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THE QUARTERLY DOSE

From The ACCP Community-Based PRN

STAY IN THE KNOW

What's Happening in the PRN

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Texas Tech Jerry H Hodge School of Pharmacy

Hello everyone!! We have a couple very exciting things coming up in the ACCP Community-based PRN. First, the Community-based Focus Session for the upcoming 2023 ACCP Annual Meeting that will take place in Dallas, TX from November 11th-14th. The focus session for this year will focus on community pharmacists as frontline healthcare workers and the emerging or expanding services we are seeing in the community setting. More details will be forthcoming about the annual meeting and focus session as we are assigned a date and time.

The Community-based PRN was one of the winners of the 2022 PRN ACCP-PAC Challenge this past year. This means we get to pick our preferred time for the PRN Business and Networking meeting at the 2023 Annual Meeting. This is great news for a PRN as new as ours! Thank you to everyone who contributed and to everyone for supporting the Community-based PRN!

The programming committee for the PRN is now full steam ahead to plan programming events for the upcoming year. We are shooting to host a programming event once per quarter to engage our members. Be on the lookout for an event in February where our PRN will be partnering with the ACT collaborative for an exciting session. There will be more news to come on this session and other session for the future as the programming committee gets them planned.

You are always welcome to reach out with ideas and questions at Emily.eddy@ttuhsc.edu

UPCOMING EVENTS

ACCP COMMUNITY-BASED PRN AND ACT PHARMACY COLLABORATIVE RESEARCH ROUNDTABLE

Thursday, March 9th at 1 -2 pm EST/ 10 - 11 am PST

If you're interested in community-based research, attend this discussion for networking and brainstorming! See the listserv email for more info and **attend via Zoom HERE.**

Hosted by The ACT Pharmacy Collaborative (click for more info) *and our PRN*

IN THIS ISSUE

CLINICAL UPDATES

(see last page for all citations)

Navigating the Amoxicillin Shortage

Jennifer Siebenberg, PharmD Candidate 2023 and Emily Eddy, PharmD, MSLD, BCACP
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Amoxicillin is one of the most common antibiotics prescribed for ear infections, sinusitis, and pneumonia in children. With the ongoing shortage of amoxicillin suspension in a time when infections are high, patients may be wondering what alternatives can be used. The shortage of amoxicillin suspension started in November 2022 with the anticipation it would last several months. Due to this shortage, manufacturers have limited the amount of amoxicillin suspension a pharmacy may order at a time. If your pharmacy has a short supply of amoxicillin suspension, one solution may be to reach out to other pharmacies in your area to help patients find who has it in stock so they may still fill their prescriptions.

Another alternative option is to have the amoxicillin suspension formulation switched to tablets or capsules. Amoxicillin capsules may be opened and the contents mixed with juice, applesauce, or pudding. Tablets may be crushed to a fine powder and be mixed as well. Either way, the patient needs to completely finish the mixture to ensure they receive the full medication dose.

Another alternative would be to have the medication changed to a different antibiotic that is not on shortage. Examples would include Augmentin, cephalosporins like cephalexin or cefdinir, or clindamycin. Cephalexin, cefdinir, and clindamycin suspensions are currently available to order. If Augmentin suspension is unavailable, the IR tablet formulation may also be crushed. Clindamycin and cefdinir capsules may also be opened and sprinkled if needed.

The American Academy of Pediatrics has outlined alternatives in regards to formulations, as well as their Red Book Systems-Based Table has guidance to alternative antibiotics that may be used.

CDC Updated Opioid Prescribing Guidelines

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University of Buffalo School of Pharmacy and Pharmaceutical Sciences

Evidenced based CDC opioid prescribing guidelines (11/3/22) have been published since the previous 2016 version. Significant updates include determining if opioids need to be initiated, selecting the correct opioid and dosages, duration of therapy, conducting follow-up, and assessing the risks and potential harms (3). In addition to clinical factors, it is recommended to individualize prescribing plans based on patient preferences, conditions, pain level, and input (4). Since guidelines are emphasizing holistic, individualized patient care, community-based pharmacy is heavily impacted (5).

