, BCPS, DABAT

There is a continuum of care for patients with opioid use disorder (OUD), and harm reduction is a vital building block to that care.¹ Consider harm reduction as the umbrella that may serve as resources in caring for patients with OUD. It includes engaging patients with OUD to minimize harms, such as overdose and infection, while maximizing their physical, mental, and social well-being with treatment options.² Given the vast description, several opportunities exist to offer harm reduction resources, which may be offered as services or supplies. Services may include, but are not limited to, overdose education and naloxone training, or hepatitis and HIV prevention and treatment services. Supplies may include medications for opioid use disorder (MOUD), naloxone dosage forms, clean syringes and needles, substance-testing kits, or wound care materials. Each potential resource is intended to lessen the harm for patients with OUD, whether used separately or as a bundle of care. The [Wisconsin Department of Health Services](https://www.dhs.wisconsin.gov/opioids/safer-use.htm) (DHS) supports efforts in harm reduction and safe use of drugs.³ With any potential harm reduction service offering, collaboration with DHS should be sought in efforts to streamline or target resources and to avoid duplicate work.

ABATEMENT STRATEGIES TO CONSIDER

Ample opportunities exist for pharmacies to offer harm reduction resources. First, pharmacists are one of the most accessible and trusted healthcare providers, which makes spearheading opportunities for harm reduction ideal for the profession.⁴ Historically, treatment for OUD has been focused on specialized prescribers and other psychiatric services, though more recent efforts have evaluated pharmacist services in providing harm reduction resources.⁵ Second, collaboration between pharmacists and providers prescribing buprenorphine may result in high retention and adherence rates in managing patients with OUD, and high patient satisfaction.⁶ With the Drug Enforcement Administration (DEA) and the Substance Abuse and Mental Health Administration (SAMHSA) eliminating the requirements related to the X-waiver for buprenorphine prescribing in 2023, increased collaboration efforts with practitioners should be sought in attempt to ease access to MOUD. While methadone prescribing for OUD has historically been dispensed exclusively by methadone treatment programs, a small feasibility study found that collaboration between pharmacists and physicians dispensing take home methadone is associated with high 3-month retention rates and 100% medication adherence.⁷ Also, occurring in 2023 was the Food and Drug Administration (FDA) approval

1. Harm Reduction. Department of Health and Human Services. Accessed October 11, 2022. <https://www.hhs.gov/overdose-prevention/harm-reduction>
2. Harm Reduction. Substance Abuse and Mental Health Service Administration. Updated August 16, 2022. Accessed October 11, 2022. <https://www.samhsa.gov/find-help/harm-reduction>
3. Safer Use/Harm Reduction. Wisconsin Department of Health Services. Updated October 12, 2022. Accessed October 27, 2022. <https://www.dhs.wisconsin.gov/opioids/safer-use.htm>
4. Blank C. Pharmacists top most trusted professionals in Gallup poll. Drug Topics. January 10, 2020. Accessed October 27, 2022. <https://www.drugtopics.com/view/pharmacists-top-most-trusted-professions-gallup-poll>
5. Bach P, Hartung D. Leveraging the role of community pharmacists in the prevention, surveillance, and treatment of opioid use disorders. *Addict Sci Clin Pract*. 2019;14(1):30. Published 2019 Sep 2. doi:10.1186/s13722-019-0158-0
6. Wu LT, John WS, Ghitza UE, et al. Buprenorphine physician-pharmacist collaboration in the management of patients with opioid use disorder: results from a multisite study of the National Drug Abuse Treatment Clinical Trials Network. *Addiction*. 2021;116(7):1805-1816. doi:10.1111/add.15353
7. Wu LT, John WS, Morse ED, et al. Opioid treatment program and community pharmacy collaboration for methadone maintenance treatment: results from a feasibility clinical trial. *Addiction*. 2022;117(2):444-456. doi:10.1111/add.15641

of over the counter (OTC) naloxone. While the cost to patients may vary across geographical areas, pharmacies are encouraged to have the product available. In Wisconsin, OTC availability supplements the existing standing order for pharmacist naloxone prescribing, thus increasing patient access. Lastly, for any prescribed opioid analgesic, new legislation by the FDA requires manufacturers to make prepaid mail-back envelopes available to outpatient pharmacies as an additional opioid disposal option for patients. Given these amenities, as well as supply dispensing, pharmacies have the potential to be a “one-stop shop” for many harm reduction resources.

EQUITY CONSIDERATIONS

Like many aspects of healthcare, harm reduction resources are not immune from inequity. Providing equitable harm reduction has a long and troubling history of underperformance, but emerging data in this area are encouraging. In the US, the overdose epidemic has disproportionately affected Black and American Indian people, as well as other racial and ethnic minority groups.⁸ From 2012 through 2018, opioid-involved overdose deaths in Black patients has outpaced overdose deaths in White patients.⁹ Black and Hispanic people who use drugs are less likely to have received or used naloxone, received overdose prevention training, and obtain a naloxone refill compared to White people who use drugs.⁸ Opioid overdose is also the leading cause of death immediately after the release of people from jail or prison.¹⁰ Providing MOUD for these patients is associated with an 80% reduction in overdose mortality risk in the first month post-release. Regardless of circumstances, there is a growing need to target these underrepresented populations, which may include focusing harm reduction resources in certain geographical areas, or at certain institutions such as jails, prisons, homeless shelters, and federally qualified health centers. Ideally, with the elimination of the X-waiver and OTC naloxone availability, focus on increased access to MOUD for historically underserved populations should be targeted.

RESOURCE AND FUNDING CONSIDERATIONS

Several resources and monetary needs would need fulfillment to implement and expand harm reduction resources for pharmacies. Over the last several decades, community pharmacists have shouldered increased responsibilities including medication therapy management, point-of-care testing, and vaccine administration, in addition to their conventional dispensing and management responsibilities. With these trends of increased pharmacy workloads, significant efforts would be needed to successfully incorporate a sustainable pharmacy model for harm reduction implementation. Resources and funding considerations for harm reduction services would include:

- Pharmacist personnel
- Pharmacy technician personnel
- Point-of-care testing for infectious diseases

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8. Lopez AM, Thomann M, Dhatt Z, et al. Understanding Racial Inequities in the Implementation of Harm Reduction Initiatives [published correction appears in Am J Public Health. 2022 Jun;112(6):e2]. Am J Public Health. 2022;112(S2):S173-S181. doi:10.2105/AJPH.2022.306767
 9. Furr-Holden D, Milam AJ, Wang L, Sadler R. African Americans now outpace whites in opioid-involved overdose deaths: a comparison of temporal trends from 1999 to 2018. Addiction. 2021;116(3):677-683. doi:10.1111/add.15233
 10. Lim S, Cherian T, Katyal M, et al. Association between jail-based methadone or buprenorphine treatment for opioid use disorder and overdose mortality after release from New York City jails 2011-2017 [published online ahead of print, 2022 Oct 28]. Addiction. 2022;10.1111/add.16071. doi:10.1111/add.16071

- Training time for pharmacy personnel
- Education time for patients

Resources for supplies would also need to be considered, above current inventory needs, including:

- Syringes
- Needles
- Alcohol swabs
- Wound care materials
- Advertising
- Opioid mail-back envelopes



Medications available for dispensing are another modality of harm reduction. Medications may include treatment of patients with OUD and treatment or prevention of infectious disease complications.

Medications to treat OUD:

- Buprenorphine with or without naloxone
- Naltrexone

Infectious disease treatment and prevention:

- Emtricitabine/tenofovir
- Dolutegavir
- Raltegravir

While some of these harm reduction resources are already available at pharmacies, additional effort would be needed to execute each of these harm reduction resources to maximize benefit to the targeted population. The fixed and variable costs concerning each resource may differ based on geographical area, so an evaluation of current needs should be considered.

STORIES

As an emergency medicine pharmacist and clinical toxicologist, I care for patients presenting with a multitude of needs, both with and without OUD. First, working in emergency medicine, patients with OUD are too often cared for due to an acute opioid overdose. Our multidisciplinary approach to care includes access to naloxone and buprenorphine induction at no cost to the patient, as we are connecting them with other substance use disorder services. Second, patients may seek care due to complications from OUD. This includes management of infectious complications from injection drug use or for management of opioid withdrawal syndrome. Lastly, as a toxicologist through a regional poison center, I see the effects from opioid overdose and withdrawal. I hear about many patients annually who intentionally and/or unintentionally overdose on prescription or non-prescription opioids, both adults and pediatrics. Not every patient who experiences an overdose may need every aspect of harm reduction; however, some resources may be helpful for patients with and without OUD, such as overdose training and naloxone prescriptions.

DOSE OF REALITY & REAL TALKS WISCONSIN

Contributed by: Danielle M. Womack, MPH

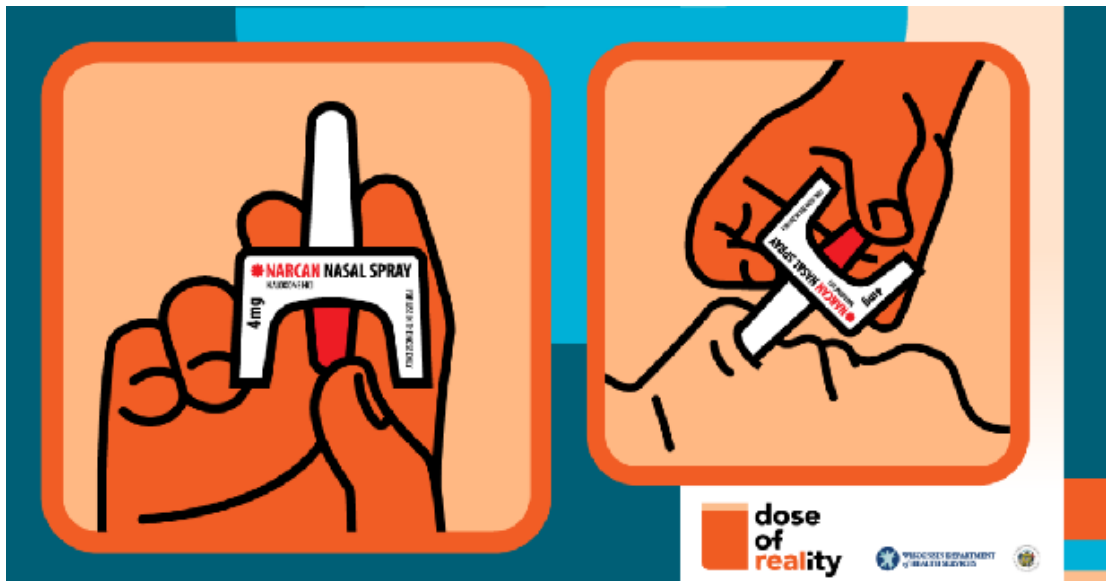
The Wisconsin Department of Health Services leads the [Dose of Reality](#) program that provides information to healthcare providers and patients about prescription pain relievers, fentanyl, and heroin misuse and abuse.¹

The Dose of Reality program offers resources for professionals,² including tips for talking to patients and guidance for prescribers and pharmacists, as well as media materials, including flyers, online images, posters, and social media posts.³ These materials can be sent to pharmacies free of charge for display or distribution to patients. Many materials focus on Drug Take Back Day, but other materials are relevant and available year-round.

The Wisconsin Department of Health Services also hosts a program, titled [Real Talks Wisconsin](#), designed to provide tools for conversations about substance abuse.⁴ Pharmacists may find these resources beneficial if they are unsure how to talk to patients about substance abuse.

RESOURCE AND FUNDING CONSIDERATIONS

All Dose of Reality and Real Talks Wisconsin resources are free to all pharmacies in Wisconsin.



1. Dose of reality: Opioids in Wisconsin. Wisconsin Dept of Health Services. Updated June 28, 2023. Accessed July 3, 2023. <https://www.dhs.wisconsin.gov/opioids/index.htm>.
2. Dose of reality: Resources for professionals. Wisconsin Dept of Health Services. Updated June 19, 2023. Accessed June 30, 2023. <https://www.dhs.wisconsin.gov/opioids/professionals.htm>.
3. Dose of reality: Partner materials. Wisconsin Dept of Health Services. Updated April 24, 2023. Accessed July 3, 2023. <https://www.dhs.wisconsin.gov/opioids/professionals.htm>.
4. Real Talks Wisconsin: Change the conversation on substance use. Wisconsin Dept of Health Services. Updated June 28, 2023. Accessed July 3, 2023. <https://www.dhs.wisconsin.gov/real-talks/index.htm>.

USING THE ePDMP AS A CLINICAL TOOL

Contributed by: Danielle M. Womack, MPH

In addition to specific requirements pharmacies must follow relating to uploading data to the Wisconsin Enhanced Prescription Drug Monitoring Program (ePDMP),¹ the ePDMP also provides a multitude of clinical tools that pharmacies can use to assist in opioid stewardship. Data-driven alerts that present on the patient report when processing a query include: 1) concurrent benzodiazepine and opioid prescriptions, 2) long-term opioid therapy with multiple prescribers, 3) high daily dose of opioids, 4) early refill, 5) multiple prescribers or pharmacies, and 6) multiple same day prescriptions.² The intent is to alert ePDMP users to potential indicators of abuse, diversion, or overdose risk. Of note, methadone prescribed to treat opioid use disorder (for example, regimens managed by opioid treatment programs or methadone clinics) is not recorded in the ePDMP.

