PCSS Providers Clinical Support System

Managing Pain in the Setting of Co-morbid Substance Use Disorder

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ASPMN
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ASPMN American Society for Pain Management Nursing SUPPORTING NURSES MANAGING PAIN

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Conflict of Interest Disclosure

- Presenters do not have any conflicts of interest

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Dedication

- This presentation is dedicated to:

Ellyn Schreiner, MPH, RN-BC, CHPN, a dedicated pain and hospice nurse/educator and former president of the American Society of Pain Management Nursing (2015-2016). Ellyn was originally scheduled to moderate this session. She died from complications of COVID-19 April 14, 2020.

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Target Audience

- The overarching goal of PCSS is to train a diverse range of healthcare professionals in the safe and effective prescribing of opioid medications for the treatment of pain, as well as the treatment of substance use disorders, particularly opioid use disorders, with medication-assisted treatments.

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Educational Objectives

- At the conclusion of this activity participants should be able to:
  - •Develop treatment strategies to treat acute and chronic pain in individuals with opioid use disorder receiving medications for opioid use disorder.
  - •Discuss pain management strategies for individuals with pain who are currently engaged in illicit substance use.
  - •Describe challenges in pain management strategies for individuals with substance use disorder in remission not utilizing medications for opioid use disorder

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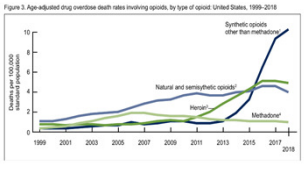
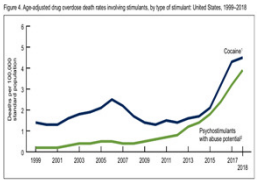
Scope of the Problem



- 67,367 overdose deaths (20.7 per 100,000)
- 47,590 involved opioids
- Increases in deaths from cocaine/psychostimulant



Multiple drugs may have contributed to mortality

Drug Overdose Deaths in the United States, 1999–2018
https://www.cdc.gov/nchs/products/databriefs/db356.htmOverdose death rates.
https://www.cdc.gov/nchs/data/databriefs/db356-h.pdf

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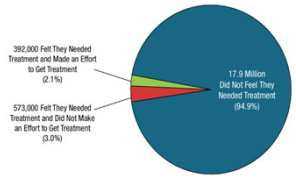
2018: Treatment Need > Treatment Received

- Estimated 21.2 million people age 12 of older (7.8%) need treatment > estimated 3.7 million people age 12 or older (1.4%) received treatment



https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHNationalFindingsReport2018/NSDUHNationalFindingsReport2018.pdf

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Opioid Use Disorder (OUD) – DSM-V

A problematic pattern of opioid use leading to clinically significant impairment or distress

- Opioids taken in larger amounts for longer than expected
- Unsuccessful attempts to cut down or control use
- Craving or strong desire/urge to use opioids

- Significant time spent in activities to obtain, use, or recover from effects
- Use in hazardous situations
- Continued use despite recognition of related social/interpersonal problems

- Failure to fulfill major role obligations
- Important social, occupational, or recreational activities given up due to use
- Use despite knowledge of physical/psychological problems

- Tolerance and withdrawal (not applicable when taken as medically indicated)

Mild = 2-3
Moderate= 4-5
Severe ≥ 6

https://pcssnow.org/wp-content/uploads/2014/02/5B-DSM-5-Opioid-Use-Disorder-Diagnostic-Criteria.pdf

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Baseline Considerations

Does the patient have active substance use?

Is the patient in withdrawal or at risk for withdrawal?

Is the patient in remission from substance use (including alcohol)?
- On medications for treatment
- In abstinence-based program

Does the patient have adequate support systems?

