PCSS O TRAINING
PROVIDERS' CLINICAL SUPPORT SYSTEM For Opioid Therapies

Demystifying Buprenorphine Prescribing for Youth With Opioid Use Disorders

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National Institute on Drug Abuse

June 21, 2017

Providers' Clinical Support System – Opioid Therapies (PCSSO)

- Grant funded by SAMHSA
- Coalition of professional organizations
- Overarching goal: To offer evidence-based trainings on the safe and effective prescribing of opioid medications in the treatment of pain and/or opioid addiction.
- AAP = 2 Webinars per grant year (6 total)
- www.pcss-o.org

CME

CME credit is available for this Webinar upon completion of an evaluation.

More information will be provided near the end of this presentation.

Speaker

Geetha A Subramaniam MD, DFAACP, DFAPA

The speaker has no relevant financial relationships with the manufacturer(s) of any commercial product(s) and/or provider(s) of commercial services discussed in this CME activity.

Dr Subramaniam does intend to discuss an unapproved/investigative use of a commercial product/device in this presentation.

Educational Objectives

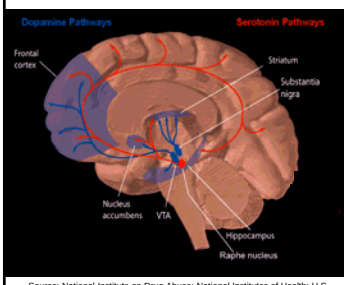
At the conclusion of this activity participants should be able to:

- ✓ Describe the risk factors for and consequences of non-medical use of opioid medication in the pediatric population.
- ✓ Describe current treatment options for opioid use disorder (OUD)
- ✓ Learn the approach to office-based treatment with buprenorphine for detoxification and maintenance of remission for adolescent OUD.
- ✓ Implement an office-based treatment regimen with buprenorphine for adolescent OUD
- ✓ List factors that impact treatment retention and effectiveness in these patients
- ✓ Review the current training and DEA requirements for prescription of buprenorphine.

First Some Basics

- **Terminology**: Opium, opiate, opioid
- **3 OP Receptors**: Mu (MOP), Kappa (KOP) & Delta (DOP)
- **Types:**
  - Natural: morphine, codeine
  - Semi-synthetic: oxycodone, hydrocodone, heroin, buprenorphine
  - Synthetic: methadone, Fentanyl

Adolescent Brain Development

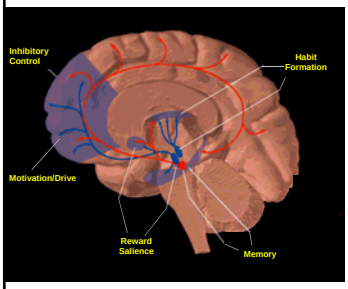


- Brain size peaks at 14-15y
- Increase in white matter (connectivity)
- Brain blood/oxygen flow in adolescence decreases into adulthood (i.e. the system is getting more energy efficient)

Source: National Institute on Drug Abuse; National Institutes of Health; U.S. Department of Health and Human Services.

Adapted from slide by James Bjork, PhD

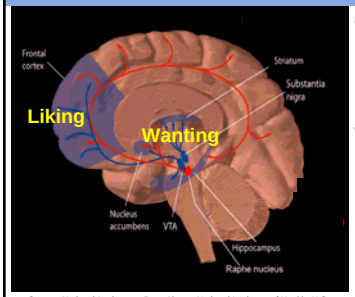
During Adolescence: Brain Structures Governing Cognitive Control and Reward Behavior Are still Developing



- Maturation/thinning of frontal cortex is last/delayed relative to other cortical areas

