

Integrating Opioid Use Disorder Treatment in Clinical Care

P. Todd Korthuis, MD, MPH

Professor of Medicine Chief, Section of Addiction Medicine Oregon Health and Science University



P. Todd Korthuis Disclosures

• Dr. Korthuis has no has no relevant financial relationship(s) with ACCME defined commercial interests to disclose.

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 is to make available the most effective medication-assisted treatments to serve patients in a variety of settings, including primary care, psychiatric care, and pain management settings.



Educational Objectives

- At the conclusion of this activity participants should be able to:
 - Identify models for integrating opioid use disorder (OUD) pharmacotherapy into primary care settings
 - Review keys to successful OUD pharmacotherapy implementation in clinical practice
 - Identify strategies for preventing diversion of buprenorphine/naloxone



Opioid Use Disorder Pharmacotherapy

- Methadone
 - Requires opioid treatment program (OTP) referral
- Buprenorphine
 - Requires Drug Addiction Treatment Act (DATA) 2000 waiver training
 - Office-based (or OTP) prescribing
- Naltrexone
 - Office-based (or OTP) prescribing



Opioid Use Disorder Pharmacotherapy in Primary Care

 Integration into primary care expands access to OUD treatment¹



- Buprenorphine and methadone reduce opioid use, overdose,
 HIV, HCV, and criminal activity more than behavioral treatment alone^{2,3}
- Agency for Healthcare Research and Quality (AHRQ) commissioned technical brief to identify promising models for optimizing pharmacotherapy integration

¹ Cicero JAMA Psychiatry 2014
 ² Mattick Cochrane 2014
 ³ Mattick Cochrane 2009



AHRQ Technical Brief

- 11 Key informants
 - Small group telephone discussions
- Literature review
 - Published 1995 2016
 - Ovid MEDLINE,
 - PsychINFO, etc.
 - Gray sources
 - ClinicalTrials.gov
 - Health Services
 Research Projects in
 Progress, etc

www.effectivehealthcare.ahrq.gov/reports/final.cfm

- 5 Clinicians
- 4 Policy experts
- 1 Professional society
- 1 Patient in remission

5,892 abstracts 475 full text articles 27 inform models of care

14 Gray literature citations



Four Common Components for Integration Models had some level of each component

Pharmacotherapy buprenorphine naltrexone

Coordination and integration of OUD treatment with other medical and psychological needs

Provider and community education and outreach

Psychosocial services

Korthuis, P.T., et al., *Primary Care-Based Models for the Treatment of Opioid Use Disorder: A Scoping Review*. Ann Intern Med, 2017. **166**(4): p. 268-278.



Primary Care Practice-Based Approaches Representative, not exhaustive

- 1. Office-based opioid treatment
 - Buprenorphine HIV Evaluation and Support Collaborative (BHIVES)
- 2. Hub and spoke approaches
- 3. Nurse care manager approaches

Korthuis, P.T., et al., *Primary Care-Based Models for the Treatment of Opioid Use Disorder: A Scoping Review*. Ann Intern Med, 2017. **166**(4): p. 268-278.



Office-Based Opioid Treatment (OBOT)

Pharmacologic:

 Buprenorphine-naloxone prescribed during office visits

Coordination/Integration of Care:

• Some practices designate clinic staff member as coordinator

Education/Outreach:

- DATA 2000 waiver training
- Access to PCSS

Psychosocial:

- On-site brief counseling by physician or other staff
- Off-site referrals

Expanded to Nurse Practitioners and Physician Assistants in 2017
 <u>Funding</u>: Provider reimbursement of billable visits

Fiellin DA, et al. Am J Addiction. 2008;17(2):116-20. Fiellin DA, et al. N Engl J Med. 2006;355(4):365-74. Fiellin DA, et al.Am J Drug Alcohol Abuse. 2002;28(2):231-41.



Integrating Buprenorphine into Clinical Practice

- Preparing the Whole Team
 - Front desk/phone room staff
 - Medical assistant
 - Nurse
 - Physicians
 - Counselor
 - Clinic medical director



• OK to start small and slow – just start!





Who Does What?

