Improving Opioid Prescribing: The CDC Guideline for Prescribing Opioids for Chronic Pain, and Considerations for Dentistry

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American Dental Association's 2018 Opioid Webinar Series

February 14, 2017

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PCSS Providers Clinical Support System

Established benefits of opioids

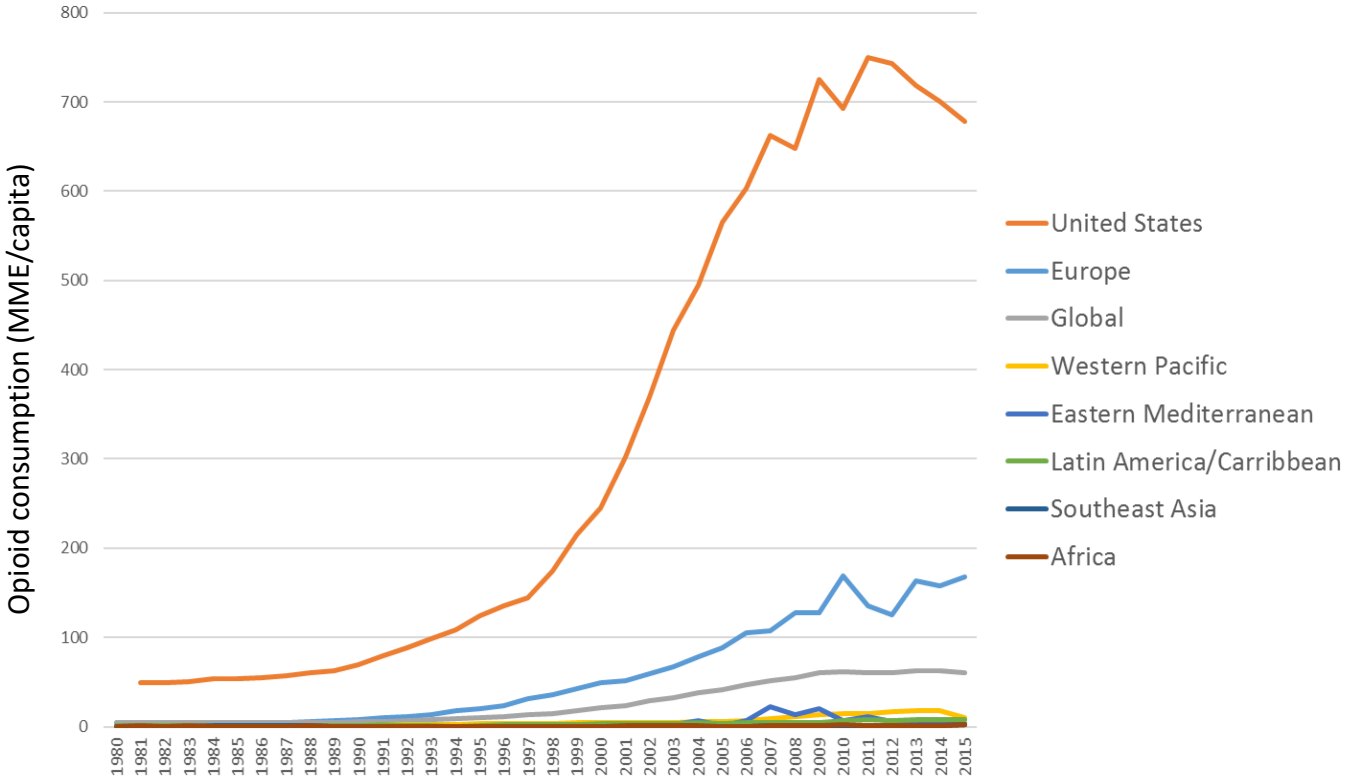
- Reduce severe, acute pain (by about 20%-30%)
- Relieve pain associated with cancer and other painful conditions at the end of life
- Benefits not established for long-term pain relief or improved function in chronic pain

Chronic pain and prescription opioids

- In 1st RCT of long-term opioid therapy for chronic pain, opioids less effective than nonopioid pain treatment
  - Pain relief: small, significant advantage for nonopioid therapy
  - Function: no difference between opioid and nonopioid therapy
  - Medication-related adverse symptoms: significantly more with opioid therapy
- Opioids frequently prescribed for chronic pain
  - Chronic pain accounts for ~50% of U.S. rx opioid market
  - 4-5% of American adults use opioid pain medication long-term

Krebs E et al. Effectiveness of opioid therapy vs. non-opioid medication therapy for chronic back & osteoarthritis pain over 12 months: a pragmatic randomized trial. Presented at Society for General Internal Medicine 2017 Annual Meeting.

US prescription opioid use increased dramatically since late 1990s and decreased slightly since 2011



Sources: International Narcotics Board; World Health Organization population dataBy: Pain & Policy Studies Group, University of Wisconsin/WHO Collaborating Center, 2017

How much do dentists contribute to opioid prescribing?

- 18.5 million prescriptions in 2012 (6.4% of US total)*
- Among clinical specialties in the US from 2007-2012, the largest drops in opioid-prescribing rates occurred in emergency medicine (–8.9%) and dentistry (–5.7%)*
- In South Carolina in 2012-2013, where dentists represented 8.9% of unique prescribers, they prescribed 44.9% of initial opioid fills**

*Levy B, Paulozzi L, Mack KA, Jones CM. Trends in Opioid Analgesic-Prescribing Rates by Specialty, U.S., 2007-2012. *Am J Prev Med*. 2015 Sep;49(3):409-13.
**McCauley JL et al. Dental Opioid Prescribing and Multiple Opioid Prescriptions Among Dental Patients: Administrative data from the South Carolina Prescription Drug Monitoring Program. *J Am Dent Assoc.* 2016 Jul;147(7):537-544.

New evidence: short-term opioid exposure in opioid-naïve patients associated with long-term opioid use

