Concurrent Management of Chronic Pain and Addiction

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Accreditation

• The American Academy of Pain Medicine is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

• Credit Designation:
The American Academy of Pain Medicine designates this live activity for a maximum of 1 AMA PRA Category 1 Credit(s)™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.
Speaker and Planning Committee, Disclosures

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  - Cara Therapeutics (consultant)
  - Charleston Labs (advisory board)
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  - No relevant financial relationships

Planners

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The contents of this activity may include discussion of off label or investigative drug uses. The faculty is aware that is their responsibility to disclose this information.
Target Audience

• The overarching goal of PCSS-O is to offer evidence-based trainings on the safe and effective prescribing of opioid medications in the treatment of pain and/or opioid addiction

• Our focus is to reach providers and/or providers-in-training from diverse healthcare professions including physicians, nurses, dentists, physician assistants, pharmacists, and program administrators
Educational Objectives

• At the conclusion of this activity participants should be able to:

1. Devise a plan to incorporate risk assessment tools into clinical practice when managing patients with chronic pain.

2. Utilize information from risk assessment tools in order to stratify patients’ risk for abuse and addiction and develop a differential diagnosis.

3. Implement an individualized pain management plan for patients with addiction that addresses risk and integrates the perspectives of patients, their social support systems, and health care providers in the context of available resources.
The recently released *National Pain Strategy* envisions an environment in which:

"People experiencing pain would have timely access to patient-centered care that meets their biopsychosocial needs and takes into account individual preferences, risks, and social contexts, including dependence and addiction."
Definition of Terms

**Misuse**

Use of a medication (for a medical purpose) other than as directed or as indicated, whether willful or unintentional, & whether harm results or not.

**Abuse**

Any use of an illegal drug

The intentional self-administration of a medication for a non-medical purpose, such as altering one’s state of consciousness, eg, getting high.

**Addiction**

A primary, chronic, neurobiological disease, with genetic, psychosocial, & environmental factors influencing its development & manifestations.

Behavioral characteristics include one or more of the following: Impaired control over drug use, compulsive use, continued use despite harm, craving.

Severity of the disorder is based on the number of criteria endorsed:

- Mild: 2 to 3 criteria
- Moderate: 4-5 criteria
- Severe: ≥6 criteria

These 3 DSM-5 categories broadly correlate with:

- Misuse (mild)
- Abuse (moderate)
- Addiction (severe)
Problem

ADRB=aberrant drug-related behavior

Who Misuses/Abuses Opioids & Why?

- Pain patients seeking more pain relief
- Pain patients escaping emotional pain
- Recreational abusers
- Patients with the disease of addiction
Spectrum of Behaviors

Nonmedical users (nonpatients)  Pain patients

- Addicted (SUD)
- Substance abuser
- Recreational user
- Self-treater
- Adherent
- Chemical coper
- Substance abusers
- Addicted (SUD)

SUD = substance-use disorder
Risk Factors for Addiction

## Patient Risk Factors for Opioid Abuse

<table>
<thead>
<tr>
<th>Biological</th>
<th>Psychiatric</th>
<th>Social</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Age ≤45 years</td>
<td>• Substance use disorder</td>
<td>• Prior legal problems</td>
</tr>
<tr>
<td>• Gender</td>
<td>• Polysubstance use</td>
<td>• History of motor vehicle accidents</td>
</tr>
<tr>
<td>• Family history of drug or alcohol abuse</td>
<td>• Preadolescent sexual abuse (in women)</td>
<td>• Poor family/social support</td>
</tr>
<tr>
<td>• Cigarette smoking</td>
<td>• Major psychiatric disorder (eg, personality disorder, anxiety, depression, bipolar disorder)</td>
<td>• Isolation</td>
</tr>
<tr>
<td>• Physical Illness</td>
<td>• Psychological stress</td>
<td>• Involvement in a problematic subculture</td>
</tr>
<tr>
<td>• Pain severity/duration</td>
<td></td>
<td>• Unemployed</td>
</tr>
<tr>
<td>• Nonfunctional status due to pain</td>
<td></td>
<td>• Focus on opioids</td>
</tr>
<tr>
<td>• Exaggeration of pain</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Unclear pain etiology</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Sleep disorder</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Reason Providers Fail to Assess Risk

- Pessimism regarding treatment effectiveness
- Fears about patient sensitivity
- Perceived time constraints