Adapted from slide by James Bjork, Ph.D

Drugs of Abuse Interfere with the Brain's Natural Learning Circuits

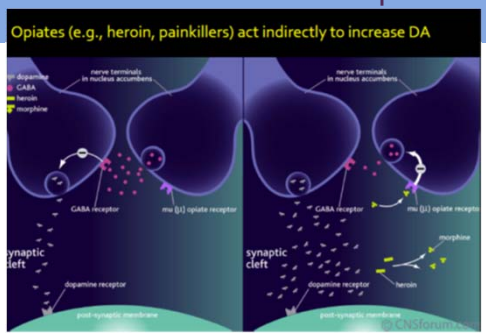


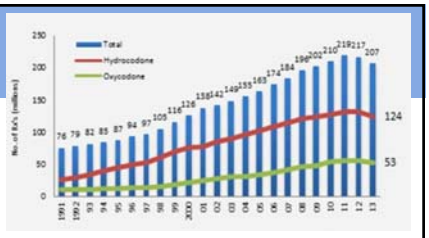
- **Addiction** could result from the **"hijacking" of learning circuitry**
- Drugs may cause the brain to artificially remember (learn) the high too strongly- people may then "want" the drug even though they no longer like the way it makes them feel.

Source: National Institute on Drug Abuse; National Institutes of Health; U.S. Department of Health and Human Services.

Slide adapted from James Bjork, Ph.D

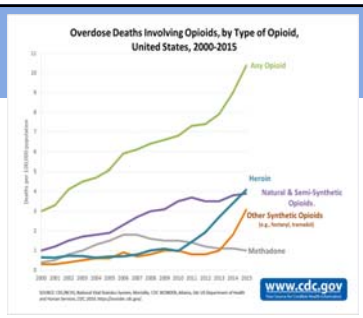
At the level of the Receptor



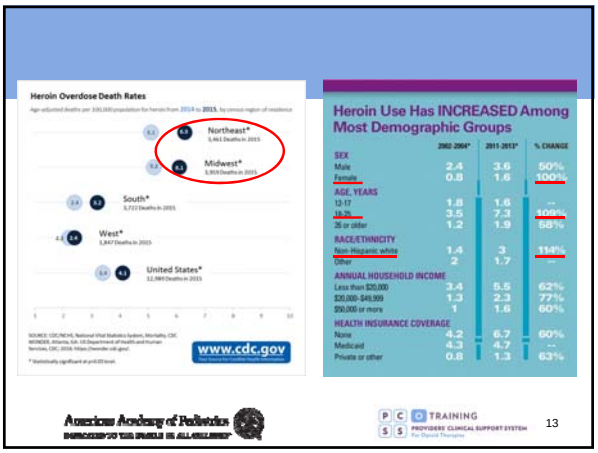


Since 1999, sales of prescription opioids in the U.S. have **quadrupled**.

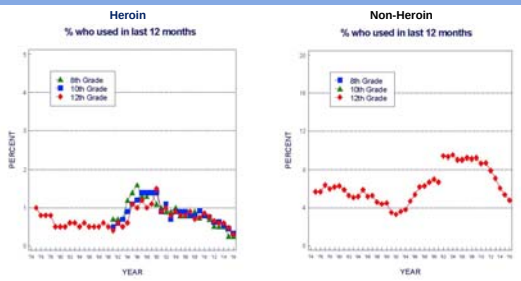
https://www.cdc.gov/drugoverdose/opioids/index.html
https://www.cdc.gov/drugoverdose/pdf/hhs_prescription_drug_abuse_report_09.2013.pdf



die every day from an **opioid overdose** (that includes prescription opioids and heroin).

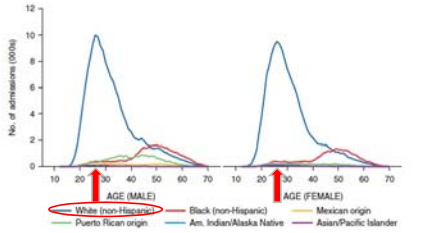


Monitoring the Future (MTF) Study



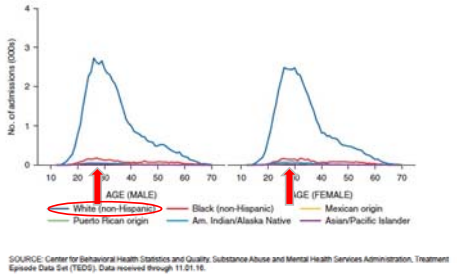
Source: Johnston LD, et al., Monitoring the Future – National Results on Adolescent Drug Use: Overview of Key Findings, 2016