ABATEMENT STRATEGIES TO CONSIDER

Pharmacists and pharmacist delegates can review patient history via the ePDMP to look for concerning activities such as repeated early/late refills, multiple prescribers, multiple pharmacies, and multiple same-day or same-week prescriptions. Law enforcement alerts, such as arrests for unlawful possession, reports of theft, and overdose reports are also included.

Each scenario presents an opportunity to make an intervention or prevention. Early refills may indicate overuse, whereas late refills might indicate a dose exceeds the patient's needs or that the patient may be experiencing adverse events preventing them from taking the medication as prescribed.

Pharmacists and pharmacist delegates can also screen for high-alert regimens, such as long-term opioid therapy, high daily doses of opioids, and opioids concurrently prescribed with benzodiazepines or sedating medications. These are opportunities to implement risk mitigation strategies such as co-prescribing



1. Prescription Drug Monitoring Program (PDMP) - Wisconsin. Wisconsin Dept of Safety and Professional Services. Accessed June 26, 2023. <https://pdmp.wi.gov>.
2. Prescription Drug Monitoring Program (PDMP) - Wisconsin. Controlled Substances Board Report 24: 2023 Quarter 1 Summary. Wisconsin Dept of Safety and Professional Services. Accessed July 5, 2023. <https://dsps.wi.gov/Documents/BoardCouncils/CSB/WIePDMPReport2023Q1.pdf>.

an opioid antagonist (e.g., naloxone) or discussing weaning/discontinuation of concomitant benzodiazepines or sedating medications with the prescribing provider. Discontinuation of these medications may prompt a discussion with patients on how to dispose of unused medications safely.

The ePDMP provides several training documents and videos.³ The ePDMP also offers free Electronic Healthcare Record (EHR) integration, providing users with one-click access to monitored prescription drug history reports about patients.⁴

RESOURCE AND FUNDING CONSIDERATIONS

Complete ePDMP access is free to all pharmacies in Wisconsin. However, integration of checking ePDMP as part of the routine workflow will require time due to the need to develop policies, procedures, and training for site staff. A plan for education and training on what to do with the information being obtained needs to address the concerns identified without jeopardizing patient care, safety, or confidentiality. Pharmacy technicians are able to receive delegate access linked from a pharmacist account. Additionally, once operationalized, pharmacies should consider the time it takes to review a patient's ePDMP record before dispensing a monitored substance.

A plan for education and training on what to do with the information being obtained needs to address the concerns identified without jeopardizing patient care, safety, or confidentiality

STORIES

The quarterly Wisconsin Controlled Substances Board Report of the Wisconsin ePDMP summarizes encouraging trends identified across monitored prescription drugs. The report from first quarter of 2023 identified a decrease in overall dispensing of the most prescribed opioids and benzodiazepines, including largest decreases in the dispensing of oxycodone/acetaminophen, tramadol, and hydrocodone/acetaminophen. Additionally, it highlighted the inclusion of buprenorphine-naloxone in the top 15 dispensed monitored prescription drugs; a positive trend with respect to medication-assisted treatment for opioid use disorder.²

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3. Training Materials. Prescription Drug Monitoring Program (PDMP) - Wisconsin. Wisconsin Dept of Safety and Professional Services. Accessed June 26, 2023. <https://pdmp.wi.gov/training-materials>.
 4. EHR Integration Services. Prescription Drug Monitoring Program (PDMP) - Wisconsin. Wisconsin Dept of Safety and Professional Services. Accessed July 2, 2023. <https://pdmp.wi.gov/ehr-integration-services>.

OPIOID DASHBOARDS

Contributed by: Nicole Green, RPh, BSP, DPLA

Dashboards have gained popularity as a means of presenting integrated, recent visual representations of information generated by patients and clinicians. They consolidate various data such as patient needs, goals, and interventions in real-time. Dashboard use has shown promising results in enhancing knowledge, promoting better health outcomes, and improving the delivery of healthcare in many sectors.¹ To support your work and describe the needs in your community, there are dashboards at state² and national³ levels that contain opioid-related data and quality metrics. Filtering these dashboards allows for a more focused view of your patient population of interest at the state or county level.

Further, an organizational opioid dashboard provides an overview of your patient population, an understanding of current state that reveals gaps and opportunities, and allows for monitoring of progress. A dashboard should provide population, provider, and patient level data to support identification of needs, outreach, and ultimately track progress. Dashboards are customizable to your needs and should align with the metrics important to your quality improvement work and your organization.

ABATEMENT STRATEGIES TO CONSIDER

Pharmacies in many settings may be able to feed EHR and/or pharmacy data into a dashboard to guide practice for their particular care setting and patient population. Hospital settings provide valuable information regarding ED visits related to overdose or medications such as opioids and/or benzodiazepines that may contribute to a patient's risk of falling. Pharmacists practicing in ambulatory care roles, such as primary care clinics, can collaborate in patient care to identify patients at risk of an overdose and ensure patients and their family members have naloxone. They may also assist in opioid or benzodiazepine taper regimens. Pharmacists in community pharmacy settings are able to use an opioid dashboard to ensure that at risk patients are not only identified for naloxone, but also to assist in reducing or eliminating barriers such as stigma or affordability.

It is important to do a current state assessment of your prescribing patterns and in, many circumstances, the workflow around prescribing or monitoring of patients who are prescribed opioids. This will ensure that you have an upfront idea of what you want to track, the workflows that may be required in order to accurately track the information and the ability to challenge the data once it populates. In order to get accurate data, you may need to clean up other supporting processes. For example, if your dashboard is specific to patients who use opioids chronically, you will need to ensure a workflow step to include appropriate end dates for short term opioid

1. Dowding D, Randell R, Gardner P, et al. Dashboards for improving patient care: review of the literature. *Int J Med Inform.* 2015;84:87–100. doi:10.1016/j.ijmedinf.2014.10.001.
2. Dose of reality: Opioid Data. Wisconsin Dept of Health Services. Updated June 5, 2023. Accessed July 3, 2023. <https://www.dhs.wisconsin.gov/opioids/data-reports-studies.htm>.
3. The drug overdose epidemic: Behind the numbers. Centers for Disease Control and Prevention. Updated May 8, 2023. Accessed July 3, 2023. <https://www.cdc.gov/opioids/data/index.html>.

prescriptions during prescription order entry and medication reconciliation. You will want to determine how intermittent/infrequent prescriptions attribute to your dashboard. Remember that dashboards are often 'live' and the data updates as metrics change. This means that you may need to save reports of your progress so that you can show improvement over time. Interventions can range from presentations to individualized Academic Detailing visits to referrals.

Be sure to track dates of interventions so that you can make the connections between improvements and interventions.

Dashboards can also provide guidance on where to start. You may decide that you have limited resources and you can start your outreach in the area of greatest need/impact. Your dashboard may also reveal opportunities to do pilots to assess what works and what could be revised in your intervention. Remember to look at both the percentage and numbers! Looking at either alone may underscore the true impact you have made.

EQUITY CONSIDERATIONS

Dashboards support a broad overview of your population and the particular metric that you are looking to monitor and track, as well as real-time surveillance. Looking at your data will allow you to identify where the gaps have not been closed and where a deeper dive may be needed. By applying filters within your dashboard, such as prescriber, clinic location or even geographic location, you may uncover trends to help better understand where you need to shift your focus, do deeper outreach or provide more one-to-one outreach and education.

Having varied and multiple metrics within your dashboard will support the deeper understanding that may be needed to truly impact patients within your dashboard who are not experiencing the same quality improvement gains as others. Consider what unique needs or characteristics are present in your sub-populations that are not making the same improvements as others.

RESOURCE AND FUNDING CONSIDERATIONS

Existing state and national dashboards are free and public. This may be a useful place to begin to better understand recent priorities within your state and county. If pursuing an integrated dashboard within a pharmacy, clinic, hospital, or health-system, a multi-disciplinary team of clinicians and informatics professionals is a great way to start this initiative! Be sure to define your shared goals, metrics (measures of success), stakeholders and communication plan early on. This will ensure that your dashboard aligns with your goals and keeps you on track. Your goals could align with your organization, with clinical guidelines, and/or community needs.

The ideal dashboard will gather data from multiple data points, bringing them together for a single view and be supported by your informatics team with ongoing support through the testing phases. Though there is certainly testing and build considerations prior to go live, the issues often don't fully present themselves until you roll it out. You will want to plan for continued support for some time after you go live, and for ongoing maintenance.

Dashboard specifics will vary depending on your practice setting and the data that is available to you for incorporation. Consider the following data pieces to support your specific patient identification and outreach needs:

- ePDMP
- Morphine Equivalent Daily Dose (MEDD) or Morphine Milligram Equivalents (MME)/day
- Coverage or payment methods
- Drug interactions
- Drug combinations that increase the risk of an opioid-related adverse event

To move this initiative forward, it will require ownership (e.g., dedicated staff, opioid stewardship team) and support for their time will be important for continued success. Opioid related initiatives can be complex and require supplemental resources such as policies and procedures, treatment recommendations, and pain management care plans; staff education and patience are also needed. Depending on patient characteristics, tapers for example, may take months to complete. If you set a goal with insufficient time, you may not see that progress is occurring.

STORIES

Our team of ambulatory pharmacists, embedded in family medicine clinics across ThedaCare, are committed to driving improvements in Opioid Stewardship initiatives. We defined our bold aim metrics related to naloxone (education, prescription and access), assistance in tapering opioids and/or benzodiazepines as well as, reduction in benzodiazepine co-prescription.

Patient co-morbidities, such as sleep apnea, obesity or depression, in addition to medication factors including MEDD, use of 'Z drugs' or other sedating medications, increases the risk of overdose. The risk significantly increases when opioids and benzodiazepines are used together. Our team of ambulatory pharmacists chose this as one of our metrics to improve the health of our community.

Using formal education through CME presentations, as well as Academic Detailing visits individually with providers, we shared best practices to limit and regularly review the use of these medications together. We also offered to assist with tapering patients off either medication, once the provider has initiated that conversation. Within one year of project implementation, there were 144 fewer patients receiving both opioids and benzodiazepines. The majority of these involved a referral to the ambulatory pharmacist.

Tapering patients takes time and commitment. It takes time to have mindful and individualized conversations, to have timely follow up after each dose reduction and to confirm readiness for the next step. This is difficult to accomplish within a typical provider visit; as pharmacists we offered a unique partnership with incredible value to our clinicians and to our patients.

Additional Resources

1. Trends in nonfatal and fatal overdoses involving benzodiazepines – 38 states and the District of Columbia 2019-2020. *MMWT* 2021;70(34):1136-1141
2. Combining opioids and benzodiazepine: effects on mortality and severe adverse respiratory events. *Annals of Palliative Medicine* 2020;9(2):542-557
3. Prescribing Opioids for Pain-The New CDC Clinical Practice Guideline. *N Engl J Med* 2022; DOI; 10.1056/NEJMp2211040
4. National Institute on Drug Abuse, National Institutes of Health. <https://nida.nih.gov/> Accessed June 22, 2023.

ELECTRONIC HEALTH RECORD (EHR) BEST PRACTICE ALERTS (BPA)

Contributed by: Tyler J. Prickette, PharmD, BCPS, Martha A. Maurer, PhD, MPH, MSSW

Electronic Health Record (EHR) Best Practice Alerts (BPAs) are defined as clinical decision support (CDS) tools embedded in the EHR. BPAs alert clinicians about patients who meet specified criteria for being at risk for negative health outcomes or for being a good candidate for a particular intervention or treatment.¹ BPAs have demonstrated effectiveness in varied areas of clinical practice including improving hypertension control, reducing repetitive lab testing, and evidence-based screening in pediatric diabetes care.²⁻⁴

Efforts to optimize opioid prescribing can be challenging to implement because of the difficulty in providing prescribers with information about patients' past drug use patterns and other risk factors to inform prescribing decisions. Prescribers often do not have the bandwidth to obtain and integrate all relevant patient information necessary for optimally informing their prescribing decisions. Developing BPAs that are integrated into EHRs automates a cognitively complex and sometimes data scarce process for the prescriber in real-time. This can also facilitate the sharing of information throughout the health system. BPAs embedded in EHRs have been shown to optimize opioid prescribing and dispensing.⁵⁻⁷

Examples of opioid-related clinical scenarios commonly addressed by BPAs within EHRs include: 1) prescribing or discussing naloxone, 2) high-dose morphine milligram equivalent (MME) dosages, 3) opioid and benzodiazepine co-prescribing, and 4) opioid treatment agreements. Opioid-related BPAs are often informed by and designed to be consistent with national authoritative opioid prescribing guidelines, such as the Centers for Disease Control and Prevention (CDC) guidelines or state medical examining board guidelines.⁸

Similar to the BPAs found in acute care EHRs, community pharmacy sites may receive BPAs that can enhance patient care at the point of medication consultation and dispensing.