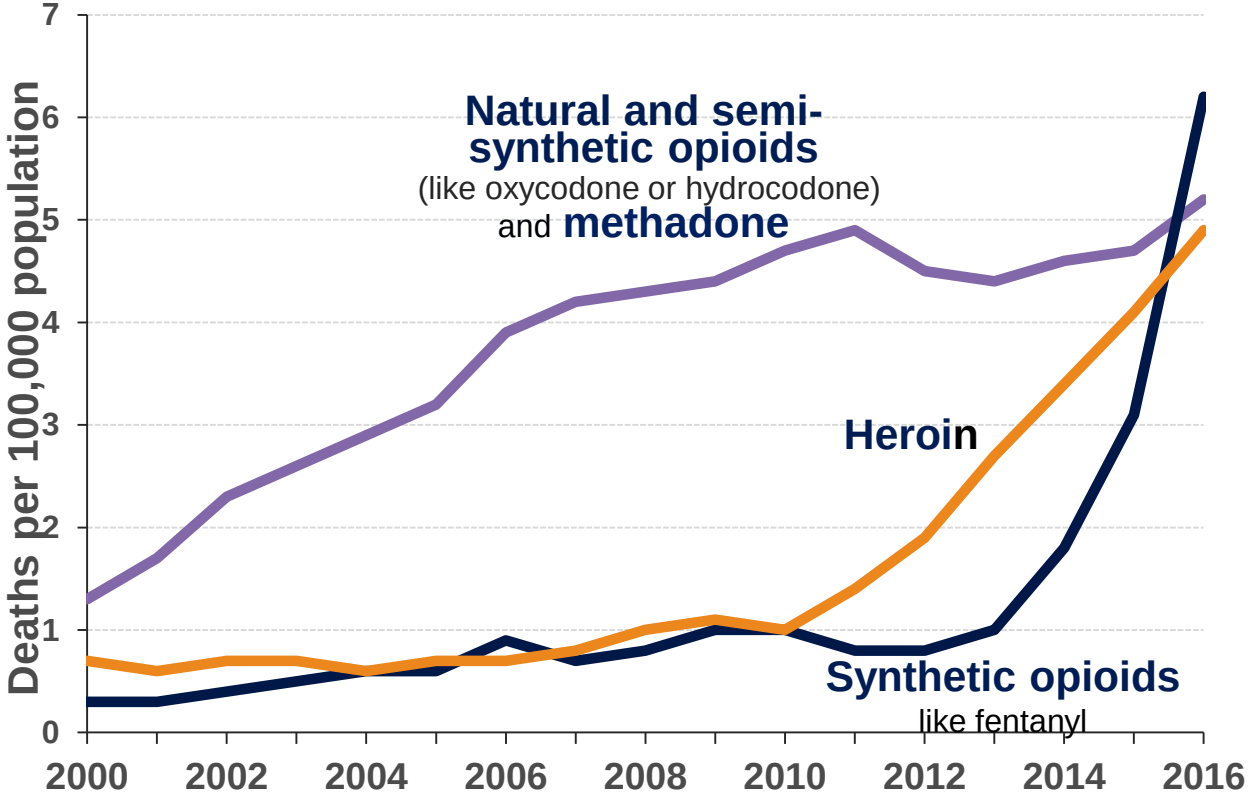
- If prescribed ≥1 day, probability of continued use at 1 year = 6.0%*
- New persistent opioid use in 5.5-6.4% of adults who received opioids postoperatively vs 0.4% in controls**
- Odds of long-term opioid use higher if seen by a high- vs. low-intensity opioid prescriber in the ED (aOR 1.30, p<0.0001)***

* Shah A, Hayes CJ, Martin BC. Characteristics of Initial Prescription Episodes and Likelihood of Long-Term Opioid Use — United States, 2006–2015. MMWR Morb Mortal Wkly Rep 2017;66:265–269

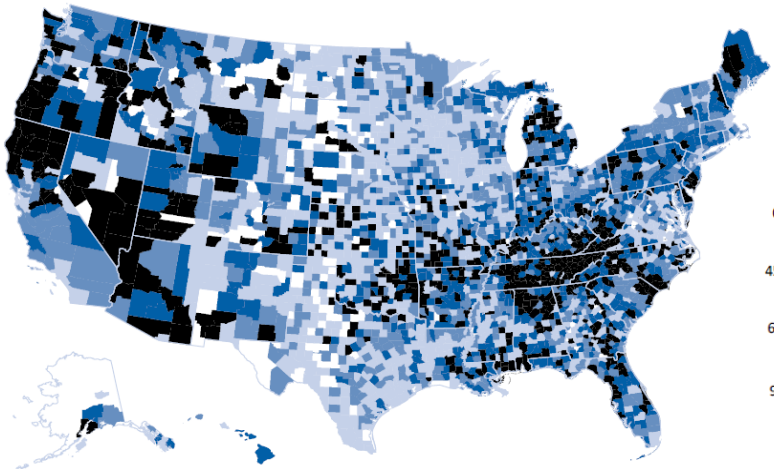
** Brummett CM, Waljee JF, Goesling J et al. New Persistent Opioid Use After Minor and Major Surgical Procedures in US Adults. JAMA Surg. 2017 Apr 12:e170504. doi: 10.1001/jamasurg.2017.0504. [Epub ahead of print]

*** Barnett ML, Olenski AR, Jena AB. Opioid-Prescribing Patterns of Emergency Physicians and Risk of Long-Term Use. N Engl J Med. 2017 Feb 16; 376(7)

Opioid-related overdose deaths

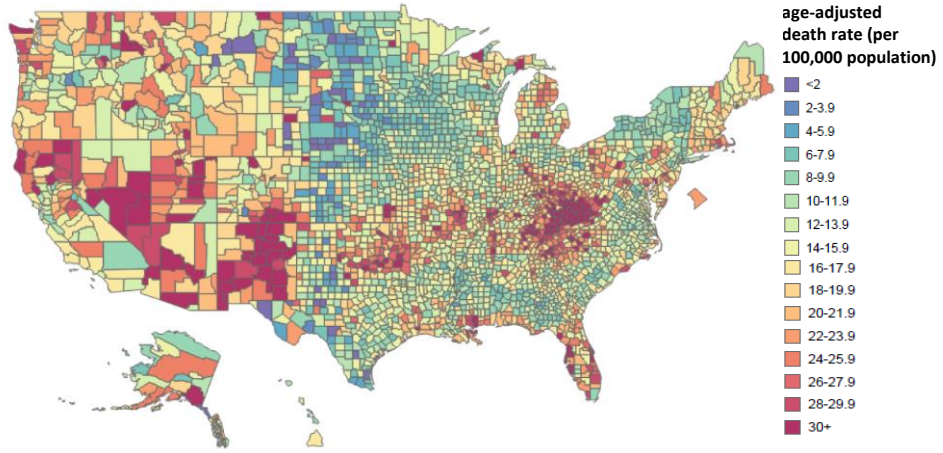


SOURCE: National Vital Statistics System Mortality File.



GP Guy, K Zhang, MK Bohm, J Losby, B Lewis; R Young, LB Murphy, D Dowell. Vital Signs: Changes in Opioid Prescribing in the United States, 2006-2015. M*MWR Morb Mortal Wkly Rep. 2017.*

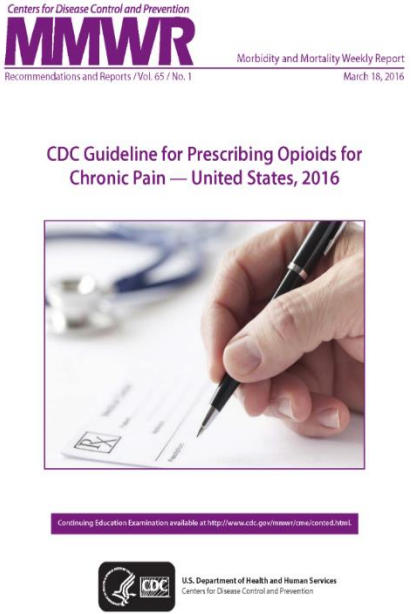
Amounts of opioids prescribed, by county—United States, 2015



Rossen LM, Bastian B, Warner M, Khan D, Chong Y. Drug poisoning mortality: United States, 1999-2016. National Center for Health Statistics. 2017

Drug poisoning death rates, by county—United States, 2016

12 recommendations,* including



- When opioids are used for acute pain, prescribe no more than needed
- Check Prescription Drug Monitoring Program (PDMP) data
- Avoid concurrent benzodiazepines and opioids when possible
- Arrange medication-assisted treatment for opioid use disorder

*Some of the recommendations might be relevant for acute care settings or other specialists, such as emergency physicians or dentists, but use in these settings or by other specialists is not the focus of the guideline. Readers are referred to other sources for prescribing recommendations within acute care settings and in dental practice, such as … the Pennsylvania Guidelines on the Use of Opioids in Dental Practice

