Amid COVID-19 crisis, pain therapeutics telehealth services by pharmacist clinicians fill unique void and mitigate risk

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Abstract
Patients with chronic pain syndromes are facing additional challenges from syndrome coronavirus 2 (SARS-CoV-2) virus compared with the general population. New reasons for compounded social isolation and commensurate opioid dose creeping and suicidality/anxiety, difficulty in obtaining legitimate medications, proper comprehensive evaluations, ongoing opioid risk stratification for opioid abuse/misuse, safe opioid tapers if necessary, and other opportunities for pharmacist intervention are clear. We discuss opportunities for pharmacist-run telehealth visits, reimbursement for services, and various aspects of interventions during this time of international emergency where all healthcare professionals have been asked to step up to help combat the mutual threat of COVID19. Clinical pharmacists in every specialty area are part of the essential healthcare workforce, but those practicing pain management in particular are in unique positions to assist all providers in adhering to chronic pain guidelines and various government mandates, and to foster optimal outcomes to complex patients with chronic pain. Furthermore, those that are available by telemedicine allow for improved access to quality and appropriate pain medication management, and additionally support opioid risk mitigation strategies, helping fill an unmet access to those at higher risk. This practice has the potential to help offset primary care provider workload, allowing for a decreased overall burden, especially in a complex, time-consuming, and high-risk patient population.

Keywords
Telehealth, pain management, clinical pharmacist, coronavirus, SARS-CoV-2, COVID-19

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While the majority of the world has been put on pause to reduce the impact of infection spread, other chronic diseases continue unabated and largely ignored in the midst of this new normal. Chronic pain sufferers worldwide are among those who are finding themselves put on hold, and who have a particularly high malady progression risk medically, socially, and emotionally. Within the United States, there have been appropriate recommendations to delay and minimize use of several elective surgeries and procedures, which may have benefitted this group. These procedures may include several types of interventional pain procedures (steroidal injections, nerve ablations, orthopedic surgeries, spinal surgeries, etc.), as well as various other non-pharmacologic modalities that are used to reduce chronic pain (physical therapy, chiropractor, acupuncture, etc.). All of these modalities contribute a significant portion to the entire multimodal approach to chronic pain treatment and are therapies that millions of patients with chronic pain rely on for relief.

As a result of this collapse of normal medical care, there has been an enhanced reliance on medication modalities to be used as stop gaps for the treatment of chronic pain. However, one critical change within this landscape has been the increased difficulty to perform appropriate monitoring for these patients, especially those maintained on opioid regimens. With reduced capacities to see patients face-to-face and the rise of the utilization of telehealth technology itself, the normal “standards of care” in regard to monitoring pain medications (including lab work, urine drug screens, physical examinations, etc.) are becoming less frequently performed and with lower priority. This has also applied to regulations resolved around the prescribing of controlled substances. Since March 2020, the Drug Enforcement Administration, federal government, and several state governments have issued changes in several controlled substance prescribing policies that have allowed the prescribing of controlled substances without physical examination (only through televideo vs telephone appointments), relaxed some restrictions on early refills of schedule III through V prescriptions, increased flexibility in regard to oral prescribing, and allowed bulk manufacturers of controlled substances to increase available supply to avoid existing or potential drug shortages. While all of this is important in the context of enhancing social distancing, it only adds to the growing complexity of management of this population during this pandemic.

**Public health problem of chronic pain at a crossroads with coronavirus**

The overall and total impact of coronavirus on chronic pain patients still remains unclear, but we believe that social isolation, lack of medical and behavioral health priority, lack of overall support, and increased access to opioids, all coupled with other sedative hypnotics and increased anxiety, is a perfect storm for poor outcomes, and could serve to fuel an underpinning opioid crisis. Chronic pain converging with opioid usage (legitimate and over/under prescribing) continues to be a growing and ongoing public health crisis, given chronic pain is already among the most common, costly, and disabling medical conditions. Opioid prescribing rates have trended down over the latter part of 2010s, thanks in large part to recognition of the importance of opioid risk mitigation and effective integration of the interdisciplinary pain team model; however, opioid overdose deaths continue to skyrocket to record highs year after year (mainly due to illicit fentanyl and heroin use). Opioid risks in addition to all of these startling public health issues are primarily what has driven the United States government and Department of Defense (DoD) to increase priority in not only effectively managing patients chronic pain, but to also actively attempt to reduce opioid usage rates throughout the country.