1. Fry C. Development and evaluation of best practice alerts: Methods to optimize care quality and clinician communication. *AACN Adv Crit Care* 2021;32(4):468-472. doi:10.4037/aacnacc2021252
2. Swedlund M, Norton D, Bristler J, Chen G, Cruz L, Hanrahan L. Effectiveness of a best practice alert at improving hypertension control. *Am J Hypertens* 2019;32(1):70-76. doi:10.1093/ajh/hpy155
3. Bejjanki H, Mramba LK, Beal SG, et al. The role of a best practice alert in the electronic medical record in reducing repetitive lab tests. *ClinicoEcono Outcomes Res* 2018;10:611-618. doi:10.2147/CEOR.S167499
4. DeSalvo D, Bartz SK, Mockler B, Sonabend RY. Use of best practice alerts to improve adherence to evidence-based screening in pediatric diabetes care. *Journal of Nursing & Interprofessional Leadership in Quality & Safety*. 2018;2(1). Retrieved from <https://digitalcommons.library.tmc.edu/uthoustonjquasafe/vol2/iss1/7>
5. Duan L, Lee MS, Adams JL, Sharp AL, Doctor JN. Opioid and naloxone prescribing following insertion of prompts in the electronic health record to encourage compliance with California state opioid law. *JAMA Netw Open* 2022;5(5):e229723. doi:10.1001/jamanetworkopen.2022.9723
6. Malte CA, Berger D, Saxon AJ, et al. Electronic medical record alert associated with reduced opioid and benzodiazepine co-prescribing in high-risk veteran patients. *Med Care* 2018;56(2):171-178. doi:10.1097/MLR.0000000000000861
7. Coffman R, Johnson A, Frede S, Pleiman M, Johnson K. The evaluation of mandatory alerts on long-acting opioid prescriptions and the use of a community pharmacy naloxone protocol. *J Am Pharm Assoc* 2021:S1544-3191(21)00493-3. doi:10.1016/j.japh.2021.11.032
8. Dowell D, Ragan KR, Jones CM, Baldwin GT, Chou R. CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States, 2022. *MMWR Recomm Rep* 2022;71(No. RR-3):1-95. DOI: <http://dx.doi.org/10.15585/mmwr.rr7103a1>

ABATEMENT STRATEGIES TO CONSIDER

Health system pharmacy teams are ideally positioned to lead or guide the implementation of opioid-related BPAs within their health system's EHR. Pharmacists play a critical role in initiating and implementing these types of BPAs in EHRs and are effective at optimizing opioid prescribing practices consistent with evidence-based clinical guidelines (e.g., [Centers for Disease Control Guidelines for Prescribing Opioids for Chronic Pain](#)).⁹

The pharmacy team will need to collaborate with information technology colleagues and potentially with the EHR software vendor to integrate these new functionalities into the EHR system. This will likely require multiple quality improvement assessment cycles that involve the gathering and incorporation of feedback from end-users.

Establishing a new BPA within an EHR will require educating prescribers and staff about the new workflow and its implications for the patient-centered treatment plan.

EQUITY CONSIDERATIONS

The CDC acknowledges that health inequities may contribute to increased opioid overdose deaths and other negative opioid-related health outcomes. The CDC lists potential populations who may be disproportionately affected by the drug overdose crisis; these populations include, but are not limited to, persons who are:¹⁰

- Disadvantaged by reduced economic stability
- Experiencing disabilities, homelessness, mental health conditions, or incarceration
- Those with limited educational attainment, limited access to healthcare, limited health literacy, and/or limited access to substance use treatment
- From a non-English speaking population, tribal population, rural communities, or from a geographically underserved area
- From a racial and ethnic minority group
- From a sexual and gender minority group

In general, BPAs are intended to promote a standardized delivery of healthcare, which in theory should support health equity. For example, there was a disparity in the sex and race of patients who were being offered a particular heart therapy, with fewer female patients and fewer Black patients being offered the therapy. An automated BPA for this heart therapy was implemented and demonstrated that a BPA embedded into the EHR, which was activated at the point of care based on objective patient data, altered provider's clinical decision behaviors and reduced the race and sex-based disparities that existed among those who were offered the heart therapy. This is an example of how a BPA which is informed by guideline recommendations can be a real-time reminder to providers about best practices for all patients, therefore enhancing standardization of healthcare delivery and reducing health disparities and improving health equity.¹¹

BPAs are intended to promote a standardized delivery of healthcare, which in theory should support health equity

9. Coughlin DJ, Gainor C, Gaston CL, et al. The opioid abuse and misuse epidemic: implications for pharmacists in hospitals and health systems. *Am J Health Sys Pharm* 2014;71(18):1539-1554. doi:10.2146/ajhp140157

10. Promoting health equity. Centers for Disease Control and Prevention. Published November 12, 2021. Accessed December 6, 2022. <https://www.cdc.gov/drugoverdose/health-equity/info.html>.

11. Thalappillil A, Jackson A, Althouse A, et al. Impact of an automated best practice alert on sex and race disparities in implantable cardioverter-defibrillator therapy. *J Am Heart Assoc* 2022;11(7):e023669. <https://doi.org/10.1161/JAHA.121.023669>

BPAs integrated into EHRs, such as those meant to identify patients who would benefit from naloxone, serve to facilitate expanding access to naloxone. Such expansion of naloxone should include marginalized groups and promote health equity. However, drug use is often stigmatized and provider education may need to address providers' implicit biases about drug use, race, gender, and socioeconomic status. BPAs can also provide information on access to care in addition to more uniform care, assisting with addressing any social determinants of health that could impact access to a medication or service.

The [Health Equity in the Response to Drug Overdose](#) webpage provides resources (e.g., reports, frameworks, guidance, and resource repositories from local, state, and national entities) on health equity in the drug overdose response. These tools and resources can assist health systems consider root causes of health inequities across populations and the interconnected system of upstream inequities when addressing drug overdoses in their communities.

RESOURCE AND FUNDING CONSIDERATIONS

Many EHR systems have built-in opioid-related BPAs that health systems and/or pharmacies can choose to activate. In some cases, there may be an additional cost to purchase a module or package with the opioid-related BPA functionality. In other cases, EHR vendors may offer the BPA functionality free of charge.

The process of implementing the BPA will require staff time to work through testing the technology and functionality of the alert so that it is customized to that particular healthcare setting. Additional staff time will also be needed to develop training materials and conduct provider education leading up to the launch of the BPA.

If there is already a pharmacist, an existing team, or a committee that has focused on opioid stewardship projects, they may be willing to take the lead on managing the implementation process, as well as subsequent monitoring and maintenance.

It may be beneficial and efficient to seek guidance from other pharmacies or health systems that have already implemented an opioid-related BPA. They may be able to offer suggestions for addressing challenges along the way and make the process more efficient. Similarly, the software vendor may have experts who could serve as a consultant for the implementation process.

STORIES

Fort HealthCare (FHC), the primary healthcare system and only hospital in Jefferson County, recognized the critical need to address the opioid crisis in the county and in the past five years has implemented extensive opioid stewardship initiatives.

In 2018, FHC implemented an EHR-based CDS functionality, referred to as the “opioid toolkit” which extracts and evaluates patient data contained in the EHR and alerts providers in real-time while they are prescribing opioids, when certain patient-related criteria are met. To ensure the optimal implementation and effectiveness of the CDS opioid toolkit, it was necessary for FHC to develop infrastructure such as opioid stewardship working groups and health system policies

about standardized opioid treatment agreements. The CDS opioid toolkit was activated in early 2020.

The toolkit included three alerts that are triggered at the point of ordering an opioid medication or related medication. The first alert revolves around the use of opioid treatment agreements. FHC expects that patients enter into an opioid treatment agreement with their primary care provider when the use of opioids is expected to be chronic, or longer than three months. An alert will fire at the point of prescribing an opioid when the system recognizes that a patient has been receiving an opioid for three months or greater consistently. Similarly, an alert will fire at the point of opioid prescribing if a patient has an opioid treatment agreement that is expired. Lastly with treatment agreements, an alert will fire to providers who are not included in the established agreement if they try to prescribe a different opioid, to increase awareness of concurrent opioid prescriptions. Treatment agreements encourage mutual accountability between the patient and provider. There is an additional alert that notifies providers at the point of ordering when patients are considered high risk and to consider co-prescribing naloxone.

Treatment agreements encourage mutual accountability between the patient and provider

The implementation of these alerts within our workflows have brought safe opioid prescribing to the forefront of our providers minds when working on pain management. We have seen increasing utilization of both treatment agreements and naloxone. Like all process improvements, FHC is continuously looking to improve this process to increase our naloxone prescribing and more thoughtful prescribing of opioids or related controlled substances. Ideally, we would like alerts to fire prior to the point of prescribing, as most orders will not be placed until after the patient has left the clinic, which decreases the likelihood a conversation will be had with the patient. While utilizing BPAs, timing of the alert to providers or staff must be considered to allow for providers to have the conversations which impact patient care.

METHADONE AND BUPRENORPHINE

Contributed by: Dustie Zimmerman, PharmD

From 2019 to 2020, 1.6 million people in the United States reported having opioid use disorder (OUD) within the past year.¹ Methadone, buprenorphine, and naltrexone are approved by the US Food and Drug Administration for the treatment of OUD. Methadone and buprenorphine decrease opioid related mortality, and therefore are preferred to other treatments, such as naltrexone or inpatient detoxification, for OUD.² Opioid use disorder is a chronic condition; ongoing treatment with medications is superior to non-medication assisted treatment and therefore should be offered to all patients for an unrestricted amount of time.³

Methadone and buprenorphine decrease opioid related mortality, and therefore are preferred to other treatments, such as naltrexone or inpatient detoxification, for OUD

Methadone

Methadone is a potent synthetic opioid with activity at the mu- (MOR), kappa- (KOR) and delta- (DOR) opioid receptors, as well as serving as a N-methyl-D-aspartate antagonist.⁴ Methadone is the preferred full opioid agonist for OUD due to its weak activation of the dopaminergic system, resulting in a lower potential for euphoric effects.⁵ Since methadone blocks the re-uptake of serotonin and norepinephrine, it may also have some additive antidepressant effects.⁶

Methadone powder or tablets dissolved in water, and oral liquid concentrate formulations are dispensed daily at opioid treatment programs for OUD detoxification and maintenance treatment. Whereas methadone tablets are dispensed at outpatient pharmacies for the management of severe pain. Methadone is a scheduled II controlled substance under the FDA Controlled Substances Act and falls under the Wisconsin Chapter Phar 8 legislation when dispensed for pain at outpatient pharmacies. Code of Federal Regulations, Title 42, Section 8 requires methadone products used for OUD to be dispensed only from state approved opioid treatment programs.

Methadone treatment is traditionally initiated prior to the patient experiencing opioid withdrawal symptoms. A minimum of 40 mg/day of methadone is required to minimize opioid cravings.⁷

1. Substance Abuse and Mental Health Services Administration. (2020). Key substance use and mental health indicators in the United States: Results from the 2019 National Survey on Drug Use and Health (HHS Publication No. PEP20-07-01-001, NSDUH Series H-55). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Retrieved from <https://www.samhsa.gov/data/>
2. Wakeman SE, Laroche MR, Ameli O, et al. Comparative Effectiveness of Different Treatment Pathways for Opioid Use Disorder. JAMA. 2020;3(2):e1920622.
3. Fiellin DA, et al. Primary Care-Based Buprenorphine Taper vs Maintenance Therapy for Prescription Opioid Dependence: A Randomized Clinical Trial. *Mama Intern Med.* 2014;174(12):1947-54.
4. Barbosa Neto JO, Garcia MA, Garcia JBS. Revisiting methadone: pharmacokinetics, pharmacodynamics and clinical indication. *Rev Dor.* 2015;16:60-6
5. Cai NS, Quiroz C, Bonaventura J, Bonifazi A, Cole TO, Purks J, et al. Opioid-galanin receptor heteromers mediate the dopaminergic effects of opioids. *J Clin Invest.* 2019;129(7):2730-44.
6. Sunilkumar MM, Lockman K. Practical pharmacology of methadone: a long-acting opioid. *Indian J Palliat Care.* 2018;24(Suppl 1):S10-s4.
7. Methadone Hydrochloride Oral Concentrate [package insert]. Eatontown, NJ: Hikma Pharmaceuticals USA Inc.; September 2021.

