INTRODUCTION AND BACKGROUND

In February, you will participate in a simulated, team-based ***telehealth*** visit of a patient with pain who is taking opioids. 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. In addition, please review the Session Instruction Guide provided by your faculty that outlines the activities students will complete during the IPE session.

TABLE OF CONTENTS

IPE Session Preparation

1	Note your pre-assigned session time: All students were pre-assigned to a specific IPE session date and time by their faculty. If you have questions or a conflict with the session date and time assigned to you, please reach out to your faculty.

2	**Complete the voluntary, anonymous 15-question pre-session survey** Please self-evaluate your confidence providing care to a patient taking opioids **prior** to completing the assigned reading below. Results from this voluntary survey will be used for quality improvement and interprofessional research. Thank you in advance! ✓ Access the Pre-session survey here.
3	**Review pre-session materials** ✓ Review this handout. Required reading is labeled as ✧ **Required**. Optional reading is labeled as ❖ **Optional**. ✓ Review the Patient Case, including history, screening tool results, and Prescription Monitoring Program (PMP) report in this handout (p. 19 – 23). ✓ Review the **Session Instruction Guide** provided by your faculty for an overview of the IPE session.
4	**Register in Zoom** ✓ Instructions to register in Zoom for the IPE session you were pre-assigned to attend will be emailed from medicine.ipoc@wsu.edu at the end of January, with an additional email reminder 3-4 days prior to the session. Registration includes demographic questions that the study team is required to report to our federal grant funders, the Health Resources and Services Administration (HRSA).
5	**At the START of the IPE Session** ✓ Ensure you are following the ***telehealth*** etiquette expectations noted on the next page. ✓ Log in to IPE session via Zoom preferably 5 – 10 minutes prior to the start time. • To ensure accurate attendance logs, these sessions require all attendees to sign into a Zoom account. If you are not signed into a Zoom account and attempt to join the meeting, you will receive a message that says, "This meeting is for authorized participants only" and prompt you to sign in. • If you are a WSU student, please login to your WSU account through WSU's single sign-on (SSO). If you are from an institution other than WSU, please login to your institutions' SSO. ✓ If you do not register in Zoom prior to the start of the IPE session, you will need to answer the registration questions to enter the IPE session. The individual direct access Zoom meeting link is provided following the registration process noted above. ✓ Have this handout accessible during the session.

Excused Absences

If you are experiencing an illness or an unexpected circumstance that prevents your virtual attendance at the IPE session, please email:

i. your faculty instructor; **and**

ii. the Interprofessional Opioid Curriculum (IPOC) team at: medicine.ipoc@wsu.edu

as soon as possible to discuss potential options for rescheduling.

IPE Session Overview

During the interprofessional education (IPE) education session, you will collaborate virtually with a team of students from other health professions, e.g., nursing, medicine, pharmacy, social work, physician assistant/associate, chemical dependency professional, nutrition, athletic training, to provide collaborative care to a patient with pain who is taking opioids. The session will simulate a team-based *telehealth* visit. During the session, each team will:

1. Interact with students from other health professions
2. Practice using first-person, non-stigmatizing language
3. Collect and assess patient information from the following two sources:
    i. Written patient case; and
    ii. Interview with a standardized patient, i.e., a paid actor
4. Develop a holistic interprofessional (IP) treatment plan for a patient with pain who is taking opioids
5. Discuss the treatment plan with the patient.

LEARNING OBJECTIVES

By the end of the IPE session, students should be able to:

- Describe the roles and responsibilities of the healthcare team and how they work together to provide team-based care to patients using opioids.
- Utilize appropriate non-stigmatizing language when caring for patients taking or potentially misusing opioids.
- 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.
- Evaluate a patient for potential opioid misuse or opioid use disorder as a member of the healthcare team.
- Differentiate between treatment options for a patient with an opioid use disorder and/or pain management.
- Work collaboratively with the healthcare team and the patient to develop a patient care plan.

SECTION I. TELEHEALTH ETIQUETTE

The IPE session will simulate a team-based *telehealth* visit. Students are expected to follow standard *telehealth* etiquette throughout the IPE session.