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Screen for Opioid Withdrawal
Clinical Opioid Withdrawal Scale

Symptoms	Scores
Resting pulse rate	0 ≤ 80; 1 = 81-100; 2 = 101-120; 4 ≥ 120
Sweating	0 (no report) – 4 (sweat streaming off face)
Restlessness	0 (sits still) – 5 (unable to sit still for more than a few seconds)
Pupil size	0 (pinned or normal) – 5 (only rim of iris is visible)
Bone or joint aches	0 (no pain) – 4 (rubbing joints/muscles, can't get comfortable)
Runny nose / tearing	0 (absent) – 4 (constantly running/tearing)
GI upset	0 (no GI symptoms) – 5 (multiple episodes of vomiting/diarrhea)
Tremor	0 (absent) – 4 (gross tremor / muscle twitching)
Yawning	0 (absent) – 4 (yawning several times per minute)
Anxiety / Irritability	0 (none) – 4 (difficulty participating in assessment due to anxiety)
Gooseflesh skin	0 (smooth skin) – 5 (prominent piloerection)
Score	5-12 = mild; 13-24 moderate; 23-36 = moderately severe; > 36 = severe withdrawal

Wesson, Ling. *J Psychoactive Drugs*, 2003;*35*(2):253-9

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Physical Examination

Eyes	Examine pupil size to determine pinpoint vs dilated; inspect sclerae for signs of jaundice to identify potential liver dysfunction
Nose	Inspect for excoriation, perforation of nasal septum, or epistaxis which may be signs of insufflation injury
Ears	Inspect for ruptured tympanic membrane or signs of infection which may be secondary to neglect/violence/trauma
Oropharynx	Inspect teeth poor repair, gum disease, or abscess. Assess oropharynx for signs of infection
Cardiopulmonary	Evaluate for murmurs, arrhythmias or pulmonary abnormalities
Abdomen	Evaluate for hepatomegaly or hernia
Extremities	Examine for musculoskeletal abnormalities such as fracture, traumatic amputations; indicating trauma. Evaluate for edema potentially indicating renal dysfunction
Skin	Examine for abscesses, rashes, cellulitis, thrombosed veins, scars, track marks from injection, or burns

Psychological Screening: A Vital Role for Nurses

- Use open-ended questions
- Active listening
- Be empathetic, accepting, holistic
- Reduce Stigma
  - Words we use
  - Our behaviors
- Take time to hear their story or requests or concerns

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Suicide Evaluation and Triage


RESOURCES

- Download this card and additional resources at www.sprc.org or at www.stopasuicide.org
- Resource for Implementing The Joint Commission 2007 National Patient Safety Goal 15 www.sprc.org/library/jcnpsgoal.pdf
- SAFE-T drew upon the American Psychiatric Association Practice Guidelines for the Assessment and Treatment of Patients with Suicidal Behaviors www.psychiatryonline.com/pracguide/pracguidetopic_14.aspx
- Practice Parameter for the Assessment and Treatment of Children and Adolescents with Suicidal Behavior. Journal of the American Academy of Child and Adolescent Psychiatry, 2001, 40 (7 Supplement): 24s-51s

ACKNOWLEDGEMENTS

- Originally conceived by Douglas Jacobs, MD, and developed as a collaboration between Screening for Mental Health, Inc. and the Suicide Prevention Resource Center.
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National Suicide Prevention Lifeline
1.800.273.TALK (8255)

www.sprc.org www.mentalhealthscreening.org

SAFE-T
Suicide Assessment Five-step Evaluation and Triage
for Mental Health Professionals

1. IDENTIFY RISK FACTORS: Note those that can be modified to reduce risk
2. IDENTIFY PROTECTIVE FACTORS: Note those that can be enhanced
3. CONDUCT SUICIDE INQUIRY: Suicidal thoughts, plan behavior and intent
4. DETERMINE RISK LEVEL/INTERVENTION: Determine risk. Choose appropriate intervention to address and reduce risk
5. DOCUMENT: Assessment of risk, rationale, intervention and follow-up

NATIONAL SUICIDE PREVENTION LIFELINE
1.800.273.TALK (8255)

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Risk Stratified Interventions

