INTRODUCTION AND BACKGROUND

These introduction and background materials regarding chronic pain and opioid use disorder (OUD) were created as REQUIRED preparation to ensure that all students have the same baseline information. Please complete your review prior to the opioid education session. It should take approximately 1-1.5 hours to complete. This handout may be used as a resource during the interprofessional education (IPE) session. These materials are not intended to be a comprehensive pain management training.

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Instructions for the IPE Session

	Task
1	PRIOR to the IPE Session: • Please follow the instructions provided by your faculty to sign up for a session. • To evaluate your confidence providing care to a patient taking opioids, **please complete the optional, 15-question, pre-session survey prior to completing the rest of this reading** (see link below). It will take ~5-6 minutes to complete. The results of this voluntary survey will be used for quality improvement and interprofessional research. Thank you in advance for your participation. ✓ **Pre-session survey** • Review the ✧ **Required** reading in this handout:

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	Task
	✓ Background information to help you prepare for your standardized patient interaction. ✓ Links to ✧ Required resources (noted as ✧ Required) ❖ Optional links to other helpful resources are provided throughout. Students can select which of these resources to review (noted as ❖ Optional). ✓ The patient case (including history, screening tool results, PMP report)
2	At the START of the IPE Session: • Login to the Zoom link that will be emailed to you from medicine.ipoc@wsu.edu 2 – 3 days prior to the session, as well as on the day of the session. If you are a WSU student, please login to your WSU account through WSU's single sign-on. • Have this handout available to access during the session

IPE Session Overview

During the upcoming interprofessional education (IPE) training session, you will work via Zoom with a team of students from other health professions (nursing, medicine, pharmacy, social work, physician assistant, chemical dependency professional) to provide collaborative care to a patient with pain who is taking opioids. Each team will meet and interview a standardized patient (i.e., a paid actor) during the session. Team members will collaborate to develop a holistic treatment plan. Teams will discuss the treatment plan with the patient. During the session, each team will:

1. Meet interprofessional health care team members
2. Practice using first-person, non-stigmatizing language
3. Collect and assess patient information, including:
   - Review of patient history
   - 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
4. Develop a team-based treatment plan for a patient with pain who is taking opioids
5. During the IPE session, you should participate by demonstrating the roles and responsibilities of your profession when caring for patients with chronic pain and/or opioid use disorder (OUD). To help the sessions run smoothy, students will volunteer for a role on the team. Roles include IPE Team Leader, Timekeeper, Notetaker, Spokesperson, Lead Interviewer, and Team Members. While physicians are the assumed "team leader" in many clinical settings, all health professionals will be "leaders" depending on the context.

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LEARNING OBJECTIVES

By the end of the IPE 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.

SECTION I. ROLES AND RESPONSIBILITIES

Goal: Recognize roles and responsibilities of individual team members, particularly noting areas of overlap.

See the following description of roles and responsibilities related to providing care for a patient who is taking opioids for pain or who may be misusing opioids.

Medical Assistant (MA-C)
Has initial contact with the patient prior to the prescriber
Administers and interprets oral, paper, or electronic screens (i.e. PHQ-9, GAD-7, Suicide, etc.)
Updates patient's medical records
Communicates concerns about aberrant behaviors, excessive somnolence to prescriber.
Can be delegated to assess opioid uses through the Prescription Monitoring Program (PMP)
Communicates information to the health care team (e.g. requests for prescription renewal, lack of adherence to pain care agreement, patient/family reports of symptoms/concerns)
Collects and prepares laboratory specimens such as a urine sample

Prescriber (MD, DO, ARNP, PA-C)
For patients with acute, subacute, or chronic pain, assesses patient and their medical record for diagnosis or underlying cause of pain
Diagnoses opioid use disorder or opioid dependence
Establishes functional goals with patients
Makes tapering or risk decisions based on opioid morphine equivalent dose
Uses information from Prescription Monitoring Program (PMP), screening tools, and urine drug screens to guide opioid prescribing

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Prescribes pain treatment including starting, tapering, and discontinuing of opioid, non-opioid, and non-pharmacologic therapies
Identifies need for specialized referrals (e.g. pain management specialists, pain psychologist)
Counsels the patient on safe and appropriate use of opioid and non-opioid medications
Monitors for safety and efficacy of therapy

Chemical Dependency Professional (CDP)
Formulates a behavioral health treatment plan which consists of goals designed to promote recovery and utilizes a holistic model for treatment
Serves as the substance use disorder specialist on the healthcare team
Provides counseling to the patient and family (as allowed by licensing boards) related to a substance use disorder
Makes referrals to community resources such as addiction and pain support groups
Provides emotional support