Telehealth Etiquette Checklist	
Attire ✓ The same level of professional attire as in-person care, e.g., no baseball hats, no athleisure wear, etc.	Environment ✓ Ensure the physical space you are in is suitable for protecting the patients' privacy, e.g., not a public space or place where other adults or children can overhear or wander in ✓ Avoid background noise and distractions ✓ Ensure adequate lighting ✓ Avoid eating, drinking, chewing gum

Technology	Communication
✓ Verify webcam and microphone are working prior to the *telehealth* visit ✓ Turn on webcam ✓ Adjust webcam to eye level ✓ Mute microphone when you are not speaking, especially for team interviews ✓ Turn off notifications/alerts on devices	✓ Introduce yourself and everyone present ✓ Speak clearly and deliberately ✓ Choose empathetic language ✓ Use non-verbal language to signal you are listening ✓ Maintain eye contact by looking at the camera ✓ Be aware of facial expressions and body language to demonstrate active engagement ✓ Narrate actions, e.g., say "Excuse me while I write some notes" if looking away from the camera ✓ Pause to allow transmission delay ✓ Verbalize and clarify next steps such as follow up
Adapted from AMA Telehealth Visit Etiquette Checklist[1]	

❖ Optional: Additional resources that feature guidance to prepare for *telehealth* visits:

- Tips for Expressing Empathy via Telemedicine [2] from the Institute for Healthcare Improvement
- The HHS telehealth website has guides for implementing *telehealth* based on profession.[3]

SECTION II. SIGNIFICANCE

As the world recovers from the COVID-19 pandemic, the opioid epidemic rages on. In 2020, more than 91,799 drug overdose deaths occurred in the U.S., with over 75% involving an opioid.[4] The Centers for Disease Control and Prevention (CDC) estimates that prescription opioid misuse in the U.S. results in an annual economic burden of over $78.5 billion dollars.[5] Up to 29% of people prescribed opioids for chronic pain misuse their medications and 8-12% of people using opioids for chronic pain relief develop an opioid use disorder.[6] Considering these statistics, it is imperative that health professional education programs intentionally prepare graduates to care for patients with chronic pain who are prescribed opioids. It also important that students in health profession programs are aware of Harm Reduction, "a set of practical strategies and ideas aimed at reducing negative consequences associated with drug use."[7]

SECTION III. ROLES AND RESPONSIBILITIES

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

Review the following description of healthcare roles and responsibilities related to providing holistic care for a patient who is taking opioids for pain or who may be misusing opioids. Holistic care refers to looking at a patient as a whole being and impacted by multiple elements such as biophysical, emotional, social, and spiritual. This is referred to as "holistic/bio-psychosocial-spiritual."

Athletic Trainer (LAT/ATC)
Advocates for the patient and provides emotional support
Brings awareness to and addresses the physical activity factors affecting the patient. Ex: pain with movement, physical movement goals, implications for activities of daily living
Identifies appropriate resources and facilitates referrals
Provides patient education
Helps facilitate a therapeutic exercise/modality plan for patients

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

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, e.g., excessive somnolence, to the 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

Registered Dietitian Nutritionist (RDN)
Reviews patient history and profile for nutrition status and assessment of possible nutrient deficiencies
Calculates nutrient and fluid needs and make recommendations for improving nutrition status
Discusses intake and meal timing alongside nutrition-related signs and symptoms
Counsels the patient on the effects of opioid use on dietary status and the role of nutrition in opioid use disorder
As part of the healthcare team, makes recommendations on appropriate interventions
Monitors and evaluates medical nutrition therapy plan

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
Calculates morphine equivalent dose (MED)
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

Physical Therapist (PT)
Consults with the patient to learn about their physical condition and symptoms
Diagnoses movement dysfunction and develops a treatment plan
Counsels the patient on proper therapeutic exercise techniques
Incorporates soft tissue mobilization, joint mobilization, and spinal manipulation as appropriate
Complete assessment of risk for falls and counsel accordingly
Assists patient with the use of mobility equipment, such as walkers
Monitors and evaluates the patients' progress with physical therapy
Provides patient education on pain and applies pain-relieving modalities such as a transcutaneous electrical nerve simulation (TENS) unit.

Prescriber (MD, DO, ARNP, PA-C)
For patients with acute, subacute, or chronic pain, assesses the patient and their medical record for diagnosis or underlying cause of pain
Diagnoses opioid use disorder or opioid dependence
Establishes functional goals with the patient
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
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

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

SECTION IV. 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 for the new WA State Opioid Prescribing Requirements.[8]

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 [9] (4 pages)
Medicine (MDs and PAs) [10] (7 pages)
Pharmacists [11] (4 pages)
Osteopathic providers (DOs and PAs) [12] (2 pages)

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

Goal: During the IPE session students should practice using person-first, non-stigmatizing language.

Person-first language refers to the individual first and the disease-state/disability second, e.g., "a patient with autism" rather than "an autistic patient."