Adding to the strain on healthcare brought by the COVID-19 pandemic and opioid crisis is another expanding issue. The number of generalist physicians practicing across the US has been declining over the past decade, as rates of medical school graduates entering specialty practices have been rising. This has caused higher vacancy rates, increased burn-out rates (45% compared with 25% in other specialties), high-turnover, difficulty in recruiting, and larger patient panel sizes for primary care providers under normal circumstance; let alone the stress put forth by the coronavirus. This is perhaps more concerning within the chronic pain context, given not only the complexity of chronic pain itself, but the fact that pain/opioid education and training in the United States is completely lacking, significantly reducing the familiarity for clinicians when treating chronic pain. This is precisely where the pain management clinical pharmacist (PMCP) working in telehealth can meet between these two ever-expanding crossroads.

**The pain management clinical pharmacist: bridging the crossroads**

The integration of a PMCP position can help bridge the gap involving the chronic pain public health problem and the challenges brought by coronavirus, all while potentially reducing the burden on general practitioners. It supports several government and DoD mandates and clinical guidelines, allows for improved access to quality and appropriate pain medication management, supports opioid risk mitigation strategies, and allows for safer monitoring in accordance with this foundational guidance. An overwhelming amount of clinical evidence supports that primary care pain management programs inclusive of PMCPs improve opioid prescribing, increase patient satisfaction, reduce overall pain intensity, improve physical
functioning, and reduce overall costs.\textsuperscript{26–30} Furthermore, the majority of clinical pharmacist assessments and examinations can be done in a virtual setting which would enhance the access and level of care for patients who are not exposed to such access on a normal basis, but especially during this pandemic.

It is the unique and advanced training in pain therapeutics that PMCPs have that allows them the niche opportunity to improve such patient outcomes and help clinicians mitigate risk. In modern medicine, PMCPs primarily require completion of a doctorate of pharmacy from an accredited college of pharmacy, completion of a 1-year generalized pharmacy practice residency program, and completion of a 1-year pain and palliative care pharmacy residency program, collectively culminating into 8–10 years of training. These programs help foster and garner various skills and abilities that make PMCPs an inimitable healthcare clinician. See Table 1 for an exhaustive breakdown of potential roles, which in summary include an ability to conduct pain management and functionality assessments, initiate, modify, or recommend patient-center medication treatment plans optimizing non-opioid and opioid medication regimens (including the specifics to monitoring these patients), recommend non-pharmacologic modalities/assessments that fit the patient’s pain pathology as part of these treatment plans, assist providers in management of patients on high dose opioid agonists or unique opioid medications (such as methadone and fentanyl), and an ability to interpret and review pharmacokinetic and pharmacogenomic clinical data as it relates to medication usage (urine and serum drug screen interpretation).

PMCPs that practice specifically in telehealth are in unique positions to address several of these growing concerns regarding pain management in the United States that have only been further derailed by COVID-19, as well as to enhance access to a specialty level of pain management care to an extremely high-risk population. Through electronic consultation, PMCPs are able to help provide treatment recommendations and decisions after review of the patient chart and consultation with the patient’s primary care practitioner. With access to telemedicine technology, they are also able to conduct full patient interviews and assessments that allow them to be managed and monitored by the practicing PMCP.

The financial obstacle

Unfortunately, one major hurdle that prevents many private healthcare systems from integrating and implementing PMCPs (or any clinical pharmacists) into clinical roles is the lack of nation-wide provider status allotted to the profession of pharmacist. Given pharmacists are still not considered providers by the Centers for Medicare and Medicaid Services (CMS), they cannot be properly (or equivalently) billed for their service. There are several exceptions to this rule, of course, as there have been a handful of states that have granted provider status to pharmacist specialists, and others that allow for billing for specific pharmacist specialist services.

Billing parameters for pharmacists are variable and specific by state and insurance plans. Many pharmacists must demonstrate their worth by showing an improvement in CMS metrics, such as high-risk medications, cardiovascular and diabetes prevention, among others for a select patient population. This type of panel management can be done virtually; however, the dollar amount corresponds to cost avoidance, not revenue. This concept is often lost during financial decisions of an organization who are evaluating pharmacist positions during a pandemic.

Another option is low-level billing, such as “incident to” a physician. Unfortunately, the reimbursement for these activities is very small. In addition, the telehealth legislation passed in most states is vague and often times does not identify pharmacists as a billable provider. Therefore, pharmacists are faced with providing these services for free or on a cash paying scale to the patient.