- Front desk/phone room staff
 - Scheduling, face/voice of practice
- Medical Assistant or Nurse
 - Measure Clinical Opioids Withdrawal Scale (COWS) if needed during induction; collect/run urine drug screen (UDS); check Prescription Drug Monitoring Plan (PDMP)
- Primary Care Provider
 - Confirm DSM-5 diagnosis, assess comorbid conditions, monitor progress
- Clinic medical director
 - Ensure protocols in place and appropriate billing
- Counselor (if available—absence shouldn't prevent starting OBOT)
 - Behavioral counseling, monitoring



Essential Training for Clinic Team Goal: Develop Shared Philosophy and Scope

- Recognizing and monitoring withdrawal symptoms (vs. "acting out")
- Importance of timely buprenorphine refills (vs. "we'll let the provider know...")
- Embrace substance use disorder as medical condition (vs. moral failure)
- Urine drug screening as medical safety (vs. policing activity)
- Timing of buprenorphine induction
- Relapse is common and does not equal failure
 - Goal is to limit duration and build on success



Timing of Buprenorphine Induction

- Schedule patient for induction soon after intake visit
 - Or provider education on home induction
- Must be in at least mild-to-moderate opioid withdrawal in order to begin induction
 - The more severe the withdrawal, the greater the relief
- Withdrawal symptoms typically begin
 - 12-24 hours after last dose of a short-acting opioids like heroin
 - 2-4 days after last dose of long acting opioids like methadone

SAMHSA, *Medications for Opioid Use Disorder*. Treatment Improvement Protocol (TIP) Series 63; 2018. Available at https://store.samhsa.gov/product/SMA18-5063FULLDOC





Clinical Opioid Withdrawal Scale (COWS)

- Measures withdrawal symptoms
- Guides timing of first dose of buprenorphine
- Easily administered by medical assistants and nurses



COWS Assessment Rates 11 Withdrawal Symptoms:

- Resting pulse rate
- Sweating
- Restlessness
- Pupil size
- Bone or joint aches
- Runny nose

- GI upset
- Tremor
- Yawning
- Anxiety or irritability
- Goose bumps



Flowshe	ets											
Eile	Add <u>R</u> o	∃ +E ow Add <u>G</u> roup	Add LDA	Cascade	m [₽] Add <u>C</u> ol	Insert Col	Compact	n∎ L <u>a</u> st Filed	Detail <u>s</u> D	ata Validate	Go to Date	Values (
DSM-V	Clinical	Opiate Withd	Witho	lrawal (Adult)	Infec	tious Screen	ing Flows	sheet Data	ED RN Basi	c Assessme	nt Vital S	Signs I
Clinical	0 🗹	Mode: Accordion	Expanded	View All								
Clinical C	Dp 🗹											10/000
											0044	10/23/
		Clinical Opiate	Withdra	wal Scale						k	0544	
		Resting pulse ra	ate							1	l - pulse ra	ite 8
		Sweating								0	- no repor	t of
		Restlessness								0	- able to s	sit still
		Pupil size								1	- pupils p	ossi
		Bone or joint ac	hes							1	- mild/diff	use
		Runny nose or t	earing								0 - not p	resent
		Gi upset								0	- no GI S	ymp
		Tremor								10	1 - tremor (can
		Yawning									0 - no ya	wning
		Anxiety or irritat	bility								0	- none
		Gooseflesh skin	1							() - skin is :	smo
		Clinical Opiate Withdrawal Total Score										
	-	Clinical Opiate Withdrawal Scale Score									4	
		Key: Score 5-1	12 = mild	13-24 = mod	derate; 25	-36 = moder	ately severe;	more than 3	6 = severe wi	thdrawal		

Withdrawal severity: Mild 5-12; Moderate 13-24; Moderately severe 25-36; Severe >36



Giving First Dose Buprenorphine A Rough Guide

- COWS ≥ 8, <u>or</u>…
- COWS < 8, <u>and</u> no self-reported opioid use in the past 3 days <u>and</u> clinical UDS negative for opioids*

* Non physiologically dependent patient to prevent relapse, or someone who has completed withdrawal

SAMHSA, *Medications for Opioid Use Disorder*. Treatment Improvement Protocol (TIP) Series 63; 2018. Available at https://store.samhsa.gov/product/SMA18-5063FULLDOC



Prior to Buprenorphine Induction

- Counsel patient on:
 - Alternatives
 - Induction timing
 - Precipitated withdrawal
 - Role of behavioral treatment
- Treatment agreement
- PDMP check
- Potential Labs:
 - UDS, HIV, HCV, HBV, CBC, liver enzymes, urine pregnancy
- Write buprenorphine prescription