Heroin Admissions in 2015: by gender, age and ethnicity



SOURCE: Center for Behavioral Health Statistics and Quality. Substance Abuse and Mental Health Services Administration, Treatment Episode Data Set (TEDS). Data received through 11.01.16.

Non-Heroin Opioid Admissions 2015: by gender, age and ethnicity

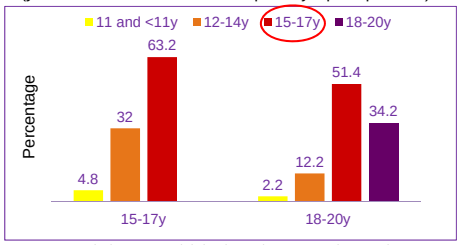


SOURCE: Center for Behavioral Health Statistics and Quality. Substance Abuse and Mental Health Services Administration, Treatment Episode Data Set (TEDS). Data received through 11.01.16.

Age of First Use of Opioids

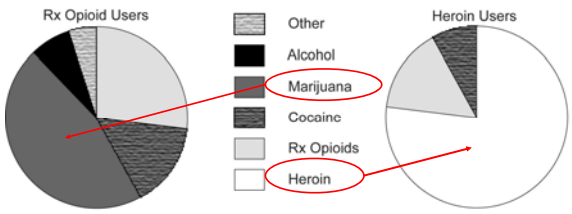
Treatment Episode Dataset (TEDS):1992-2010

(youth treatment admissions for primary Opioid problem)



OAS:SAMHSA. Treatment Episode Data Set -- Admissions (TEDS-A) -- Concatenated, accessed Dec 2012

Self-reported "Drug of First Choice"



Subramaniam and Stitzer-Drug Alcohol Depend (2009)

What are the Characteristics of Youth With Opioid Use Disorder Presenting to Treatment?

- Older teen (> 16 y)
- Mostly male (but high proportion of female)
- Predominantly Caucasian (~ 90%)
- Poor Academic performance, drop out of school
- Reside in non-urban areas
- Higher rates of Multiple Substance use (cannabis most common)
- High rates of Psychiatric Disorders (> 70%)
- High Injection Drug Use among heroin users (40-70%)

Hopfer et al., 2000; Clemmey et al., 2004; Gordon et al., 2004; Marsch et al., 2005; Subramaniam and Stitzer., 2009, Subramaniiam et al, 2009

DSM-5 Criteria for Substance Use Disorder

1. Use in larger amounts or for longer periods of time than intended
2. Unsuccessful efforts to cut down or quit.
3. Excessive time spent taking the drug
4. Failure to fulfill major obligations
5. Continued use despite knowledge of problems
6. Important activities given up
7. Recurrent use in physically hazardous situations
8. Continued use despite social or interpersonal problems
9. Tolerance
10. Withdrawal
11. Craving

Severity is designated according to the number of symptoms endorsed:

- 0 - 1: No diagnosis
- 2 - 3: mild SUD
- 4 -5 : moderate SUD
- 6 or more: Severe SUD

Slide courtesy of Sharon Levy, MD, FAAP

Physiologic Adaptations: Tolerance and Withdrawal

- Tolerance is the need for increasing amounts of the substance to achieve the desired effect.
- Withdrawal is a physiological response to a rapid decline in receptor binding, due to either rapidly decreasing concentrations of the opioid, or presence of a blocking agent.

Tolerance and withdrawal alone are not sufficient to make a diagnosis of addiction.