Assessments for Opioid Abuse and Addiction

- Predictive tools
- Diagnostic tools
- Urine drug testing
- Prescription-monitoring programs
- Pill counts
- Include patient’s support system (eg, family and friends)

Limitations of Familiar Screening Tools

• Designed to identify patients who already have problems managing substance intake
  • *Not* to predict who may develop problems
• *Not* designed to screen specifically for opioid abuse
• Often take a long time to administer and require unique skills to interpret

Assessment Tool Criteria

- Predictive
- Brief
- Easy to administer and interpret
- Geared to opioid abuse rather than alcohol or other substances
- Validated in patients with pain
- Applicable to a variety of clinical settings
- Self-administered

# Validated Risk Stratification Tools for Opioid Misuse

<table>
<thead>
<tr>
<th>Tool</th>
<th>Description</th>
<th>Time</th>
<th>Diagnostic accuracy</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opioid Risk Tool (ORT)</td>
<td>10-item patient self-report that assesses risk of ADRBs</td>
<td>1 min</td>
<td>At cutoff of &gt;4 or unspecified, sensitivity was 0.20-0.99 &amp; specificity was 0.16-0.88 to detect opioid overdose, addiction, abuse, or misuse (5 studies)</td>
<td>-</td>
</tr>
<tr>
<td>Screener and Opioid Assessment for People with Pain–Revised (SOAPP®-R)</td>
<td>24-item patient self-report: assesses risk of drug-related behaviors</td>
<td>&lt;10 min</td>
<td>At cutoff of &gt;3 or unspecified, sensitivity was 0.25 &amp; 0.53 &amp; specificity was 0.62 &amp; 0.73 for detection of opioid overdose, addiction, abuse, or misuse for likelihood ratios close to 1 (2 studies)</td>
<td>Designed to prevent patient deception. Require licensing agreement but no fee for clinical use.</td>
</tr>
<tr>
<td>Current Opioid Misuse Measure (COMM)</td>
<td>17-item patient self-report: identify patients on long-term opioid therapy exhibiting ADRBs</td>
<td>&lt;10 min</td>
<td>At cutoff of ≥10, sensitivity was 0.74 &amp; specificity was 0.73 for detection of ADRB (1 study)</td>
<td>Require licensing agreement but no fee for clinical use.</td>
</tr>
<tr>
<td>Diagnosis, Intractability, Risk, Efficacy (DIRE)</td>
<td>7-item clinician interview: predict analgesic efficacy &amp; patient adherence with long-term analgesic therapy</td>
<td>&lt;2 min</td>
<td>At cutoff of 13, sensitivity was 94% &amp; specificity was 87% with poor vs good/fair adherence (1 study)</td>
<td>-</td>
</tr>
</tbody>
</table>

# Validated Risk Stratification Tools for Opioid Misuse

<table>
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<th>Tool</th>
<th>Description</th>
<th>Time</th>
<th>Diagnostic accuracy</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pain Assessment &amp; Documentation Tool (PADT)</td>
<td>Clinician-directed interview: 4 domains to document potential ADRB during pain treatment</td>
<td>Few minutes</td>
<td>Not yet evaluated</td>
<td>Only small component addresses abuse risk</td>
</tr>
<tr>
<td>Cut down/Annoyed/Guilty/Eye-Opener Adapted to Include Drugs (CAGE-AID)</td>
<td>4-question clinician-administered tool: screen for substance abuse disorders</td>
<td>&lt;5 min</td>
<td>Cutoff of 2: 91% sensitivity &amp; 98% specificity in adolescents&lt;br&gt; Cutoff of 1: 88% sensitivity &amp; 55% specificity in adults&lt;br&gt; Cutoff of 1 or 2: sensitivity of 0.79 &amp; 0.70 &amp; specificity of 0.77 &amp; 0.85 (1 study each)</td>
<td>-</td>
</tr>
<tr>
<td>Addiction Behaviors Checklist (ABC)</td>
<td>20-item clinician-administered tool: track behaviors characteristic of opioid addiction in chronic pain patients</td>
<td>Described as “brief”</td>
<td>At cutoff of 3 or greater (using ABC data from initial visit only), sensitivity was 87.50% &amp; specificity was 86.14% (1 study)</td>
<td>-</td>
</tr>
<tr>
<td>Single-item form of the Coping Strategies Questionnaire</td>
<td>1 question to predict opioid misuse: “It’s terrible and I feel it is never going to get better”</td>
<td>Very brief</td>
<td>Highly predictive vs SOAPP-R</td>
<td>Study published as abstract</td>
</tr>
</tbody>
</table>