However, doses greater than 60 mg/day are associated with higher program adherence, and clinical stabilization is commonly achieved at doses 80-120 mg/day.⁷ Due to methadone’s high interpatient variability in absorption and metabolism, slowly titrating the dose over weeks or months is advised.⁷ Dose stabilization is expected to take weeks.⁷ Methadone maintenance therapy should be offered to all patients for an unrestricted amount of time due to OUD being a chronic condition.³

Buprenorphine

Buprenorphine is a semi-synthetic opioid with partial MOR activity and full antagonist KOR activity.⁸ Buprenorphine’s high binding affinity for the MOR creates a tight bond so other opioids with low binding affinity, such as heroin or oxycodone, cannot act on the opioid receptor. The ceiling effect of buprenorphine, results in a blunting of euphoria and lower risk of respiratory depression, irrespective of a dose increase.⁹ To minimize the risk of sudden precipitated withdrawal, buprenorphine should only be initiated after the patient exhibits opioid withdrawal symptoms.⁸

Buprenorphine for OUD is available in a sublingual tablet, buccal film, and long-acting monthly intramuscular injection.¹⁰ Many enteral buprenorphine products contain naloxone, which is minimally absorbed and has no clinical effect on patient care, to discourage injection of buprenorphine.¹¹⁻¹² If injected, however, the naloxone would blunt the effect of buprenorphine and therefore reduce the likelihood of abuse. The combination product is generally recommended for maintenance therapy.¹¹ Buprenorphine product selection should be based on cost, insurance coverage, and patient preference.¹¹ Traditionally, induction of buprenorphine begins after moderate opioid withdrawal symptoms are present and is initiated in an inpatient setting. More recently, buprenorphine induction has evolved to occur more frequently in the emergency department or from a provider’s office. However, many rural areas lack inpatient detoxification centers or providers who specialize in OUD. Many rural emergency departments do not carry medications used for OUD and do not have policies in place to manage patients with OUD. Please review the “AAPP Pharmacist Toolkit: Buprenorphine Initiation and Dosing Strategies” for more information about the different dosing guidance of buprenorphine.¹¹

Barriers to Treatment

In 2020, only 11.2% of the 2.5 million people over the age of 12 with OUD in the United States received pharmacological treatment.¹ Barriers to OUD treatment include access to opioid treatment programs (OTPs) or providers, treatment cost, work schedule conflicts, childcare responsibilities, and stigma from healthcare professionals.¹²⁻¹⁵

In 2020, only 11.2% of the 2.5 million people over the age of 12 with OUD in the United States received pharmacological treatment

8. Buprenorphine HCL tablets [package insert]. Eatontown, NJ: Hikma Pharmaceuticals USA Inc.; April 2022
9. Davis CM, Valentino N. Pharmacist Toolkit: Medication Management of Opioid use Disorders. AAPP. Retrieved from: <https://aapp.org/guideline/oud/pdf?view=link-0-1530209527&.pdf>
10. Sublocade-buprenorphine solution [package insert]. North Chesterfield, VA: Indivior Inc.; August 2022.
11. Almeida IS, Noel M. AAPP Pharmacist Toolkit: Buprenorphine Initiation and Dosing Strategies. AAPP. Retrieved from: <https://aapp.org/guideline/buprenorphine/pdf?view=link-9a3ef504-e6a3-11ec-b5d3-bd0a0de7565a&.pdf>
12. Iazes CK, Morrow JD. Reconsidering the Usefulness of Adding Naloxone to Buprenorphine. *Front Psychiatry*.2020;11:549272. 2020 Sep 11. doi:10.3389/fpsy.2020.549272
13. Peckham AM, Ball J, Colvard MD, et al. Leveraging Pharmacist to Maintain and Extend Buprenorphine Supply of Opioid Use Disorder Amid COVID-19 Pandemic. *AM J Health-Syst Pharm*. 2021;78(7):613-618.
14. Simon C, Vincent L, Coulter A, et al. The Methadone Manifesto: Treatment Experiences and Policy Recommendations From Methadone Patient Activists. *AM J Public Health*. 2022;112 (s2): s117-s122.
15. Lister JJ, Lister HH. Improving Methadone Access for Rural Communities in the USA: Lessons Learned from COVID-19 Adaptions and International Models of Care. *Rural and Remote Health*. 2021;21:6770.

Only Substance Abuse and Mental Health Services Administration (SAMHSA)-certified OTPs registered with the Drug Enforcement Administration (DEA) can dispense methadone for the treatment of OUD.¹³ Daily clinically supervised administration of oral methadone and oral buprenorphine products are required at most OTPs, although the Code of Federal Regulations, Title 42, Section 8 only requires supervised administration for methadone.

At OTPs, patients are required to travel to the facility daily within a narrow timeframe to be administered their dose. Most facilities are closed on Sundays; Many patients are not granted Sunday take home doses until they have established and maintained sobriety for more than thirty days.¹⁵ During the COVID-19 pandemic, facilities requested waivers to allow ‘stable’ patients a 28-day take-home supply and ‘less stable’ patients a 14-day take-home supply.¹⁶ However, some facilities have reversed these flexible take-home supply options with the introduction of the COVID-19 vaccine. Additionally, some OTPs do not allow children on the premises and patients must navigate daily childcare coverage and cost.¹⁴

Many OTPs are for-profit facilities that only accept out of pocket payers or limited forms of insurance.¹⁴ Some programs can cost up to \$250 a week and if patients cannot pay, they are forced into an accelerated financial detox schedule.¹⁴ OTPs have decreased doses or stopped treatment if a patient misses a dose or tests positive for other illicit drugs.¹⁴

Previously, a practitioner was required to obtain an X-wavier to prescribe buprenorphine products for OUD. As of January 2023, DEA and SAMHSA has eliminated the requirements for the X-wavier through the passing of the Mainstreaming Addiction Treatment (MAT) act.²¹ Currently, only a DEA registrant number is needed to prescribe buprenorphine products and there is no limit on the number of patients a provider can treat.^{21,22} In some states, such as California, Idaho, Montana, New Mexico, Ohio, Tennessee, Utah, and Washington, a pharmacist with a DEA registration number may prescribe buprenorphine for OUD within their scope of practice.^{21,22}

Additional Resources

- AAPP Pharmacist Toolkit: Medication Management of Opioid Use Disorder, available at <https://aapp.org/guideline/oud/pdf?view=link-0-1530209527&.:pdf>
- AAPP Pharmacist Toolkit: Buprenorphine Initiation and Dosing Strategies, available at <https://aapp.org/guideline/buprenorphine/pdf?view=link-9a3ef504-e6a3-11ec-b5d3-bd0a0de7565a&.:pdf>
- SAMSHA Wavier Elimination (MAT Act) available at <https://www.samhsa.gov/medications-substance-use-disorders/waiver-elimination-mat-act#>

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16. Pasman E, Kollin R, Broman M, et al. Cumulative Barriers to Retention in Methadone Treatment Among Adults from Rural and Small Urban Communities. *Addiction Science & Clinical Practice*. 2022;17(35).
 17. Addiction Services and Pharmacotherapy (ASAP)- Madison. Addiction Treatment Questions and Answers: Treatment: What is Phasing?. 2022. Retrieved from: <https://www.clinicofhope.com/faq#47815-treatment--what-is-phasing>
 18. Substance Abuse and Mental Health Services Administration. Opioid Treatment Program (OTP) guidance. 2020. Retrieved from: <https://www.samhsa.gov/sites/default/files/otp-guidance-20200316.pdf>
 19. Substance Abuse and Mental Health Services Administration. Opioid Treatment Program Directory. 2022. Retrieved from: <https://dpt2.samhsa.gov/treatment/directory.aspx>
 20. DEA and SAMHSA Eliminate X-Wavier Requirements. American Society of Hospital Pharmacist (ASHP). 13 January 2023. Retrieved from: <https://www.ashp.org/News/2023/01/13/dea-and-samhsa-eliminate-x-wavier-requirements?loginreturnUrl=SSOCheckOnly>
 21. Waiver Elimination (MAT Act). Substance Abuse and Mental Health Services Administration (SAMHSA). 7 June 2023. Retrieved from: <https://www.samhsa.gov/medications-substance-use-disorders/waiver-elimination-mat-act>
 22. Mid- Level Practitioners Authorization by State. Drug Enforcement Administration (DEA). Updated 2 December 2022. Retrieved from: https://www.deadiversion.usdoj.gov/drugreg/practioners/mlp_by_state.pdf

The long-acting monthly buprenorphine injection must be administered by a healthcare professional.¹⁰ However, it is only available through a restricted program, or REMS program.¹⁰ For long-acting monthly buprenorphine injection, the healthcare setting and pharmacy must be trained and certified in the REMS program to order and dispense.¹⁰ Processes and procedures must also be established to ensure the medication is administered by a healthcare provider.¹⁰

ABATEMENT STRATEGIES TO CONSIDER

According to the SAMHSA, only 24 OTPs exist in Wisconsin.¹⁹ Similar to the rest of the United States, there is a particular shortage of accessible OTPs in rural areas.¹⁵

To increase availability to patients, the DEA should grant pharmacists the ability to administer methadone and buprenorphine for the treatment of OUD. Pharmacists could report all administered doses to the prescription drug monitoring program (PDMP), which would allow patients the flexibility to travel to different pharmacies if needed. Pharmacists should be permitted to prescribe and administer long-acting buprenorphine to improve access to treatment.¹³

Rural hospitals hold a unique position to aid with the initiation of medications for OUD in the emergency department, urgent care, or during hospitalization. Following induction in the emergency department, hospital pharmacists could facilitate transitions of care by providing discharge education and take-home doses, as well as coordinating follow up appointments via telehealth services. In some instances, hospital pharmacies could also provide dispensing and administration services for areas where community pharmacies have limited hours.

With the recent change in X-waiver requirements, Wisconsin pharmacists could leverage tools such as collaborative practice agreements to improve treatment access. This would allow pharmacists to evaluate the effectiveness of medications for OUD, and adjust them accordingly, in collaboration with providers following the initial diagnoses of OUD and induction.¹³ Legislation should increase third party billing to allow pharmacists to provide these services in-person or through telehealth.¹³

Currently, pharmacists are the highest trained clinicians who are unable to prescribe medications for opioid use disorders in Wisconsin.²² Wisconsin legislation should support pharmacist prescribing of medications for OUD to improve access to care for patients.

EQUITY CONSIDERATIONS

Distance to Treatment

Due the geographical nature of Wisconsin, community and hospital pharmacies should have the availability to dispense, administer, and bill for methadone or buprenorphine to limit patient's driving distances. Pharmacies could potentially work in collaboration with licensed methadone clinics to expand hours in specific or emergent situations. This flexibility will also allow patients to access their medication 24/7 to help with hardships such as employment and childcare.¹⁴ Pharmacies should consider delivery services for homebound or disabled patients.¹⁴ Take-home doses of methadone or buprenorphine should be increased, especially in the winter months when travel is more difficult. Allowing pharmacists to prescribe or adjust medication for OUD

via telehealth, will also decrease patient travel time to a provider's office. Policies should decrease barriers to emergency department OUD treatment initiation.¹³ Emergency department treatment initiation will allow patients to obtain treatment in areas where OUD providers are unavailable.

Additional Resource

UW Addiction Consultation Provider Hotline,
Phone: 1-800-472-0111
Email: AddictionHotline@fammed.wisc.edu
More information available at:
<https://www.fammed.wisc.edu/addiction-hotline/>

Stigma

Prior to offering methadone or buprenorphine services, pharmacists should undergo specialized training to limit stigmas placed on this patient population.¹³ Community and hospital pharmacies should include private spaces to protect patient's confidentiality.

Cost

Policies should prohibit accelerated tapering schedules and financial detoxification due to a patient's inability to pay for treatment.¹⁴ Funding should be provided for patient assistance programs for those unable to pay for treatment.¹³ Reimbursement from third-party billing should be increased so pharmacies can afford to offer extended services.¹³

RESOURCE AND FUNDING CONSIDERATIONS

Education and Training

- Funding of stigma reduction education for all pharmacy personnel.¹³
- Sufficient training for pharmacists to administer all long- acting injectable medications, including long-acting buprenorphine, with adequate insurance reimbursement.¹³

Administration and Dispensing

- Funding to change Wisconsin legislation to allow pharmacies to administer and dispense all medications for OUD treatment.
- Patient assistance programs to fund the cost of medications and pharmacy services for patients without insurance coverage or with low income.¹³
- Increase reimbursement from third-party payer systems for pharmacist-administered and dispensed methadone and buprenorphine OUD treatment.
- Reimbursement for hospital pharmacies to administer and dispense methadone and buprenorphine.

Expanding access to Providers

- Funding to implement collaborative practice agreements between pharmacists and providers.
- Improve reimbursement for pharmacists' medication management appointments and telehealth services.
- Funding to support Wisconsin legislation that includes pharmacists as eligible prescribers.¹³

Additional Resource

The Network for Public Health Law, SUD-Related Emergency Department Mandates, available at <https://www.networkforphl.org/wp-content/uploads/2021/10/50-State-Survey-SUD-Related-Emergency-Department-Mandates.pdf>

OUD is a chronic condition and lifelong treatment is essential to preventing relapse. Success should be measured as reducing the amount of supplemental illicit opioid used, retention within treatment, and mortality.

I recommend reviewing “The Methadone Manifesto”, which the Urban Survivors Union (USU) has published to express drug users’ concerns and recommendations on methadone treatment for patients with OUD.¹⁴ The USU recommends methadone treatment centers strive for improved retention rates within the program, harm-reduction treatment model implementation, and decreased incidents of overdose.¹⁴

Pharmacists have the ability to support OUD remission and prevent overdose deaths within the community and hospital setting. Future legislation and grants should incorporate the pharmacists’ critical role in the treatment of OUD.

