Interprofessional Team-based Opioid Education Introduction and Background
(Video-Conference Version)

This program was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS). The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS or the U.S. Government.

IPE SESSION OVERVIEW:
During the upcoming interprofessional education (IPE) training session, you will work with a team of students from other health professions (nursing, medicine, pharmacy, social work, and physician assistant) to provide collaborative care to a patient with pain who is taking opioids. Due to COVID-19, all interactions will occur virtually through Zoom. Instead of meeting a standardized patient, teams will participate in an unfolding video case. Although teams will not be meeting a standardized patient, teams will still be able to work together virtually to assess the patient and develop a treatment plan. During the session, each team will:
- Discuss roles and responsibilities of health care team members
- Practice using person-first, non-stigmatizing language
- Collect and assess patient information including:
  - Review of patient histories
  - Evaluation of screening tool results
  - Review of a prescription monitoring program (PMP) report
  - Calculation of a morphine equivalent dose (MED)
  - Evaluation of potential aberrant behaviors
- Develop a team-based treatment plan for a patient with pain who is taking opioids

It is likely that you will be the only student representing your profession on your team; therefore, it is important for each student to understand their profession’s role in providing patient care.

LEARNING OBJECTIVES:
By the end of the in-class session, students should be able to:

1. Describe the roles and responsibilities of the healthcare team and how they work together to provide team-based care to patients using opioids.
2. Utilize appropriate non-stigmatizing language when caring for patients taking or potentially misusing opioids.
3. Express one’s knowledge and opinions to healthcare team members with confidence, clarity, and respect, working to ensure common understanding of information, treatment, and care decisions.
4. As a member of the healthcare team, evaluate a patient for potential opioid misuse or opioid use disorder.
5. Differentiate between treatment options for a patient with an opioid use disorder and/or pain management.
6. Work collaboratively with the healthcare team and the patient to develop a patient care plan.
REQUIRED READING

Many national and state organizations have created practice guidelines and other recommendations related to pain management and opioid prescribing. The goal of this IPE session is to give participants a brief overview of pain treatment as it relates to opioids. The materials included within are not adequate training for comprehensive pain management.

Section I: Washington State Opioid Prescribing Requirements

“In response to the opioid crisis in Washington State and across the country, the legislature directed five prescribing boards and commissions to develop and adopt new opioid prescribing requirements. The Department of Health, in collaboration with the boards and commissions, is providing education and outreach on Washington’s new opioid prescribing requirements.”


The following link provides current profession-specific toolkits for opioid prescribing including mandatory continuing education requirements:


Implementation of the opioid prescribing rules will be highlighted throughout the IPE session. Prior to the session, review your profession-specific toolkit handout available on the IPE session website. You will need to know the roles and responsibilities of your profession when providing care to a patient with chronic pain who is taking opioids.

The toolkits contain handouts for: the public/patient, dental, nursing, osteopathic, podiatry, pharmacy, and medical.

Section II: Using appropriate person-first, non-stigmatizing language

During the IPE session, all participants should practice using person-first, non-stigmatizing language. Person-first language refers to the individual first and the disease-state/disability second. For example, “a patient with autism” rather than “an autistic patient.” When providing care to a patient using opioids, all members of the healthcare team must be familiar with the following definitions.

**Opioid misuse:** Opioid use contrary to the directed or prescribed pattern of use, regardless of the presence or absence of harm or adverse effects. One might “misuse” opioids to manage pain symptoms or “misuse” by using medications prescribed to someone else.

**Opioid abuse:** Intentional use of the opioid for a nonmedical purpose, such as euphoria or altering one’s state of consciousness.

**Addiction:** Pattern of continued use with experience of, or demonstrated potential for, harm (e.g., “impaired control over drug use, compulsive use, continued use despite harm, and craving”).
**Opioid tolerance:** Defined as a “decrease in pharmacologic response following repeated or prolonged response” to an opioid. This is normal and expected.

**Dependence:** Physical dependence is “a state of adaptation that is manifested by a drug class-specific withdrawal syndrome that can be produced by abrupt cessation, rapid dose reduction, decreasing blood level of the drug, and/or administration of an antagonist.” Psychological dependence is “a subjective sense of need for a specific psychoactive substance, either for its positive effects or to avoid negative effects associated with its abstinence.”

