Access to care – a BC perspective: how pharmacists can be supported in helping patients with OUD overcome barriers to care

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The opioid crisis is a multifaceted problem which cannot effectively be addressed with any single solution. Because of this, a multi-pronged approach incorporating psychosocial determinants of health alongside existing measures is necessary to improve the situation. Through my pharmacy practice, I have become aware that individuals using opiates face a multitude of access barriers to care.

People with opioid use disorder (OUD) may struggle not only with their addiction, but with their physical and mental health, and with other psychosocial determinants of health such as poverty or disability. The most common access issues I see in my practice are limited awareness of treatments that could help with OUD, difficulty finding or accessing healthcare providers willing to offer these treatments, barriers to paying for the cost of the treatment, trouble qualifying for support programs, and difficulty dealing with other physical and mental health issues.

Pharmacists are well-positioned to help patients navigate many of these barriers, but the current compensation model and regulatory environment do not allow them to spend their time helping, much as they may wish to do so. Here, I propose that provincial health policymakers consider making changes that encourage pharmacists and pharmacies to assist opioid users in overcoming barriers to care, thereby leveraging a willing, capable, and accessible profession to help address the opioid crisis.

Barriers to accessing care for people with OUD

Individuals with OUD are more likely to struggle with comorbidities, including physical and mental health issues.[2,3] These comorbidities can create barriers to care, for example, if the person's health problems take up a significant portion of their time or financial resources, they may be less able to address their OUD. Certain mental health issues may also cause patients to be distrustful of medical professionals, further creating barriers to care. Additionally, some providers may have stigmas toward those living with mental health conditions.[4]

People with OUD are also more likely to live in poverty, or in a lower income bracket,[5] though it is important to note that OUD can affect people of all backgrounds. Having limited financial means can create or contribute to barriers to care.

For individuals who are struggling with a dependency, it can be challenging to navigate the bureaucracy surrounding provincial drug benefit programs or social benefit programs. In British Columbia, the Psychiatric Medications Plan (Plan G) program was created with the goal of helping people access medications for their mental health. However, the program has inadvertently created bureaucratic and administrative barriers for patients. The program offers 3 months of bridge coverage before a patient must complete the application, but if they are unable to do so within this timeframe, their coverage will end.[1] Plan G has made some progress in addressing these barriers. For example, the program now allows applicants to simply declare that the cost of medications is a significant barrier and that their household income is less than $42,000 per year.

In addition, some individuals may live in areas where they have limited or no access to healthcare providers who are willing to work with patients who have addictions. They may also live prohibitively far away from the nearest pharmacy that offers treatment, further adding barriers to care. The goal should be for all Canadians to have access to treatment for opioid use disorder.

How pharmacists and pharmacies can help

As accessible, community-based healthcare providers, pharmacists are well-positioned to help address

many of the biggest barriers to patients with opioid use disorder. Here, I propose several ways that pharmacists could help improve access to care for OUD patients, which would ultimately help combat the opioid crisis.

Daily opioid agonist therapy (OAT), such as methadone, is typically dispensed on a daily schedule, with the pharmacist and patient in regular contact. This regular face-to-face contact presents an opportunity for additional healthcare provision. Given changes to the dispensing fee model, pharmacists could dedicate some time during their appointment to discussing and evaluating the patient's overall health, both physical and mental. If a patient appears to be struggling or to need additional support, the pharmacist could then assist in referring them for appropriate and timely healthcare.

Pharmacies could also offer services designed to help people access financial benefits or to navigate other bureaucracies, which would directly increase access to care. For this service, pharmacies could partner with social workers who could potentially meet with clients before or after treatment to offer personalized support. This type of strategy would leverage this valuable daily contact with OUD patients and ultimately, significantly increase access to care.