PHARMACIST-ADMINISTERED MEDICATIONS FOR OPIOID USE DISORDER (MOUD)

Contributed by: Matt Huppert, PharmD

With the ongoing national opioid crisis, the use of medications for opioid use disorder (MOUD) and medication-assisted treatment (MAT) regimens are extremely important. Medications approved for opioid use disorder (OUD) include buprenorphine, methadone, and naltrexone. With pharmacists being one of the most accessible healthcare providers for patients, offering these services in pharmacies is crucial.^{1,2}

With pharmacists being one of the most accessible healthcare providers for patients, offering these services in pharmacies is crucial.

In March of 2023, the American Society of Health-System Pharmacists (ASHP) formally proposed legislation and a protocol to assist states in leveraging pharmacists to improve access to MOUD by allowing pharmacists to initiate, modify, discontinue, and administer medications approved for MOUD.³

In the state of Wisconsin, pharmacists are able to provide administration of non-vaccine injections to patients under pharmacy administrative code statutes Phar 7.13.⁴ Naltrexone (Vivitrol®) is a widely available non-vaccine injection provided to patients suffering from OUD. The long-acting monthly buprenorphine injection must be administered by a healthcare professional and is only available through a restricted program, or Risk Evaluation and Mitigation Strategy (REMS) program.⁵ For long-acting monthly buprenorphine injection, the healthcare setting and pharmacy must be trained and certified in the REMS program to order and dispense. Processes and procedures must also be established to ensure the medication is administered by a healthcare provider.⁵

Previously, a practitioner was required to obtain an X-waiver to prescribe buprenorphine products for OUD. As of January 2023, DEA and SAMHSA has eliminated the requirements for the X-waiver through the passing of the Mainstreaming Addiction Treatment (MAT) act.⁶ Currently, only a DEA registrant number is needed to prescribe buprenorphine products and

1. Green TC, Serafinski R, Clark SA, Rich JD, Bratberg J. Physician-Delegated Unobserved Induction with Buprenorphine in Pharmacies. *N Engl J Med.* 2023;388(2):185-186. doi:10.1056/NEJMc2208055.
2. Ford JH 2nd, Gilson AM, Bryan G, Augustine C, Gassman M, Mott DA. Community pharmacy-based injectable naltrexone service delivery models and best practices. *Res Social Adm Pharm.* 2021;17(7):1332-1341. doi:10.1016/j.sapharm.2020.10.004
3. ASHP Releases Model MOUD Prescribing Legislation, State Protocol. American Society of Health-system Pharmacists. Published March 24, 2023. Accessed June 28, 2023. <https://www.ashp.org/news/2023/03/24/ashp-releases-model-moud-prescribing-legislation-state-protocol?loginreturnUrl=SSOCheckOnly>.
4. Wisconsin Legislature: Chapter phar 7. Wisconsin State Legislature. Wisconsin Pharmacy Examining Board. Published December 2020. Accessed October 28, 2022. https://docs.legis.wisconsin.gov/code/admin_code/phar/7.
5. Sublocade-buprenorphine solution [package insert]. North Chesterfield, VA: Indivior Inc.; August 2022.
6. Waiver Elimination (MAT Act). Substance Abuse and Mental Health Services Administration (SAMHSA). Updated June 7, 2023. Accessed July 5, 2023. <https://www.samhsa.gov/medications-substance-use-disorders/waiver-elimination-mat-act>.

there is no limit on the number of patients a provider can treat.^{6,7} In some states, such as California, Idaho, Montana, New Mexico, Ohio, Tennessee, Utah, and Washington, a pharmacist with a DEA registration number may prescribe buprenorphine for OUD within their scope of practice.^{6,7}

ABATEMENT STRATEGIES TO CONSIDER

First, a pharmacy must abide by the state regulations to provide non-vaccine injections to patients.^{4,8} Once requirements have been met, a pharmacy is able to provide non-vaccine injection services to patients. However, it is best to create partnerships with OUD Treatment specialists in order to provide this service through patient referrals. A pharmacy could also create a self-referral form for patients to begin the process of receiving MOUD.

Pharmacies can work to establish partnerships with prescribing offices, emergency and urgent care providers, local departments of health and other prescribers providing OUD therapy. Forming a rapport with these entities will allow the pharmacy's OUD services to remain top of mind for these prescribers and increase volume of referrals. The pharmacy providing administration of these non-vaccine injections may find value in the use of an appointment-based model for patients to receive monthly naltrexone injections. This model may include discussion of intake forms, insurance coverage, medication history, anatomic administration site, and follow up appointments. The appointment-based model provides a framework for appropriate staffing and management of patient load to facilitate a smoother experience for patients and staff. Additionally, both the pharmacist and patient come to the appointment with knowledge of what to expect from the medication after administration. Lastly, the appointment-based model allows pharmacy staff to track patient adherence to medication. Pharmacists and pharmacy staff may also be able to implement medication adherence services such as in-home medication administration or electronic reminders for injection appointments.

EQUITY CONSIDERATIONS

There are patients struggling with OUD that do not have access to transportation or do not have stable housing while going through OUD treatment. The pharmacy providing MOUD therapy should consider how they will address these disparities. It may be beneficial to consider the administration of these medications at a patient's home or satellite location to meet the needs of patients who are not able to travel to the pharmacy.

Moreover, patients may be transitioning from inpatient treatment centers to treatment in the outpatient setting. Periods during these transitions of care may increase vulnerability and noncompliance. It is important to establish transition of care services and facilitate communication with inpatient centers during the discharge process. Pharmacies that receive discharge plans will have better success in providing individualized care for those patients.

It is important to establish transition of care services and facilitate communication with inpatient centers during the discharge process.

7. Mid- Level Practitioners Authorization by State. Drug Enforcement Administration (DEA). Updated December 2, 2022. Accessed July 5, 2023. https://www.deadiversion.usdoj.gov/drugreg/practioners/mlp_by_state.pdf.
8. University of Wisconsin-Madison. Injectable medication (IM and SubQ non-vaccine) - online ce course. Division of pharmacy professional development. Published January 10, 2022. Accessed October 28, 2022. <https://ce.pharmacy.wisc.edu/pd/injectable-medications-im-subq-non-vaccine/>.

Lastly, third party payers may be a barrier for patients wishing to receive opioid use therapy. Some insurance plans restrict the site of care a patient can receive treatment, and may enforce quantity limits. Therefore, it may be necessary to create a plan with a patient as they transition to an insurance or patient assistance program that covers injectable medication. Generally, a patient can transition to oral medication during the time they are not able to receive injectable medication.

RESOURCE AND FUNDING CONSIDERATIONS

Personnel training will likely be the most significant cost associated with implementing non-vaccine injections for opioid use treatment. Pharmacy managers and owners need to consider the costs of training pharmacists to provide non-vaccine injections to meet state requirements. Some drug manufacturers will provide online or onsite, product-specific staff training at no cost which may offset some implementation costs for the pharmacy.

To support implementation, pharmacy staff will also need to be trained to utilize an appointment-based model. If not already established, the pharmacy may need to investigate and implement a technology solution for patient appointments. Additionally, the pharmacy could consider implementing services to enhance adherence to visits such as providing transportation or calling patients to remind them of their appointment to limit the instances of patient no-shows, which ultimately impact the financial viability of new patient care services.

Inventory management may also be a consideration for the pharmacy manager. Generally, the acquisition costs for injections to treat OUD are higher than oral counterparts. Carrying cost, and risk of deadstock may be important when considering implementing non-vaccine administration.

STORIES

In providing this service, pharmacies provide access to patients that other healthcare facilities are not able to provide. Our pharmacy worked with a patient and his father during a time when the patient's insurance would not pay for an injectable medication to treat OUD. We worked with the patient's family by providing options on how to continue treatment. We offered oral therapy treatment or paying the cash price for injectable naltrexone. The family elected to pursue therapy with naltrexone injection, and we contacted the prescriber to facilitate care. It took two months for a coverage determination to be made by the third party payor, but our pharmacy was able to fill the gap in therapy during this delay and ensure the patient has access to the care they needed.

OPIOID ANTIDOTES: NALOXONE

Contributed by: Diane Johnson, PharmD, BCPS

Naloxone is a medication used to reverse the effects of opioids on the mu opioid receptors. Specifically, naloxone reverses the respiratory depression that is seen in an opioid overdose, and can therefore save a life.¹ Naloxone has historically been a prescription medication in the United States, but has been available without a prescription in each state by special designation. The Wisconsin Department of Health Services (DHS) has issued a Statewide Standing Order that delegates authority to pharmacists to dispense naloxone without a prescription.² Federal, state, and county efforts have expanded access to naloxone, a life-saving medication that must be readily available, by reducing barriers. More recently in March 2023, the U.S. Food and Drug Administration (FDA) approved naloxone nasal spray for over-the-counter (OTC) nonprescription use, thus theoretically further reducing barriers to patient access. DHS offers partner materials that pharmacies can utilize to promote conversations about naloxone, opioids, and safe medication disposal.

The Wisconsin Department of Health Services (DHS) has issued a Statewide Standing Order that delegates authority to pharmacists to dispense naloxone WITHOUT a prescription.

While insurance plans pay for naloxone when administered at a medical facility, coverage varies for take-home naloxone that is intended to be kept on hand in the event of an opioid overdose. Naloxone is highly effective, even when given by an individual who has had no formal naloxone use training, and the medication has very low risk for long-term harms.³ To overcome cost being an obstacle to naloxone access, the NARCAN Direct Program (NDP) was created to provide naloxone at no cost to community agencies that then distribute for free to individuals who are at risk of an opioid accidental overdose or may witness an opioid accidental overdose. Many pharmacies have obtained available grant funding to distribute naloxone to individuals at no cost. Pharmacists play a critical role in addressing the opioid epidemic as the patient's most widely accessible healthcare provider and have a key opportunity to discuss naloxone while counseling patients on the safe use and disposal of their opioid prescription medications.⁴

Providing overdose education is a valuable intervention that can create awareness of the risk with both use and misuse of opioids.⁵⁻⁶ It is important that all who are exposed to opioids

1. Ryan SA, Dunne RB. Pharmacokinetic properties of intranasal and injectable formulations of naloxone for community use: a systematic review. *Pain Manag.* 2018 May;8(3):231-245.
2. Statewide naloxone standing order for pharmacist. Wisconsin Dept of Health Services. Accessed October 24, 2022. <https://www.dhs.wisconsin.gov/library/f-01802.htm>.
3. Krieter P, Chiang N, Gyaw S, Skolnick P, Crystal R, Keegan F, Aker J, Beck M, Harris J. Pharmacokinetic Properties and Human Use Characteristics of an FDA-Approved Intranasal Naloxone Product for the Treatment of Opioid Overdose. *J Clin Pharmacol.* 2016 Oct;56(10):1243-53.
4. Valliant S, Burbage S, Pathak S, Urlick B. Pharmacists as accessible health care providers: quantifying the opportunity. *J Manag Care Spec Pharm.* 2022 Jan;28(1):85-90.
5. Adewumi AD, Hollingworth SA, Maravilla JC, Connor JP, Alati R. Prescribed Dose of Opioids and Overdose: A Systematic Review and Meta-Analysis of Unintentional Prescription Opioid Overdose. *CNS Drugs.* 2018 Feb;32(2):101-116.
6. Oliva EM, Richardson J, Harvey MA, Bellino P. Saving Lives: The Veterans Health Administration (VHA) Rapid Naloxone Initiative. *Jt Comm J Qual Patient Saf.* 2021 Aug;47(8):469-480.

receive overdose education, including patients and their caregivers, those using opioids as prescribed, and those misusing opioids. Patients should be aware that even at prescribed doses, accidental overdose events can occur and that any patient can experience an overdose, not only those with high-risk comorbidities or drug interactions.⁵ People that use or misuse opioids intermittently can lose tolerance if they are abstinent, and therefore, are at risk for accidental overdose when they resume taking opioids. Using phrases that patients can relate to, for example comparing having a naloxone kit to a fire extinguisher, are often effective. Patients can relate that having a safety measure available is important, even if you do not plan to need it. Having meaningful conversations in a supportive and non-judgmental manner can decrease negative stereotypes and stigma, as well as prevent opioid harm.

ABATEMENT STRATEGIES TO CONSIDER

Pharmacy staff should be prepared to discuss opioid overdose education with patients. Being comfortable, open, and honest with our patients can help to de-stigmatize this topic. Overdose inherently has a negative connotation due to the stigma associated with drug misuse. Educating on the risk of overdose, what can be done to prevent it, and how to treat it is an important discussion. At the time of writing, naloxone is approved for OTC use but is not yet readily available, and the implications of how this will affect patient care are not yet known. Because patients will be able to pick up naloxone without speaking to a healthcare provider, the pharmacy team may need to go the extra step to identify patients that would benefit from overdose education. It is unclear if insurance will stop covering it or if the statewide standing order will be needed. The following information is correct at the time of writing, but you are encouraged to reach out to the DHS to get the most up to date information.

There are many resources to aid pharmacies in obtaining a supply of naloxone for distribution to patients at no cost. Wisconsin DHS, the NDP, and community agencies may contact the county government to obtain naloxone that can be given to patients free-of-charge. Pharmacists can initiate the conversation by proactively offering naloxone to patients and caregivers who are obtaining an opioid prescription medication. Conversely, pharmacies can prompt customers to start the conversation with their pharmacist by utilizing the DHS Partner Materials.