Slide courtesy of Sharon Levy, MD, FAAP

Opioid Withdrawal Symptoms

Early – 6 hours	Peak -72hours
Dysphoric Mood/Anxiety	Nausea/Vomiting
Runny nose	Diarrhea
Muscle aches/cramps	Stomach cramps
Lacrimation	Cravings
Sweating	Goosebumps
Tachycardia	Depression
Hypertension	

Typically rated using "Clinical Opioid Withdrawal Scale (COWS)" or similar scale

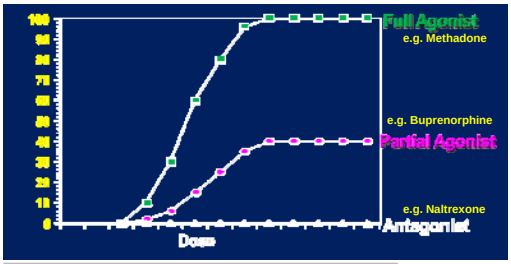
Overview of Treatment for Opioid Use Disorder

Non-pharmacologic	Pharmacologic
Residential Treatment	Detoxification: buprenorphine, methadone, clonidine, "comfort meds"
Intensive Outpatient/Partial	
12-Step Fellowships	Maintenance Agonist Therapy methadone, buprenorphine (partial)
Individual or Group Therapy	
Family Therapy	Antagonist Therapy naltrexone PO or IM
Therapeutic School/Community	

Opioid dependence is a chronic, relapsing neurological condition; patients who remain in long-term treatment generally do best. Supportive therapy combined with pharmacologic treatment seems to produce the best outcomes.

Adapted from a slide by Sharon Levy, MD, FAAP

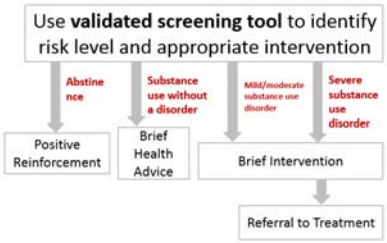
Comparison of Receptor Activity Level: Full vs. Partial Agonist vs. Antagonist



Note partial agonists never fully activate the receptor, even at very high doses.

Slide Courtesy of Sharon Levy, MD, PCSS-O

Role of Pediatrician: Screen, Identify and Intervene



Slide courtesy of Sharon Levy, MD, FAAP

http://pediatrics.aappublications.org/content/138/1/e20161211

Role of Pediatrician: Educate

Easy to get from medicine cabinet	62%
Available everywhere	52%
Not illegal	51%
Easy to get through other people's prescriptions	50%
Can claim you have a prescription if caught	49%
Cheap	43%
Safer to use than illegal drugs	35%
Less shame attached to using	33%
Easy to purchase over the Internet	32%
Fewer side effects than street drugs	32%
Parents don't care as much if you get caught	21%

Slide courtesy of Sharon Levy, MD, FAAP

Partnership for Drug-Free Kids. The Partnership Attitude Tracking Study (PATS): Teens in grades 7 through 12 2005; May 16, 2006.

AAP Policy

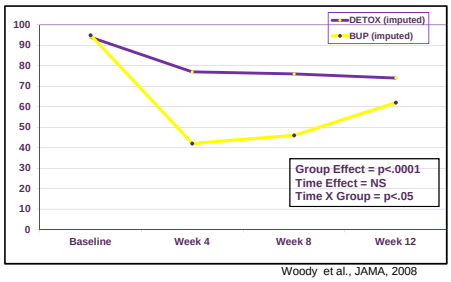
The AAP recommends that pediatricians consider offering pharmacological treatments to their adolescent and young adult patients with moderate/severe opioid use disorders and/or discuss referrals to other providers for this service.

http://pediatrics.aappublications.org/content/138/3/e20161893

CTN Study: Buprenorphine for Youth OUD

Opioid Positive Urines: 12 weeks Bup vs Detox

(Missing = Positive, N=152)