Registered Nurse (RN)
Administers and interprets oral, paper, or electronic screens (i.e. PHQ-9, GAD-7, Suicide, etc.)
Interviews patient for opioid use and conducts pill counts as needed
Communicates concerns about aberrant behaviors, excessive somnolence to prescriber
Updates patient's medical records
Administers opioids and non-opioids
Advocates for patients
Can calculate morphine equivalent dose
Can be delegated to assess opioid uses through the Prescription Monitoring Program (PMP)
Counsels the patient on safe and appropriate use of opioid and non-opioid medications
Monitors for safety and efficacy of therapy

Pharmacist (PharmD, RPh)
Reviews patient profile for appropriateness of prescribed medication
Makes recommendations to the patient for self-care
Calculates morphine equivalent dose
As part of the healthcare team, makes recommendations on appropriate treatments
Assesses opioid use through the Prescription Monitoring Program (PMP)
Counsels the patient on safe and appropriate use of opioid and non-opioid medications
Monitors for safety and efficacy of medication therapy

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Social Worker (MSW)
Advocates for the patient/family
Brings awareness to and addresses psychosocial-spiritual factors impacting the patient (ex. Financial concerns, relationship concerns, mental health struggles, quality of life, etc.)
Provides emotional support
Provides behavioral therapy/psychoeducation to the patient/family
Identifies appropriate resources and facilitates referrals
Facilitates coordination of care

SECTION II. WASHINGTON STATE OPIOID PRESCRIBING REQUIREMENTS

Goal: Gain familiarity with your profession's opioid prescribing requirements.

In response to the opioid crisis, the WA state legislature passed laws in 2017 and 2019 directing health profession boards/commissions to develop and adopt new opioid prescribing requirements. The Department of Health, in collaboration with the boards and commissions, has developed profession-specific toolkits to describing the new WA State Opioid Prescribing Requirements.

Profession-specific Toolkit
✧ **Required:** Please review your *profession-specific toolkit* handout by clicking on the links below. If your profession is not listed, there is not a toolkit available.
Advanced registered nurse practitioners (4 pages)
Medicine (MDs, DOs, and PAs) (7 pages)
Pharmacists (4 pages)
Osteopathic providers (2 pages)

SECTION III. USING APPROPRIATE PERSON-FIRST, NON-STIGMATIZING LANGUAGE

Goal: During the IPE session, all students 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."

Definitions: When providing care to a patient using opioids, all healthcare team members must be familiar with the following definitions:

Term	Definition
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.

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Term	Definition
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."[2]
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."[11]
Opioid use disorder	"A substance use disorder involving opioids."[2]
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."[2]

Non-stigmatizing language: 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.

Term	Words to use	Reasoning
Addict, abuser, junkie	Person with a substance use disorder, person experiencing a drug problem	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.
Abuse	Misuse, inappropriate use, harmful use	"Abuse" suggests there is a choice. In reality, these disorders are medical conditions.
Clean, dirty	Negative, positive, substance-free	Use of "clean" and "dirty" associates the patient with filth.
Habit, drug habit	Substance use disorder, opioid use disorder	"Habit" or "drug habit" implies that the problem is related to a lack of willpower to overcome the habitual behavior.
User	Person who misuses drugs	"User" is stigmatizing as it labels a person by their behavior.

Adapted from The National Alliance of Advocates for Buprenorphine Treatment, "The Words We Use Matter. Reducing Stigma through Language."

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SECTION IV. USING OPIOIDS FOR PAIN MANAGEMENT AND OPIOID USE DISORDER (OUD)

Goal: Identify a patient's category of pain. Discuss appropriate opioid prescribing.

"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."[2] "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."[3]

Important considerations for healthcare team members 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).
"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."[3]
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.[3]
All healthcare team members 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).[2]

SECTION V. ASSESSMENT OF PATIENT

Goal: Utilize a variety of patient information to assess a patient with chronic pain.

In addition to the patient history, the following are sources of information that can inform the healthcare team about a patient taking and/or misusing opioids. More detail is provided in the sub-sections below:

Sub-section	Topic
A	Screening tool results

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Sub-section	Topic
B	Prescription monitoring program (PMP) report
C	Morphine equivalent dose (MED) calculation
D	Aberrant behaviors
E	DSM 5 diagnostic criteria for opioid use disorder

A: SCREENING TOOLS

Goal: Score and interpret common screening tools.