Definitions: Healthcare professionals 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. Additionally, someone may "misuse" to experience a euphoric high.
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	"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."[13]
Substance use disorder (SUD)	"Substance use disorders occur when the recurrent use of alcohol and/or drugs causes clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home."[14]

Term	Definition
Opioid use disorder (OUD)	"A substance use disorder involving opioids."[13]
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."[13]

Non-stigmatizing language: Stigmatizing language is demeaning to patients who are then more likely to disengage from needed care. Healthcare team members should be aware of and avoid the use of stigmatizing language. 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" makes assumptions; labels the person negatively regardless of status.
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" negatively 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*.[15]

❖ Optional:

- Words Matters – Terms to Use and Avoid When Talking About Addiction from the National Institute on Drug Abuse
- I'm Still a Person: The Stigma of Substance Use & the Power of Respect by Dr. Audrey Begun (MSW, PH.D.) For students interested in learning more through an interactive workbook, please follow the link to download a free digital copy.

SECTION VI. 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. Unintentional overdose deaths from prescription opioids have more than quadrupled since 1999."[13] "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."[16]

Important considerations for healthcare team members who care for patients taking opioids include:
Guidelines emphasize three categories of pain. It is important to recognize when a patient is transitioning to a new category and how treatment options are impacted. The three categories of pain are: • Acute (0-6 weeks) • Subacute (6-12 weeks) • 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."[16]
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, professionals should focus on preventing an inappropriate transition from acute/subacute opioid use to chronic opioid use, especially when other alternatives for treating pain may be equally effective and safer in the long-term.[16]
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."[13] Opioid use disorder' is diagnosed by the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5).

SECTION VII. 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.

A: SCREENING TOOLS

Goal: Score and interpret common screening tools.

Screening Tools
Many screening tools are available to assess opioid misuse, substance abuse, and/or mental health disorders. Each has unique scoring. Many tools are modified over time based on changes in practice. ✧ **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 [17] (1 page) • Opioid use: ORT-OUD (Opioid Risk Tool-OUD) [18] (1 page) • Depression: PHQ-9 (Patient Health Questionnaire) [19] (3 pages) ❖ **Optional:** The NIDA Screening and Assessment Tools Chart has links to numerous tools.[20]

B: PRESCRIPTION MONITORING PROGRAM (PMP) REPORTS

Goal: Gain familiarity with PMP reports.

Washington State has an online prescription monitoring program (PMP). The primary purpose of the PMP is to centrally track all schedule II through V controlled substance prescriptions.

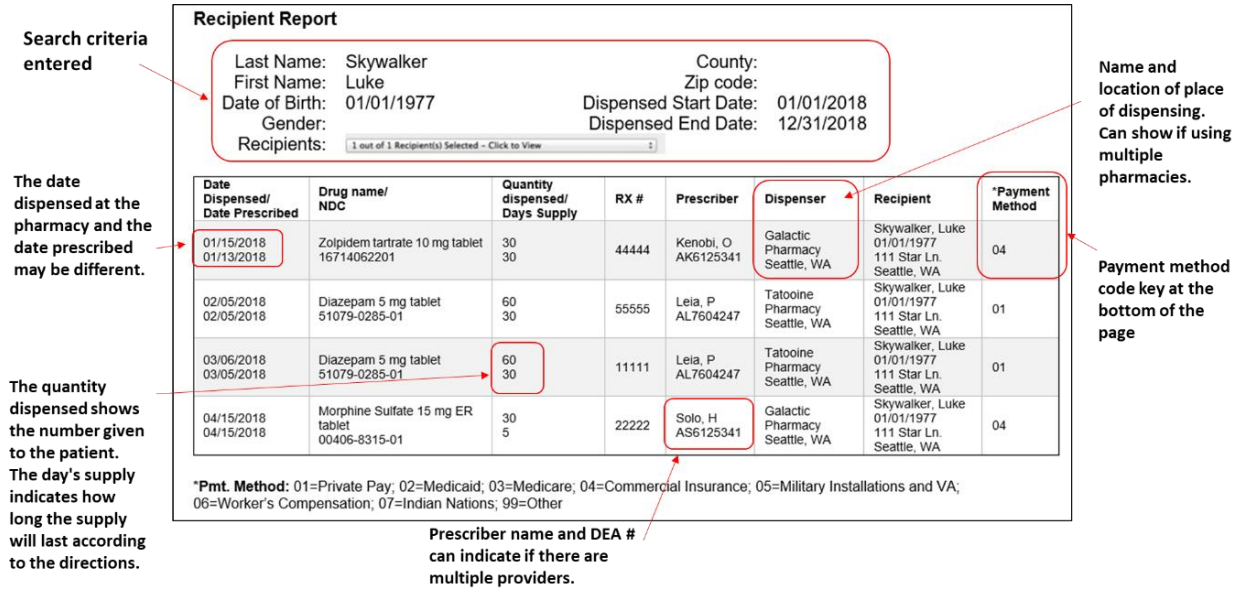
Per the WA State Opioid Prescribing Requirements, all prescribers and pharmacists in Washington state are required to register with the PMP.