Woody et al., JAMA, 2008

Drivers of Treatment Success

- **Abstinence from Opioids**: Early abstinence, staying in treatment, receiving additional non-study medications; baseline injection use and having severe medical/ psychiatric problems
- **Retention in Treatment**: Early adherence to treatment, early opioid negative urine drug screen, any medication treatment in the month prior to study entry, non-heroin use. Lower retention: Emerging adults (vs. older adults). Daily dosing is associated with lower retention

Buprenorphine Formulations

- **Film Strips**
  - Brand name only.
  - Combination with naloxone
  - **Suboxone®** sublingual film. Available as 2(.5), 4(1), 8(2) or 12(3) mg
  - **Bunavail®** buccal film. Available as 2.1 (0.3), 4.2 (0.7) or 6.3 (1)mg
  - Dissolve more rapidly than tablets (advantage for observed dosing)
  - Individually wrapped, reduces accidental ingestion by young children

CAUTION: Accidental ingestion of buprenorphine by young children may result in over-sedation and respiratory suppression. Individually wrapped films may reduce accidental ingestion.

Adapted from a slide by Sharon Levy, MD, FAAP

Buprenorphine Formulations

- **Tablets**
  - Available as generic
  - Combo (buprenorphine/naloxone) and mono (buprenorphine) available
  - 2(.5)/8 (2) mg formulations available
  - Newer 1.4(0.36)/5.7(1.4) menthol-flavored **Zubsolv®** tablets (combo)
  - Mono-product has higher misuse potential; indicated only in pregnancy.

CAUTION: Accidental ingestion of buprenorphine by young children may result in over-sedation and respiratory suppression.

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Begin with a Comprehensive Initial Evaluation

- ✓ Complete history of substance use, past treatments
- ✓ Medical history and review of systems
- ✓ Current medications and Allergies
- ✓ Brief Psychiatric History - Suicide/Depression/ADHD
- ✓ Psychosocial history including psychosocial support
- ✓ Physical exam
- ✓ OUD Diagnosis – DSM 5 criteria
- ✓ Treatment Plan, including medications prescribed
- ✓ Plan for Referral - Psychiatric disorders, Hepatitis-C infection, etc.

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Opioid Withdrawal Symptoms

Early – 6 hours	Peak -72hours
Dysphoric Mood/Anxiety	Nausea/Vomiting
Runny nose	Diarrhea
Muscle aches/cramps	Stomach cramps
Lacrimation	Cravings
Sweating	Goosebumps
Tachycardia	Depression
Hypertension	

Typically rated using "Clinical Opioid Withdrawal Scale (COWS)" or similar scale

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Withdrawal Management

Buprenorphine is started when the patient is in active opioid withdrawal:

- Plan in advance as patients must be opioid-free for several hours and present in active withdrawal
- Offer ancillary medications (clonidine, ibuprofen, Pepto-bismol, Bentyl/other meds for stomach cramps)
- Use a treatment contract
- Be available for check-ins and dose adjustments in the first few days of withdrawal management

Adapted from a slide by Sharon Levy, MD, FAAP

Sample Buprenorphine Contract

I agree to stop using all drugs, including opioids, alcohol, marijuana and other street drugs. I will request additional support if I am unable to remain drug-free.
I understand that it is dangerous to mix buprenorphine with alcohol or other sedatives (such as Valium, Klonopin, Ativan). Mixing could result in accidental overdose, coma or death. I will not use alcohol or sedatives while I am taking buprenorphine.
Buprenorphine may make me sleepy. I will not drive a car or operate dangerous machinery while taking buprenorphine until I have been cleared to do so.
I agree to cooperate with urine drug testing whenever requested by my doctor to detect whether I have used substances. My doctor will decide how often I should be tested; in most cases I will be tested AT LEAST weekly.
I will schedule and keep all recommended appointments. My parent or guardian will accompany me to my appointments until I have been cleared to come by myself.
I agree that my parent or guardian will hold my buprenorphine medication. I will never sell, share or otherwise distribute my medication. My parent will provide me one dose at a time and watch me take it. If my medication is accidentally swallowed by a child I will call 911 or Poison Control at 1-800-222-1222.
I will always take my buprenorphine by placing it under my tongue to d be absorbed. I will never inject buprenorphine because IV use can lead to sudden and severe opioid withdrawal. I will not skip or alter doses without speaking to my doctor.
I will give consent for my doctor to communicate with physicians, therapists, probation officers and parents to discuss my treatment and progress, including drug test results.
I will report changes in my medical condition to my doctor so that all of my treatment can be coordinated. I will discuss pain management prior to any elective procedure and as soon as possible after an emergency.
I agree to participate in counseling to support my medical treatment. I will discuss a counseling plan with my doctor.
PATIENT SIGNATURE AND DATE:

Induction

- Ensure that young women are not pregnant
- Start medication when a COWS indicates moderate withdrawal (>8). Abstinence prior to starting buprenorphine
  - 12-18 hrs for short-acting opioids (heroin)
  - 24-36 hrs for sustained-release opioid medications
  - 36 hrs for methadone (30mg x 2 weeks; 15mg x 1 day; no methadone x 1 day; then induce on BUP/NX)
- Obtain a baseline urine drug screen

Adapted from a Slide by Sharon Levy, MD, FAAP

Induction

- Start with 2-4 mg. Observe the first dose (and demonstrate for parents)
- Rescore COWS after 45 min
  - If the score has decreased but still indicates moderate withdrawal, administer a second dose
- Some patients will have withdrawal symptoms controlled with 4 mg; for others consider a second 2-4 mg dose few hours later
- Advise the patient not to change the dose without speaking to a physician.
- Titrate dose to suppress withdrawal symptoms and cravings.

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Buprenorphine
Side Effects and Drug Interactions

- Generally well tolerated when used as prescribed.
- Common side effects:
  - Headache
  - Nausea/vomiting
  - Constipation
  - Urinary retention/hesitancy
  - Drowsiness
  - Dry mouth
  - Perspiration
  - Sexual dysfunction/decreased libido
- It is very rare that one has to discontinue meds due to AEs
- Elevations in liver transaminases possible (rare, but patients with Hep C are at higher risk)
- Few clinically significant drug interactions; particularly uncommon in adolescents

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Follow-up

- See patients frequently while on medication – weekly until a stable dose is achieved, and then at least monthly after that.
- Ask about medication adherence and side effects
- Evaluate and monitor mental health symptoms.
- Use patient history, parental report and drug testing to monitor sobriety and medication adherence.
- For patients on buprenorphine, titrate the dose to balance craving suppression and side effects.
  - Most adolescents will stabilize on a dose between 4 and 16 mg buprenorphine per day.

Slide courtesy of Sharon Levy, MD, FAAP

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AAP Policy


Testing for Drugs of Abuse in Children and Adolescents

- Urine drug testing may have a role in assessing adolescents for substance use disorders in certain circumstances, and in monitoring adolescents in treatment for an identified substance use disorder.
- Invasive
- Complex – potential for false positive false negative results
- Confidentiality issues
- Never be the sole basis for making a diagnosis

http://pediatrics.aappublications.org/content/133/6/e1798.full

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Maintaining and Terminating Medications

- The optimal length of time for medication treatment is not known.
- In adults longer duration of treatment is associated with better abstinence outcomes. There are no long-term studies in youth and the impact of exposure to long term agonists/antagonists on the developing brain are unknown.
- As a clinical rule of thumb, we recommend avoiding changing medications during periods of stress – final exams, summer vacation, high school graduation, etc.
- Patients who discontinue medications should continue in counseling and should be monitored closely for relapse for an extended period of time.

Slide courtesy of Sharon Levy, MD, FAAP

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Preventing and Managing Relapse

- Encourage patients to remain abstinent from all substances to minimize the chance of a relapse to opioid use.
- Advise patients and parents to plan “structured time”
- If employed, advise parents to monitor income.
- Encourage patients and families to continue monitoring over the summer, as substance use tends to increase when kids are out of school.
- Maintain or increase prosocial/psycho-social activities over the summer: individual counseling, group programs, 12-step meetings, etc.