Screening Tools
✧ **Required:** Please review the PEG, ORT, and PHQ-9 by clicking on the links below. Know how to score and interpret each of these assessment tools.
Pain: PEG (Pain, Enjoyment, General Activity) scale (1 page)
Opioid use: ORT (Opioid Risk Tool) (1 page)
Depression: PHQ-9 (Patient Health Questionnaire) (1 page)
❖ Optional: 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 numerous tools.

B: PRESCRIPTION MONITORING PROGRAM (PMP) REPORTS

Goal: Gain familiarity with PMP reports. Students in pharmacy or medicine should know how to interpret these 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.
Per the WA State Opioid Prescribing Requirements, all prescribers and pharmacists in Washington state are required to register with the PMP. • 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. Delegates may include a 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 with requirements varying between professions. Examples of when a PMP query is usually required includes the following: • Prior to prescribing opioids for a new episode of pain. • During the transition from subacute to chronic pain management. • Routinely for chronic pain patients prescribed opioids, depending on patient risk level. • Regularly for patients who are being treated for addiction disorder.

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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.

Search criteria entered

Recipient Report

Last Name: Skywalker
First Name: Luke
Date of Birth: 01/01/1977
Gender:
Recipients: 1 out of 1 Recipient(s) Selected - Click to View
County:
Zip code:
Dispensed Start Date: 01/01/2018
Dispensed End Date: 12/31/2018

Date Dispensed/ Date Prescribed	Drug name/ NDC	Quantity dispensed/ Days Supply	RX #	Prescriber	Dispenser	Recipient	*Payment Method
01/15/2018 01/13/2018	Zolpidem tartrate 10 mg tablet 16714062201	30 30	44444	Kenobi, O AK6125341	Galactic Pharmacy Seattle, WA	Skywalker, Luke 01/01/1977 111 Star Ln. Seattle, WA	04
02/05/2018 02/05/2018	Diazepam 5 mg tablet 51079-0285-01	60 30	55555	Leia, P AL7604247	Tatooine Pharmacy Seattle, WA	Skywalker, Luke 01/01/1977 111 Star Ln. Seattle, WA	01
03/06/2018 03/05/2018	Diazepam 5 mg tablet 51079-0285-01	60 30	11111	Leia, P AL7604247	Tatooine Pharmacy Seattle, WA	Skywalker, Luke 01/01/1977 111 Star Ln. Seattle, WA	01
04/15/2018 04/15/2018	Morphine Sulfate 15 mg ER tablet 00406-8315-01	30 5	22222	Solo, H AS6125341	Galactic Pharmacy Seattle, WA	Skywalker, Luke 01/01/1977 111 Star Ln. Seattle, WA	04

***Pmt. Method:** 01=Private Pay; 02=Medicaid; 03=Medicare; 04=Commercial Insurance; 05=Military Installations and VA; 06=Worker's Compensation; 07=Indian Nations; 99=Other

The date dispensed at the pharmacy and the date prescribed may be different.

The quantity dispensed shows the number given to the patient. The day's supply indicates how long the supply will last according to the directions.

Name and location of place of dispensing. Can show if using multiple pharmacies.

Payment method code key at the bottom of the page

Prescriber name and DEA # can indicate if there are multiple providers.

C: MORPHINE EQUIVALENT DOSE (MED) CALCULATION

Goal: Recognize the purpose of the MED. Students in pharmacy, medicine, and nursing should be able to calculate and interpret MED.

MED Overview
Morphine equivalent dose (MED) determines a patient's cumulative intake of any drugs in the opioid class over 24 hours to help reduce the likelihood of overdose. It may also be referred to as Morphine Milligram equivalents or MME.
"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."[4]
Patients with high MEDs are at increased risk for overdose and developing an opioid use disorder.[3] For instance, 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.
Many online MED calculators are available. We recommend you use the Washington state AMDG calculator. Please note: The online calculators should NOT be used to determine doses for opioid conversions for pain management.

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During the session, you will need to calculate a MED for your standardized patient. To do this, your team will need to verify the medication/strengths/doses that your standardized patient is currently taking to calculate his/her MED.
❖ Optional: If you would like to 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.
❖ Optional: For more information on how to calculate an MED, see the CDC's Calculating Total Daily Dose of Opioids for Safer Dosage (2 pages)

D: ABERRANT BEHAVIORS

Goal: Recognize and address aberrant behaviors.