- 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

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 interpreting the information.



C: MORPHINE EQUIVALENT DOSE (MED) CALCULATION

Goal: Recognize the purpose of the MED. During the session, your team 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 their 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."[21]
Patients with high MEDs are at increased risk for overdose and developing an opioid use disorder.[16] 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 Opioid Conversion Calculator from the Oregon Pain Guidance. Please note: The online calculators should NOT be used to determine doses for opioid conversions for pain management.
❖ Optional: If you would like to practice calculating an MED, navigate to the 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 morphine equivalents per day. ❖ **Optional:** For more information on how to calculate an MED, see the CDC's Calculating Total Daily Dose of Opioids for Safer Dosage [21] (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.
The table below indicates behaviors which may be 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 (forgery, alteration) of prescription	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
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	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 From National Institute on Drug Abuse[22]

Patients may become defensive when discussing concerning behaviors. During the IPE session, the standardized patient may be reluctant to changes and/or suggestions. As you read this, reflect on how you will navigate these difficult conversations. Resources to aid conversation about challenging topics are below.

Motivational Interviewing

"Motivational Interviewing is a person-centered counseling style for addressing the common problem of ambivalence about change."[23] Review the questions below to build your self-awareness about encouraging motivation to change:[24]

✓ Do I keep myself sensitive and open to this person's issues, whatever they may be? × Or am I talking about what I think the problem is?
✓ Do I invite this person to talk about and explore his/her/their own ideas for change? × Or am I jumping to conclusions and possible solutions?
✓ Do I encourage this person to talk about his/her/their reasons for not changing? × Or am I forcing him/her to talk only about change?
✓ Do I ask permission to give my feedback? × Or am I presuming that my ideas are what he/she/they really needs to hear?
✓ Do I reassure this person that ambivalence to change is normal? × Or am I telling him/her/them to be proactive and push ahead for a solution?
✓ Do I help this person identify successes and challenges from his/her/their past and relate them to present change efforts? × Or am I encouraging him/her/them to ignore or get stuck on old stories?
✓ Do I seek to understand this person? × Or am I spending a lot of time trying to convince him/her to understand me and my ideas?

✓ **Do I summarize for this person what I am hearing?** ✗ Or am I just summarizing what I think?
✓ **Do I value this person's opinion more than my own?** ✗ Or am I giving more value to my viewpoint?
✓ **Do I remind myself that this person is capable of making his/her/their own choices?** ✗ Or am I assuming that he/she/they is not capable of making good choices?
❖ Optional: For more information about Motivational Interviewing, see: • Motivational Interviewing as a Counseling Style[23] (29 pages) • Motivational Interviewing Network of Trainers (MINT)[25] (YouTube video)

Trauma-informed Care

Trauma-informed care is a care delivery approach that "realizes the widespread impact of trauma and understands the potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, and staff; … and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to …resist re-traumatization."[26] Trauma-informed care is increasingly recognized as "best practice," especially for persons seeking treatment for behavioral health issues, many of whom have histories of trauma. Many individuals don't recognize the impact of trauma on their lives/issues, or they avoid thinking about or discussing their trauma. Recognizing trauma and providing safe, compassionate care, while ensuring that people are not re-traumatized during treatment, is important. Trauma-informed care shifts the focus from "what's wrong with you?" to "What happened to you?"

❖ Optional: For more information about Trauma-Informed Care, see Trauma-Informed Care: A Sociocultural Perspective.[27] (25 pages)

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

Goal: Recognize that OUD is diagnosed through DSM5 criteria.

Opioid Use Disorder Diagnostic Criteria
The Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM5) 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 DSM5 Opioid Use Disorder Diagnostic Criteria (9 pages)[28]

SECTION VIII. TREATMENT PLAN OPTIONS

Goal: During the IPE session, your healthcare team will develop a tailored, 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.