So how does this update impact community-based pharmacy? The better question is how does it not? Community pharmacists have historically bridged the gap between physicians and patients, and the change in opioid prescribing will only make this bridge more necessary (5). Evidence shows that concomitant opioid and benzodiazepine use increases the risk for overdose and death. Community pharmacists are in a position where they can verify concomitant use from their system and with the patient prior to dispensing. Additionally, in most states, community pharmacies can dispense naloxone through a standing order (6). Community pharmacists can provide naloxone and proper, timely counseling to patients at risk for opioid overdose. The guidelines also emphasize the use of over-the-counter medications for acute pain and community pharmacists are an accessible resource to determine therapy options (4).

The updated prescribing guidelines opens avenues for community-based pharmacies to advocate for patient care with their unique position and patient relationships. They can advocate for their patients by offering naloxone, working closely with them to taper, and developing an opioid medication plan. Community-based pharmacy is continuing to advance, which makes it essential for them to advocate for their patients and communities' health.

For a handy resource developed by the authors, see page 3 or go to https://tinyurl.com/3299n2yw

CLINICAL UPDATES

(see last page for all citations)

FIGURE 1: SUMMARY OF CDC GUIDELINES FOR PRESCRIBING OPIOIDS

CDC Recommendation	Impact and Rationale	Implementation Considerations
1. Maximize use of nonpharmacologic and nonopioid pharmacologic therapies as appropriate for **acute pain**. Consider opioids if benefits outweigh the risks.	• Nonopioid therapies are at least as effective for common acute conditions (low back pain, neck pain, etc.)	• Maximize use of non-opioid pharmacological and nonpharmacological options o topical or oral NSAIDs, acetaminophen, ice, heat, or exercise
2. Maximize use of nonpharmacological and nonopioid therapies for **subacute and chronic pain.** Consider initiating opioids if the benefits outweigh the risks.	• Increased risk for serious harms related to long-term, dose dependent, opioid therapy • Exercise therapy can reduce pain and improve function after treatment • Insufficient evidence for long-term benefits of opioid therapy for chronic pain	• Noninvasive nonpharmacologic approaches for chronic pain management: o Exercise (aerobic, aquatic, resistance, etc.) o Weight loss as appropriate (hip/knee osteoarthritis) • Nonopioid pharmacological options o Few are NSAIDs, acetaminophen, or duloxetine
3. Prescribe **immediate-release** (instead of extended-release or long-acting) for acute, subacute, or chronic pain.	• ER/LA opioids: methadone, transdermal fentanyl, ER versions of oxycodone, hydromorphone, morphine • Higher risk of overdose with ER/LA opioids compared to IR opioids • ER/LA opioids are **NOT** more effective or safer than intermittent use of IR opioids • Time-scheduled ER/LA opioids do **NOT** reduce risk of opioid use disorder	• ER/LA opioids should **not** be prescribed for: o Acute pain o Initial opioid treatment for subacute or chronic pain. o Intermittent or as-needed use • **Use ER/LA opioids for:** o Severe, continuous pain and if patients tried and failed 1 week of daily oral doses of IR opioids (daily doses of 60 mg morphine, 30mg oxycodone, or equianalgesic doses)
4. Prescribe the **lowest effective** dose for acute, subacute, or chronic pain for initial, opioid-naïve patients. Evaluate risks and benefits for continuous therapy.	• Opioid doses of 50-90 MME/day have **minimal** greater improvement in pain intensity compared to <50 MME/day and **no difference** in mean improvement in function. • Risks for serious harms increase at higher doses	• Lowest effective dose determined by starting with label recommendation and adjusted based on pain and clinical factors • Recommended lowest starting dose for **opioid-naive** patients is a single dose of ~**5-10 MME OR daily dose of 20-30 MME/day**
5. Assess **risks and benefits** of changing opioid dosage. Work with patients to optimize nonpharmacological therapy, taper, lower, or discontinue dosages as appropriate. Avoid rapid dose reduction or abrupt discontinuation.	• Long-term, high dose chronic pain therapy increases risk of adverse events • Abrupt discontinuation of long-term, high dose therapy is associated with adverse events (mental health crisis, overdose events, overdose death)	• Longer duration of opioid therapy might require a longer taper (several months to years) o **Tapers of 10% per month or slower** • For patients who have taken opioids for shorter durations (e.g., weeks to months rather than years) o **Decrease of 10% of the original dose per week** or slower until ~30% of original dose is reached, followed by a weekly decrease of ~10% of remaining dose → less likely to trigger withdrawal