Finally, pharmacies have the potential to offer multidisciplinary healthcare that specializes in providing targeted healthcare for specific conditions or groups of conditions. Pharmacies could be given the option to specialize in particular patient populations, such as opioid use disorder, mental health, cancer, or diabetes. These specialized pharmacies could then offer specialized programs and services targeted to the community they aim to serve. OUD-focused pharmacies could offer different services tailored to OUD, and patients would feel safe and supported knowing they are being cared for by a specialized team. This could be a great way to incentivize pharmacies to increase access to care in underserved areas as well.

Proposed policy and regulatory changes

Pharmacists are not currently supported in helping patients overcome the barriers to care, much as they would like to help and are well-positioned to do so. Here, I propose policy and regulatory changes that could help address this problem.

The dispensing fee model for opioid agonist therapy (OAT) pays the pharmacist for dispensing the medication.[6] Under this model, pharmacists are not compensated for time spent evaluating a patient's health or for helping them navigate financial barriers to accessing care, for example. However, this represents a missed opportunity, as pharmacists could be leveraging their daily contact with patients to provide additional healthcare that reduces patient barriers and therefore, potentially helps improve their OUD.

An expanded compensation model could allow the pharmacist time to provide more comprehensive healthcare, including evaluating a patient's health, counselling, referrals, and other forms of support. For those receiving OAT, this would leverage the existing daily contact between the pharmacist and patient and would be an efficient use of existing resources and infrastructure to improve the opioid crisis.

In addition, support from pharmacists and pharmacies could help increase the impact of existing support programs such as Plan G in BC. By pairing social workers with pharmacies, patients could access financial support at the same time as they receive OUD treatment, making the pharmacy a one-stop shop.

Currently, pharmacists in BC are able to dispense sublingual OAT medications such as methadone, but cannot administer extended-release buprenorphine, an injectable, long-lasting form of OAT.[7] If pharmacists were able to offer injections, this would increase access to care by moving the location of treatment to the local pharmacy, and this would allow physicians to delegate, increasing their availability to additional OUD patients. Policymakers should consider the potential benefits of allowing pharmacists to adminis-

ter injectable OAT. This is not a far stretch, given that community pharmacists have been administering subcutaneous injections for over 10 years in British Columbia.

Finally, policymakers and regulatory bodies should consider changes that encourage pharmacies to specialize in specific therapeutic areas. As mentioned previously, these "boutique" pharmacies could offer specialized care and support outside of just medication provision. This would make use of existing community hubs to create better patient care experiences, and ultimately increase access for patients.

Conclusion

The opioid crisis has been worsening for years, and it is essential to leverage all existing healthcare infrastructure as efficiently as possible to attack this complicated issue from all angles. Here, I have proposed several ways that pharmacists could be encouraged to help support OUD patients. Pharmacists and pharmacies could offer health and financial counselling if the dispensing fee model was changed to compensate for time spent in these roles.

Pharmacists could partner with social workers to offer support in navigating social benefit plans as part of a one-stop shop experience. And finally, pharmacies could be encouraged to specialize in health conditions, offering an unparalleled care experience to patients that addresses not only their OUD but also other aspects of their psychosocial wellbeing.

Though the current compensation model does not allow for this support, some simple changes could be made that would unleash a lot of unused potential in our profession. Policymakers and regulatory bodies should consider these ideas, as they would leverage existing infrastructure in a highly efficient manner. With some simple changes, a willing, capable, and highly accessible profession could be enabled to do more to fight the opioid crisis and support this vulnerable population.

ACKNOWLEDGEMENTS

Editorial Assistance. Editorial assistance was provided by Laura Tennant, HBSc, and STA Healthcare Communications (Montreal, Canada). Support for this assistance was funded by Indivior Canada.

Disclosures. Ajit Johal has received honorarium for speaking about vaccines for the following organizations: he has participated in Advisory Boards for AA Pharma and Sanofi Pasteur; he was a speaker/consultant for Boehinger Ingelheim, McKesson Canada, Ensemble IQ, GSK, Merck, AstraZeneca, Seqirus, Novo Nordisk. Ajit has worked for the UBC Faculty of Pharmaceutical Sciences.

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