RISK LEVEL	RISK / PROTECTIVE FACTOR	SUICIDALITY	POSSIBLE INTERVENTIONS
High	Psychiatric disorders with severe symptoms, or acute precipitating event; protective factors not relevant	Potentially lethal suicide attempt or persistent ideation with strong intent or suicide rehearsal	Admission generally indicated unless a significant change reduces risk. Suicide precautions
Moderate	Multiple risk factors, few protective factors	Suicidal ideation with plan, but no intent or behavior	Admission may be necessary depending on risk factors. Develop crisis plan. Give emergency/crisis numbers
Low	Modifiable risk factors, strong protective factors	Thoughts of death, no plan, intent or behavior	Outpatient referral, symptom reduction. Give emergency/crisis numbers

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Protective Factors

Protective factors, even if present, may not counteract significant acute risk

Internal: ability to cope with stress, religious beliefs, frustration tolerance

External: responsibility to children or beloved pets, positive therapeutic relationships, social supports

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Pain Management – General Considerations in the Context of OUD

Overall Goal – Harm Reduction

Harm reduction approach

- Root in public health
- Do not endorse illicit drug use – accept as reality
- Minimize the 'harmful consequences
- What is ideal?
- What is realistic?

Consider…

- If active use, refer for addiction treatment if possible
- Close collaboration with prescribing facility is essential for patients with pain also enrolled in methadone or buprenorphine/naloxone maintenance programs
  - Maintenance medication dosed once daily not likely to manage pain

Kampman & Jarvis. *J Addict Med*. 2015;9:358-367; Broglio & Matzo. *Am J Nurs*. 2018;118(10):30-8; https://www.hhs.gov/opioids/sites/default/files/2018-12/naloxone-coprescribing-guidance.pdf

Pain Management

- Maximize use of multimodal analgesia to include non-opioids and when possible nonpharmacologic treatment
- Prescribe opioid therapy for pain **ONLY** if you have:
  - Experience or can collaborate with addiction medicine
  - Nursing and/or social work support to co-manage
  - Ability to prescribe small amounts frequently (every three days or one week)

Key references:

Nonopioid pharmacologic treatments for chronic pain. **AHRQ Publication No. 20-EHC010 April 2020**

Noninvasive nonpharmacological treatment for chronic pain. **AHRQ Publication No. 20-EHC009 April 2020**

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Consider…

- Utilize universal precautions for opioid prescribing
- Recognize fears that may arise in patients- AT risk for relapse
- Support patients by ensuring safe, appropriate pain management

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Employ Non-Pharmacologic Strategies (if available)

- Online Pain Self-Management[1]
- Cognitive Behavioral Therapy (CBT)[2]
- Mindfulness-Oriented Recovery Enhancement[3]
- Mindfulness Meditation[4]
- Combination CBT and acceptance based therapy[5]

[1]Wilson et al. *Addictive Behaviors.* 2018; *86*:130-7; [2] Barry et al. *Drug Alcohol Depend.* 2019;194:460-7. (2019). [3]Garland et al. *J Consul Clin Psychol,* 2014;*82*(3):448-59. [4] Khusid& Vythilingam. *Military Med.* 2016;181:969-75. [5] Ilgen et al. 2016. *Addiction.* 2016;*111*:1385-93

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Ensure Prescriptions for Opioid Reversal

- Prescribe naloxone rescue kits for **ALL** patients who are:
  - On high dose opioids
    - > 50 mg morphine equivalent daily
  - At risk for overdose
    - Frail, organ dysfunction, etc.
  - Diagnosed with substance use disorder
    - Active use
    - On MOUD
    - In remission not on MOUD
  - Safety risks in the home

U.S. Department of Health and Human Services, Surgeon General. 2018. https://www.hhs.gov/opioids/sites/default/files/2018-12/naloxone-coprescribing-guidance.pdf

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Acute Pain Management Strategies- OUD Active Use

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General Considerations

- Utilize opioid sparing medications[1]
- Consider initiation of MOUD if patient willing to start[2]
  - No special waiver needed if admission was NOT related to OUD
- Intravenous Patient Controlled Analgesia (IV-PCA) may be best option to determine dose needs or use scheduled instead of as needed opioids[3]
- May still have withdrawal symptoms – treat with clonidine or tizanidine[4]