Induction and Stabilization Dosing Schedule Tailor to Patient

	Suggested Dosing*	Maximum Dose*
Day 1	2-4mg (wait 45 min) + 4mg if needed	8-12mg
Day 2	Day 1 dose + 4mg if needed (single dose)	12-16mg
Day 3	Day 2 dose + 4mg if needed (single dose)	16mg
Day 3-28	May increase dose 4mg per week, if needed (single dose)	24mg

*Suboxone equivalents dose: 8mg Suboxone = 5.7mg Zubsolv, 4.2mg Bunavail

SAMHSA, *Medications for Opioid Use Disorder*. Treatment Improvement Protocol (TIP) Series 63; 2018. Available at: https://store.samhsa.gov/product/SMA18-5063FULLDOC



Home Induction

- Office-based induction can be a barrier to initiation
- Pilot trials of home vs. office-based inductions demonstrate comparable retention rates and safety
- Patient selection:
 - Understand induction process
 - Prior bup experience predicts success
 - Can contact provider for problems
- Provider available for phone consultation

Lee, J. D., Vocci, F., & Fiellin, D. A. (2014). Unobserved "home" induction onto buprenorphine. *Journal of Addiction Medicine, 8*(5), 299–308.

SAMHSA, *Medications for Opioid Use Disorder*. Treatment Improvement Protocol (TIP) Series 63; 2018. Available at https://store.samhsa.gov/product/SMA18-5063FULLDOC



SS

PROVIDERS' CLINICAL SUPPORT SYSTEM 21



Home Induction Hand-Out

Day One Summary: 4 mg under your tongue, wait 1-3 hours. If still feel sick, take 4 mg again. Wait 1-3 hours. If still sick, take 2-4 mg again. Do not take more than 12 mg on Day 1.



Lee, J. D., Vocci, F., & Fiellin, D. A. (2014). Journal of Addiction Medicine, 8(5), 299-308.

Buprenorphine/Naloxone Treatment Phases

- Induction (1-3 days)
 - Must be in moderate withdrawal
 - Start with 4mg and gradually increase
 - Titrate to effect (average dose 16mg)
- Stabilization/Maintenance
 - Combine with random UDS and counseling, if available
 - Lack of counseling shouldn't prevent treatment
 - Provider medical management as "counseling"
 - Patients typically continue buprenorphine for years

SAMHSA, *Medications for Opioid Use Disorder*. Treatment Improvement Protocol (TIP) Series 63; 2018. Available at https://store.samhsa.gov/product/SMA18-5063FULLDOC



Typical Buprenorphine Clinic Schedule A Rough Guide—Tailor to Practice and Patient

	Before Induction	Induction (Days 1-3)	Month 1	Month 2	Month 3 and after
Prior authorization	Х				
Treatment agreement	Х				
Clinic visit	Х	2x/week	Weekly	Every 2 weeks	Every 4 weeks
Counseling	Х		Weekly	Every 2 weeks	Every 4 weeks
Refill	-	1-3 day supply	7 day supply	14 day supply	28 day supply
UDS	Х	Х	Weekly	Every 2 weeks	Months

• Very stable patients often require less frequent visits and UDS

Recurrence of use reverts to Month 1 schedule until stable again

Buprenorphine HIV Evaluation and Support Collaborative (BHIVES)

Pharmacologic:

Buprenorphine-naloxone

Coordination/Integration of Care:

- Integration of OUD, primary care, and HIV care into same setting
- Nonphysician staff coordinates care

Education/Outreach:

 Patient and provider educational material available

Psychosocial:

- On-site services vary, includes both individual and group counseling
- Funding: Patient insurance, Ryan White Care Act



Fiellin JAIDS 2011, Altice JAIDS 2011, Korthuis JAIDS 2011, Korthuis JAIDS 2011

BHIVES

Observational study in 11 HIV clinics (n=386)

At 12 months, integrated treatment:

- Decreased heroin/opioid use¹
- Increased ART uptake²
- Improved quality of care, quality of life^{3, 4}

Conclusion:

 Integrating buprenorphine in feasible and safe in HIV primary care

¹ Fiellin JAIDS 2011 ² Altice JAIDS 2011

³ Korthuis JAIDS 2011 ⁴ Korthuis JAIDS 2011



Collaborative Models for Buprenorphine Implementation



Hub - and - Spoke

Pharmacologic:

Primarily buprenorphine-naloxone

Coordination/Integration of Care:

- Coordination and integration between hub and spoke as well as within each spoke
- RN case manager and/or care connector (peer or behavioral health specialist) organizes care coordination

Other:

- Hub provides consultation services
- Available to manage clinically complex patients, MAT tapering, methadone prescribing

Funding:

CMS State Medicaid waiver

Education/Outreach:

 Outreach to community prescribers to increase pool of providers with buprenorphine prescribing waivers

Psychosocial:

- Embedded within spoke site
- Includes social workers, counselors, community health teams



Hub and Spoke Model



Brooklyn JR, Sigmon SC. Vermont Hub-and-Spoke Model of Care for Opioid Use Disorder: Development, Implementation, and Impact. Journal of Addiction Medicine (2017). 11(4):286-292

Increased Treatment Engagement in Vermont



Brooklyn JR, Sigmon SC. Vermont Hub-and-Spoke Model of Care for Opioid Use Disorder: Development, Implementation, and Impact. Journal of Addiction Medicine (2017). 11(4):286-292

Variations on Hub and Spoke

- Group Practices with Internal Buprenorphine Team
 - 1-2 providers do buprenorphine inductions (hub)
 - Other primary care providers continue refills/monitoring (spokes)
- Primary Care Opioid Treatment Program Partnerships
 - Opioid treatment programs (hub) provide induction and behavioral support services
 - Primary care practices (spokes) prescribe maintenance buprenorphine



Nurse Care Manager Model "Massachusetts Model"

Pharmacologic:

Primarily buprenorphine-naloxone

Coordination/Integration of Care:

- Nurse Care Manager manages patients in coordination with primary care and medical assistant
- Use of care partner to assist with SBIRT

Funding:

 State Medicaid reimburses
 Federally Qualified Health Center (FQHC) nurse care manager visits

LaBelle, C.T., et al.. J Subst Abuse Treat, 2016. **60**: p. 6-13. Alford, D.P., et al.. Arch Intern Med, 2011. **171**(5): p. 425-31.

Education/Outreach:

- Physician training program
- Health Department trains on best practices
- Nurse Care Managers receive:
 - Initial 8 hour and quarterly MAT training
 - Site visits
 - Email and telephone support
 - Case review
 - Access to addiction list serve

Psychosocial:

 Integrated counseling services onsite or nearby



Buprenorphine Diversion

- Variable diversion in RADARS¹
- When diverted, mostly used for self-treatment of withdrawal
- Low overdose risk decreases possibility of harm if diverted
- Less abuse with combination product

¹Lavonas EJ. Abuse and diversion of buprenorphine sublingual tablets and film. *J Substance Abuse Treatment* 2014; 47:27-34.



Diversion and Misuse

Diversion:

 Unauthorized rerouting or misappropriation of prescription medication to someone other than for whom it was intended

Misuse:

• Taking medication in a manner, by route or by dose, other than prescribed

Lofwall M, Buprenorphine Diversion and Misuse in Outpatient Practice. *J Addiction Med* 2014; 8:327-332



Reasons for Buprenorphine Diversion and Misuse

Reasons for Diversion

- Peer pressure
- Help addicted friend and family
- Make money

Reasons for Misuse

- Habit
- Perceived under-dosing
- Relieve opioid withdrawal and craving
- Get high
- Relieve anxiety, depression, and pain





Recognizing Diversion

Patient Red Flags

- Requesting maximum doses
- Higher than needed doses
- Past history of diversion or misuse
- Partner or friends using opioids
- Signs of injection

Monitoring

- Pill Counts
- Negative urine buprenorphine or norbuprenorphine
- Prescription Drug Monitoring Program (PDMP)
 - Have staff check each visit





Risk of Diversion and Misuse

- Other full opioid agonists, preferred over
 - Methadone, preferred over
 - Buprenorphine, preferred over
 - Naltrexone (antagonist)

 Cicero, T.J., et al., *Relationship between therapeutic use and abuse of opioid analgesics in rural, suburban, and urban locations in the United States.* Pharmacoepidemiol Drug Saf, 2007. **16**(8): p. 827-40.
 Lofwall M, Buprenorphine Diversion and Misuse in Outpatient Practice. *J Addiction Med* 2014; 8:327-332



Buprenorphine/Naloxone: Decreased Diversion Potential

DIVERSION

- Precipitated withdrawal when injected
- When diverted, mostly used for self-treatment of withdrawal, instead of intoxication
- Low overdose risk decreases possibility of harm if diverted