Naloxone can be given to these patients via automatic dispensing machines, as part of a harm reduction kit, or as a stand-alone product. Patients do not have to provide their name, the rationale for wanting naloxone, or a prescription to obtain naloxone. Pharmacies should first trial billing insurance for patients to obtain naloxone. While insurance coverage varies, there are insurance plans that provide at least partial, if not full, coverage of naloxone. If the pharmacy is unable to carry a supply of free naloxone, and the patient's insurance does not cover naloxone or the patient is unable to afford naloxone, the pharmacy should direct the patient to other community locations that do offer naloxone at no cost. The DHS maintains an updated list of available naloxone sites organized by county at [naloxone-availability.xlsx \(live.com\)](#) and a map of participating locations [here](#). Of note, if it is listed "per purchase" this may or may not be true (i.e., it might be free) so it is recommended to contact a specific location to learn more. Pharmacies or individuals can also sign up for emails from the DHS that include alerts, data and reports, newsletters and events surrounding Wisconsin's opioid epidemic.⁷ There is also an online video with instructions on how to use a naloxone device [here](#) for patients or family

7. Dose of reality: Get the facts on opioids. Wisconsin Dept of Health Services. <https://www.dhs.wisconsin.gov/opioids/facts.htm>. Accessed October 23, 2022.

members that are interested. Finally, Wisconsinites who are unable or unwilling to access in-person services may request free intramuscular naloxone be mailed to them directly by visiting [NEXT Distro](#).

To get started offering free naloxone at your facility, the first step is to contact your county health department to determine what services or local resources are currently available. Find your county health department here: [Local Public Health | Wisconsin DHS](#). If no local resources are in place, the next step would be to contact the Wisconsin DHS [Dose of Reality: Resources for Professionals | Wisconsin Department of Health Services](#) to get connected with resources.

Additional Resources

- Narcan Direct [Home | NARCANDirect.com](#)
- [Dose of Reality: Resources for Professionals | Wisconsin Department of Health Services](#)
- [Dose of Reality: Safer Use/Harm Reduction | Wisconsin Department of Health Services](#)
- Find your county health department: [Local Public Health | Wisconsin DHS](#)
- Wisconsin Voices for Recovery: [Wisconsin Voices for Recovery](#)

Wisconsin Voices for Recovery is an organization that is part of the Narcan Direct Program and has established ways to provide free naloxone to those that otherwise might not have access. This organization can provide information on how to get a program started if there are no county resources in place. Wisconsin Voices for Recovery supplies Nalox-ZONE boxes that contain naloxone, a rescue breathing kit, and information for addiction resources (bilingual). They also provide free training scheduled throughout the year or arranged in advance for your group. For more information you can contact them at naloxzone@fammed.wisc.edu.

EQUITY CONSIDERATIONS

Patients who are uninsured or underinsured would traditionally have limited access to naloxone due to the high cost of the medication. With the available resources to provide free naloxone, this should no longer be the case. Having naloxone available in high foot traffic areas will increase access. The rural setting may have less access to other healthcare resources, therefore, the pharmacy is an ideal setting to carry free naloxone kits and enroll in the statewide standing order. Overdose education and naloxone should be offered to all patients, regardless of their presentation, indication for opioids, or comorbid medical conditions.



RESOURCE AND FUNDING CONSIDERATIONS

To increase access to naloxone, the pharmacy would first need to determine if an automated dispensing system would be most appropriate. If so, this could be purchased with grant funding (or supplied by the state DHS) as it would otherwise be an upfront cost. Additional cost and resource considerations include training time for staff. All pharmacists dispensing naloxone under a standing order must complete a one-hour training developed by the Pharmacy Society of Wisconsin (PSW). Follow these steps to access the training:

1. Go to the PSW Online CE webpage (link is external)
2. Type “Naloxone Statewide Standing Order Training” in the search box
3. Select the “Naloxone Statewide Standing Order Training” course title in the list of options that appear
4. Select the “Register” button in the course description screen and follow the prompts to register
5. Complete the 1-hour training

Additional considerations include time spent reviewing and compiling community resources, printing materials for patients, and providing patient education. Resources are found at [naloxone education resources](#).

Lastly, nalmefene, a prescription opioid antagonist mechanistically similar to naloxone, was recently approved by the FDA for the emergency treatment of known or suspected opioid overdose in adult and pediatric patients 12 years of age and older.^{8,9} While widespread programs are not yet in place to promote increased patient access to nalmefene like there are for naloxone, opportunities are likely on the horizon. As access increases and pricing becomes more competitive, pharmacists should consider all therapeutic options to ensure patients receive the care they need at the most affordable price.

STORIES

While it is crucial to offer naloxone and overdose education to those patients (and their friends/caregivers) that misuse opioids or illicit stimulants (due to the risk for contamination with fentanyl), we must also remember our patients that are prescribed opioids for the short or long-term. Many patients initially decline naloxone along with their prescribed opioids stating that they would never overdose or need naloxone. It is important to not end the discussion there, but instead provide further education as to why naloxone is still important. Educating patients that an accidental overdose can occur at prescribed doses and utilizing motivational interviewing can be helpful to increase acceptance of the education and the naloxone kit. Pharmacy students/interns have been shown to be as effective as pharmacists in providing naloxone education and training, so can be utilized if present in the pharmacy.¹⁰

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8. FDA approves prescription nasal spray to reverse opioid overdose. U.S. Food and Drug Administration. Published May 22, 2023. Accessed July 5, 2023. <https://www.fda.gov/news-events/press-announcements/fda-approves-prescription-nasal-spray-reverse-opioid-overdose>.
 9. Opvee-nalmefene nasal spray [package insert]. Santa Monica, CA: Opiant Pharmaceuticals; May 2023.
 10. Rothbauer K, Genisot A, Frey T, Johnson D. Integration of Pharmacy Student Interns into a Naloxone Telephone Outreach Service. J Pain Palliat Care Pharmacother. 2022 Aug 23:1-8.

MEDICATION DISPOSAL DROP BOX

Contributed by: Prati Wojtal, MS, RPH, FASHP

In September 2014, the Drug Enforcement Administration (DEA) published an update to Code of Federal Regulations (CFR), Title 21 (Food and Drugs), Part 1317 (Disposal), Subpart B allowing for Disposal of Controlled Substances from Ultimate Users and Other Non-Registrants by law enforcement and DEA registrants.¹

Section 1317.40 specifies the DEA registrants authorized to collect, through the modification of their DEA registration to be a collector, include manufacturers, distributors, reverse distributors, narcotic treatment programs, hospitals/clinics with an on-site pharmacy, and retail pharmacies. Also included are long-term care facilities with a registered hospital/clinic or a retail pharmacy that becomes authorized for collection with a modified DEA registration (1317.80).

Proper disposal of unused medications can prevent overdoses and protect waterways from becoming polluted by pharmaceuticals.

One of the authorized collection activities collectors may conduct is to install, manage, and maintain collection receptacles, more commonly known as medication drop boxes. The DEA has specific rules and regulations with regards to requirements for the inner liner (1317.60), secure placement and security of the collection receptacle (1317.75), and displaying prominent signage.

Proper disposal of unused medications can prevent overdoses and protect waterways from becoming polluted by pharmaceuticals. Medication drop boxes are a safe and secure way to responsibly dispose of unwanted medications.

ABATEMENT STRATEGIES TO CONSIDER

Install a Medication Drop Box using these 10 simple steps:

1. Review Drug Enforcement Agency (DEA) regulations for Consumer Drug Take Back (CDTB) - [Code of Federal Regulations, Title 21, Part 1317 – Disposal](#).
 - a. For more detailed information, please review the [final ruling on the disposal of drugs](#) from September 9, 2014.¹
2. Identify program/initiative champions and stakeholders and bring them into the process early so they can contribute to workflow changes and champion this service.
 - a. Share regulations with administrative leadership and site security and review costs/benefits, ensuring all stakeholders are supportive.
 - i. Note: Site pharmacies are responsible for each step of the process since they are the registrants of the Controlled Substance Registration Certificate; however,

1. Food and Drugs, Disposal. 21 CFR §1317 (2014).

pharmacy leaders may need to get approval from someone at a higher level such as the business owner, clinic leadership or hospital leadership. Sites that have security on site will want to connect with those stakeholders for their expertise.

3. Select an approved vendor for drop box receptacle and disposal service.
 - a. Contacting your current reverse distributor is a good place to start.
4. Select a location for the receptacle in accordance with DEA regulations - [Title 21, Chapter II, Subpart B, Part 1317.75](#)
 - a. The receptacle must be securely fastened to a permanent structure so that it cannot be removed.
 - b. Signage must be prominently displayed on the outer container of the disposal box indicating that only Schedule II-V controlled and non-controlled substances, if a collector chooses to commingle substances, are acceptable substances. For example:
 - i. "Only Schedule II-V controlled substances and non-controlled substance permitted. Schedule I controlled substances that are not lawfully possessed by the ultimate user and other illicit or dangerous substances are not permitted. Healthcare facility waste not permitted."
 - ii. "Accepted: Unused or expired prescription medication (included Schedule II-V controlled substances); Unused or expired over-the-counter medication; Pet Medication; Not Accepted: Schedule I controlled substances; illegal drugs; thermometers; inhalers; lotions/liquids; aerosol cans; needles; hydrogen peroxide."
 - c. Placement must be located in the immediate proximity of a designated area where controlled substances are stored and at which an employee is present (e.g., can be seen from the pharmacy counter) in accordance with the DEA registrant location, except:
 - i. At a hospital/clinic: A collection receptacle shall be located in an area regularly monitored by employees and shall not be located in proximity of any area where emergency or urgent care is provided.
 - ii. At a narcotic treatment program: A collection receptacle shall be located in a room that does not contain any other controlled substances and is securely locked with controlled access. At a long-term care facility: A collection receptacle shall be located in a secured area regularly monitored by long-term care facility employees.
5. Prepare and document your pharmacy's standard operating procedure in accordance with DEA regulations including:
 - a. Keys - how many, where they're kept, and who has access
 - b. Oversight of receptacle and roles
 - c. Process for scheduling pickup and replacing inner liners
 - d. Record-keeping
 - e. Staff training
6. Modify eligible DEA Registration to collect pharmaceutical controlled substances from ultimate users (to be completed by DEA registrant/POA (power of attorney who is authorized to act on behalf of the DEA registrant)):
 - a. VISIT: <https://apps.deadiversion.usdoj.gov/webforms2/spring/disposalLogin?execution=e3s1>
 - b. ENTER your login information, all found on your existing DEA registration certificate
 - c. SELECT your collection method: Collection Receptacle
 - d. SIGN and certify your collector status registration electronically
 - e. SAVE and print a copy of your new registration certificate

7. Maintain Inner Liner Recordkeeping in accordance with Title 21 CFR 1304.22(f)
(2) - [https://www.ecfr.gov/current/title-21/chapter-II/part-1304/subject-group-ECFR220d26113f6a5/section-1304.22#p-1304.22\(f\)](https://www.ecfr.gov/current/title-21/chapter-II/part-1304/subject-group-ECFR220d26113f6a5/section-1304.22#p-1304.22(f)).
 - a. Date each unused inner liner is acquired, unique identification number and size (e.g., 5-gallon, 10-gallon, etc.) of each unused inner liner acquired.
 - b. Date each inner liner is installed, the address of the location where each inner liner is installed, the unique identification number and size (e.g., 5-gallon, 10-gallon, etc.) of each installed inner liner, the registration number of the collector, and the names and signatures of the two employees that witnessed each installation.
 - c. Date each inner liner is removed and sealed, the address of the location from which each inner liner is removed, the unique identification number and size (e.g., 5-gallon, 10-gallon, etc.) of each inner liner removed, the registration number of the collector, and the names and signatures of the two employees that witnessed each removal.
 - d. Date each sealed inner liner is transferred to storage, the unique identification number and size (e.g., 5-gallon, 10-gallon, etc.) of each sealed inner liner stored, and the names and signatures of the two employees that transferred each sealed inner liner to storage.
 - e. Date each sealed inner liner is transferred for destruction, the address and registration number of the reverse distributor or distributor to whom each sealed inner liner was transferred, the unique identification number and the size (e.g., 5-gallon, 10-gallon, etc.) of each sealed inner liner transferred, and the names and signatures of the two employees that transferred each sealed inner liner to the reverse distributor or distributor.
 - f. [Example of a Drug Disposal Serialization Inner Liner Tracking Sheet](#)
8. Track quantity (pounds) of medication collected, and report as needed to demonstrate your pharmacy's and/or organization's community service.
9. Educate your patients about proper medication disposal with every pharmacist consultation and the location of your medication drop box.
10. Build awareness - Let your community know about your new drop box! Post on social media, ask local elected leaders and senior centers to include information on your box in their newsletters, and/or reach out to local media with a press release.