For acute pain severe enough to require opioids

- Prescribe the lowest effective dose
- Prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids
- Prescribe no greater quantity than needed for expected duration of pain severe enough to require opioids (≤3 days usually sufficient; >7 days rarely needed)

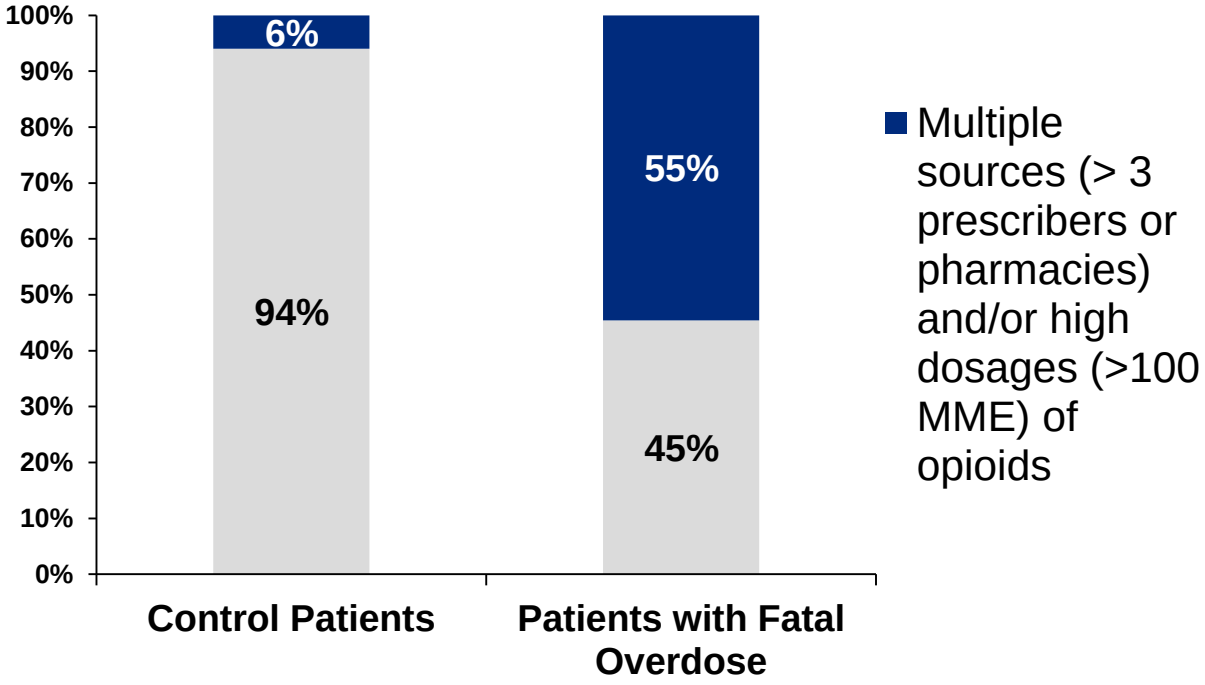
New evidence: ibuprofen + acetaminophen equivalent to opioids + acetaminophen for acute pain*

- For patients in the emergency department with acute extremity pain, no significant differences in pain reduction between
  - ibuprofen 400mg + acetaminophen 1000mg (4.3 point↓**)
  - oxycodone 5mg + acetaminophen 325mg (4.4 point↓**)
  - hydrocodone 5mg + acetaminophen 300mg (3.5 point↓**)
  - codeine 30mg + acetaminophen 300mg (3.9 point↓**)

*Chang AK et al. Effect of a Single Dose of Oral Opioid and Nonopioid Analgesics on Acute Extremity Pain in the Emergency Department: A Randomized Clinical Trial. *JAMA*. 2017 Nov 7;318(17):1661-1667.

**pain intensity assessed at 2 hours using the 11-point numerical rating scale (NRS)

Most prescription opioid overdose deaths involve high dosages and/or multiple sources; information on both is available in PDMP data

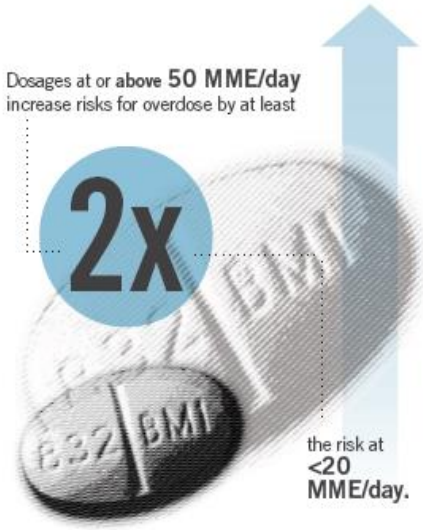


Gwira Baumblatt et al. High Risk Use by Patients Prescribed Opioids for Pain and its Role in Overdose Deaths. *JAMA Intern Med* 2014; 174: 796-801.

CALCULATING TOTAL DAILY DOSE OF OPIOIDS FOR SAFER DOSAGE

available at cdc.gov/drugoverdose/prescribing/resources.html

HOW SHOULD THE TOTAL DAILY DOSE OF OPIOIDS BE CALCULATED?



1. **DETERMINE** the total daily amount of each opioid the patient takes.
2. **CONVERT** each to MMEs—multiply the dose for each opioid by the conversion factor. (*see table*)
3. **ADD** them together.

CAUTION:

- Do not use the calculated dose in MMEs to determine dosage for converting one opioid to another—the new opioid should be lower to avoid unintentional overdose caused by incomplete cross-tolerance and individual differences in opioid pharmacokinetics. Consult the medication label.

Calculating morphine milligram equivalents (MME)

OPIOID (doses in mg/day except where noted)	CONVERSION FACTOR
Codeine	0.15
Fentanyl transdermal (in mcg/hr)	2.4
Hydrocodone	1
Hydromorphone	4
Methadone	
1-20 mg/day	4
21-40 mg/day	8
41-60 mg/day	10
≥ 61-80 mg/day	12
Morphine	1
Oxycodone	1.5
Oxymorphone	3

These dose conversions are estimated and cannot account for all individual differences in genetics and pharmacokinetics.

USE EXTRA CAUTION:

- **Methadone:** the conversion factor increases at higher doses
- **Fentanyl:** dosed in mcg/hr instead of mg/day, and absorption is affected by heat and other factors

*These dosage thresholds are based on overdose risk when opioids are prescribed for pain and should not guide dosing of medication-assisted treatment of opioid use disorder.

Mobile App

- Features include:
  - MME calculator
  - Prescribing guidance
  - Motivational interviewing

available for download on the App store and on Google play

If you find concerning information in the PDMP, take action to improve patient safety

- Discuss safety concerns including increased overdose risk
- Consider opioid use disorder and discuss concerns
- Do not dismiss patients from care—use the opportunity to provide potentially lifesaving information and interventions

PRESCRIPTION DRUG MONITORING PROGRAMS (PDMPs)

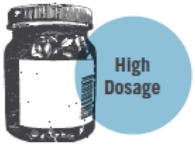
WHAT IS A PDMP?

A PDMP is a statewide electronic database that tracks all controlled substance prescriptions. Authorized users can access prescription data such as medications dispensed and doses.

PDMPs improve patient safety by allowing clinicians to:

- Identify patients who are obtaining opioids from multiple providers.
- Calculate the total amount of opioids prescribed per day (in MME/day).
- Identify patients who are being prescribed other substances that may increase risk of opioids—such as benzodiazepines.