It is important to recognize that a pharmacist with clinical residency training or experience must be compensated appropriately, and that compensation much come from somewhere. The focus must be on what these trained pharmacists’ averse outcomes and related expenses these clinicians are preventing and what the site, insurance payer, and patient are gaining. Quantifiable costs could include preventable hospitalizations, preventable drug errors and adverse events, reduction in drug diversion and relapse, as well as a reduction in visits to the patient’s primary care provider, urgent care, or emergency room.

There is a growing number of pharmacists working on prior authorization approvals for offices to streamline the process; however, this service too is difficult to quantify a return on investment, unless there was a higher-level prior authorization to be completed and the pharmacist could provide justification of time well spent. However, often times more routine prior authorizations can be handled as other routine office matters. Pharmacists can certainly be involved in protocol development and triaging of these office workflows as well.

In New York, for example, pharmacists can bill incident to; however, as indicated above the payment structure is grossly inadequate. It is noteworthy that the Department of Veterans Affairs Health Care Administration does recognize pharmacists as providers, thus has been billing for pharmacist services for decades.

Conclusion

During this time of international emergency, all healthcare professionals have been asked to step up to help combat the mutual threat of COVID-19, but especially those involved in the management of chronic pain. Clinical
Table 1. Roles of a pain management clinical pharmacist.

| Pain and Functionality Assessmenta | • Able to assess patients from both an objective and subjective perspective to identify areas/generators of chronic pain  
| | • Able to hypothesize potential underlying pathology based on review of symptomatology and any available imaging  
| Patient-Centered Treatment Recommendations | • Ability to recommend specific non-pharmacologic modalities that matches with underlying pathology supported by clinical trial evidence  
| | • Evaluation of analgesic pain medication regimen, with particular focus on analgesic therapies and potential drug interactions  
| | • Initiating, modifying, and or recommending medication regimens in patients who have already been tried on standard low doses of opioids and adjuvant medications (such as antidepressants, anticonvulsants, NSAIDs, acetaminophen and others when appropriate) and failed these alone and combined with non-medication therapies  
| | • Assist providers in optimizing the formulary for pain management drug therapy selection, including consideration for lower cost medications and decreasing physician burden in regard to completion of non-formulary requests  
| Opioid Assessment and Monitoring | • Assisting providers with ability to recognize when opioid medications may be appropriate and delineating which one could be beneficial over others (including guidance on selection of opioids with neuropathic pain relieving properties, and buprenorphine)  
| | • Working with providers to provide risk assessment evaluation and documentation with validated tools and lab analysis (Screener and Opioid Assessment for Patients with Pain [SOAPP], Current Opioid Misuse Measure [COMM], Risk Index for Overdose or Serious Opioid-induced Respiratory Depression [RIOSORD], Urine Drug Screen [UDS], ethyl glucuronide levels, etc.) on any patient chronically on opioid therapy  
| | • Aiding providers in reducing overall opioids usage, with particular emphasis on patients receiving one or more opioids chronically at MEDD equal to or exceeding 100 mg/day.  
| | • Minimizing risk factors that increase risk of opioid induced respiratory depression, including minimizing use of other medications that suppress respiratory drive and assessing substance abuse (including alcohol use) screenings.  
| | • Assessment of adherence to all pain medications in patients deemed to be non-compliant by their PCP.  
| | • Assist providers with management of any patient on fentanyl and/or methadone, a predetermined morphine equivalent daily dose, and high risk of drug/drug or drug/disease interaction.  
| | • Collaborate with PCP to complete all required electronic documents (i.e. Opioid treatment agreements) to ensure maximum patient safety.  
| | • Evaluate for need of at-home rescue naloxone for all patients on chronic opioid therapy, assist in increasing distribution of naloxone, and educate patient regarding at-home rescue naloxone therapy.  
| | • Perform pharmacokinetic and clinical monitoring of medications (i.e. serum opioids, urine drug screens), order and analyze appropriate laboratory tests and other diagnostic studies necessary to monitor and support the patient’s drug therapy to ensure the patients appropriate clinical responses to drug therapy.  
| | • Analyze and interpret pharmacogenomic results as it relates to current medication therapy.  

*This does not include an ability to diagnose, as diagnosing is outside of the scope of practice for pharmacists.*

pharmacists of all types are part of this healthcare workforce, but PMCP specialists in particular are in unique positions to assist all providers in adhering to chronic pain guidelines and various government mandates, and to foster optimal outcomes to complex patients with chronic pain. Furthermore, those that are available by telehealth allow for improved access to quality and appropriate pain medication management, and additionally support opioid risk mitigation strategies, helping fill an unmet access to those at higher risk. This practice has the potential to help offset primary care provider workload, allowing for a decreased overall burden, especially in a complex, time-consuming, and high-risk patient population.

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