Overview of Aberrant Behaviors
During the IPE session, your standardized patient will exhibit certain behaviors. Your team will need to decide if they 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:	**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:**
Selling medications or obtaining them from non-medical sources	Asking for, or even demanding, more medication
Falsification of prescription (forgery, alteration)	Asking for specific medications
Injecting medications meant for oral use; oral or IV use of transdermal patches	Stockpiling medications during times when pain is less severe
Resistance to changing medications despite deterioration in function or significant negative effects	Use of the pain medications during times when pain is less severe
Loss of control over alcohol use	Use of the pain medication to treat other symptoms
Use of illegal drugs or controlled substances that are not prescribed for the patient	Reluctance to decrease opioid dosing once stable

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Recurrent episodes of:	And, in the earlier stages of treatment:
• 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	• 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 From National Institute on Drug Abuse

E: DSM5 CRITERIA FOR DIAGNOSING OPIOID USE DISORDER (OUD)

Goal: Recognize that OUD is diagnosed through DSM5 criteria.

Opioid Use Disorder Diagnostic Criteria
The DSM 5 (Diagnostic and Statistical Manual of Mental Disorders, 5th Edition) includes diagnostic criteria for Opioid Use Disorder (OUD). To be diagnosed with OUD, 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.
❖ Optional: Refer to the DSM 5 Opioid Use Disorder Diagnostic Criteria (9 pages)

SECTION VI. TREATMENT PLAN OPTIONS

Goal: During the IPE session, your healthcare team will develop an individualized, holistic treatment plan for your patient and discuss it with them. 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. Highlights of important points to consider are detailed below:

A.	Treatment of chronic pain
1	Prescribing opioids for chronic pain • In 2016, the CDC published its Guideline for Prescribing Opioids for Chronic pain. ✧ **Required:** To gain familiarity with the highlights of the CDC guidelines, please review: ✓ CDC Guideline for prescribing opioids for chronic pain factsheet (2 pages) ✓ CDC Checklist for prescribing opioids for chronic pain (1 page) • In addition to the CDC guidelines, there are other state and national resources related to prescribing opioids for pain. Differences exist between the recommendations from various organizations. For example, the WA State Opioid Prescribing Requirements require: ✓ Completion of a written pain agreement for patients with chronic pain (12+ weeks) ✓ Consultation with a pain management specialist when prescribing >120 mg/day ❖ Optional: Resources to review about treating chronic pain with opioids: ✓ WA State AMDG Opioid Guideline summary (2 pages)

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A.	Treatment of chronic pain
	✓ CDC Guideline for Prescribing Opioids for Chronic Pain, 2016 (49 pages)
2	Co-prescribing of opioids with other high-risk medications: • The WA 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: ✓ Benzodiazepines ✓ Barbiturates ✓ Sedatives ✓ Carisoprodol ✓ Non-benzodiazepine hypnotics (i.e. zolpidem)
3	Complementary/Alternative Medicine (CAM) for treatment of pain: • Definition of CAM: Diagnosis, treatment and/or prevention which complements mainstream medicine by contributing to a common whole. ✓ Comprises wide range of modalities outside "conventional medicine" ✓ Emphasizes holistic approach • Strongest evidence of non-pharmacological CAM approaches for pain management: [5] ✓ Cognitive Behavioral Therapy (CBT) – address how thoughts and behavior influence pain ✓ Music therapy ✓ Physical exercise/ Yoga/Tai chi ✓ Pain self-management/Rehabilitation programs • Lower evidence CAM options vary with pain type: ✓ Massage/Healing touch ✓ Distraction/Biofeedback ✓ Nutrition/Diet/Supplements ✓ Acupuncture ✓ Art Therapy ✓ Gaming/Virtual Reality ✓ Mindfulness/Meditation/Prayer ✓ Hypnosis/Guided Imagery ✓ Ice/Heat ✓ TENS unit ((transcutaneous electrical nerve stimulation)/Spinal Cord Stimulator ✓ Spinal Manipulation: Osteopathic/Chiropractic • Nonopioid pain relief options: ✓ Non-opioid analgesics: Aspirin, NSAIDS Antidepressants Anticonvulsants Anxiolytics/Hypnotics Corticosteroids Nerve blocks/Anesthetics ✓ Adapt pain ladder to meet individual needs (see Figure 1. on next page)