[1]Kumar et al. *Anesth Analg.* 2017;*125*:1749-60 Vadivelu et al. *Curr Pain Headache Rep. 2016;20*(5):35;Wenzel et al. *Anesthesiol Clin.* 2016;34:287-301 [2]DEA. 2018. https://www.deadiversion.usdoj.gov/21cfr/cfr/1306/1306_07.htm [3]Sen et al. *Curr Pain Headache Rep.* 2016;3:16. [4]Gowing et al., *Cochrane Database Syst Rev.* 2014;*3*:CD002024

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Discharge Planning

- Develop safe discharge plan
- Refer to outpatient treatment if patient willing to engage
  - If not and have started MOUD inpatient will have to discontinue prior to discharge
  - Avoid a gap in care
- Prescribe naloxone for overdose prevention due to higher risk for overdose due to loss of tolerance

American Society of Addiction Medicine. 2020. https://www.asam.org/docs/default-source/quality-science/npg-jam-supplement.pdf?sfvrsn=a00a52c2_2; U.S. Department of Health and Human Services, Surgeon General. 2018. https://www.hhs.gov/opioids/sites/default/files/2018-12/naloxone-coprescribing-guidance.pdf

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Chronic Pain Management Strategies –OUD Active Use

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Utilize Non-Opioid Analgesics Multimodal Analgesia

- Opioids may not be consideration unless
  - Serious illness
  - End of Life
- If opioids necessary consider
  - Frequent visits
  - Dispensing small amounts of medications
  - Frequent Urine toxicology screens
  - Friends/family to help
  - Assessment of home situation

Walsh & Broglio. *Nurs Clin N Am.* 2016:433-447

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Acute Pain Management Individuals on Medications for Opioid Use Disorder (MOUD aka MAT)

Medications for Opioid Use Disorder (MOUD)

Medication	Action	Dose	Where obtained?	Comments
Methadone	Full mu agonist	60-120 mg (usual doses – may be higher or lower) PO once daily	Must be administered through a federal Opioid Treatment Program Patient goes daily for observed dosing May graduate to take doses home on weekends or have weekly pick-ups	• Provides analgesia for 6-12 hrs • More than once daily dosing necessary for pain management • Many drug/drug interactions • Can cause QTc prolongation
Buprenorphine/ naloxone Buprenorphine (pregnancy) Buprenorphine implants or injection	Partial mu agonist	8-24 mg sublingual or transmucosal daily 320 mg implant q6mo 100- 300 mg monthly injection	Prescribed by physicians, nurse practitioners, and physician assistants in ambulatory office setting who have waiver Consider obtaining waiver	• May provide analgesia if given in split doses (every 8 or 12 hours) • If pure mu opioids administered, need higher doses • Implants can be removed prior to six months • Fewer interactions than methadone
Naltrexone	Full mu antagonist	50 mg orally daily 380 mg monthly intramuscular depot	Injection administered by any clinician who is prescriber	• Also used for alcohol use disorder • Blocks the effects of **opioids – not a good choice for those with pain requiring opioid therapy**

Source document for information in table Kampman & Jarvis. *J Addict Med*. 2015;9:358-367; Broglio & Matzo. *Am J Nurs*. 2018;118(10):30-8

Acute Pain Management and MOUD – Evidence

- No prospective designed studies
- Evidence based on limited controlled retrospective studies, case series
- Findings:
  - Continuation of methadone and buprenorphine during acute pain events is feasible
  - Discontinue naltrexone
  - Higher doses of opioids may be necessary in this population
  - Use of multimodal analgesia recommended but reported use is inconsistent

Veazie et al. Department of Veterans Affairs. VA ESP Project #09-199; 2019.