Yokell Curr Drug Abuse Rev 2011 Larance Drug & Alc Dep 2011 Bazazi J Addict Med 2011



Strategies to Limit Diversion

- Caution when prescribing
 - Use lowest dose that works
- Urine toxicology screens
 - Include buprenorphine
- PDMP queries
- Pill Counts
- Long-acting preparations
 - Monthly XR-naltrexone depot injection
 - Monthly buprenorphine depot injection
 - 6-Month buprenorphine implant (stable patients)



Buprenorphine Diversion Prevention Checklist

- Talk
 - Define and discuss diversion; examples and triggers
- Examine
 - Non-healing track marks, abscesses, nasal erosions
- Listen
 - Repeated early refill and dose increase requests
- Monitor
 - Buprenorphine testing, PDMP, pill counts
- Collaborate
 - Family, pharmacist, counselor feedback



Lofwall M, Buprenorphine Diversion and Misuse in Outpatient Practice. *J Addiction Med* 2014; 8:327-332

When Patients Misuse or Divert

- Stress willingness to continue working together, and...
- Consider higher level of care
 - Increase visit frequency?
 - Referral for dispensarybased buprenorphine/methadone?
 - Referral for residential treatment? (but...make sure "higher level of care" ≠ "no care")
- Consider switch to long-acting naltrexone or buprenorphine





Provider Implementation Resources

- USCF Substance Use Consultation "Warm Line"
 - (855) 300-3595; Mon-Fri, 10:00am-6:00pm ET
- Provider Clinical Support System (PCSS)
 - www.pcssNOW.org
- ECHO
 - <u>https://echo.unm.edu/opioid-focused-echo-programs/</u>
- SAMHSA, Medications for Opioid Use Disorder. Treatment Improvement Protocol (TIP) Series 63; 2018. Available at <u>https://store.samhsa.gov/product/SMA18-5063FULLDOC</u>



Addiction Medicine ECHO Support for Primary Care Providers

- Weekly tele-mentoring CME conference
 - Case presentations
 - Panel discussion
 - Brief Didactic
- Inter-professional panel
 - Addiction medicine physicians
 - Addiction psychiatrist
 - Counselor
 - Peer
 - https://echo.unm.edu/opioid-focused-echo-programs/

Komaromy M, et al. (2016) Project ECHO (Extension for Community Healthcare Outcomes): A new model for educating primary care providers about treatment of substance use disorders. Subst Abus. 37(1):20-4.



References

- Alford, D.P., et al., Collaborative care of opioid-addicted patients in primary care using buprenorphine: five-year experience. Arch Intern Med, 2011. **171**(5): p. 425-31.
- Altice FL, et al. HIV treatment outcomes among HIV-infected, opioid-dependent patients receiving buprenorphine/naloxone treatment within HIV clinical care settings: results from a multisite study. J Acquir Immune Defic Syndr. 2011;56 Suppl 1:S22-32.
- Bazazi, A.R., et al., Illicit use of buprenorphine/naloxone among injecting and noninjecting opioid users. J Addict Med, 2011. 5(3): p. 175-80.
- Brooklyn JR, Sigmon SC. (2017). Vermont Hub-and-Spoke Model of Care for Opioid Use Disorder: Development, Implementation, and Impact. Journal of Addiction Medicine, 11(4):286-292.
- Cicero, T.J., et al., *Relationship between therapeutic use and abuse of opioid analgesics in rural, suburban, and urban locations in the United States.* Pharmacoepidemiol Drug Saf, 2007. **16**(8): p. 827-40.
- Cicero, T.J., et al., *The changing face of heroin use in the United States: a retrospective analysis of the past 50 years.* JAMA Psychiatry, 2014. **71**(7): p. 821-6.
- Fiellin DA, et al. Long-term treatment with buprenorphine/naloxone in primary care: results at 2-5 years. Am J Addiction. 2008;17(2):116-20.
- Fiellin DA, et al. Counseling plus buprenorphine-naloxone maintenance therapy for opioid dependence. N Engl J Med. 2006;355(4):365-74.
- Fiellin DA, et al. Treatment of heroin dependence with buprenorphine in primary care. Am J Drug Alcohol Abuse. 2002;28(2):231-41.
- Fiellin DA, et al. Drug treatment outcomes among HIV-infected opioid-dependent patients receiving buprenorphine/naloxone. J Acquir Immune Defic Syndr. 2011;56 Suppl 1:S33-8.
- Komaromy M, et al. (2016). Project ECHO (Extension for Community Healthcare Outcomes): A new model for educating primary care providers about treatment of substance use disorders. Subst Abus. 2016;37(1):20-4.
- Korthuis, P.T., et al., Primary Care-Based Models for the Treatment of Opioid Use Disorder: A Scoping Review. Ann Intern Med, 2017. 166(4): p. 268-278.