**Substance use disorder:** “Substance use disorders occur when the recurrent use of alcohol and/or drugs causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home.” From [https://www.samhsa.gov/disorders/substance-use](https://www.samhsa.gov/disorders/substance-use)

**Opioid use disorder:** “A substance use disorder involving opioids.” From ASAM National Practice Guideline

**Opioid treatment program:** “A program certified by the United States, Substance Abuse and Mental Health Services Administration (SAMHSA)…. that engages in supervised assessment and treatment… of individuals who are addicted to opioids.” From ASAM National Practice Guideline

Additionally, healthcare team members should be aware of and avoid the use of stigmatizing language. Examples of stigmatizing language and more appropriate word choices are noted below. Person-first language should be used whenever possible.

<table>
<thead>
<tr>
<th>Words to avoid</th>
<th>Words to use</th>
<th>Reasoning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Addict, abuser,</td>
<td>Person with a substance use disorder,</td>
<td>Terms like addict, abuser, and junkie are demeaning. They do not differentiate between the person and his/her disease. It is better to use language that suggests that the person has a problem that can be addressed.</td>
</tr>
<tr>
<td>junkie</td>
<td>person experiencing a drug problem</td>
<td></td>
</tr>
<tr>
<td>Abuse</td>
<td>Misuse, inappropriate use, harmful use</td>
<td>“Abuse” suggests there is a choice. In reality, these disorders are medical conditions.</td>
</tr>
<tr>
<td>Clean, dirty</td>
<td>Negative, positive, substance-free</td>
<td>Use of “clean” and “dirty” associates the patient with filth.</td>
</tr>
<tr>
<td>Habit, drug habit</td>
<td>Substance use disorder, opioid use disorder</td>
<td>“Habit” or “drug habit” implies that the problem is related to a lack of willpower to overcome the habitual behavior.</td>
</tr>
<tr>
<td>User</td>
<td>Person who misuses drugs</td>
<td>“User” is stigmatizing as it labels a person by their behavior.</td>
</tr>
</tbody>
</table>

Adapted from The National Alliance of Advocates for Buprenorphine Treatment, “The Words We Use Matter. Reducing Stigma through Language.”
Section III: Using opioids for pain management and Opioid Use Disorder (OUD)

“Opioid use is associated with increased mortality. The leading causes of death in people using opioids for nonmedical purposes are overdose and trauma. The number of unintentional overdose deaths from prescription opioids has more than quadrupled since 1999” (American Society of Addiction Medicine (ASAM) Guidelines). “Monitoring and vigilance are critical to ensure effective and safe use of opioids for the thousands of Washington residents who are on opioids chronically, especially for those on high doses” (Washington State Agency Medical Directors’ Group (AMDG) Guidelines).

Important considerations for the healthcare team who care for patients taking opioids include:

- **WA State Prescribing Requirements emphasize the three categories of pain. It is important to recognize when a patient is transitioning to a new category and how treatment options are impacted.**
  - Those three categories of pain are: acute (0-6 weeks), subacute (6-12 weeks), and chronic (>12 weeks) (WA State Prescribing Requirements).
  - “Acute pain, whether related to disease, injury, or recent surgery, usually diminishes with tissue healing, whereas chronic pain typically lasts >3 months and involves neurological, emotional, and behavioral features that often impact a patient’s quality of life, function, and social roles” (AMDG Guidelines).
  - When appropriately prescribed and managed, opioids may be an effective treatment option for acute and subacute pain. For certain patients, opioids may be an option for treating chronic pain. However, a focus should be on preventing the inappropriate transition from acute and subacute opioid use to chronic opioid use especially when other alternatives for treating pain may be equally effective and safer in the long-term (AMDG Guidelines).
  - All members of the health care team need to be involved in managing the care of a patient taking opioids. Appropriate prescribing of opioids includes the following:
    - Evaluate patient for risk and benefits
    - Evaluate current opioid use
    - Document patient treatment plan
    - Limit quantity and days of therapy of opioids
    - Provide patient education
    - Monitor for safe opioid use
  - Despite best practices, some patients may develop opioid use disorder (OUD). “Opioid use disorder is a chronic, relapsing disease, which has significant economic, personal, and public health consequences.” “Opioid use disorder” is diagnosed by the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5) (ASAM Guidelines).