WHAT SHOULD I CONSIDER WHEN PRESCRIBING OPIOIDS?



High Dosage

Talk to your patient about the risks for respiratory depression and overdose. Consider offering to taper opioids as well as prescribing naloxone for patients taking 50 MME/day or more.

Multiple Providers

Counsel your patient and coordinate care with their other prescribers to improve safety and discuss the need to obtain opioids from a single provider. Check the PDMP regularly and consider tapering or discontinuation of opioids if pattern continues.

Drug Interactions

Whenever possible, avoid prescribing opioids and benzodiazepines concurrently. Communicate with other prescribers to prioritize patient goals and weigh risks of concurrent opioid and benzodiazepine use.

WHEN SHOULD I CHECK THE PDMP?

State requirements vary, but CDC recommends checking at least once every 3 months and consider checking prior to every opioid prescription.

WHAT SHOULD I DO IF I FIND INFORMATION ABOUT A PATIENT IN THE PDMP THAT CONCERNS ME?

Patients should not be dismissed from care based on PDMP information. Use the opportunity to provide potentially life-saving information and interventions.

1. **Confirm that the information in the PDMP is correct.**
   Check for potential data entry errors, use of a nickname or maiden name, or possible identity theft to obtain prescriptions.
2. **Assess for possible misuse or abuse.**
   Offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients who meet criteria for opioid use disorder. If you suspect diversion, urine drug testing can assist in determining whether opioids can be discontinued without causing withdrawal.
3. **Discuss any areas of concern with your patient and emphasize your interest in their safety.**

available at cdc.gov/drugoverdose/prescribing/resources.html

Opioid use disorder

- Previously classified as opioid abuse or opioid dependence (DSM-IV)
- Defined in DSM-5 as a problematic pattern of opioid use leading to clinically significant impairment or distress
  - manifested by at least two defined criteria
  - occurring within a year

If you suspect opioid use disorder

- Discuss your concern with your patient
- Provide an opportunity for your patient to disclose related concerns or problems
- Arrange for assessment with a substance use disorder specialist
- Do not dismiss patients from care—use the opportunity to provide potentially lifesaving information and interventions

Resources for opioid use disorder treatment

- SAMHSA's buprenorphine provider locator (https://www.samhsa.gov/medication-assisted-treatment/physician-program-data/treatment-physician-locator)
- SAMHSA's Opioid Treatment Program Directory (http://dpt2.samhsa.gov/treatment/directory.aspx)
- SAMHSA's Provider Clinical Support System for Opioid Therapies (pcssNOW.org) offers expertise in the treatment of substance use disorders, opioid use disorder, and on the interface of pain and opioid misuse

Web based training: Applying CDC's Guideline for Prescribing Opioids

- Opportunities to practice communication throughout
- One module focuses on communication
- Stand alone modules
- Interactive scenarios
- Resource links
- Checks knowledge
- Allows practice

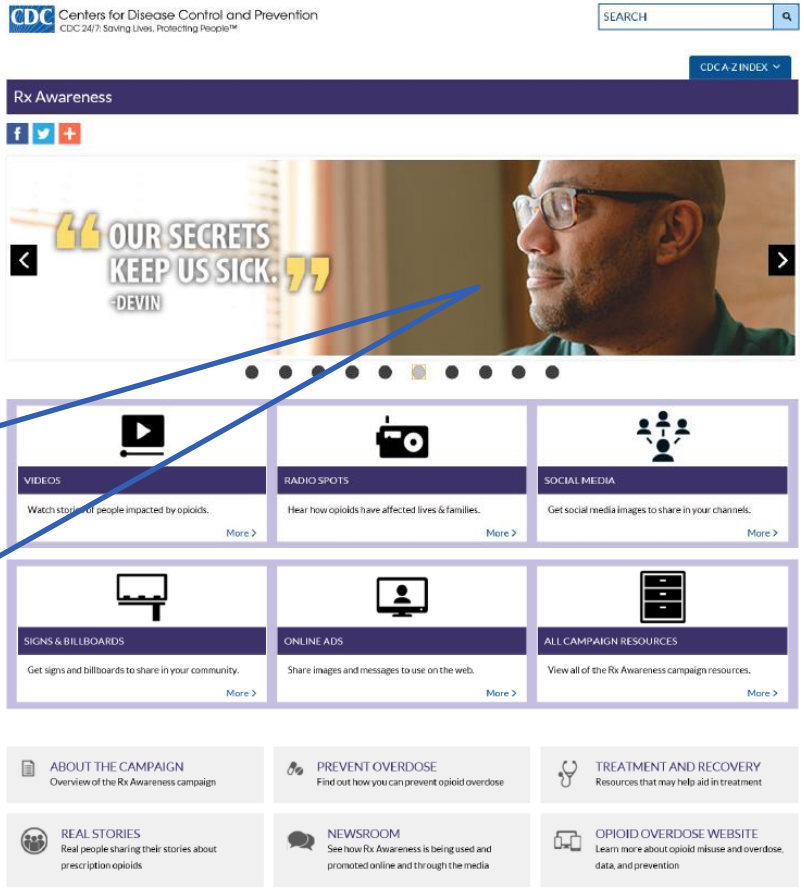
available at cdc.gov/drugoverdose/training/

Rx Awareness campaign

"The first time I ever took prescription opioids is when I got my wisdom teeth taken out….

I must have gotten a 30-day script. I took them all in three days."

- Devin



CDC.gov/RxAwareness

For more information, contact CDC
1-800-CDC-INFO (232-4636)
TTY: 1-888-232-6348 www.cdc.gov

The findings and conclusions in this report are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention.

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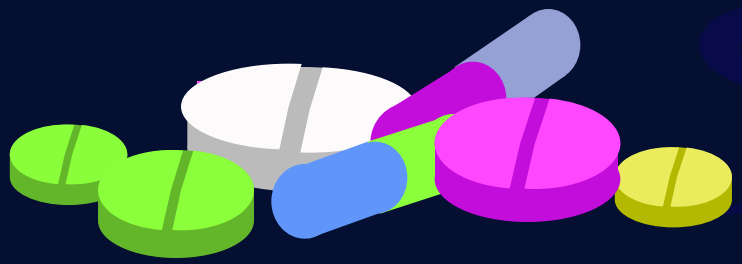
Prescribing Opioids in Dentistry: Requirements, Responsibilities, and Alternatives