Methadone - Acute Pain

- Verify methadone dose from Outpatient Treatment Program (OTP)
  - If cannot verify (night/weekend), then can prescribe up to 40 mg daily (best in divided doses) or per institution policy
- Options for acute pain management with methadone only
  - Add additional doses of methadone to provide pain management – ex: 10 mg in afternoon and evening- Clearly document on prescription/chart for '**pain management**'
  - If can not use oral, utilize methadone IV at 50% of oral dose
  - Utilize methadone in split dosing (q6 – 12 hours) – clearly document AND discuss with OTP

Bryson. *Cur Opin Anaesthes.* 2014; 27:359-64; Harrison et al. *Anesthesiol Clin*, 2018;36:345-59; Koller et al. *Ex Opin Pharma.* 2019;20(16):1993–2005; Taveros & Chuang, *BMJ Support Pall Care*, 2017;7:383-9

Methadone - Perioperative Pain

- Continue methadone for opioid maintenance if possible
  - May need to decrease/hold dose in cases of hemodynamic instability
- Utilize multimodal analgesia including regional analgesia
- If utilizing opioids utilize least amount/lowest dose while maintaining analgesia- **May however need higher doses than those without OUD**
- Consider EKGs especially if utilizing other QTc prolonging medications
- Arrange for discharge plan if prescribing opioids for discharge (communicate with OTP)
- Prescribe naloxone for overdose prevention
- Ensure education on tapering opioids post-discharge

Cornett et al. *Cur Pain Headache Rep.* 2019;23:49; Koller et al. *Ex Opin Pharma.* 2019;20(16):1993–2005; Ward et al. *Anesth Analg.* 2018;127:539–47

Buprenorphine - Acute Pain

- Mu opioid receptors occupied by buprenorphine but not activated
- If patient requires opioids for pain – WILL REQUIRE higher doses to overcome occupied mu receptors
- If buprenorphine discontinued takes up to 72 hours to disassociate from mu receptors
- If patient admitted on buprenorphine with pain crisis/trauma/surgery

Buprenorphine - Acute Pain

- No consensus guidelines - suggested options
  - Continue buprenorphine – and split/increase doses and use multimodal analgesia
  - Continue buprenorphine (with possible wean to 12 mg daily) and treat with multimodal analgesia and immediate release mu-opioid agonists
  - Wean or discontinue buprenorphine prior to a surgery and use multimodal analgesia and mu-opioid agonists to treat pain – restart buprenorphine after acute pain resolves

American Society of Addiction Medicine. 2020. https://www.asam.org/docs/default-source/quality-science/npg-jam-supplement.pdf?sfvrsn=a00a52c2_2; Koller et al. *Ex Opin Pharma*. 2019;20(16):1993–2005;Leighton, Crock. *Anesth Analg* 2017;125:1779–83; Ward et al. *Anesth Analg*. 2018;127:539–47; Warner et al. *Mayo Clin Proc*. 2019. 1-5; Veazie et al. Department of Veterans Affairs. VA ESP Project #09-199; 2019

Buprenorphine Continuation

- Continue buprenorphine therapy and consider divided doses every 6-8h and can increase dose to maximum of 32 mg daily
- Utilize multimodal analgesia
- Treat acute pain with mu-opioid agonists such as fentanyl, hydromorphone or morphine or sublingual or intravenous buprenorphine if available
- Ensure monitoring for respiratory depression

You can override the mu receptors with higher doses of opioids

American Society of Addiction Medicine. 2020. https://www.asam.org/docs/default-source/quality-science/npg-jam-supplement.pdf?sfvrsn=a00a52c2_2 Harrison et al. *Anesthesiol Clin*, 2018;36:345-59; Koller et al. *Ex Opin Pharma*. 2019;20(16):1993–2005 Lembke. *Pain Med*. 2018;20:Foundation for Medical Education and Research n Mayo Clin Proc. 425-8; Veazie et al. Department of Veterans Affairs. VA ESP Project #09-199; 2019 Ward et al. *Anesth Analg*. 2018;127:539–47; Warner et al. *Mayo Clin Proc*. 2019. 1-5

Buprenorphine Discontinuation

- May consider discontinuing on the day of surgery and it may require higher doses of opioid to overcome buprenorphine
- If wean over 3-5 days, if pain/intolerable withdrawal, use methadone 30 mg daily, immediate release or extended release opioid prior to admission
- If pain resolves allow for mild withdrawal -resume buprenorphine

Must weigh risks discontinuing buprenorphine – higher risk for overdose if discharged without restarting buprenorphine