Two helpful resources when providing care to a patient using opioids with potential opioid use disorder are:


Section IV: Assessment of patient

The following are sources of information that can inform the healthcare team about a patient taking and/or misusing opioids:

- Histories: History of present condition, social, family, and past medical history
- Screening tools and interpretation of results
- Prescription monitoring program (PMP) report
- Morphine equivalent dose (MED) calculation
- Aberrant behaviors
- DSM 5 diagnostic criteria for opioid use disorder

A. Screening tools:

- Many self-report assessment tools are available for health professionals to use when providing care to a patient using opioids.
- During the IPE session, you will use the following screening tools:
  - Pain: PEG (Pain, Enjoyment, General Activity) scale
  - Opioid use: ORT (Opioid Risk Tool) – for standardized patient version
  - Opioid use: DAST: (Drug Abuse Screening Test) – for video patient case
  - Depression: PHQ-9 (Patient Health Questionnaire)

*Prior to the IPE session, review these three specific tools available on the IPE session website. Know how to score and interpret each of them.*

- In addition to the above screening tools, many other screening tools are available to assess opioid misuse, substance abuse, and/or mental health disorders. The AMDG Assessment Tool website has links to a numerous tools (http://www.agencymeddirectors.wa.gov/AssessmentTools.asp). Some of the more common validated screening tools include the following:
  - Current Opioid Misuse Measure (COMM)
  - Screener and Opioid Assessment for Patients with Pain - Revised (SOAPP-R)
  - Opioid Risk Tool (ORT)
  - CAGE Adapted to Include Drugs (CAGE-AID)
  - DIRE (predicts the efficacy of analgesia and adherence with long-term opioid therapy)
  - GAD-7 (Generalized Anxiety Disorder) Questionnaire
  - AUDIT (Alcohol Use Disorder Identification Test)

B. Prescription monitoring program (PMP) reports:

- Washington State has an online prescription monitoring program (PMP).
- The primary purpose of the PMP is to centrally track prescription drug use of controlled substances (i.e. schedule II through V).
- Most states have their own individual PMP systems and regulations.
- The Washington State RxSentry Prescription Monitoring Program is “a web-based system that facilitates the collection, analysis, and reporting of information on the prescribing, dispensing, and use of prescription drugs.”
• Per the WA State Opioid Prescribing Requirements, all prescribers and pharmacists in Washington state are required to register with the PMP.
  o Once a prescriber has an active PMP account, the prescriber is permitted to delegate performance of a required PMP query to an authorized health care designee.
  o Delegates may include nurse, medical assistant, or others.
• WA State Opioid Prescribing Requirements indicate that the PMP must be queried at specific times during the opioid prescribing process. Each profession may have slight differences to the timing of the required PMP queries. Examples of when a PMP query is usually required includes the following:
  o Prior to prescribing opioids for a new episode of pain.
  o During the transition from subacute to chronic pain management.
  o Routinely for patients prescribed opioids for chronic pain, depending on patient risk level.
  o Regularly for patients who are being treated for addiction disorder.
• Additional information on PMPs including Washington’s PMP may be found in the Resource Guide.
• As part of the IPE session, your team will need to interpret a mock PMP report for your patient. The following image shows a mock PMP report with tips on interpretation of information.

C. Morphine Equivalent Dose (MED) Calculation (may also be referred to as Morphine Milligram equivalents or MME):
• Morphine equivalent dose (MED) determines a patient’s cumulative intake of any drugs in the opioid class over 24 hours in an effort to help reduce the likelihood of overdose.
• Purpose: “Calculating the total daily dose of opioids helps identify patients who may benefit from closer monitoring, reduction or tapering of opioids, prescribing of naloxone, or other measures to reduce risk of overdose.” [https://www.cdc.gov/drugoverdose/pdf/calculating_total_daily_dose-a.pdf]
Patients with high MEDs are at increased risk for overdose and developing an opioid use disorder (AMDG guidelines).
- There is a 122-fold increase in developing opioid use disorder in patients using chronic high dose opioids (>120 mg/day MED).
- Overdose risk approximately doubles at doses between 20 and 49 mg/day MED, and increases nine-fold at doses of 100 mg/day MED or more.

The Washington State Opioid Prescribing Requirements require mandatory consultation with a pain management specialist when prescribing over 120 mg/day MED unless exempt. Note that exemptions may vary by profession and are specified in Washington administrative code.

To calculate a MED, determine the total daily amount of each opioid the patient is taking, convert each opioid to morphine equivalents using a conversion table, and add them together. For more information on how to calculate an MED, see the CDC’s Calculating Total Daily Dose of Opioids for Safer Dosage available at https://www.cdc.gov/drugoverdose/prescribing/clinical-tools.html.