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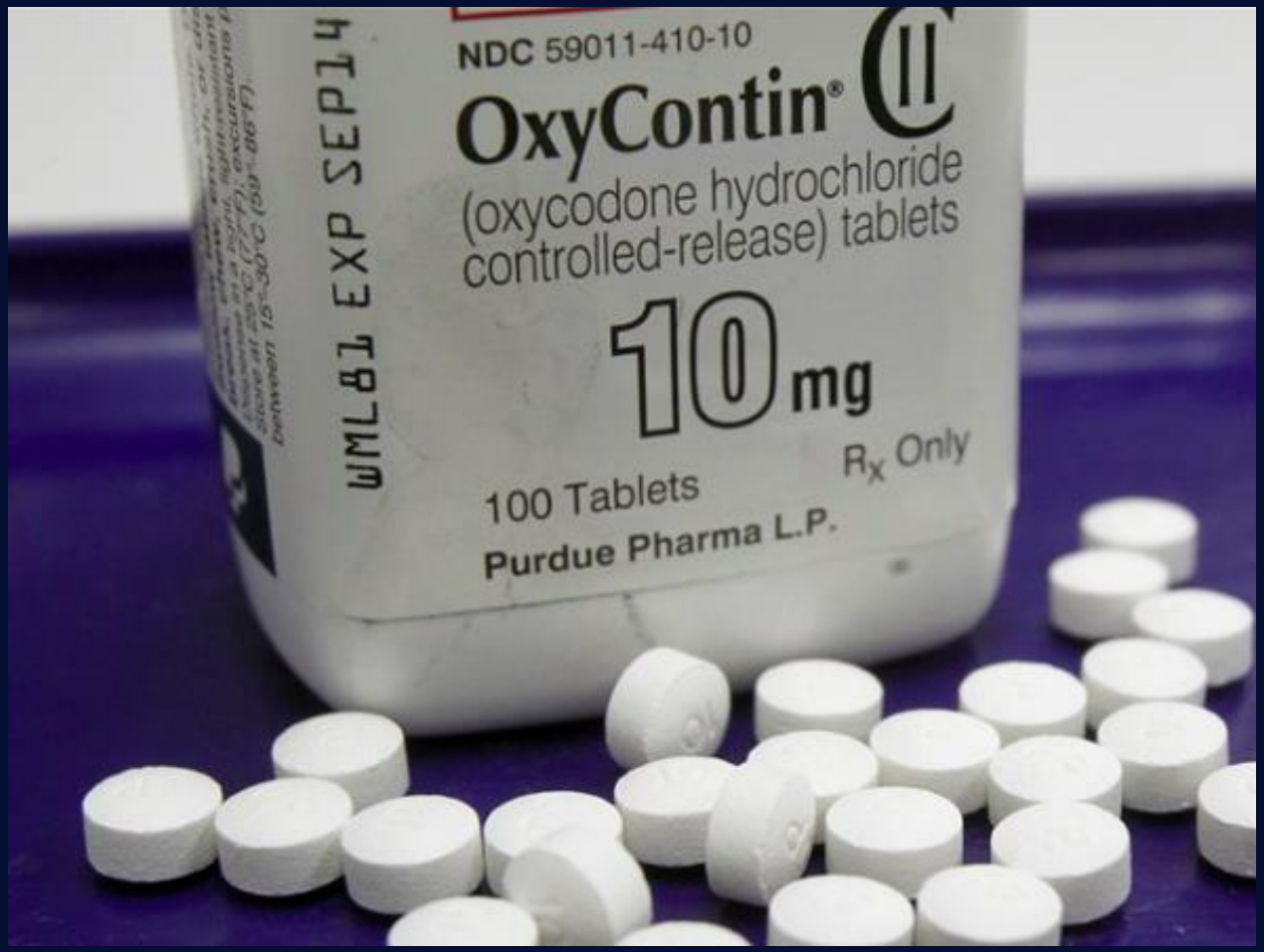
PCSS Providers Clinical Support System

Managing Chronic Pain



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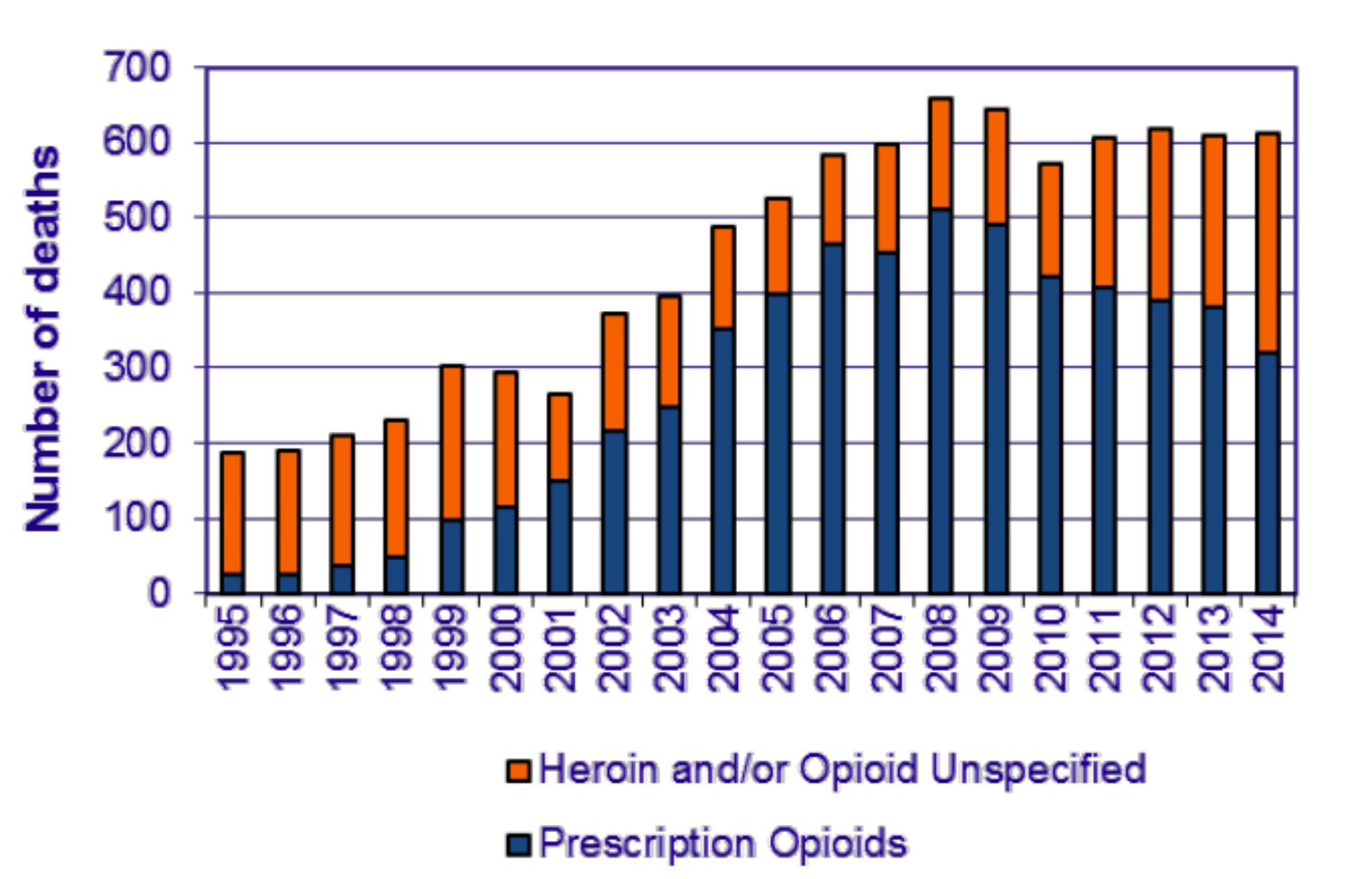
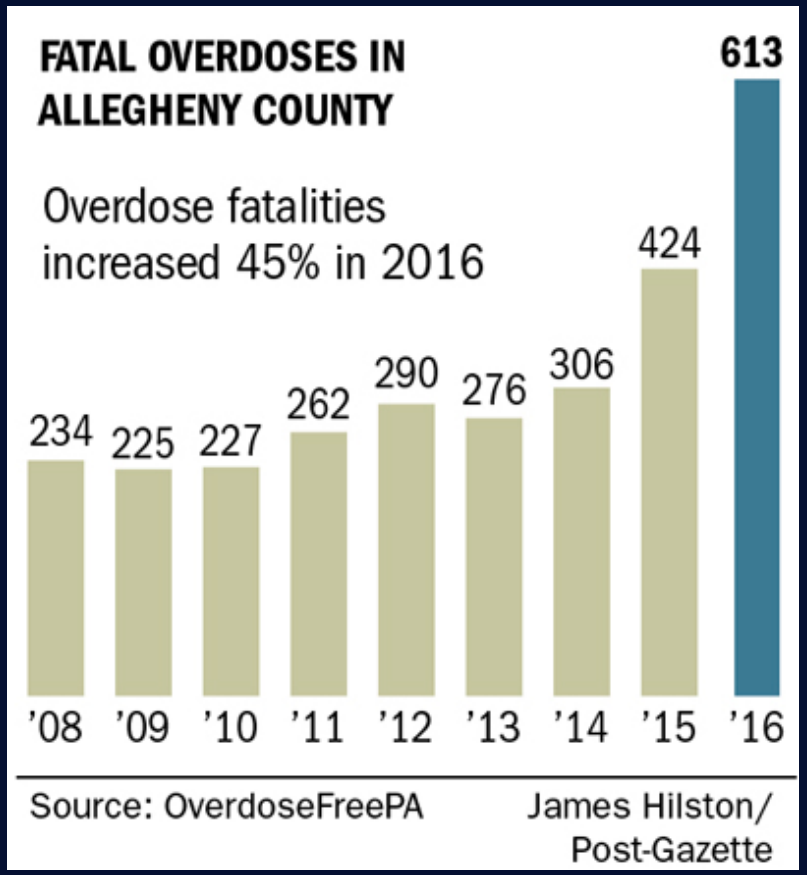
Opioid Epidemic: Why Now?