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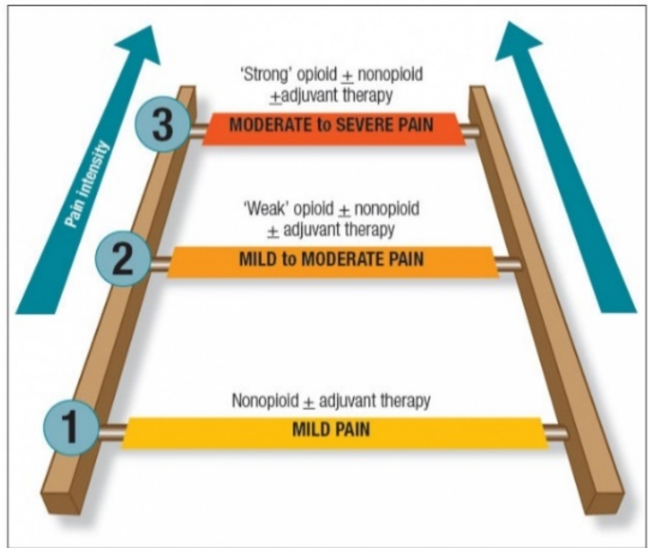
A.	Treatment of chronic pain
	 **Figure 1.** A modern rendition of the original 1986 WHO pain ladder with 3 steps. Patients begin at the first rung and then based on pain intensity progress, rung by rung, up the ladder as pain worsens. ❖ Optional: Resource to review about nonopioid treatment options CDC. Nonopioid Treatments for Chronic Pain (2 pages)
4	Tapering/discontinuing of opioids: • The CDC suggests, "tapering plans should be individualized and should minimize symptoms of opioid withdrawal while maximizing pain treatment with nonpharmacologic therapies and nonopioid medications."[6] • Opioids should never be abruptly discontinued in patients routinely taking opioids. ❖ Optional: Resources to review about tapering: ✓ CDC Pocket Guide Tapering Opioids for Chronic Pain (4 pages) ✓ HHS Guide for Clinicians on the Appropriate Dosage Reduction or Discontinuation of Long-Term Opioid Analgesics (6 pages)

B.	Treatment of Opioid Use Disorder (OUD)
1	Medication-Assisted Treatment (MAT) • "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." [7] • Primary MAT programs for opioid dependency includes the following:

MAT Programs	Overview
Opioid Treatment Programs (OTPs)	• OTPs "provide MAT for individuals diagnosed with an opioid use disorder. OTPs also provide a range of services

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B.	Treatment of Opioid Use Disorder (OUD)	
		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."[8] • Only OTPs can dispense methadone for the treatment of OUD. In addition to dispensing methadone, they can dispense buprenorphine. ❖ Optional: The SAMSHA Opioid Treatment Program Directory provides information on locations in each state.
	Buprenorphine treatment practitioners	• Qualified prescribers can prescribe buprenorphine for the treatment of OUD in settings other than opioid treatment programs (OTP), upon completion of specialized training to become a "buprenorphine waivered practitioner." • Physicians must complete 8 hours of training. • Nurse practitioners and physician assistants must complete 24 hours of training. ❖ Optional: The SAMSHA Buprenorphine Treatment Practitioner Locator lists providers that are authorized to prescribe buprenorphine for OUD.
	Naltrexone	"Naltrexone can be prescribed and administered by any practitioner licensed to prescribe medications, and is available in a pill form for Alcohol Use disorder or as an extended-release intramuscular injectable for either Alcohol and Opioid Use disorder."[12]
	❖ **Optional:** Resources regarding MAT: ✓ American Society of Addiction Medicine (ASAM) National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use (66 pages) ✓ SAMHSA TIP 63: Medications for Opioid Use Disorder - Full Document (322 pages)	
2	Behavioral health and other treatment services • Evidence shows that integration of behavioral health strategies, such as the following, can help to improve treatment outcomes: ✓ Cognitive behavioral therapy ✓ Contingency management (i.e. behavioral-based rewards) ✓ Group support	

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B.	Treatment of Opioid Use Disorder (OUD)
	• Complementary/Alternative Medicine (CAM) and non-pharmacologic options previously noted for treatment of pain can also be used to assist in management of OUD. ❖ Optional: The SAMHSA Behavioral Health Treatment Services Locator helps patients to find treatment facilities for substance abuse, addiction, and/or mental health problems.

C.	Patient safety and patient education
1	Overview • 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. • All people taking opioids, whether prescribed or from another source, are at risk for developing OUD. Specific risk factors for OUD 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.[9]
2	**Opioid overdose prevention** • Naloxone is a medication (opioid antagonist) that rapidly reverses the effects of opioids. • According to the WA 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. • There are several ways to access naloxone in WA State:[10] ✓ A prescription for naloxone can be written by any prescriber. Any pharmacy can then fill that prescription. • In August 2019, WA State implemented a Standing Order to Dispense Naloxone, 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." ❖ **Optional:** Resources about naloxone and/or other patient education materials: ✓ stopoverdose.org ✓ WA DOH Overdose Education and Naloxone Distribution ✓ Patient education handouts from the WA State Department of Health

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C.	Patient safety and patient education
3	**Resource Guide** ❖ Optional: A resource guide for these IPE sessions is available at https://opioideducation.wsu.edu/resource-guide/. It includes a wealth of additional resources for those who are interested in learning more.