References

- Korthuis PT, et al. Improving adherence to HIV quality of care indicators in persons with opioid dependence: the role of buprenorphine. J Acquir Immune Defic Syndr. 2011;56 Suppl 1:S83-90.
- Korthuis PT, et al. Improved quality of life for opioid-dependent patients receiving buprenorphine treatment in HIV clinics. J Acquir Immune Defic Syndr. 2011;56 Suppl 1:S39-45.
- LaBelle, C.T., et al., Office-Based Opioid Treatment with Buprenorphine (OBOT-B): Statewide Implementation of the Massachusetts Collaborative Care Model in Community Health Centers. J Subst Abuse Treat, 2016. **60**: p. 6-13.
- Larance, B., et al., *The diversion and injection of a buprenorphine-naloxone soluble film formulation*. Drug Alcohol Depend, 2014.
 136: p. 21-7.
- Larance, B., et al., *Post-marketing surveillance of buprenorphine-naloxone in Australia: diversion, injection and adherence with supervised dosing.* Drug Alcohol Depend, 2011. **118**(2-3): p. 265-73.
- Lavonas, E.J., et al., Abuse and diversion of buprenorphine sublingual tablets and film. J Subst Abuse Treat, 2014. 47(1): p. 27-34.
- Lee, J. D., et al. (2014). Unobserved "home" induction onto buprenorphine. *Journal of Addiction Medicine*, 8(5), 299–308.
- Lofwall M (2014). Buprenorphine Diversion and Misuse in Outpatient Practice. J Addiction Med, 8:327-332
- Mattick RP, et al. Buprenorphine maintenance versus placebo or methadone maintenance for opioid dependence. Cochrane Database Syst Rev. 2014(2):CD002207.
- Mattick RP, et al.. Methadone maintenance therapy versus no opioid replacement therapy for opioid dependence. Cochrane Database Syst Rev. 2009(3):CD002209.
- SAMHSA, Medications for Opioid Use Disorder. Treatment Improvement Protocol (TIP) Series 63; 2018. Available at https://store.samhsa.gov/product/SMA18-5063FULLDOC
- Yokell, M.A., et al., *Buprenorphine and buprenorphine/naloxone diversion, misuse, and illicit use: an international review.* Curr Drug Abuse Rev, 2011. **4**(1): p. 28-41.
- www.effectivehealthcare.ahrq.gov/reports/final.cfm



PCSS Mentor 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 medicationassisted 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



PCSS Discussion Forum

Have a clinical question?

?

Ask a Colleague

A simple and direct way to receive an answer related to medication-assisted treatment. Designed to provide a prompt response to simple practicerelated questions.

Ask Now >



?





PCSS-MAT is a collaborative effort led by the American Academy of Addiction Psychiatry (AAAP) in partnership with the: Addiction Technology Transfer Center (ATTC); American Academy of Family Physicians (AAFP); American Academy of Neurology (AAN); American Academy of Pain Medicine (AAPM); American Academy of Pediatrics (AAP); American College of Emergency Physicians (ACEP); 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 Psychiatric Nurses Association (APNA); American Society of Addiction Medicine (ASAM); American Society for Pain Management Nursing (ASPMN); Association for Medical Education and Research in Substance Abuse (AMERSA); International Nurses Society on Addictions (IntNSA); National Association of Community Health Centers (NACHC); National Association of Drug Court Professionals (NADCP), and the Southeast Consortium for Substance Abuse Training (SECSAT).

For more information: www.pcssNOW.org



@PCSSProjects



Funding for this initiative was made possible (in part) by grant nos. 5U79TI026556-02 and 3U79TI026556-02S1 from SAMHSA. The views expressed in written conference materials or publications and by speakers and moderators do not necessarily reflect the official policies of the Department of Health and Human Services; nor does mention of trade names, commercial practices, or organizations imply endorsement by the U.S. Government.