- 1996 Purdue Pharmaceutical Company introduces OxyContin.
- Porter and Jick: Abstract
- 2000 – 2014 overdose deaths increase 137%
- 2007-2012: 740 million Vicodin and OxyContin pills sold in WV, equaling 433 pills per resident
- One (1) OxyContin pill = $80.00
- One (1) bag of heroin = $10.00
- 2010 OxyContin reformulated
- Since 2010, overdose deaths decrease for prescription opioids and increase for heroin, fentanyl and now carfentanyl

Prescriptions vs Heroin

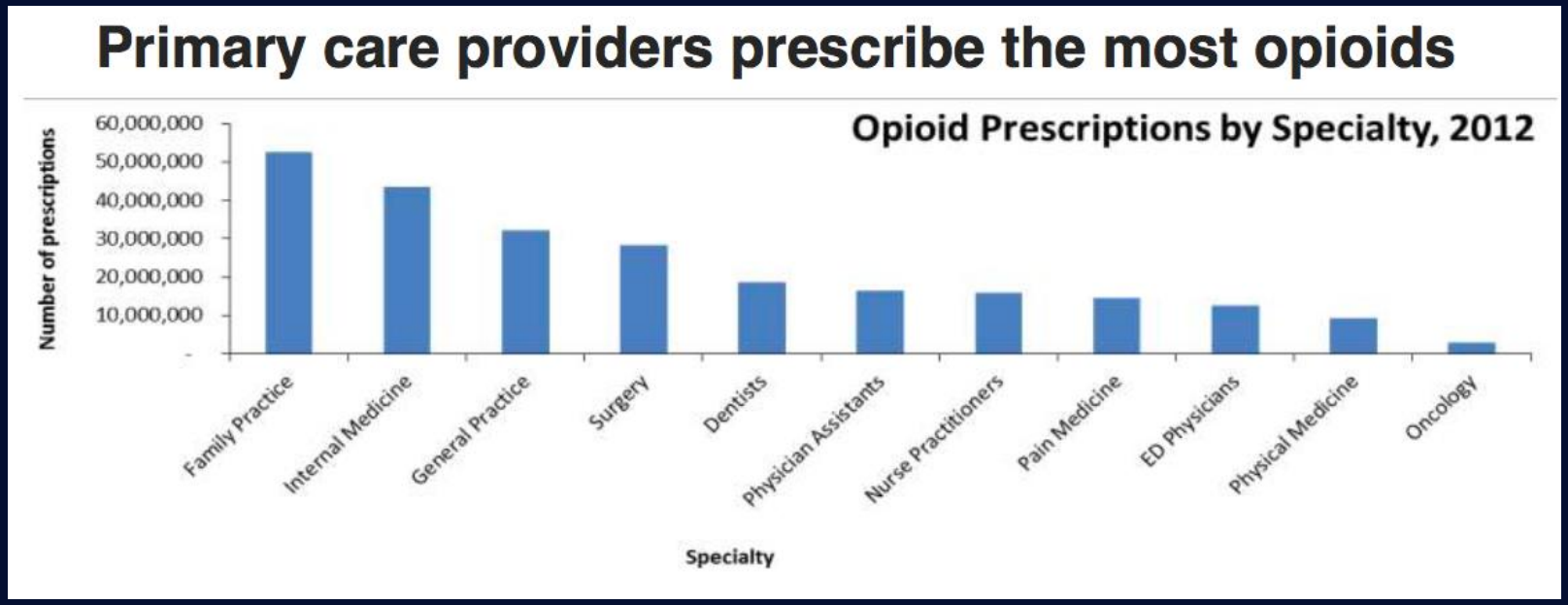


Pittsburgh/Allegheny County

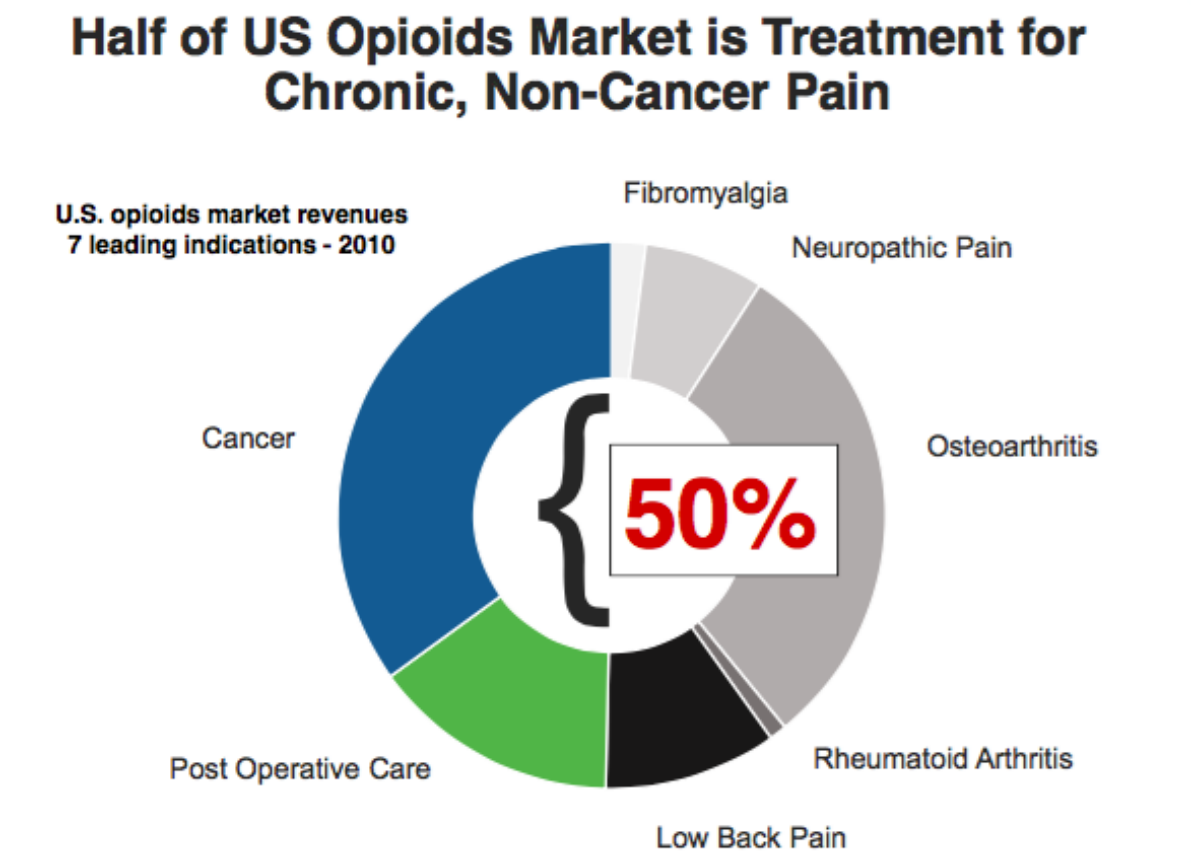


Estimates for 2017:
750 overdose fatalities

Opioid Prescriptions by Dentists



Opioid Market: Chronic Pain



Top Prescription in US

	2011	2012	2013	2014	2015
Total*	4,014	4,155	4,236	4,325	4,368
1. levothyroxine	105	112	117	120	121
2. lisinopril	89	99	102	104	106
3. APAP/hydrocodone	137	136	129	119	97

*millions of prescriptions

Medicines Use and Spending in the U.S.
IMS Institute for Healthcare Informatics, April 2016.

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Trends: Opioid Prescribing in Dentistry

- ✓ Dentists prescribe 12.2% of all immediate-release opioids (Vicodin® or Percocet®).
- ✓ Dentists most often treat acute inflammatory pain that is either post-surgical or odontogenic/inflammatory.
- ✓ The need and effectiveness of opioid analgesics following dental surgery is difficult to predict.
- ✓ Dentists and OMFS's may often be prescribing an opioid analgesics to adolescents and young adults for the first time in their lives (3-4 million wisdom teeth extractions).

Golubic et al. Opioid prescribing in dentistry. Compend CE Dent 2011.

Centrally-Acting Analgesics: South Carolina

South Carolina PDMP 2012-2013 by Dentists.
653,650 opioid prescriptions.
99.9% were for immediate release formulations.
People younger than 21 year was 11.2%.
Refills represent only 3.8%.

Hydrocodone / APAP	76.1%
Oxycodone / APAP	12.2%
Codeine / APAP	6.8%