American Society of Addiction Medicine. 2020. https://www.asam.org/docs/default-source/quality-science/npg-jam-supplement.pdf?sfvrsn=a00a52c2_2 Bryson. *Cur Opin Anaesthes*. 2014; 27:359-64; Jonan et al. *Pain Physician*. 2018;21:E1-12; Ward et al. *Anesth Analg*. 2018;127:539–47

Naltrexone - Acute Pain

- Discontinue naltrexone IM 4 weeks or oral naltrexone 72 hours prior to planned surgery
- In event of trauma/acute pain/unplanned surgery may need to use 6-20x of usual dose of mu opioid to obtain efficacy
- Utilize multimodal analgesia to maximize analgesia without use opioids
- Do not restart naltrexone until one week to 10 days after the last opioid dose

Bryson, *Cur Opin Anaesthesiology*, 2014;27, 359-64; Harrison et al. *Anesthesiol Clin*, 2018;36:345-59; Veazie et al. Department of Veterans Affairs. VA ESP Project #09-199; 2019 Ward et al. *Anesth Analg*. 2018;127:539–47

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Naltrexone - Acute Pain

- Discharge planning include plan for restarting naltrexone
- Safety plan for administration, tapering, storage and disposal if discharged with opioids
- Naloxone for opioid reversal
- Education about increased risk for overdose due to decreased tolerance

Ward et al. *Anesth Analg*. 2018;127:539–47

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Chronic Pain Management Strategies for those on MOUD

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General Principles

- Utilize multimodal analgesia
- Opioid therapy should be used only in cases of unresolved pain due to trauma, surgery or injury, progressive disease, end-of-life
  - Ensure use of universal precautions for opioid prescribing (treatment agreements, urine drug screens, prescription drug monitoring program checks, frequent follow-up and reassessment, communication with prescriber of MOUD)
- Utilize nonpharmacologic measures if available
- Always ensure there is a prescription for naloxone for opioid reversal

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Methadone for OUD and Pain

- Collaborate with Opioid Treatment Program(OTP) as only these programs can prescribe methadone for opioid use disorder
- Individual continues with OTP
  - Some evidence for better analgesia utilizing methadone- ex: 10 mg in afternoon and evening- Clearly document on prescription/chart for 'pain management'
  - Can utilize other opioids if additional methadone contraindicated (prolong QTc) – USE caution not to trigger craving

American Society of Addiction Medicine. 2020. https://www.asam.org/docs/default-source/quality-science/npg-jam-supplement.pdf?sfvrsn=a00a52c2_2
Taveros & Chuang, *BMJ Support Pall Care*, 2017;7:383-9

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Buprenorphine for OUD and Pain

- Obtain waiver to prescribe buprenorphine/naloxone for opioid use disorder
  - Split doses of buprenorphine/naloxone for pain management – utilize up 24 mg daily (generally insurance approval becomes problematic at doses greater than 24 mg daily and no significant evidence for increased efficacy)
- Generally do not use mu-opioids with buprenorphine unless patient hospitalized with acute pain

American Society of Addiction Medicine. 2020. https://www.asam.org/docs/default-source/quality-science/npg-jam-supplement.pdf?sfvrsn=a00a52c2_2
Streltzer et al. *Am J Addictions*. 2015;24:357- 61

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Naltrexone for OUD and Pain

- Utilize multimodal analgesia WITHOUT opioids
- If opioids required collaborate with addiction specialists to rotate to an agonist therapy

Educate on risks for accidental overdose if relapse during transition

American Society of Addiction Medicine. 2020 https://www.asam.org/docs/default-source/quality-science/npg-jam-supplement.pdf?sfvrsn=a00a52c2_2

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Acute and Chronic Pain Management Strategies in Remission not on MOUD

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Treatment Strategies

- Multimodal approach including non-pharmacologic strategies
- Continue or engage in psychosocial programs
- Offer non-pharmacologic strategies if available
- Naloxone for opioid reversal even if NOT on opioids due to risk of relapse

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Take Home Points

1. Consistently utilize safe prescribing techniques for individuals with opioid use disorder
2. ***Treat patients with opioid use disorder with compassion – it is a disease, not a moral failing***
3. Consider further education on pain and addiction management if there are limited resources for referral in your community