Many online MED calculators are available. We recommend you use the Washington state AMDG calculator available at: http://www.agencymeddirectors.wa.gov/calculator/dosecalculator.htm
- Please note: The online calculators should NOT be used to determine doses for opioid conversions.

During the session, you will need to calculate a MED for your patient.

PRACTICE MED Calculation: To give you practice calculating an MED, navigate to the WA AMDG calculator and calculate an MED for a patient taking the following opioids each day:
- 5 tablets of oxycodone/acetaminophen 10 mg/325 mg
- 2 extended release tablets of morphine sulfate 30 mg

The correct answer is 135 mg/day MED indicating the patient is above 120 mg MED and at increased risk of overdose and opioid use disorder.

D. Aberrant behaviors:

During the IPE session, the patient in the video case will exhibit certain behaviors. Your team will need to decide if the behaviors are aberrant (and associated with medication misuse) or if the behaviors are the result of untreated pain.

Aberrant behaviors are those that are suggestive of potential substance misuse and/or addiction. Some behaviors may appear aberrant but may be the result of unresolved pain or a mental health disorder.

Patients may become defensive when discussing concerning behaviors. You are encouraged to reflect now on how you would navigate these difficult conversations.

The table below indicates behaviors associated with medication misuse or addiction.
Behaviors more likely to be associated with medication misuse/addiction:

- Selling medications or obtaining them from non-medical sources
- Falsification of prescription—forgery or alteration
- Injecting medications meant for oral use; oral or IV use of transdermal patches
- Resistance to changing medications despite deterioration in function or significant negative effects
- Loss of control over alcohol use
- Use of illegal drugs or controlled substances that are not prescribed for the patient
- Recurrent episodes of:
  - Prescription loss or theft
  - Obtaining opioids from other providers in violation of treatment agreement
  - Increases in dosing without provider’s instruction
  - Running short with medication supply, and requests for early refills

Behaviors that look aberrant that could be associated with addiction but may be more a part of stabilizing a patient’s pain condition, and less predictive of medication misuse/addiction:

- Asking for, or even demanding, more medication
- Asking for specific medications
- Stockpiling medications during times when pain is less severe
- Use of the pain medications during times when pain is less severe
- Use of the pain medication to treat other symptoms
- Reluctance to decrease opioid dosing once stable
- And, in the earlier stages of treatment:
  - Increasing medication dosing without instruction to do so from the provider
  - Obtaining prescriptions from sources other than the primary pain provider
  - Sharing or borrowing similar medications from friends/family


E. **DSM5 criteria for diagnosing Opioid Use Disorder (OUD):**

- The DSM 5 (Diagnostic and Statistical Manual of Mental Disorders, Fifth edition) defines and classifies various mental disorders.
- The DSM 5 includes diagnostic criteria for Opioid Use Disorder (OUD). To be diagnosed with opioid use disorder, a patient must have at least two of the criteria within a 12-month period.
- **Diagnosis of OUD often involves consultation with an addiction specialist.**
- The DSM 5 Opioid Use Disorder Diagnostic Criteria is available in the Resource Guide.

**Section IV: Treatment plan options**

During the IPE session, your team will develop an individualized treatment plan for your patient. Establishing a trusting relationship with your patient should be a priority.

Numerous treatment plan options are available for a patient with unresolved pain and/or suspected opioid use disorder. Brief summaries follow below:

A. **Treatment of pain**

   i. Prescribing opioids for pain
   ii. Co-prescribing of opioids with other high-risk medications
   iii. Complementary/alternative medicine (CAM) options for treatment of pain
iv. Tapering/discontinuing of opioids
v. Referral options for treatment of pain

B. Treatment of opioid use disorder
   i. Treatment options for opioid use disorder
   ii. Referral options for opioid use disorder