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Psychiatric Care and Psychosocial Support

- Patients should be evaluated and treated concurrently for co-occurring psychiatric disorders. Integrated care or referral to specialty MH care
- All patients in treatment for OUD should have regular psychosocial support via individual or group counseling with an experienced counselor.
- Behavioral treatment options: Motivational Interviewing/MET, Contingency management, CBT, family therapy, 12-step facilitationa
- 12-step meetings are free and universally available. Another option is SMART recovery

Treatment of Opioid Overdose

Signs:

- Respiratory depression – usual cause of death
- Coma, pinpoint pupils (may dilate with hypoxia), hypothermia, non-cardiogenic pulmonary edema

Treatment:

- Naloxone (Narcan) nasal or IV., prn
- EVZIO® autoinjector application
- If no response, treat for sedative/hypnotic OD
- Monitor methadone overdose patients for 24- 48 hrs.
- Single naloxone dose lasts 1-4 hours
- Naloxone may not work well for buprenorphine because of the higher receptor affinity.

Distribution of intranasal naloxone is a major public health initiative that has reduced mortality from opioid overdose. Patients and parents can fill a prescription for naloxone from the treating physician or receive naloxone and training from a local public health department.

Adapted from a slide by Sharon Levy, MD, FAAP

Diversion and PDMP

Diversion refers to giving away or selling or giving a prescribed medication.

- There are 2 main situations in which diversion occurs:
  - Opioid-dependent individuals illegally purchasing buprenorphine to treat their dependence vs. non-opioid dependent individuals using buprenorphine for euphoria
- Teens may also sell or trade it for other drugs.

Prescription Drug Monitoring Programs (PDMP): are state-run electronic databases used to track the prescribing and dispensing of controlled prescription drugs to patients.

As with any other medication, careful prescription monitoring is essential. Monitor lost prescriptions, requests for early refills or increasing dosage.

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Parents

- Are often aware of the teen's addiction (to opioids)
- Often benefit from education about opioids, complications, treatment options
- Can be encouraged play a supportive role – ensure adherence to medications, treatment, meetings, etc.
- May benefit from guidance on how to provide structure, support and positive reinforcement for success
- Patient confidentiality issues need to be respected
- Educated about overdose (OD) and OD prevention strategies
- May benefit from referral for personal treatment

Documentation
Follow-up Visits (Prescriptions)

- At Follow-up visits:
  - Self-report of substance use, not limited to opioids
  - Reports of medication adherence, side effects, cravings
  - Participation in school and/or work and establish goals
  - Participation in counseling, support groups
  - Urine drug tests and other lab tests, if indicated
  - Collateral report on progress (from parent or guardian) if available
  - Treatment plan including dose/changes to medications prescribed
- Prescribers must keep a record of every prescription written for each patient.
- The DEA periodically audits buprenorphine prescribers to insure best practices are maintained

Adapted from a slide by Sharon Levy, MD, FAAP

Confidentiality
Teens Presenting With Parents

- In many cases, especially those with OUD, adolescents will present for treatment with the knowledge, and often with the support, of parents.
- Managing confidentiality is a clinical decision. Consider:
  - Sharing clinical impressions and treatment recommendations.
  - Involve parents if a teen's behavior puts him/her in acute danger. Parents can be taught to effectively monitor and support recovery
  - Avoid sharing details that are not directly relevant to treatment.
  - Parents have access to medical records and may seek information if they desire.

Adapted from a slide by Sharon Levy, MD, FAAP

Confidentiality Laws

- Rules regarding "emancipation" or "mature minors" which allow children under the age of majority (usually 18y) to obtain medical care are dictated by states. Check with a lawyer or other expert regarding local law.
- In most states, minors can access substance abuse services without parental consent.