A.	Treatment of pain
•	**CDC guideline for prescribing opioids for pain:** In 2016, the CDC published its Guideline for Prescribing Opioids for Chronic pain. The CDC updated its guideline in 2022. ✧ **Required:** To gain familiarity with the 2022 CDC guideline, please review: • Clinical Practice Guideline at a Glance • Initiating Opioid Therapy • Continuing Opioid Therapy ❖ Optional: The CDC provides many resources about the new guideline: • CDC Training for Healthcare Professionals • What's Different summarizes changes between the 2022 and 2016 guidelines • Guideline Recommendations and Guiding Principles • CDC Clinical Practice Guideline for Prescribing Opioids for Pain, 2022 [29] (95 pages)
•	**Other guidelines and resources:** In addition to the CDC guideline, there are other state and national resources related to prescribing opioids for pain. For example, the WA Department of Health, in collaboration with state boards and commissions, developed the WA State Opioid Prescribing Requirements described in Section IV above. 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: • WA State Opioid Prescribing Requirements • The University of Washington Medicine has a Pain and Opioid Provider Hotline. Information about this free resource is available here.
•	**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, i.e., zolpidem
•	**Complementary and Integrative Health for treatment of pain:** • Complementary health approaches are a group of diverse "systems, practices, and products whose origins come from outside of mainstream medicine."[31] ✓ Emphasizes holistic approach • **Non-pharmacological options**: Strength of evidence on non-pharmacological pain management approaches varies depending on patient population, pain type, and

A.	Treatment of pain

intervention specifications. Evidence is available for numerous physical and psychological approaches including the following: [31, 32]

✓ Cognitive Behavioral Therapy (CBT) – address how thoughts and behavior influence pain	✓ Acupuncture
✓ Physical therapy	✓ Music Therapy / Art Therapy
✓ Physical exercise/ Yoga/Tai chi	✓ Gaming/Virtual Reality
✓ Pain self-management/Rehabilitation programs	✓ Hypnosis/Guided Imagery
✓ Mindfulness/Meditation/Prayer	✓ Ice/Heat
✓ Massage/Healing touch	✓ TENS unit (transcutaneous electrical nerve stimulation)
✓ Distraction/Biofeedback	✓ Spinal Manipulation: Osteopathic/Chiropractic/Physical therapy
✓ Nutrition/Diet/Supplements	✓ Low-level laser therapy

- **Nonopioid medication options:**

✓ Topical and oral NSAIDS	✓ Antidepressants (tricyclic, tetracyclic, SNRIs)
✓ Acetaminophen	✓ Anticonvulsants (e.g., gabapentin)
✓ Capsaicin and lidocaine patches	

❖ Optional:

- CDC Nonopioid therapies for pain management
- Summary of complementary health approaches for chronic pain: Chronic Pain: In Depth [31]
- Nutritional Approaches for Musculoskeletal Pain and Inflammation: What the Science Says [33]
- Inter-Association Consensus Statement: The management of medications by the sports medicine team (9 pages)

- **Tapering/discontinuing of opioids:**
  - Providers should carefully weigh benefits and risks and exercise care when changing the dosage 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."[34]
  - **Opioids should never be abruptly discontinued in patients routinely taking opioids** unless the patient has indications of a life-threatening issue, such as warning signs of an overdose.

❖ Optional: Resources to review about tapering:

- Tapering Opioids CDC training module (featuring 34 video modules)
- Opioid Taper Decision Tool from the U.S. Dept. of Veterans Affairs (16 pages)
- HHS Guide for Clinicians on the Appropriate Dosage Reduction or Discontinuation of Long-Term Opioid Analgesics [35] (6 pages)

A.	Treatment of pain
•	Monitoring and follow up: • According to the 2022 CDC guideline, "clinicians should evaluate benefits and risks with patients within 1–4 weeks of starting opioid therapy for subacute or chronic pain or of dosage escalation."[29] ✓ If starting immediate-release opioids at a low dosage (<50 MME/day), follow up interval closer to 4 weeks can be considered. ✓If continuing long-term opioid therapy, suggested interval of every 3 months or more frequently for most patients. ✓ If tapering, suggested to follow up frequently (at least monthly). ❖ Optional: See recommendation 7 within CDC Clinical Practice Guideline for Prescribing Opioids for Pain, 2022 [29] (95 pages)

B.	Treatment of Opioid Use Disorder (OUD)
•	Medication for Opioid Use Disorder (MOUD) • Medications for Opioid Use Disorder (MOUD) includes pharmacotherapy that target the brain, in combination with counseling and behavioral therapies, to provide a "whole-patient" approach to treatment. • MOUD includes the following:

MOUD	Overview
Buprenorphine	• Buprenorphine is a partial opioid agonist. • Buprenorphine can be prescribed for the treatment of OUD in settings other than OTPs. As of December 2022, any prescriber with a standard DEA registration number can prescribe buprenorphine for OUD if permitted by applicable state laws.[37]
Methadone	• Methadone is a long-acting, full opioid agonist. • Methadone for OUD treatment can only be provided through an Opioid Treatment Program (OTP). OTPs are accredited by a SAMHSA-approved accrediting body and certified by SAMHSA. In addition to dispensing methadone, OTPs can dispense buprenorphine. • Patients receiving MOUD through an OTP must receive counseling or other behavioral therapy. • ❖ Optional: The SAMSHA Opioid Treatment Program Directory provides information on locations in each state. [36]
Naltrexone	• Naltrexone is an opioid antagonist that blocks opioid receptors. • "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."[38]