C. Patient safety

D. Patient education

A. Treatment of pain

i. Prescribing opioids for pain:
   • There is a multitude of state and national recommendations and resources related to prescribing opioids for pain. The resources noted below are meant to provide participants with a brief overview of pain treatment and opioid prescribing. They are not comprehensive.
   • Differences exist between the recommendations from various organizations, in particular, when it comes to the specific MED thresholds.
   • State resources: The Washington State Opioid Prescribing Requirements include requirements for profession-specific opioid prescribing. Highlights from the requirements include:
     o For patients with chronic pain (12+ weeks), a written agreement for treatment must be completed.
     o A consultation with a pain management specialist is mandatory when prescribing over 120 mg/day MED.
     o Please review your WA State prescriber toolkit available at: [Link]
     o Another helpful state resource is the WA State AMDG Opioid Guideline summary available at [Link]
   • National resources: References/pocket guides are available that summarize when it is appropriate to prescribe opioids, particularly when prescribing opioids for management of chronic pain (i.e. pain ≥3 months). Links to CDC resources are available below:
     o CDC Guideline for prescribing opioids for chronic pain factsheet. Available at [Link]
     o CDC Checklist for prescribing opioids for chronic pain. Available at [Link]

ii. Co-prescribing of opioids with other high-risk medications
   • The Washington State Opioid Prescribing Requirements require that opioids not be prescribed with the following medications without documentation in patient record, discussion of risks, and consultation with prescribing practitioners of other medications:
     o Benzodiazepines
     o Barbiturates
     o Sedatives
     o Carisoprodol
• Non-benzodiazepine hypnotics (i.e. zolpidem)

• In addition, the opioid prescribing rules require confirmation or prescription of naloxone when:
  o Opioids are prescribed to a high-risk patient.
  o General opioid prescribing when clinically indicated.

iii. Complementary/Alternative Medicine (CAM) and non-opioid options for treatment of PAIN:

• Definition of CAM: Diagnosis, treatment and/or prevention which complements mainstream medicine by contributing to a common whole.
  o Comprises wide range of modalities outside “conventional medicine”
  o Emphasizes holistic approach

• Strongest evidence of non-pharmacological CAM approaches for pain management:
  (Evidence-based Chronic Pain Management [2011], Stannard, C., Kalso, E., Ballantyne, J.)
  o Cognitive Behavioral Therapy (CBT) – address how thoughts influence pain
  o Music therapy
  o Physical exercise/Yoga/ Tai chi
  o Pain self-management/Rehabilitation programs

• Lower evidence CAM options vary with pain type:
  o Massage/Healing touch
  o Mindfulness
  o Meditation/Prayer/Hypnosis/
    Guided imagery
  o Distraction/Biofeedback
  o Nutrition/Diet/Supplements
  o Acupuncture
  o Art therapy
  o Gaming/Virtual reality
  o Ice/Heat
  o TENS unit (transcutaneous electrical nerve stimulation)/Spinal cord stimulator
  o Spinal manipulation:
    Osteopathic/Chiropractic

• Nonopioid pain relief options:
  o Adapt pain ladder to meet individual needs
  o Non-opioid analgesics:
    ▪ Acetylsalicylic acid
    ▪ NSAIDs
    ▪ Antidepressants
    ▪ Anxiolytics/Hypnotics
    ▪ Corticosteroids
    ▪ Anticonvulsants
    ▪ Nerve blocks/Anesthetics

• The following resource highlights non-opioid treatment for chronic pain.

• Resources available in the Resource Guide:
  o CDC. Nonopioid Treatments for Chronic Pain. Available at
    https://www.cdc.gov/drugoverdose/prescribing/clinical-tools.html
iv. Tapering/discontinuing of opioids:
- Pocket guides and additional reference materials are available to guide when and how to taper opioids prescribed for chronic pain. See Resource Guide.
- According to the CDC Pocket Guide: Tapering Opioids for Chronic Pain, “Tapering plans should be individualized and should minimize symptoms of opioid withdrawal while maximizing pain treatment with nonpharmacologic therapies and nonopioid medications.”
- **Opioids should never be abruptly discontinued in patient routinely taking opioids.**
- Resources available in the Resource Guide:

B. Treatment of opioid use disorder

i. Treatment options for opioid use disorder
- Once patients are diagnosed with opioid use disorder, the following treatment options are commonly considered.
  “Medicated-Assisted Treatment (MAT) is the use of FDA-approved medications, in combination with counseling and behavioral therapies, to provide a “whole-patient” approach to the treatment of substance use disorders.” [https://www.samhsa.gov/medication-assisted-treatment](https://www.samhsa.gov/medication-assisted-treatment).
- A brief introduction to the pharmacologic treatment options for opioid use disorder is provided below. For more comprehensive, detailed information about patient management (including for special populations such as pregnant women), see the American Society of Addiction Medicine (ASAM) National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use. [https://www.asam.org/resources/guidelines-and-consensus-documents/npg](https://www.asam.org/resources/guidelines-and-consensus-documents/npg)
  - **Methadone** (Dolophine® or Methadose®):
    Methadone is used for opioid use disorder treatment and withdrawal management. Methadone is an opioid mu-agonist that binds to opiate receptors in the brain where it inhibits pain pathways and alters responses and perceptions to pain. It also suppresses withdrawal symptoms in patients who are addicted to heroin or other opioids. Methadone is administered orally. It is a long-acting opioid that requires special consideration during titration and establishment of a maintenance dose. Typical side effects from opioids (excessive sedation, respiratory depression) may be intensified with methadone due to its’ extended action in the body. When used as a treatment option for opioid use disorder, it is only available through an approved Opioid Treatment Program.
Treatment goals with methadone follow.
1. Suppress opioid withdrawal.
2. Block effects of illicit opioids.
3. Reduce opioid craving and stop/reduce the use of illicit opioids.

*ASAM National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use (part 4, pg 29-31)

- **buprenorphine** (Buprenex®, Butrans®) and combination buprenorphine and naloxone* (*Suboxone®):
  Buprenorphine is used for opioid use disorder treatment and withdrawal management and may be used in the outpatient setting. Buprenorphine is a partial mu-agonist which means the risk of overdose with buprenorphine is lower when used for opioid use disorder therapy because it does not completely “fill” the receptor. Buprenorphine has a high affinity for the mu-opioid receptor which means that it competitively displaces full agonists (such as morphine) from the mu-opioid receptors. Drug cravings are reduced while avoiding dangerous side effects and/or euphoria produced by other opioids.

Treatment goals with buprenorphine and/or buprenorphine/naloxone follow:
1. To suppress opioid withdrawal.
2. To block the effects of illicit opioids.
3. To reduce opioid craving and stop or reduce the use of illicit opioids.
4. To promote and facilitate patient engagement in recovery oriented activities including psychosocial intervention.

*ASAM National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use (part 5, pg 32-35)

* Opioid use disorder prescribing of buprenorphine monoprodut or combination buprenorphine/naloxone for requires a waiver under DATA 2000. There are specific criteria that prescribers must be to qualify for a waiver including completion of a training program.

- **naltrexone** (oral products: ReVia®, Depade® – antagonist; extended release injectable: Vivitrol®):
  Naltrexone is used to prevent relapse to opioid use by competitively blocking the effects of exogenously administered opioids and is also approved for the treatment of alcohol use disorder. Naltrexone is a long-acting, pure opioid antagonist that shows the highest affinity for mu-receptors. Non-adherence to oral naltrexone is common with an associated risk of opioid overdose upon relapse. Therefore, it is believed to be best for patients who are highly motivated and closely supervised.

Treatment goals with naltrexone follow.
1. To prevent relapse to opioids in patients who have already been detoxified and are no longer physically dependent on opioids.
2. To block the effects of illicit opioids.
3. To reduce opioid craving.
4. To promote and facilitate patient engagement in recovery oriented activities including psychosocial intervention.

*ASAM National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use (part 6, pg 35)

- **Naloxone** (Narcan®):
  Naloxone is used for the partial or complete (dose dependent) reversal of opioid effects including respiratory and CNS depression. Naloxone is a pure mu-opioid receptor competitive antagonist that displaces opioids at opioid receptor sites. It is efficacious in reversing opioid overdose and preventing fatalities. Individuals trained and authorized to administer naloxone has expanded beyond in-patient facilities and paramedics to include first responders, police officers, firefighters, correctional officers, individuals at risk for opioid overdose and their families*.

*ASAM National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use (part 13, pg 48)

* In August 2019, WA State implemented a **Standing Order to Dispense Naloxone** which is increasing wide access to naloxone. Detailed information and educational material may be found at [https://www.doh.wa.gov/YouandYourFamily/DrugUserHealth/OverdoseandNaloxone](https://www.doh.wa.gov/YouandYourFamily/DrugUserHealth/OverdoseandNaloxone)