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Some Suggested Readings

- American Society of Addiction Medicine. National Practice Guideline for the Treatment of Opioid Use Disorder. 2020 Focused Update. https://www.asam.org/docs/default-source/quality-science/npg-jam-supplement.pdf?sfvrsn=a00a52c2_2
- Barry DT, Beitel M, Cutter CJ et al. An evaluation of the feasibility, acceptability and preliminary efficacy of cognitive-behavioral therapy for opioid use disorder and chronic pain. *Drug Alcohol Depend.* 2019;194:460-7
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- Cooney MF, Broglio K. Acute pain management in opioid-tolerant individuals. *J Nurs Pract.* 2017;13(6):394-9.
- Jonan AB, Kaye AD, Urman RD. Buprenorphine formulations: Clinical best practice strategies for perioperative management of patients undergoing surgical or interventional pain procedures. *Pain Physician.* 2018;*21:* E1-E12
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- St. Marie B, Broglio K. Managing pain in the setting of opioid use disorder. *Pain Manage Nurse.* 2020;21(1):26-34.
- Substance Abuse and Mental Health Services Administration. (2018c). Medications for opioid use disorder; for healthcare and addiction professionals, policymakers, and families [Internet], Treatment improvement protocol (TIP) Series 63. Retrieved from https://store.samhsa.gov/system/files/sma18-5063fulldoc.pdf
- Taveros MC, Chuang EJ. Pain management strategies for patients on methadone maintenance therapy: systematic review of the literature. *BMJ Support Palliat Care.* 2017;7:383-9.
- Veazie S, Mackey K, Bourne D, Peterson K. Evidence Brief: Managing Acute Pain in Patients with Opioid Use Disorder on Medication-Assisted Treatment. Washington, DC: Evidence Synthesis Program, Health Services Research and Development Service, Office of Research and Development, Department of Veterans Affairs. VA ESP Project #09-199; 2019. Posted final reports are located on the ESP
- Ward EN, Quay ANA, Wilens TE. Opioid use disorders: perioperative management of a special population. *Anest Analg.* 2018; *127*(2): 539-47.
- Wilson M, Finlay M, Orr M et al. Engagement in online pain self-management improves pain in adults on medication-assisted behavioral treatment for opioid use disorders. *Addict Behav.* 2018;*86*:130-7.

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PCSS Mentoring Program

- PCSS Mentor Program is designed to offer general information to clinicians about evidence-based clinical practices in prescribing medications for opioid addiction.
- PCSS Mentors are a national network of providers with expertise in **addictions, pain, evidence-based treatment including medication-assisted treatment**.
- 3-tiered approach allows every mentor/mentee relationship to be unique and catered to the specific needs of the mentee.
- No cost.

For more information visit:

pcssnow.org/mentoring

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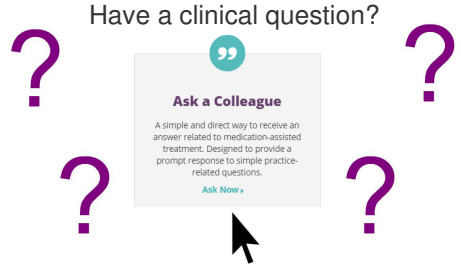
PCSS Discussion Forum

Have a clinical question?



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PCSS is a collaborative effort led by the American Academy of Addiction Psychiatry (AAAP) in partnership with:

American Academy of Family Physicians	American Psychiatric Association
American Academy of Neurology	American Society of Addiction Medicine
Addiction Technology Transfer Center	American Society of Pain Management Nursing
American Academy of Pain Medicine	Association for Medical Education and Research in Substance Abuse
American Academy of Pediatrics	International Nurses Society on Addictions
American College of Emergency Physicians	American Psychiatric Nurses Association
American College of Physicians	National Association of Community Health Centers
American Dental Association	National Association of Drug Court Professionals
American Medical Association	Southeastern Consortium for Substance Abuse Training
American Osteopathic Academy of Addiction Medicine	

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