Hydrocodone / ibuprofen	3.0%
Meperidine	1.2%

MacCauley JL et al, JADA 2016

Preferred Centrally-Acting Analgesics

"Please complete the following prescription for the centrally-acting analgesic you prescribed most often in the past month."

Hydrocodone / APAP	64.0%
Oxycodone / APAP	20.2%
Hydrocodone / ibuprofen	4.6%
Codeine / APAP	4.3%
Promethazine / meperidine	3.7%
Propoxyphene / APAP	1.2%

Moore PA, Nahouraii HS, Zovko J, Wisniewski SR. Dental therapeutic practice patterns in the U.S. II. Analgesics, corticosteroids, and antibiotics. *Gen Dent 2006;54(3):201-207.*

Prescribing vs Utilization

- 1.7 million patients prescribed opioids following third molar extractions.
- The median milligrams of morphine equivalents was 120 MME's.
- This represents:

  24 tablets of hydrocodone 5 mg (Vicodin)

  16 tablets of oxycodone 5 mg (Percocet).

Opioid Prescribing After Surgical Extraction of Teeth in Medicaid Patients, 2000–2010
James A. Baker JA et al. JAMA 2016.

Prescribing vs Utilization

- Forty-eight patient interviews (1-day, 7-days).
- Age: 18.8 yrs (15-30)
- Female = 22 / Males =13
- 20 Vicodin® prescribed
- 12 (60%) pills unused at 7-days.
- Nausea/vomiting at 7-days interview: 24%.

"Postoperative Pain, Prescription Analgesic Use, and Complications Following Third Molar Extractions" . Welland B. et al. Compend Cont Dent Ed, 2015

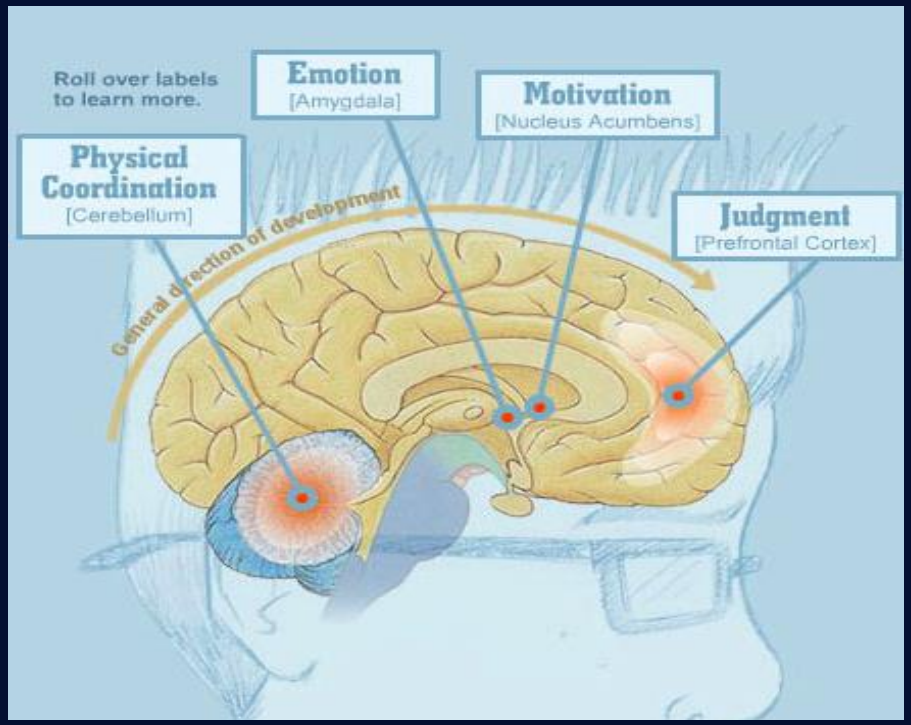
Trends for Opioids Misuse

- From 1997-2007, use increased from 74 mg/person to 369 mg person (500% increase).
- Prescription opioid drugs rank second to marijuana in categories of abused drugs.
- For first time users, friends and family were the primary source: "the AT&T plan".

Epidemic: Responding to America's Prescription Drug Abuse Crisis. US Surgeon General report 2010

Developing Adolescent Brain

Balance between pleasure center (Nucleus Acumbens) and judgement center (Prefrontal Cortex) is not completely developed until 20-25 years of age.