6. For **acute pain**, prescribe only the quantity of opioids **needed** to cover the expected duration of severe pain.	• Pain improves within days for many for common types of acute pain in primary care • Recommended initial opioid prescription is **4-7 days**	• Nontraumatic, nonsurgical acute pain can often be managed without opioids • **Patients should be evaluated at least every 2 weeks if they continue to receive opioids for acute pain** • Longer durations of opioid therapy are more likely to be needed for prolonged severe pain (e.g., severe traumatic injuries)
7. Evaluate the benefits and risks with patients **within 1-4 weeks of starting opioid therapy** for subacute or chronic pain. For continued therapy re-evaluate with each dosage escalation.	• Risk for developing opioid use disorder associated with **continued therapy for > 3 months** • **Overdose risk high during the first 2 weeks of treatment**	• Follow-up with patients **within the first 2 weeks** of starting treatment or when **dose escalation results in > 50 MME/day** • Initial follow-up interval can be closer to **4 weeks** when starting **IR opioid at a dose of <50 MME/day**
8. Evaluate risk for **opioid-related harms** and discuss risk with patients. Incorporate management plan strategies to mitigate risk and **offer naloxone.**	• History of overdose, substance use disorder, alcohol abuse, sleep-disorder, and contaminant use of benzodiazepines increases risk of opioid overdose	• Co-prescribing naloxone when prescribing opioids for patients **at increased risk for overdose**, or if taking **>50 MME/day**, or if taking **benzodiazepines with opioids** • Overdose prevention education should be offered to members of the patient's household
9. Periodically **review the patient's history of controlled substance prescriptions** to **assess combinations** that can increase the risk for overdose.	• **Concurrent treatment with opioids and benzodiazepines increases overdose risk** • Risk is further increased with treatment from multiple prescribers rather than one	• PDMP (prescription drug monitoring program) should be reviewed before initial opioid prescription and then every 3 months or more frequently as needed
10. Consider the benefits and risks of **toxicology testing** to assess prescribed and non-prescribed controlled substances.	• Before starting opioids and periodically (at least annually) during therapy, consider toxicology testing to assess controlled substances that increase risk for overdose when combined with opioids o Including non-prescribed and illicit opioids and benzodiazepines	• Confirmatory toxicology testing should be used when: o Toxicology results will **inform decisions** with major clinical or nonclinical implications o To detect specific opioids or other drugs within a class, such as those that are being prescribed, or those that cannot be identified on standard immunoassays o To confirm unexpected screening toxicology test results
11. Be cautious with concurrent **opioid pain medication and benzodiazepines** use and consider risk vs. benefit of concurrent use of opioids and other central nervous system depressants.	• **Unpredictable use of opioid and benzodiazepines** increases risk of concurrent use • Increased risk with combination of higher-dosage opioids and higher-dosage benzodiazepines or with other substance use like alcohol, illicit IV drugs, and psychoactive drugs	• Taper to discontinue benzodiazepines gradually because abrupt withdrawal can be associated with rebound effects o Rebound effects: anxiety, hallucinations, seizures, delirium tremens, and rarely death o Tapering rate should be individualized • Buprenorphine or methadone for opioid use disorder should not be withheld from patients taking benzodiazepines or other medications that depress the central nervous system
12. Detoxification without medications for opioid use disorder, is **NOT recommended** due to increased risks for resuming drug use, overdose, and overdose death.	• Medication treatment of opioid use disorder associated with reduced risk for overdose and overall deaths • FDA-approved medications for the treatment of opioid use disorder include: o **Buprenorphine (partial agonist opioid)** o **Methadone (full agonist opioid)** o **Naltrexone (opioid antagonist)**	• Use **DSM-5 to assess opioid use disorder** • For **pregnant persons**, buprenorphine or methadone is the recommended opioid use disorder therapy o Offer early to prevent harm to patient and the fetus

Member Spotlight:
Joni Carroll, PharmD, BCACP, TTS

Katie Hettinger, PharmD
Purdue University College of Pharmacy

Dr. Carroll is an Assistant Professor of Pharmacy and Therapeutics at the University of Pittsburgh School of Pharmacy. She also serves as a lead pharmacist with the Allegheny County Health Department. Dr. Carroll's passion for community pharmacy stems from the accessibility and potential of community pharmacists to bridge gaps in the fragmented healthcare some patients receive.