Agreement Between Clinical Interview & Measures of ADRB

## Opioid Risk Tool (ORT)

**Mark each box that applies**

<table>
<thead>
<tr>
<th>1. Family history of substance abuse</th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>☐ 1</td>
<td>☐ 3</td>
</tr>
<tr>
<td>Illegal drugs</td>
<td>☐ 2</td>
<td>☐ 3</td>
</tr>
<tr>
<td>Prescription drugs</td>
<td>☐ 4</td>
<td>☐ 4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. Personal history of substance abuse</th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>☐ 3</td>
<td>☐ 3</td>
</tr>
<tr>
<td>Illegal drugs</td>
<td>☐ 4</td>
<td>☐ 4</td>
</tr>
<tr>
<td>Prescription drugs</td>
<td>☐ 5</td>
<td>☐ 5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3. Age (mark box if 16-45 years)</th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>☐ 1</td>
<td>☐ 1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4. History of preadolescent sexual abuse</th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>☐ 3</td>
<td>☐ 0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5. Psychological disease</th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADD, OCD, bipolar, schizophrenia</td>
<td>☐ 2</td>
<td>☐ 2</td>
</tr>
<tr>
<td>Depression</td>
<td>☐ 1</td>
<td>☐ 1</td>
</tr>
</tbody>
</table>

ADD = attention deficit disorder; OCD = obsessive-compulsive disorder

### Risk Levels

<table>
<thead>
<tr>
<th>Total score</th>
<th>Risk</th>
<th>% with aberrant behavior</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-3</td>
<td>Low</td>
<td>6%</td>
</tr>
<tr>
<td>4-7</td>
<td>Moderate</td>
<td>28%</td>
</tr>
<tr>
<td>≥8</td>
<td>High</td>
<td>91%</td>
</tr>
</tbody>
</table>

**Exhibits high degree of sensitivity and specificity**
- 94% of low-risk patients did not display an aberrant behavior
- 91% of high-risk patients did display an aberrant behavior


N=185
The following are some questions given to all patients at the Pain Management Center who are on or being considered for opioids for their pain. Please answer each question as honestly as possible. This information is for our records and will remain confidential. Your answers alone will not determine your treatment. Thank you.

Please answer the questions below using the following scale:
0 = Never  1 = Seldom  2 = Sometimes  3 = Often  4 = Very Often

<table>
<thead>
<tr>
<th>Question</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. How often do you have mood swings?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. How often do you smoke a cigarette within an hour after you wake up?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. How often have you taken medication other than the way that it was prescribed?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. How often have you used illegal drugs (for example, marijuana, cocaine, etc.) in the past five years?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. How often, in your lifetime, have you had legal problems or been arrested?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

To score the SOAPP V.1.0-SF, add ratings of all questions:
A score of ≥4 is considered positive

<table>
<thead>
<tr>
<th>Sum of questions</th>
<th>SOAPP indication</th>
</tr>
</thead>
<tbody>
<tr>
<td>≥4</td>
<td>+</td>
</tr>
<tr>
<td>&lt;4</td>
<td>-</td>
</tr>
</tbody>
</table>

SOAPP is available in 3 formats: 5Q, 14Q, & 24Q

Please include any additional information you wish about the above answers. Thank you.
## Risk Stratification

<table>
<thead>
<tr>
<th>Lower Risk</th>
<th>Moderate Risk</th>
<th>Higher Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary care patients</td>
<td>Primary care patients with specialist support</td>
<td>Pain specialist patients</td>
</tr>
<tr>
<td>ORT Score 0-3</td>
<td>ORT Score 4-7</td>
<td>ORT Score ≥8</td>
</tr>
<tr>
<td>• No past or current history of substance use disorders</td>
<td>• May be a past history of substance use disorders</td>
<td>• Active substance use disorders</td>
</tr>
<tr>
<td>• No family history of past or current substance use disorders</td>
<td>• May be a family history of problematic drug use</td>
<td>• Major, untreated psychopathology</td>
</tr>
<tr>
<td>• No major or untreated psychopathology</td>
<td>• May have past or concurrent psychopathology</td>
<td>• Poor social support</td>
</tr>
<tr>
<td>• Consistent UDT results</td>
<td>• Not actively addicted</td>
<td>• Actively addicted</td>
</tr>
<tr>
<td>• Consistent PDMP results</td>
<td>• Usually consistent UDT results</td>
<td>• Inconsistent UDT results</td>
</tr>
<tr>
<td>• Mild to moderate pain</td>
<td>• Consistent PDMP results</td>
<td>• PDMP multiple prescribers</td>
</tr>
<tr>
<td></td>
<td>• Mild to severe pain</td>
<td>• Moderate to severe pain</td>
</tr>
</tbody>
</table>