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Patient Case

Case
Sam Jones, 63 year old male OR Samantha Jones 63 year old female, retired lawyer
Case Setting *(assume no pandemic is occurring)*
The patient has previously seen a former clinic prescriber (Dr. J. Larson) who no longer works at the clinic. Recently, the primary care clinic has adopted a team-based approach for pain management. This is the first time the patient will meet with the full team.
Chief Complaint
Here today requesting additional pain medications for ongoing back pain due to car accident.
Progress Note
Visit 1 (Three months ago): Patient was in car accident with acute back injury diagnosed as a lumbar strain with negative lumbar spine x-rays. Emergency department-initiated hydrocodone/acetaminophen 5 mg/325 mg 1 tab PO q 4-6 hours prn pain for 14 days.

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Visit 2 (2.5 months ago): Ten days following the accident, the patient had a follow-up clinic appointment with PCP. Reported continued pain (6 out of 10) despite prescribed hydrocodone/acetaminophen. Average Pain, Enjoyment, General activity (PEG) score was 7 out of 10 (with 10 indicating a poor function). Prescribed additional hydrocodone/acetaminophen 5 mg/325 mg 1 tab PO q 4-6 hours prn pain for 15 days.

Visit 3 (Two months ago): One month following the accident patient returned to clinic. Patient reported taking prescription medications every 4 hours. Patient's pain 7 out of 10. Average PEG score 7 out of 10. Prescriber increased dose of hydrocodone/acetaminophen to 10 mg/325 mg 1 tab PO q 4-6 hours prn pain and initiated carisoprodol 250 mg 1 tab PO TID and at bedtime prn back muscle spasm.

Visit 4 (Today): Patient returns having had regular refills of prescriptions from visit 3. Pain is localized to lumbar area without radiation or lower extremity weakness. There is no bowel or bladder incontinence. Exam confirms normal vital signs and no lower extremity weakness or sensory deficits. Patient requests ongoing medication refills.

Past Medical History

Allergies: Penicillin (rash)

Problem List:

1. Hypertension
2. Hyperlipidemia
3. History of depression 10 years ago. Improvement following counseling, exercise
4. Lumbar strain from car accident

Social History

1 year ago: Reports drinking occasionally 3-4 drinks per week either beer or wine. Drinks 1-2 cups of coffee per day. Does not smoke or use tobacco products. Retired lawyer who lives with spouse and two dogs. No children.

Family History

Reports father died of alcoholic cirrhosis.

Currently Prescribed Medications

1. Hydrocodone/acetaminophen 10 mg/325 mg 1 tab PO q 4-6 hours prn pain for back pain
2. Carisoprodol 250 mg 1 tab PO TID and at bedtime prn back muscle spasm
3. Lisinopril 10 mg 1 tab PO daily for hypertension
4. Rosuvastatin 20 mg 1 tab PO daily for hyperlipidemia

Vital Signs from Today's Visit

• Height: 5'6"	• HR: 73
• Weight: 155 lbs (Today) 145 lbs (3 months ago)	• RR: 16
	• BP: 125/84
• BMI: 25 (Medically overweight	• Temp: 37°C

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Lab Results

None today

Diagnostic Imaging

3 months ago (following car accident): X-rays negative

Past Surgeries

No surgeries

Results of screening tools administered today

PEG Scale Assessing Pain Intensity and Interference (Pain, Enjoyment, General Activity)

1. What number best describes your pain on average in the past week?

0 1 2 3 4 5 6 (7) 8 9 10
No Pain — Pain as bad as you can imagine

2. What number best describes how, during the past week, pain has interfered with your enjoyment of life?

0 1 2 3 4 (5) 6 7 8 9 10
Does not interfere — Completely interferes

3. What number best describes how, during the past week, pain has interfered with your general activity?

0 1 2 3 4 5 6 7 (8) 9 10
Does not interfere — Completely interferes

PEG score: 7

Calculating the PEG Score: Add the responses to the three questions, then divide by three to get a mean score out of 10 points.

Using the PEG Score: The score is best used to track an individual's changes over time. The initiation of therapy should result in the individual's score decreasing over time.