B.	Treatment of Opioid Use Disorder (OUD)
	❖ **Optional:** Resources regarding OUD and treatment options: • CDC Opioid Use Disorder: Preventing and Treating • The ASAM National Practice Guideline for the Treatment of Opioid Use Disorder: 2020 Focused Update [39] (95 pages) • SAMHSA TIP 63: Medications for Opioid Use Disorder [40] (332 pages)
•	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 • Complementary and Integrative Health and non-pharmacologic options previously noted for treatment of pain can also be used to assist in management of OUD. ❖ Optional: FindTreatment.gov helps patients find treatment facilities for substance use and/or mental health problems.[41]

C.	Patient safety and patient education
•	Overview • 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 who take 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 misuse and mental health comorbidities.[42]
•	Harm reduction • Harm reduction strategies include "safer use, managed use, abstinence, meeting people who use drugs 'where they're at,' and addressing conditions of use along with the use itself. Because harm reduction demands that interventions and policies designed to serve people who use drugs reflect specific individual and community needs, there is no universal definition of or formula for implementing harm reduction."[7]
•	Opioid overdose prevention • ***Naloxone*** is a non-controlled 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.

C.	Patient safety and patient education
	• There are several ways to ***access naloxone*** in WA State[43]: ✓ All pharmacies in WA State can provide naloxone directly to patients without a prescription through the state standing order. o 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." [44] ✓ A prescription for naloxone can be written by any prescriber. Any pharmacy can then fill that prescription. ✓ Over-the-counter naloxone has been approved by the FDA with OTC naloxone nasal spray available in some pharmacies. ✓ Individuals can order free naloxone online and have it delivered to their home. ❖ **Optional:** Resources about naloxone and/or other patient education materials: • stopoverdose.org • WA DOH Overdose Education and Naloxone Distribution [45] • Patient education handouts [8] from the WA State Department of Health

Patient Case

Case
Sam Jones, 63-year-old male/female, retired lawyer
Case Setting
Sam 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 that utilizes ***telehealth***. This is the first time the patient will meet with the full team.
Chief Complaint
Requests 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.
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. Patient reports frustration with not being able to participate in their tennis league.
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: • Hypertension • Hyperlipidemia • History of depression 10 years ago. Improvement following counseling, exercise • Lumbar strain from car accident
Social History
1 year ago: Reports drinking 3-4 drinks per week (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. Participates regularly in a tennis club in town that has access to an athletic trainer through the club.
Family History
Reports father died of alcohol-associated cirrhosis.

Currently Prescribed Medications

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

Vital Signs from Today's Visit

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

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

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

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.

Opioid Risk Tool – Opioid Use Disorder (ORT-OUD)[a]

		Yes	No
1. Family history of substance abuse	• Alcohol	1	0
	• Illegal drugs	1	0
	• Prescription drugs	1	0
2. Personal history of substance abuse[b]	• Alcohol	1	0
	• Illegal drugs	1	0
	• Prescription drugs	1	0
3. Age (mark box if 16 to 45)		1	
5. Psychological disease	• Attention deficit disorder • Obsessive compulsive disorder • Bipolar • Schizophrenia	1	0
	• Depression	1	0
TOTAL (1 point for each yes)		**2**	
Total score risk category: • Low risk for future opioid use disorder: 0 to 2 • High risk for opioid use disorder: ≥ 3			

[a] Scoring of ORT-OUD differs from the ORT.
[b] The published tool uses the terminology of "substance abuse." This potentially stigmatizing. The preferred language is "substance use disorder."

https://www.drugabuse.gov/nidamed-medical-health-professionals/screening-tools-resources/opioid-risk-tool-oud-ort-oud
Cheatle M, Compton P, Dhingra L, Wasser T, O'Brien. Development of the Revised Opioid Risk Tool to Predict Opioid Use Disorder in Patients with Chronic Non-Malignant Pain. Journal of Pain. 20 (7): 842-851, 2019.

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 TV		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		2	8	3

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
  - For 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.