ORT=Opioid Risk Tool; PDMP=Prescription Drug Monitoring Program; UDT=urine drug testing

### Behaviors Concerning for Addiction: Spectrum of Yellow to Red Flags

- Requests for increased opioid dose
- Requests for specific opioid by name, “brand name only”
- Unsanctioned dose escalation or other noncompliance with therapy on 1 or 2 occasions
- Nonadherence with other recommended therapies (eg, physical therapy)
- Resistance to change therapy despite adverse effects (eg, over-sedation)
- Deterioration in function at home and work
- Multiple dose escalations or other noncompliance with therapy despite warnings
- Nonadherence with monitoring (eg, pill counts, urine drug testing)
- Multiple “lost” or “stolen” opioid prescriptions
- Illegal activities (eg, forging prescriptions, selling prescription opioids)

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Differential Diagnosis: Aberrant Drug-Taking Behavior

- Addiction
- Pain-relief seeking & substance-use disorder
- Criminal intent (diversion)
- Pain-relief seeking
- Other psychiatric diagnosis
  - Organic mental syndrome
  - Personality disorder
  - Chemical coping
  - Depression/anxiety/situational stressors

Discussing Possible Addiction

- Give specific and timely feedback why patient’s behaviors raise your concern for possible addiction, eg, loss of control, compulsive use, continued use despite harm
- Remember patients may suffer from both chronic pain and addiction
- May need to “agree to disagree” with the patient
- Benefits no longer outweighing risks
  - “I cannot responsibly continue prescribing opioids as I feel it would cause you more harm than good”
- Always offer referral to addiction treatment
- Stay 100% in “Benefit/Risk” mindset
When to Refer to an Addiction Medicine Specialist

• When a patient:
  ▪ Is using illicit drugs
  ▪ Is experiencing problems with other prescription drugs
    – eg, benzodiazepines
  ▪ Has an addiction or abuse to alcohol
  ▪ Agrees they have an opioid addiction and wants help
  ▪ Has a dual or a trio diagnosis of pain, addiction, and psychiatric disease
Chronic Pain Patient with Addiction

- BMI 32
- History of substance use
  - Drinks 5-6 shots liquor daily
  - Frequent cannabis use
  - Occasional cocaine or crack use when available
  - Past use of heroin and methamphetamine on 2-3 occasions
- Acute lumbar disc herniation age 40
  - Epidural steroid injection, no surgery
- Progressively worsening low back pain over last 4-5 years
  - Pain now radiating into lower extremities, R>L
  - Imaging: diffuse lumbar spondylosis and degenerative disc disease
- Management
  - No indications for surgery, occasional procedural interventions
  - Chronic pharmacotherapy (non-opioid)
  - Occasional prescription of opioid analgesic
Chronic Pain Patient with Addiction

• Discussion points
  ▪ Strategies for chronic pain management in face of worsening pain and extensive substance use history
    – Will occasional opioid use evolve to possible chronic opioid therapy?
      ○ Risk management for opioid therapy?
    – Non-opioid alternatives?
Patient with Cancer Pain & Concurrent Drug Addiction

• History of substance use
  ▪ 50 pack-years smoker
  ▪ 4-5 glasses wine daily
  ▪ Frequent cannabis use

• Laryngeal cancer, treated with:
  ▪ Chemoradiation therapy
  ▪ Surgical resection

• Discussion points
  ▪ Cancer pain management during:
    - Active cancer treatment?
    - Survivorship?
  ▪ Risk management and ongoing monitoring?
Opioid Addicted Patient with Acute Pain

- History of substance abuse and addiction
  - Nicotine
  - Alcohol
  - THC
  - Cocaine
  - Prescription opioids
- Motorcycle accident
  - Bilateral femur fractures
  - $2^0 / 3^0$ burns on legs
- Treatment
  - Underwent ORIF fracture repair
  - Requires daily burn dressing changes

ORIF = open reduction and internal fixation
Opioid Addicted Patient with Acute Pain

• Discussion points
  ▪ Pain management:
    − Following postoperative ORIF fracture repair
    − For daily burn dressing changes
  ▪ As patient recovers over time, what are considerations for ongoing pain management balanced with addiction management?
Interdisciplinary Multimodal Approach is Key to Successful Pain Management

The NPS and IOM recommend a multimodal, integrated, interdisciplinary, biopsychosocial approach to pain that is tailored to individual patients’ needs.