Krebs, E. E., Lorenz, K. A., Bair, M. J., Damush, T. M., Wu, J., Sutherland, J. M., Asch S, Kroenke, K. (2009). Development and Initial Validation of the PEG, a Three-item Scale Assessing Pain Intensity and Interference. Journal of General Internal Medicine, 24(6), 733–738.

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Opioid Risk Tool (ORT)

		Mark each box that applies	Item score (female)	Item score (male)
1. Family history of substance abuse	• Alcohol	[X]	1	3
	• Illegal drugs	[ ]	2	3
	• Prescription drugs	[ ]	4	4
2. Personal history of substance abuse	• Alcohol	[ ]	3	3
	• Illegal drugs	[ ]	4	4
	• Prescription drugs	[ ]	5	5
3. Age (mark box if 16 to 45)		[ ]	1	1
4. History of preadolescent sexual abuse		[ ]	3	0
5. Psychological disease	• Attention deficit disorder • Obsessive compulsive disorder • Bipolar • Schizophrenia	[ ]	2	2
	• Depression	[X]	1	1
		TOTAL:	2	4
		Total score risk category: • Low risk for future opioid abuse: 0 to 3 • Moderate risk for future opioid abuse: 4 to 7 • High risk for future opioid abuse: ≥8		

Webster LR, Webster RM. Predicting aberrant behaviors in opioid-treated patients: Preliminary validation of the opioid risk tool. Pain Medicine 2005; 6(6):432-442, by permission of Oxford University Press on behalf of the American Academy of Pain Medicine, and Lynn R. Webster, MD, author of "The Painful Truth: What Pain is Really Like and Why it Matters to Each of Us."

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Patient Health Questionnaire (PHQ-9)

1. Over the last 2 weeks, how often have you been bothered by any of the following problems? Read each item carefully and circle your response.

	Not at all (0 points)	Several days (1 point)	More than half the days (2 points)	Nearly every day (3 points)
a. Little interest or pleasure in doing things			x	
b. Feeling down, depressed, or hopeless			x	
c. Trouble falling asleep, staying asleep, or sleeping too much				x
d. Feeling tired or having little energy			x	
e. Poor appetite or overeating			x	
f. Feeling bad about yourself, feeling that you are a failure, or feeling that you have let yourself or your family down		x		
g. Trouble concentrating on things such as reading the newspaper or watching television		x		
h. Moving or speaking so slowly that other people could have noticed. Or being so fidgety or restless that you have been moving around a lot more than usual	x			
i. Thinking that you would be better off dead or that you want to hurt yourself in some way	x			
Totals				

Score total: __13__

2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not Difficult At All	Somewhat Difficult	Very Difficult	Extremely Difficult
	x		

Scoring method for diagnosis:

- Major Depressive Syndrome is suggested if:
  - Of the 9 items, 5 or more are circled as at least "More than half the days" **AND**
  - Either item 1a or 1b is positive, that is, at least "More than half the days"
- Minor Depressive Syndrome is suggested if:
  - Of the 9 items, b, c, or d are circled as at least "More than half the days" **AND**
  - Either item 1a or 1b is positive, that is, at least "More than half the days"

Scoring method for planning and monitoring treatment:

- Question One
  - To score the first question, tally each response by the number value of each response: Not at all = 0, Several days = 1, More than half the days = 2, Nearly every day = 3
  - Add the numbers together to total the score.
  - Interpret the score by using the guide listed below:
    - <4: The score suggests the patient may not need depression treatment.
    - 5-14: Prescriber uses clinical judgment about treatment, based on patient's duration of symptoms and functional impairment.
    - >15: Warrants treatment for depression, using antidepressant, psychotherapy and/or a combination of treatment
- Question Two
  - In question two the patient responses can be one of four: not difficult at all, somewhat difficult, very difficult, extremely difficult. The last two responses suggest that the patient's functionality is impaired. After treatment begins, the functional status is again measured to see if the patient is improving.

From the Primary Care Evaluation of Mental Disorders Patient Health Questionnaire (PRIME-MD PHQ). Copyright 1999 by Pfizer, Inc.