Prescription Monitoring Program (PMP)

Recipient Report

Last Name: Jones
First Name: Sam
Date of Birth: 1/5/19XX
Gender:
Recipients: 1 out of 1 Recipient(s) Selected – Click to View

County:
Zip code:
Dispensed Start Date: One year prior
Dispensed End Date: Today

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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References

1. Telehealth Visit Etiquette Checklist. American Medical Association https://www.ama-assn.org/system/files/2020-04/telehealth-appendix-g4-telehealth-visit-etiquette-checklist.pdf.
2. Tips for Expressing Empathy via Telemedicine. Institute for Healthcare Improvement. https://www.ihi.org/communities/blogs/tips-for-expressing-empathy-via-telemedicine.
3. Best Practice Guides. HHS. https://telehealth.hhs.gov/providers/best-practice-guides/.
4. Drug Overdose Deaths Remain High. Centers for Disease Control and Prevention. https://www.cdc.gov/drugoverdose/deaths/index.html.
5. Opioid Overdose Crisis. National Institute on Drug Abuse. https://www.drugabuse.gov/drug-topics/opioids/opioid-overdose-crisis. Accessed July 15, 2021.
6. Vowles KE, McEntee ML, Julnes PS, Frohe T, Ney JP, van der Goes DN. Rates of opioid misuse, abuse, and addiction in chronic pain: a systematic review and data synthesis. *Pain*. Apr 2015;156(4):569-576. doi:10.1097/01.j.pain.0000460357.01998.f1
7. Principles of Harm Reduction. National Harm Reduction Coalition. https://harmreduction.org/wp-content/uploads/2020/08/NHRC-PDF-Principles_Of_Harm_Reduction.pdf.
8. Opioid Prescribing Toolkits. Washington State Department of Health. https://www.doh.wa.gov/ForPublicHealthandHealthcareProviders/HealthcareProfessionsandFacilities/OpioidPrescribing/HealthcareProviders/Toolkits#heading27600. Accessed December 23, 2021.
9. Washington State Opioids Prescribing Requirements for Advanced Registered Nurse Practitioners. Washington State Department of Health. https://www.doh.wa.gov/Portals/1/Documents/9220/631074-PrescriberHandout-ARNP.pdf. Accessed July 29, 2021.
10. Opioid Prescribing in Washington: What You Need to Know. Washington Medical Commission. https://wmc.wa.gov/sites/default/files/public/Newsletter/Opioid%20changes%20Booklet_Digital.pdf. Accessed December 23, 2021.
11. 2019 Washington State Opioid Prescribing Requirements Guide for Pharmacists. Washington State Department of Health. https://www.doh.wa.gov/Portals/1/Documents/Pubs/631073-OverviewHandout-Pharmacy.pdf. Accessed December 23, 2021.
12. Opioid Prescribing Documentation Checklist. Washington State Department of Health. https://www.doh.wa.gov/Portals/1/Documents/Pubs/630151.pdf.
13. The ASAM National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use. American Society of Addiction Medicine. https://www.asam.org/quality-care/clinical-guidelines/national-practice-guideline. Accessed October 13, 2022.
14. Mental Health and Substance Use Disorders. Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/find-help/disorders. Accessed July 29, 2021.