1. What enticed you to get involved with the ACCP Community-Based PRN?

Dr. Carroll was excited to join a PRN full of "movers and shakers" in the community pharmacy space. The ability to be a part of the voice for community pharmacy within ACCP and to network amongst other community pharmacy champions fueled her involvement.

2. What excites you about the future of community-based pharmacy practice?

Dr. Carroll believes community pharmacy is at a precipice for advancement and opportunity in the public health space. Through her involvement with the local health department, she has been able to bridge gaps and provide needed services to patients in her community. With expanded opportunities for pharmacists to prescribe, provide treatment, and get paid for their services occurring in Pennsylvania and Nationwide, the community pharmacists' role continues to evolve.

3. What community-based services or research projects are you currently working on?

Dr. Carroll's most recent project involves the launch of an STI home testing service with a local independent pharmacy, Hilltop Pharmacy, and the Allegheny County Health Department. Patients can obtain an at-home STI treatment kit through the health department's website or it can be picked up at the pharmacy. Patients then receive treatment at an accessible, and more discrete, location via the pharmacy. Pharmacists at Hilltop Pharmacy are able to prescribe STI treatment through standing orders with the health department. This program reaches underserved patient populations and provides further access to tests and treatment for STIs. You can read more about Dr. Carroll's work with this program here.

4. What advice do you have for students looking to pursue a career in community-based pharmacy practice?

Talk to anyone and everyone who is working on projects you are interested in! By talking to other pharmacists, you can learn about different opportunities to pursue in the pharmacy world, as well as start to get involved in projects you are passionate about. If you aren't sure how to find pharmacists doing the work you enjoy, ask around and we will connect you!

5. What do you like to do in your spare time outside of pharmacy?

Before becoming a pharmacist, Dr. Carroll was a professional dancer for Norwegian Cruise Line! She currently keeps up on her dance skills by giving back and teaching children how to dance part-time at Hill Dance Academy Theatre (HDAT). You can check out a film Dr. Carroll choregraphed and directed students in during the pandemic here. Through her continued involvement in dance, she has forged public health connections and community partners. Dr. Carroll and Dr. Ayisha Morgan-Lee, HDAT's Founder/CEO/Artistic Director, worked together to help get vaccines out to community members during the COVID-19 pandemic.

WELLNESS TIP!

By Jina Zhao, PharmD Candidate and Emily Eddy, PharmD, MSLD , BCACP
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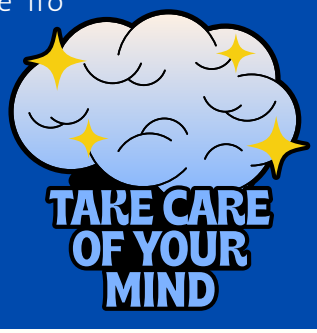
For the next six months, elevate your lifestyle with these four habits.

1. Journaling: Journaling before bed can help a person process their thoughts and emotions in a healthy way, leading to improved mental well-being. It can serve as a form of self-reflection or stress relief.
    a. Some example prompts to write about:
        i. Your goals for tomorrow.
        ii. What are you grateful for?
        iii. Any negative thoughts or emotions you may have.
2. Move your body: Take a 30–60-minute walk in nature or complete physical activity that you enjoy (8). To improve or maintain mental health, a person must also have good physical health. Potential exercises to strengthen and tone include running, swimming, weightlifting.
3. Embrace the silence (9): A person's mind can race with hundreds of thoughts every minute. Learning to sit in silence can lead to greater self-awareness, focus, inner peace, and creativity. Sit in silence for at least 10 minutes by practicing meditation and being present and living in the moment.
4. Create a proper sleep schedule (10): Sleep is essential for performance, mental health, stress reduction, improving your mood, and many other things. Tips for deep quality sleep include no screens or heavy meals two hours before bed, make your room cooler, or use blackout curtains.



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- Legislative Update

Citations

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