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Prescription Monitoring Program (PMP)

Recipient Report

Last Name:	Jones	County:	
First Name:	Sam/Samantha	Zip code:	
Date of Birth:	1/5/19XX	Dispensed Start Date:	One year prior
Gender:		Dispensed End Date:	Today
Recipients:	1 out of 1 Recipient(s) Selected – Click to View		

Date Dispensed/ Date Prescribed	Drug name/ NDC	Quantity dispensed/ Days Supply	RX #	Prescriber	Dispenser	Recipient	*Payment Method
3 months ago 3 months ago	Hydrocodone/acetaminophen 5 mg/325 mg 53746-0109-01	84 14	76248	Wilson, K AW6125341 (ER MD)	General Hospital Small town, WA	Jones, Sam 1/5/19XX 123 E. 5th Ave. Small town, WA	04
2.5 mos. ago 2.5 mos. ago	Hydrocodone/acetaminophen 5 mg/325 mg 00406-0365-23	90 15	58762	Larson, J AL7604247 (Clinic MD)	Main Ave. Pharmacy Small town, WA	Jones, Sam 1/5/19XX 123 E. 5th Ave. Small town, WA	04
2 months ago 2 months ago	Hydrocodone/acetaminophen 10 mg/325 mg 00406-0367-23	90 15	59846	Larson, J AL7604247 (Clinic MD)	Main Ave. Pharmacy Small town, WA	Jones, Sam 1/5/19XX 123 E. 5th Ave. Small town, WA	04
2 months ago 2 months ago	Carisoprodol 250 mg 51525-5901-01	56 14	59850	Larson, J AL7604247 (Clinic MD)	Main Ave. Pharmacy Small town, WA	Jones, Sam 1/5/19XX 123 E. 5th Ave. Small town, WA	04
7 weeks ago 7 weeks ago	Hydrocodone/acetaminophen 5 mg/325 mg	20 5	840921	Johnson, M AJ6125341 (Dentist)	Walmart Pharmacy Small town, WA	Jones, Sam 1/5/19XX 123 E. 5th Ave. Small town, WA	01
6 weeks ago 6 weeks ago	Hydrocodone/acetaminophen 10 mg/325 mg 00406-0367-23	90 15	61534	Larson, J AL7604247 (Clinic MD)	Main Ave. Pharmacy Small town, WA	Jones, Sam 1/5/19XX 123 E. 5th Ave. Small town, WA	04
6 weeks ago 2 months ago	Carisoprodol 250 mg 51525-5901-01	56 14	59850	Larson, J AL7604247 (Clinic MD)	Main Ave. Pharmacy Small town, WA	Jones, Sam 1/5/19XX 123 E. 5th Ave. Small town, WA	04
5 weeks ago 5 weeks ago	Tramadol 50 mg 00185-0311-10	60 10	89427	Thomson, A AT7604247 (Urgent care PA)	Walmart Pharmacy Richland, WA	Jones, Sam 1/5/19XX 123 E. 5th Ave. Small town, WA	04
30 days ago 30 days ago	Hydrocodone/acetaminophen 10 mg/325 mg 00406-0367-23	90 15	62895	Larson, J AL7604247 (Clinic MD)	Main Ave. Pharmacy Small town, WA	Jones, Sam 1/5/19XX 123 E. 5th Ave. Small town, WA	04
30 days ago 2 months ago	Carisoprodol 250 mg 51525-5901-01	56 14	59850	Larson, J AL7604247 (Clinic MD)	Main Ave. Pharmacy Small town, WA	Jones, Sam 1/5/19XX 123 E. 5th Ave. Small town, WA	04
18 days ago 18 days ago	Tramadol 50 mg 57664-0377-13	60 10	124895	Smith, T AS6125341 (Urgent care DO)	Walmart Pharmacy Small town, WA	Jones, Sam 1/5/19XX 123 E. 5th Ave. Small town, WA	01
14 days ago 14 days ago	Hydrocodone/acetaminophen 10 mg/325 mg 00406-0367-23	90 15	62387	Larson, J AL7604247 (Clinic MD)	Main Ave. Pharmacy Small town, WA	Jones, Sam 1/5/19XX 123 E. 5th Ave. Small town, WA	04
14 days ago 2 months ago	Carisoprodol 250 mg 51525-5901-01	56 14	59850	Larson, J AL7604247 (Clinic MD)	Main Ave. Pharmacy Small town, WA	Jones, Sam 1/5/19XX 123 E. 5th Ave. Small town, WA	04
5 days ago 5 days ago	Oxycodone/acetaminophen 7.5 mg/325 mg 00406-0522-01	28 7	62001	Truman, P AT6125341 (ER MD)	Main Ave. Pharmacy Small town, WA	Jones, Sam 1/5/19XX 123 E. 5th Ave. Small town, WA	01

***Pmt. Method:** 01=Private Pay; 02=Medicaid; 03=Medicare; 04=Commercial Insurance; 05=Military Installations and VA; 06=Worker's Compensation; 07=Indian Nations; 99=Other

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