Disincentives to spend sufficient time evaluating and managing the medically and behaviorally complex condition of chronic pain, due to poor reimbursement.

Insufficient numbers of interdisciplinary pain treatment centers, due to inadequate reimbursement by third-party payers for these services.

Insufficient education and training of primary care and specialist physicians who commonly care for patients with chronic pain.

Leaves pain patients out in the cold.
Barriers Driven By Reimbursement Policies

• Lack of reimbursement for:
  - Time to conduct comprehensive patient interviews, assessment, and education
  - Time spent planning and coordinating care
  - Specialty care services
  - Interdisciplinary practice
  - Psychosocial and rehabilitative services
  - Complementary and integrative medicine
  - Medication management and monitoring
  - Pain self-management programs

• Lack of access to medications
  - Rationing and medication shortages
  - High cost of abuse-deterrent formulations
  - Prior authorization
  - Fail first protocols

Current payment practices tied to the fee-for-service system tend to cover mono-therapy and interventional procedures instead of integrated, interdisciplinary, patient-centered programs and services that conform to the biopsychosocial model of care.

Advocacy: Affecting Health Care on Behalf of Our Pain Patients

• Expand pain and addiction education in medical and dental schools and CME programs
• More expansive insurance coverage and provider reimbursement for non-opioid evidence-based treatments, including:
  ▪ Behavioral health (eg, CBT, mindfulness)
  ▪ Physical and occupational therapy
  ▪ Intervenational procedures
  ▪ Complimentary approaches
• Payment reform to foster interdisciplinary care
  ▪ At least 3-months coverage for an interdisciplinary evaluation and treatment program for people with severe pain that has failed or is not expected to respond to first-line therapies, and is not expected to resolve in the foreseeable future
• NIH funding to discover safer, more effective alternatives to opioids

Conclusions

• Risk of ADRBs, misuse, abuse, and addiction must be assessed when managing patients with chronic pain
• Risk assessment can be implemented into clinical practices
• Utilize information from risk assessment tools to stratify patients’ risk for abuse and addiction and develop a differential diagnosis
• Implement an individualized pain management plan for patients with addiction that addresses their risk and integrates the perspectives of patients, their social support systems, and providers in the context of available resources
References

- PainEDU. Screener and Opioid Assessment for Patients with Pain *(SOAPP)* Version 1.0-SF.
PCSS-O Colleague Support Program and Listserv

• PCSS-O Colleague Support Program is designed to offer general information to health professionals seeking guidance in their clinical practice in prescribing opioid medications.

• PCSS-O Mentors comprise a national network of trained providers with expertise in addiction medicine/psychiatry and pain management.

• Our mentoring approach allows every mentor/mentee relationship to be unique and catered to the specific needs of both parties.

• The mentoring program is available at no cost to providers.

For more information on requesting or becoming a mentor visit: www.pcss-o.org/colleague-support

• Listserv: A resource that provides an “Expert of the Month” who will answer questions about educational content that has been presented through PCSS-O project. To join email: pcss-o@aaap.org.
PCSS-O is a collaborative effort led by American Academy of Addiction Psychiatry (AAAP) in partnership with: Addiction Technology Transfer Center (ATTC), American Academy of Neurology (AAN), American Academy of Pain Medicine (AAPM), American Academy of Pediatrics (AAP), American College of Physicians (ACP), American Dental Association (ADA), American Medical Association (AMA), American Osteopathic Academy of Addiction Medicine (AOAAM), American Psychiatric Association (APA), American Society for Pain Management Nursing (ASPMN), International Nurses Society on Addictions (IntNSA), and Southeast Consortium for Substance Abuse Training (SECSAT).

For more information visit: [www.pcss-o.org](http://www.pcss-o.org)
For questions email: pcss-o@aaap.org

Twitter: [@PCSSProjects](https://twitter.com/PCSSProjects)

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