- The Complementary/Alternative Medicine (CAM) and non-opioid options previously noted can also be used to assist in management of opioid use disorder.
- Evidence shows that integration of behavioral health strategies, such as the following, can help to improve treatment outcomes:
  - Cognitive behavioral therapy (CBT)
  - Contingency management (i.e. behavioral-based rewards)
  - Group support

ii. Referral options for opioid use disorder
- Medication assisted treatment (MAT) programs can be located online through the Substance Abuse and Mental Health Services Administration (SAMHSA).
- Opioid treatment programs (OTPs):
  - The SAMSHA Opioid Treatment Program Directory provides information on MAT locations in each state.
  - “Opioid treatment programs (OTPs) provide MAT for individuals diagnosed with an opioid use disorder. OTPs also provide a range of services to reduce, eliminate, or prevent the use of illicit drugs, potential criminal activity, and/or the spread of infectious disease. OTPs focus on improving the quality of life of those receiving treatment. OTPs must be accredited by a SAMHSA-approved accrediting body and certified by SAMHSA.” From [https://www.samhsa.gov/medication-assisted-treatment/treatment#otps](https://www.samhsa.gov/medication-assisted-treatment/treatment#otps)
  - OTPs can dispense methadone and buprenorphine.
  - The directory can be found at [https://dpt2.samhsa.gov/treatment/directory.aspx](https://dpt2.samhsa.gov/treatment/directory.aspx).
  - A list of Washington state opioid treatment programs is available at [https://www.hca.wa.gov/assets/free-or-low-cost/opioid-treatment-programs.pdf](https://www.hca.wa.gov/assets/free-or-low-cost/opioid-treatment-programs.pdf)
• Buprenorphine treatment practitioners:
  o The SAMSHA Buprenorphine Treatment Practitioner Locator provides information for providers that are authorized to prescribe buprenorphine for opioid use disorder.
  o “Under the Drug Addiction Treatment Act of 2000 (DATA 2000), physicians are required to complete an eight-hour training to qualify for a waiver to prescribe and dispense buprenorphine.” From https://www.samhsa.gov/medication-assisted-treatment/training-resources/buprenorphine-physician-training
  o Nurse practitioners and physician assistants must complete 24 hours of required training to prescribe buprenorphine.
  o The buprenorphine practitioner locator is available at https://www.samhsa.gov/medication-assisted-treatment/physician-program-data/treatment-physician-locator.

• Behavior health treatment services:
  o The SAMHSA Behavioral Health Treatment Services Locator helps patients to find treatment facilities for substance abuse, addiction, and/or mental health problems.
  o It is located at https://findtreatment.samhsa.gov/.

C. Patient safety:

All people taking opioids, whether prescribed or from another source, are at risk for developing an opioid use disorder. Specific risk factors for opioid use disorder include past or present substance abuse, untreated mental health conditions, younger age, and social or family environments that encourage misuse. Death from opioid overdose prevalence is higher in people who are middle aged and have substance abuse and mental health comorbidities. (Webster, L.R. 2017. Anesth Analg. Nov. 125 (5) accessed at https://www.ncbi.nlm.nih.gov/pubmed/29049118)

Opioid overdose prevention: Naloxone is a medication (opioid antagonist) that rapidly reverses the effects of opioids. According to the Washington State Opioid Prescribing Requirements, naloxone must be confirmed or prescribed when opioids are prescribed to a high-risk patient or should be considered when clinically indicated.

Patients, a close family member or friend, and first responders may carry a pocket-size device that contains the injectable form of naloxone or Narcan, a nasal spray version of naloxone, that can be administered in the case of a suspected overdose. You are encouraged to learn more about naloxone and its administration by going to the following website: http://stopoverdose.org/

There are several ways to access naloxone in Washington State as noted on the StopOverdose.org website (http://stopoverdose.org/section/find-naloxone-near-you/):

• “Any prescriber can write a prescription for naloxone and any pharmacy can fill that prescription.”
• “Many syringe exchange and other community programs distribute naloxone, although some distribute only to clients and not to community members at large.”
• In August 2019, WA State implemented a Standing Order to Dispense Naloxone effective until 9/1/2021 which allows pharmacists to prescribe and dispense “opioid overdose reversal medications to any person at risk of experiencing an opioid-related overdose or any person or entity in a position to assist a person at risk of experiencing an opioid-related overdose” per the authorization of the State Health Officer. Detailed information and educational material may be found at https://www.doh.wa.gov/YouandYourFamily/DrugUserHealth/OverdoseandNaloxone
D. Washington state requirements for patient education

According to the Washington State Opioid Prescribing Requirements, prescribers must provide patient education on the risks, safe and secure storage, and the proper disposal of opioids.


Resource Guide (optional): The Resource Guide provides links to various national and state-specific resources for Washington State health care providers. You are encouraged to access these materials, as needed, during the IPE session.