Lessons Learned:

- Location, location, location – Receptacles in higher traffic areas (such as a main lobby) will result in greater collection than receptacles in lower traffic areas (inside the pharmacy or space with limited hours of access).
- Space saving pros/cons – Prescription vials take up more space than the tablets/capsules inside them; however, the organizational risk increases if consumers are asked to remove the tablets/capsules prior to depositing them into the receptacle. Risks include:
 - » Spillage of tablet/capsules surrounding the receptacle
 - » Access to Protected Health Information (PHI) on vials when removing prescriptions from packaging
 - » Additional waste to manage
- Routine surveillance to determine the rate at which the disposal box is getting full. This will help determine cadence for pickups throughout the year.

Staff Saver:

Prepare a 'frequently asked questions and answers sheet' and keep a printed copy easily accessible to allow the pharmacy team to easily answer consumer questions.

EQUITY CONSIDERATIONS

According to provisional data released by the Centers for Disease Control and Prevention (CDC), drug overdose deaths in the U.S. rose by nearly 30% in 2020, the largest single-year increase ever recorded.² The consequences of the overdose crisis have disproportionately affected vulnerable populations.

Although racial or ethnic minority communities experience substance use disorders at similar rates as other groups, in recent years the rate of opioid overdose deaths has increased more rapidly in Black populations compared to White populations.³ Additionally, racial or ethnic minority groups are more likely to face criminal justice involvement for their drug use. Black individuals represent just 5% of people who use drugs, but represent 29% of everyone arrested for drug offenses and represent 33% of those in state prison for drug offenses.⁴ Racial and ethnic minority groups are also more likely to face barriers in accessing high-quality treatment and recovery support services.⁵

Racial or ethnic minority groups are more likely to face criminal justice involvement for their drug use.

Consider placing medication disposal boxes in neighborhoods of highest social vulnerability (using data from your local health department, the Wisconsin Department of Health Services (DHS), the CDC, or other databases and dashboards) and into the census blocks with the most opioid prescriptions per capita (using Enhanced Prescription Drug Monitoring Program data from the Wisconsin DHS). Another opportunity is for community collaboration with other healthcare agencies, community organizations and/or environmental organizations in your county to help you host a medication drop box and spread the word about proper disposal of unused medications.



Medication drop boxes are one of a few options available for medication disposal. On April 3, 2023, the U.S. Food and Drug Administration (FDA) announced the requirement for manufacturers of opioid analgesics dispensed in outpatient settings to make prepaid mail-back envelopes available to outpatient pharmacies and other dispensers as an additional opioid analgesic disposal option for patients.⁶ Manufacturers have 180 days to submit their proposed modification to the Opioid Analgesic Risk Evaluation and Mitigation Strategy (OA REMS). The FDA anticipates approval of the modified REMS in 2024. When implemented, outpatient pharmacies and other dispensers will have the option to order prepaid mail-back envelopes and educational materials for patients on safe disposal of opioid analgesics from manufacturers, which they may then provide to patients prescribed opioid analgesics.

2. Understanding the opioid overdose epidemic. Centers for Disease Control and Prevention. Updated June 1, 2022. Accessed June 29, 2023. <https://www.cdc.gov/opioids/basics/epidemic.html#:~:text=The%20number%20of%20drug%20overdose,death%20rates%20increased%20by%2038%25>.
3. Friedman JR, Hansen H. Evaluation of increases in drug overdose mortality rates in the US by race and ethnicity before and during the COVID-19 pandemic. *JAMA Psychiatry*. 2022;79(4):379. doi:10.1001/jamapsychiatry.2022.0004
4. Rosenberg A, Groves AK, Blankenship KM. Comparing black and White Drug Offenders. *Journal of Drug Issues*. 2016;47(1):132-142. doi:10.1177/0022042616678614
5. McKnight-Eily LR, Okoro CA, Strine TW, et al. Racial and ethnic disparities in the prevalence of stress and worry, mental health conditions, and increased substance use among adults during the COVID-19 pandemic — United States, April and May 2020. *MMWR Morbidity and Mortality Weekly Report*. 2021;70(5):162-166. doi:10.15585/mmwr.mm7005a3
6. FDA moves forward with mail-back envelopes for opioid analgesics dispensed in outpatient settings. U.S. Food and Drug Administration. Published April 3, 2023. Accessed June 26, 2023. <https://www.fda.gov/news-events/press-announcements/fda-moves-forward-mail-back-envelopes-opioid-analgesics-dispensed-outpatient-settings>.

RESOURCE AND FUNDING CONSIDERATIONS

The typical expense for installing a medication drop box is \$1500 - \$1600 annually. This will include the following:

- One receptacle delivered to installation location
- Twelve collection and shipping supplies – boxes for inside the receptacle, bar coded inner liner + zip tie, absorption pad; and pre-addressed and pre-paid shipping containers
- Incineration of all supplies and collected medications at a registered facility

STORIES

The Aurora Sinai Outpatient Pharmacy in Milwaukee installed a medication drop box in their pharmacy in 2018. Brian Johnson, supervisor for the pharmacy, shares that his team often receives inquiries from family members of deceased parents who have boxes of medication, often including narcotics, at home after their death. The family members are extremely thankful when they to bring the unused medications to their drop box rather than having the medications sitting around their homes for extended periods of time.

In 2019, the Aurora St. Luke's Outpatient Pharmacy in Milwaukee installed a medication drop box in the lobby and main entrance of the hospital. Pharmacy Manager, Joel Pietryga, shared that the site collected ~1500 pounds of unused medications in 2022. He and his team have worked with the Pain Management Service at the hospital to ensure that all patients are aware of the medication disposal box. When a pain medication or dose is changed, patients are instructed to take their unused medications to the drop box before leaving the hospital/clinic. The patient and the provider both feel more comfortable with the easy access for disposal.

Kyle Beyer, Owner/Pharmacy Manager of North Shore Pharmacy in Shorewood, Wisconsin shares that patients appreciate having a simple and local place to dispose of their unused medications, and they feel better having them destroyed rather than ending up in the water supply. His pharmacy is proud to offer the drop box as another way to show value to his community. Availability of the drop box is mentioned during patient consultations on opioid medications so the number of unused doses the patients may have at home can be reduced, keeping their community safer.

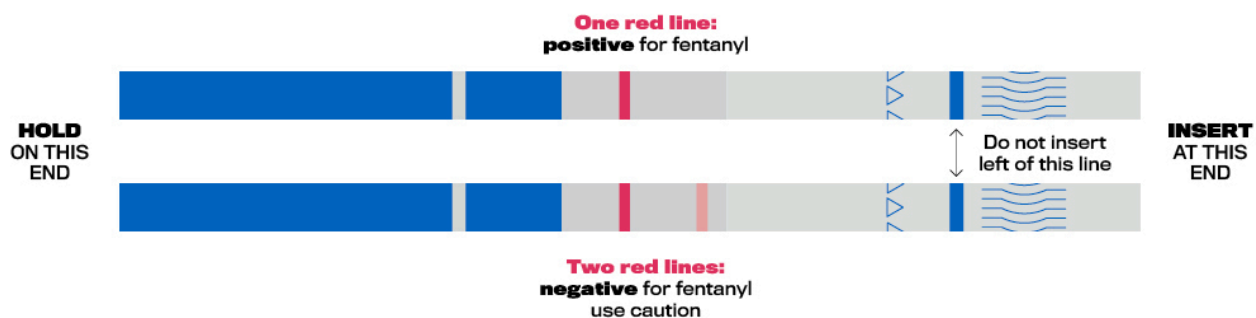
Hashim Zaibak, CEO of Hayat Pharmacy in Milwaukee, noted that patients really like the medication drop boxes in his pharmacies and feel more comfortable dropping off their medications in the pharmacy rather than taking them to a police station. The patients have an increased awareness of proper medication disposal and want to keep unused medication out of the hands of their children and grandchildren. The newly added service is a win-win for both patients and his business.

FENTANYL TEST STRIP DISTRIBUTION

Contributed by: Kristen Grimes, MAOM, MCHES

Fentanyl is a synthetic opioid that is up to 50 times stronger than heroin and 100 times stronger than morphine.¹ Fentanyl is found in multiple street drugs throughout Wisconsin, including heroin, methamphetamine, cocaine, pills, and more. The rate of deaths from synthetic opioids has significantly increased in Wisconsin from 2015 (1.9 per 100,000) to 2020 (18.1 per 100,000).²

Fentanyl test strips (FTS) are used to identify if fentanyl is present in a drug. FTS will not identify the volume of fentanyl, just that it is present. If a drug tests positive for fentanyl, there are strategies to reduce the risk of overdose which include going slow, using less, using a different administration method, or using with others.³



ABATEMENT STRATEGIES TO CONSIDER

Pharmacies that have trusted relationships with people who use drugs (PWUD) could serve as a critical access point for overdose prevention materials, such as FTS. It is important that a safe space is established to request this brief intervention. This is because drug use is often hidden and this service would be most effective when FTS can be provided anonymously. PWUD will often not accept services if they are required to provide a name due to stigma, shame, or other personal reasons.

FTS can be distributed in simple kits with brief instructions included. It takes about 30 seconds to provide education on how to use them.

1. Centers for Disease Control and Prevention. (2022). Fentanyl facts. <https://www.cdc.gov/stopoverdose/fentanyl/index.html#:~:text=Test%20strips%20are%20inexpensive%20and,%20like%20drugs%2C%20like%20carfentanil.&text=Recognizing%20the%20signs%20of%20opioid%20overdose%20can%20save%20a%20life.>
2. Wisconsin Department of Health Services. (2022). Dose of Reality: Opioid Deaths by County Dashboard. <https://www.dhs.wisconsin.gov/opioids/deaths-county.htm>
3. National Harm Reduction Coalition. Fentanyl. <https://harmreduction.org/issues/fentanyl/>

EQUITY CONSIDERATIONS

Drug use impacts all of us. We all know someone who has used/currently uses drugs, someone who was lost to overdose, or someone who secretly uses drugs that we may not be aware of. There is a significant amount of judgement and stigma associated with drug use, which prevents PWUD from seeking preventative or life-saving services. Pharmacies have an opportunity to help reduce this stigma by providing overdose prevention tools and harm reduction without judgement.

RESOURCE AND FUNDING CONSIDERATIONS

There are a variety of FTS that have recently come on the market for about \$0.70 per strip. A FTS kit usually contains 4-5 strips with instructions for use and can be placed in a small bag. The kits also may include sterile water and cookers.

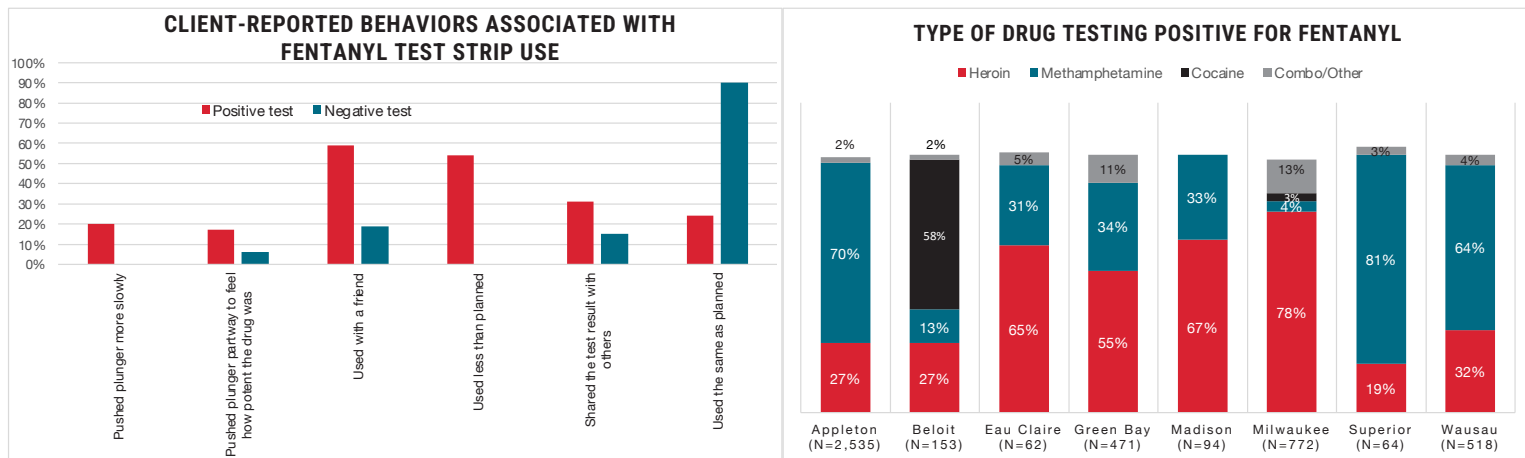
DanceSafe provides educational materials on how to use FTS with different types of drugs. This comprehensive brochure can be found at: <https://dancesafe.org/product/fentanyl-testing-strips-instruction-sheets/>

Pharmacies that participate in the Vivent Health Lifepoint satellite site program will receive FTS as part of the opioid settlement funding program.

There may also be opportunities to partner with the Wisconsin Department of Health Services (DHS) to become a FTS distribution partner. More information will be available in the future as this statewide program is fully implemented in Wisconsin.