15. The Words We Use Matter: Reducing Stigma through Language. The National Alliance of Advocates for Buprenorphine Treatment. https://www.naabt.org/documents/naabt_language.pdf. Accessed July 29, 2021.
16. Interagency Guideline on Prescribing Opioids for Pain. Washington State Agency Medical Directors' Group. http://www.agencymeddirectors.wa.gov/Files/2015AMDGOpioidGuideline.pdf. Accessed July 29, 2021.
17. PEG 3 Item Pain Scale. Washington State Agency Medical Directors' Group. https://amdg.wa.gov/Files/AssessmentTools/1-PEG%203%20item%20pain%20scale.pdf. Accessed July 29, 2021.
18. Opioid Risk Tool – OUD (ORT-OUD). National Institute on Drug Abuse. https://www.drugabuse.gov/nidamed-medical-health-professionals/screening-tools-resources/opioid-risk-tool-oud-ort-oud.
19. PHQ-9 – Nine Symptom Checklist. Washington State Agency Medical Directors' Group. https://amdg.wa.gov/Files/AssessmentTools/13-PHQ-9%20form.pdf. Accessed July 29, 2021.
20. Screening and Assessment Tools Chart. National Institute on Drug Abuse. https://www.drugabuse.gov/nidamed-medical-health-professionals/screening-tools-resources/chart-screening-tools.
21. Calculation Total Daily Dose of Opioids for Safer Dosage. Centers for Disease Control and Prevention. https://www.cdc.gov/drugoverdose/pdf/calculating_total_daily_dose-a.pdf. Accessed July 29, 2021.
22. Aberrant Drug Taking Behaviors Information Sheet. National Institute on Drug Abuse. https://www.drugabuse.gov/sites/default/files/AberrantDrugTakingBehaviors.pdf.
23. *Enhancing Motivation for Change in Substance Use Disorder Treatment: UPDATED 2019. Treatment Improvement Protocol (TIP) Series, No. 35.) Chapter 3—Motivational Interviewing as a Counseling Style*. Substance Abuse and Mental Health Services Administration 2019. https://www.ncbi.nlm.nih.gov/books/NBK571068/
24. Motivational Interviewing: Encouraging Motivation to Change: Am I doing this right? . Center for Evidence-based Practices. Case Western Reserve University. https://case.edu/socialwork/centerforebp/sites/case.edu.centerforebp/files/2021-03/miremindercard.pdf
25. Motivational Interviewing Network of Trainers (MINT). https://motivationalinterviewing.org/.
26. SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach. SAMHSA's Trauma and Justice Strategic Initiative. https://ncsacw.samhsa.gov/userfiles/files/SAMHSA_Trauma.pdf.
27. Chapter 1, Trauma-Informed Care: A Sociocultural Perspective. Trauma-Informed Care in Behavioral Health Services. Substance Abuse and Mental Health Services Administration. https://www.ncbi.nlm.nih.gov/books/NBK207195/.
28. *Diagnostic and Statistical Manual of Mental Disorders: DSM-5, 5th edition*. American Psychiatric Association; 2013.
29. Dowell D, Ragan KR, Jones CM, Baldwin GT, Chou R. CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States, 2022. *MMWR Recomm Rep*. 2022;71 (No. RR-3):1-95. doi:http://dx.doi.org/10.15585/mmwr.rr7103a1
30. Summary of 2015 Interagency Guideline on Prescribing Opioids for Pain. Washington State Agency Medical Directors' Group. https://amdg.wa.gov/Files/FY16-288SummaryAMDGOpioidGuideline_FINAL.pdf. Accessed July 29, 2021.
31. Chronic Pain: In Depth. National Center for Complementary and Integrative Health. https://www.nccih.nih.gov/health/chronic-pain-in-depth.
32. Safely and Effectively Managing Pain Without Opioids. Centers for Disease Control and Prevention https://www.cdc.gov/drugoverdose/featured-topics/pain-management.html.
33. Nutritional Approaches for Musculoskeletal Pain and Inflammation: What the Science Says. National Center for Complementary and Integrative Health. https://www.nccih.nih.gov/health/providers/digest/nutritional-approaches-for-musculoskeletal-pain-and-inflammation-science.
34. Pocket Guide: Tapering Opioids for Chronic Pain. Centers for Disease Control and Prevention. https://www.cdc.gov/drugoverdose/pdf/Clinical_Pocket_Guide_Tapering-a.pdf. Accessed July 29, 2021.
35. HHS Guide for Clinicians on the Appropriate Dosage Reduction or Discontinuation of Long-Term Opioid Analgesics. U.S. Department of Health and Human Services. https://www.hhs.gov/opioids/sites/default/files/2019-10/Dosage_Reduction_Discontinuation.pdf. Accessed July 29, 2021.
36. Opioid Treatment Program Directory. Substance Abuse and Mental Health Services Administration. https://dpt2.samhsa.gov/treatment/directory.aspx. Accessed July 29, 2021.
37. Removal of DATA Waiver (X-Waiver) Requirement. Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/medication-assisted-treatment/removal-data-waiver-requirement.
38. Naltrexone. Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/medication-assisted-treatment/medications-counseling-related-conditions/naltrexone. Accessed December 23, 2021.
39. The ASAM National Practice Guideline for the Treatment of Opioid Use Disorder: 2020 Focused Update. American Society of Addiction Medicine. https://www.asam.org/quality-care/clinical-guidelines/national-practice-guideline. 2022.
40. *Medications for Opioid Use Disorder. Treatment Improvement Protocol (TIP) Series 63 Publication No. PEP21-02-01-002*. Substance Abuse and Mental Health Services Administration; 2021.
41. Behavioral Health Treatment Services Locator. Substance Abuse and Mental Health Services Administration. https://findtreatment.samhsa.gov/. Accessed July 29, 2021.
42. Webster LR. Risk Factors for Opioid-Use Disorder and Overdose. *Anesthesia and analgesia*. 2017;125(5):1741-1748. doi:10.1213/ANE.0000000000002496
43. Find naloxone near you. Stopoverdose.org. http://stopoverdose.org/section/find-naloxone-near-you/. Accessed July 29, 2021.
44. Standing Order to Dispense Naloxone. Washington State Department of Health. https://www.doh.wa.gov/Portals/1/Documents/Pubs/150-127-StatewideStandingOrderToDispenseNaloxone.pdf. Accessed June 7, 2022.
45. Overdose Education and Naloxone Distribution. Washington State Department of Health. https://www.doh.wa.gov/YouandYourFamily/DrugUserHealth/OverdoseandNaloxone. Accessed July 29, 2021.