NOTE: Treating without specific parental consent does not guarantee confidentiality. In fact, protecting confidentiality between adolescent and parent can be particularly difficult. Therefore we recommend involving a parent in treatment whenever possible, though in most cases involving parents is best treated as a treatment goal rather than a requirement.

Adapted from a slide by Sharon Levy, MD, FAAP

Confidentiality
HIPPA and Title 42 CFR Part 2

- In a general primary care setting, "HIPPA" rules guide the confidentiality protection of medical records, including information pertaining to substance use.
- Records for treatment of OUD should be handled similarly to other confidential information, such as information about substance use in other patients.
- For substance abuse programs, federal confidentiality regulations ("42 CFR Part 2") supersede HIPPA. If federal confidentiality rules apply, a minor **must** sign a consent form for a program to release information to his or her parent or guardian.

Adapted from a slide from Sharon Levy, MD, FAAP

DATA 2000

- Waivers to provide office-based opioid dependence treatment (OBOT)
- Any physician eligible to apply for a waiver to prescribe buprenorphine for opioid dependence after completing 8 hours of "waiver" training
- Amendment: Prescribers must limit their practice to the allowable number of buprenorphine patients: up to 30 in the first year, up to 100 after the first year if the provider has obtained a waiver.
- 2016 Comprehensive Addiction and Recovery Act (CARA) extends buprenorphine prescribing privileges to qualifying NPs and PAs who complete 24 hours of specific training and apply for waiver

To date, few pediatricians have obtained waivers. Some teens may get treatment from adult providers, though there is often a gap in treatment services for younger teens.

Adapted from a slide by Sharon Levy, MD, FAAP

Ready to Get Waivered?
Training Opportunities

- Online Training for AAP Members:
  www.aap.org/mat
  Pediatric Online Waiver Training
- Webinar Training:
  June 28, 2017 5pm-9:30pm Pacific
  www.aoaam.org/events/register.aspx?id=889035
- Half & Half Courses (online & in-person)
  July 18, 2017 1pm-5pm
  Washington, DC
  pcssmat.org/event/half-and-half-pediatric-mat-waiver-training

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Or…
Request a Training in Your Community

- The AAP can identify a trainer for you.
- The AAP can help support room rental and AV needs.
- Email requests to: substanceuse@aap.org

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Q & A

- Please use the chat box to submit a question for the speakers.
- Obtaining CME
  - After the event, you will receive a link taking you to an evaluation. Upon completion, you will be emailed your CME certification.

- The American Academy of Pediatrics (AAP) is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians.
- The AAP designates this live activity for a maximum of 1.0 *AMA PRA Category 1 Credit(s)™*. Physicians should claim only the credit commensurate with the extent of their participation in the activity.
- This activity is acceptable for a maximum of 1.0 AAP credits. These credits can be applied toward the AAP CME/CPD Award available to Fellows and Candidate Members of the American Academy of Pediatrics.
- The American Academy of Physician Assistants (AAPA) accepts certificates of participation for educational activities certified for *AMA PRA Category 1 Credit™* from organizations accredited by ACCME. Physician assistants may receive a maximum of 1.0 hours of Category 1 credit for completing this program.
- This program is accredited for 1.0 NAPNAP CE contact hours of which 0 contain pharmacology (Rx), (0 related to psychopharmacology) (0 related to controlled substances), content per the National Association of Pediatric Nurse Practitioners (NAPNAP) Continuing Education Guidelines.

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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.

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PCSS-O TRAINING PROVIDERS' CLINICAL SUPPORT SYSTEM For Opioid Therapies

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PCSS-O TRAINING
PROVIDERS' CLINICAL SUPPORT SYSTEM
For Opioid Therapies

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
For questions email: pcss-o@aaap.org

Twitter: @PCSSProjects

Funding for this initiative was made possible (in part) by Providers' Clinical Support System for Opioid Therapies (grant no. 5H79TI025596) 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.