STORIES

Vivent Health implemented a FTS program in 2019. Participants returned to Vivent Health to share their experiences around the types of drugs tested, those that test positive for fentanyl, and behaviors associated with positive and negative tests. Below are the data for each of their offices that had more than 50 reports of FTS use in 2021.



SYRINGE SERVICE PROGRAMS (SSP)

Contributed by: Kristen Grimes, MAOM, MCHES

Syringe service programs (SSPs) are rooted in harm reduction, meaning they meet people where they are at, without judgement or stigma, and provide them with the tools and resources needed to be as safe as possible. SSPs provide access to sterile syringes and injection supplies, disposal of used syringes, overdose prevention supplies and harm reduction education. As a safe and trusted space, people who inject drugs (PWID) also visit SSPs for referrals to medication-assisted treatment (MAT), HIV/HCV treatment, wound care, and more.



Nearly 30 years of research has shown that comprehensive SSPs are safe, effective, cost-saving, do not increase illegal drug use or crime, and play an important role in reducing the transmission of viral hepatitis, HIV and other infections.¹ In Wisconsin, several public and private SSPs exist. While not a comprehensive list, the North American Syringe Exchange Network ([NASEN](#)) is a publicly available directory of SSPs operating in North America who have provided consent to be included in the directory. In addition to multiple public health departments in Wisconsin, Vivent Health is a strong partner for SSPs throughout the state of Wisconsin. Many of these SSPs provide harm reduction services through dedicated office locations and multiple satellite site partners, which have included pharmacies.

Additionally, there is a growing online presence to allow access to mail-based harm reduction supplies. One example is [NEXT Distro](#); a program that allows direct shipping to low- and no-access communities and encourages direct connection for PWID with in-person SSPs when possible. While recognizing in-person SSPs are best, there has been some research in recent years that have identified the benefit of mail order harm reduction in reaching previously underserved populations. This format limits geographic barriers, supports privacy and confidentiality, reaches an increased percentage of females than traditional SSPs, and encounters nearly 75% of clients who had not previously obtained syringes from safe sources.²⁻³

ABATEMENT STRATEGIES TO CONSIDER

Pharmacies that have trusted relationships with PWID could serve as a critical access point for sterile supplies, overdose prevention materials, harm reduction education and referrals.

1. Centers for Disease Control and Prevention. (2019). Summary of Information on The Safety and Effectiveness of Syringe Services Programs (SSPs). <https://www.cdc.gov/ssp/syringe-services-programs-summary.html>
2. Hayes BT, Favaro J, Davis CS, Gonsalves GS, Beletsky L, Vlahov D, Heimer R, Fox AD. Harm Reduction, By Mail: the Next Step in Promoting the Health of People Who Use Drugs. *J Urban Health*. 2021 Aug;98(4):532-537. doi: 10.1007/s11524-021-00534-1. Epub 2021 Mar 12. PMID: 33710493; PMCID: PMC7953942.
3. Hayes BT, Favaro J, Coello D, Behrends CN, Jakubowski A, Fox AD. Participants of a mail delivery syringe services program are underserved by other safe sources for sterile injection supplies. *Int J Drug Policy*. 2022 Jan;99:103474. doi: 10.1016/j.drugpo.2021.103474. Epub 2021 Oct 5. PMID: 34619446; PMCID: PMC8755579.

To offer the most effective SSP services it is important that a safe space be established for a brief intervention. SSPs are also most effective when provided anonymously. PWID need to be able to maintain anonymity as drug use is often hidden. PWID will often not accept services if they are required to provide a name due to stigma, shame, or other personal reasons.

To offer the most effective [syringe service program] it is important that a safe space be established for a brief intervention.

It is important for pharmacy staff to understand the purpose of the SSP and support its implementation. It is critical that PWID feel safe when access SSPs, as stigmatizing behavior will break this trust. It is important that pharmacy staff implementing a SSP understand how to ask questions and have discussions in a judgement-free way.

Several [tools and resources](#) about developing, implementing, and monitoring a SSP have been compiled by the Centers for Disease Control and Prevention (CDC). One comprehensive resource identified by the CDC is a toolkit for planning and establishing a new SSP offered by [The Harm Reduction Coalition](#). The toolkit walks the leader through an internal and external environmental scan and poses several questions for a development and implementation team to consider. For those practicing in rural areas, the [Comer Family Foundation Guide](#) to Establishing Syringe Services Programs in Rural, At-Risk Areas may be a useful resource for additional background and considerations specific to rural areas.

Rather than starting a new SSP on their own, another option for pharmacies is to partner with an established SSP to serve as a satellite site. Partnership often includes establishing an agreement or memorandum of understanding, training for pharmacy staff who will administer the program, coordination of supplies for distribution, and data collection forms. The partner organization administers the program and provides monthly data back to the established SSP on services delivered. Satellite site expansion is dependent on available funding for program supplies (e.g., sterile syringes and injection supplies).

EQUITY CONSIDERATIONS

Drug use can affect anyone. We all know someone who has used/currently uses drugs, someone who was lost to overdose or someone who secretly uses drugs that we may not be aware of. There is a significant amount of judgement and stigma associated with drug use, which prevents PWID from seeking services. Pharmacies serving as SSPs have an opportunity to help reduce this stigma, by normalizing SSP services, providing strategies to reduce the risk of overdose and connecting individuals to needed services. While it would be ideal for all pharmacies to offer SSP, this is unlikely given multiple competing priorities. For pharmacy chains and health systems with multiple pharmacy locations, implementation should first focus on communities with highest rates of OUD and lower access to treatments. This can be discovered through researching state or local dashboards, or collaborating with community organizations in this space.



RESOURCE AND FUNDING CONSIDERATIONS

For pharmacies that want to start their own SSP, the resources needed would be support from pharmacy management, on the job training for staff providing services, establishing a safe space to deliver services, staffing time to provide SSP services, and funding for the cost of supplies.

For pharmacies that partner with an existing SSP, the resources needed would be support from pharmacy management and staff time to provide SSP services and data collection. The existing SSP would need to consider additional funding to support the cost of supplies to support the expansion of existing services.

STORIES

Text received from a new SSP participant:

“Thank you again. Sometimes God sends someone an angel in the most awkward of ways. I was not sure what to expect and in all honesty thank you for looking at me as an equal....not some bottom feeding degenerate. I am addicted, but I’m still a person. So, appreciative you seen that!!!”

A past SSP participant who shared the following at a community event:

The client found me at the recent Fox Valley recovery celebration. She mentioned how much she has been wanting to talk with me and share her success story and how I was a part of that. She shared “You cared about me when few people did. You saw who I could be. You provided a judgement free space and never made me feel stupid. You were the first person to plant the seed of recovery.” Then she gave me her medallion of her five years being sober. She just celebrated six years of sobriety.

PHARMACY ROBBERY PREVENTION & RESPONSE

Contributed by: Danielle M. Womack, MPH

Between 2011 and 2015, Wisconsin rose from having the 30th most pharmacy robberies in the nation to the 3rd most.¹ While Wisconsin's ranking has varied since 2015, there have consistently been multiple cases of attempted or successful robberies of pharmacies. Robberies have occurred in more than a dozen counties across the state, rural and urban, and independent community, chain community, and health system pharmacies, according to law enforcement records kept by the Wisconsin Department of Justice (DOJ).

To address the threat of pharmacy robberies to pharmacies across the state, the Pharmacy Society of Wisconsin (PSW) and the Wisconsin DOJ created a [Pharmacy Robbery Prevention and Response program](#), which is designed to assist pharmacies in implementing robbery prevention measures and also to train pharmacy personnel in safer methods of response should a robbery occur.²

ABATEMENT STRATEGIES TO CONSIDER

The Pharmacy Robbery Prevention and Response program is available free of charge to PSW members and is \$10 for non-PSW members. The course is available entirely online and takes about 30 minutes to complete. Pharmacists may also receive CE credits for the course.

Pharmacies can train new hires, all employees individually, or as a group training session.

Implementation of some recommendations are simple changes in practice and are not generally associated with significant costs. Conversely, adding certain security measures, especially enhanced technology, will require capital investment.

Since the release of the training program, 98 pharmacists and 95 pharmacy technicians have completed the Pharmacy Robbery Prevention and Response program through the PSW learning platform. Additionally, the program was presented live to student pharmacists at all three Wisconsin Schools of Pharmacy over multiple years impacting hundreds of new practitioners.

1. Top 20 states for pharmacy robberies. Pharmacy Times. Published July 21, 2015. Accessed June 26, 2023. <https://www.pharmacytimes.com/view/top-20-states-for-pharmacy-robberies>.
2. Mintz H. DOJ, pharmacies partner with goal to prevent robberies. WISN. Updated March 7, 2017. Accessed June 29, 2023. <https://www.wisn.com/article/live-doj-pharmacies-partner-with-goal-to-prevent-robberies/9101499>.



THANK YOU TO AUTHORS AND REVIEWERS

THANK YOU TO THE AUTHORS OF THIS TOOLKIT:

Theresa Frey, PharmD, BCPP

Clinical Pharmacist, William S. Middleton Memorial Veterans Hospital, Madison

Nicole Green, RPh, BSP, DPLA

Pharmacy Manager, ThedaCare, Neenah

Kristen Grimes, MAOM, MCHES

Director of Prevention Services at Vivent Health, Madison

Matt Huppert, PharmD

Clinical Pharmacist, Fitchburg Family Pharmacy, Fitchburg

Diane Johnson, PharmD, BCPS

Clinical Pharmacist, William S. Middleton Memorial Veterans Hospital, Madison

Special Thanks to:

Anna Marceau, PharmD

Clinical Pharmacist, William S. Middleton Memorial Veteran's Hospital, Madison

William Peppard, PharmD, BCPS, FCCM

Pain Stewardship Coordinator, Assistant Professor of Surgery, Froedtert & the Medical College of Wisconsin, Milwaukee

Erica Martin, MHA

Health Policy and Association Management Professional, American Medical Association

Martha A. Maurer, PhD, MPH, MSSW

Health Policy Research Scientist, University of Wisconsin-Madison School of Pharmacy, Madison

Tyler J. Prickette, PharmD, BCPS

Director of Pharmacy, Fort HealthCare, Fort Atkinson

Katherine Rothbauer, PharmD

Clinical Pharmacist, William S. Middleton Memorial Veterans Hospital, Madison

Matthew Stanton, PharmD, BCPS, DABAT

Emergency Medicine Pharmacist, Froedtert Hospital, Assistant Professor, Medical College of Wisconsin School of Pharmacy, Milwaukee

Stephanie Tchen, PharmD, BCCCP

Clinical Pharmacist, Froedtert Health, Milwaukee

Prati Wojtal, MS, RPh, FASHP

Coalition Member, Take Back My Meds MKE

Danielle M. Womack, MPH

Vice President of Public Affairs, Pharmacy Society of Wisconsin, Madison

Dustie Zimmerman, PharmD

Clinical Pharmacist, HSHS St. Joseph's Hospital, Chippewa Falls, Clinical Pharmacist, Marshfield Clinic Health System, Marshfield

THANK YOU TO THE MULTIDISCIPLINARY REVIEWERS OF THIS TOOLKIT:

Melanie Engels, PharmD, MBA

Director of Pharmacy Operations & Engagement at Froedtert Health, Milwaukee

Amber Brandolino, MS

Program Evaluation Manager, 414LIFE, Institute for Health and Equity's Public & Community Health PhD Student, Medical College of Wisconsin

Allyson Rennebohm, MSN, RN

Community Engagement Nurse Coordinator, Froedtert Health, Milwaukee

Josephine Kristiansen, PharmD, BCPS

Clinical Pharmacist, Froedtert Kenosha Center, Kenosha

Ashley Thousand, LCSW, SAC

Clinical Psychotherapist, Froedtert Health, Milwaukee

Sommer Gay, PharmD

PGY2 Oncology Pharmacy Resident, Froedtert Hospital, Milwaukee

Rebecca Bauer, MD

Assistant Professor, Medical College of Wisconsin School of Pharmacy, Milwaukee

Sarah Endrizzi, MD

Assistant Professor, Medical College of Wisconsin School of Pharmacy, Milwaukee

Kristin Bialkowski, PharmD, BCCCP

Clinical Pharmacist Manager, Froedtert Hospital, Milwaukee

Ryan Werner, PharmD

Pharmacist, Walgreens, Madison

Mike Hallam, PharmD

Clinical Pharmacist, Froedtert Hospital, Milwaukee

Jennifer Hernandez-Meier, PhD, MSW

Assistant Professor, Medical College of Wisconsin School of Pharmacy, Milwaukee

TOOLKIT EDITED BY:

William Peppard, PharmD, BCPS, FCCM

Pain Stewardship Coordinator, Assistant Professor of Surgery, Froedtert & the Medical College of Wisconsin, Milwaukee

Erica Martin, MHA

Health Policy and Association Management Professional

Kate Hartkopf, PharmD, BCACP

Director of Team-based Care Strategies & Business Development, Pharmacy Society of Wisconsin, Madison



Pharmacy Society of Wisconsin

Pharmacy Society of Wisconsin • 701 Heartland Trail, Madison, WI 53717 • 608-827-9200 • www.pswi.org