Monitoring the Future

- Data come from the Monitoring the Future study, University of Michigan.
- Nationally representative sample of 6,220 individuals surveyed in high school in 12th grade.
- Followed up through age 23. Analyses are stratified by predicted future opioid misuse as measured in 12th grade on the basis of known risk factors. The main outcome is nonmedical use of a prescription opioid at ages 19 to 23.
- Predictors include use of a legitimate prescription by 12th grade, as well as baseline history of drug use and baseline attitudes toward illegal drug use.
- **RESULTS:** Legitimate opioid use before high school graduation is independently associated with a 33% increase in the risk of future opioid misuse after high school among low risk children.

Richard Miech, Lloyd Johnston, Patrick M. O'Malley, Katherine M. Keyes, Kennon Heard
Prescription Opioids in Adolescence and Future Opioid Misuse. Pediatrics 2017;139(6)

Ibuprofen vs APAP

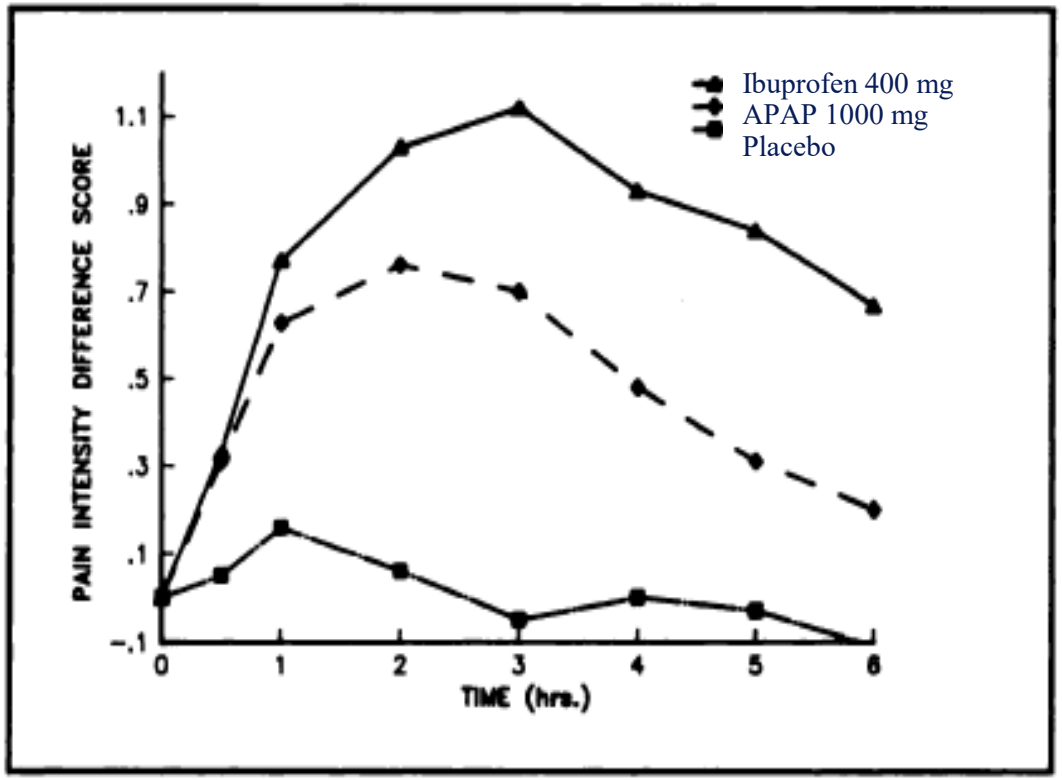
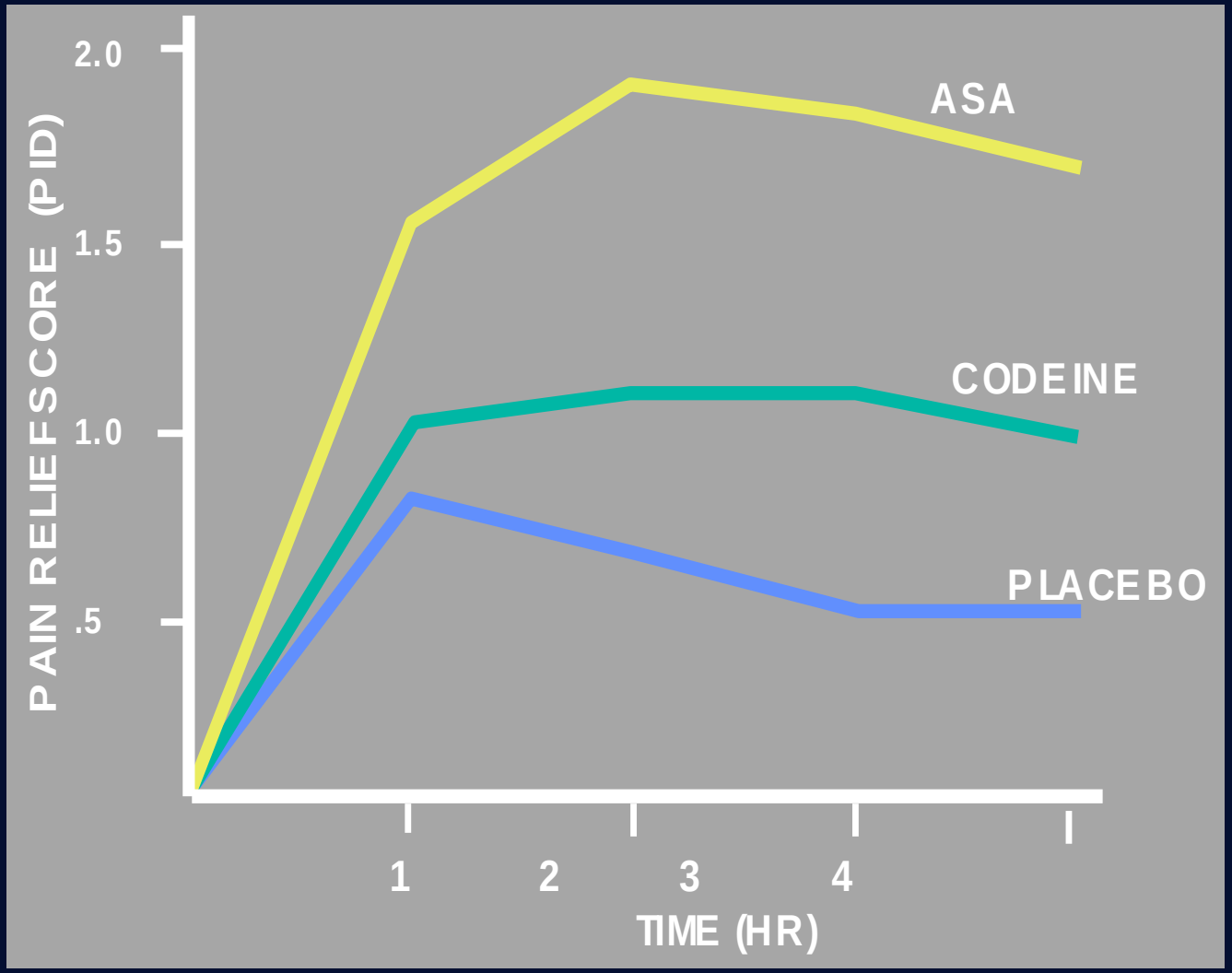


Figure 1. Mean pain intensity difference scores vs time. Pain intensity was rated on a scale of 0 = none to 3 = severe.

Cooper SA et al.: J Clin Pharmacol 1989 29:1026

ASA vs. Codeine vs. Placebo



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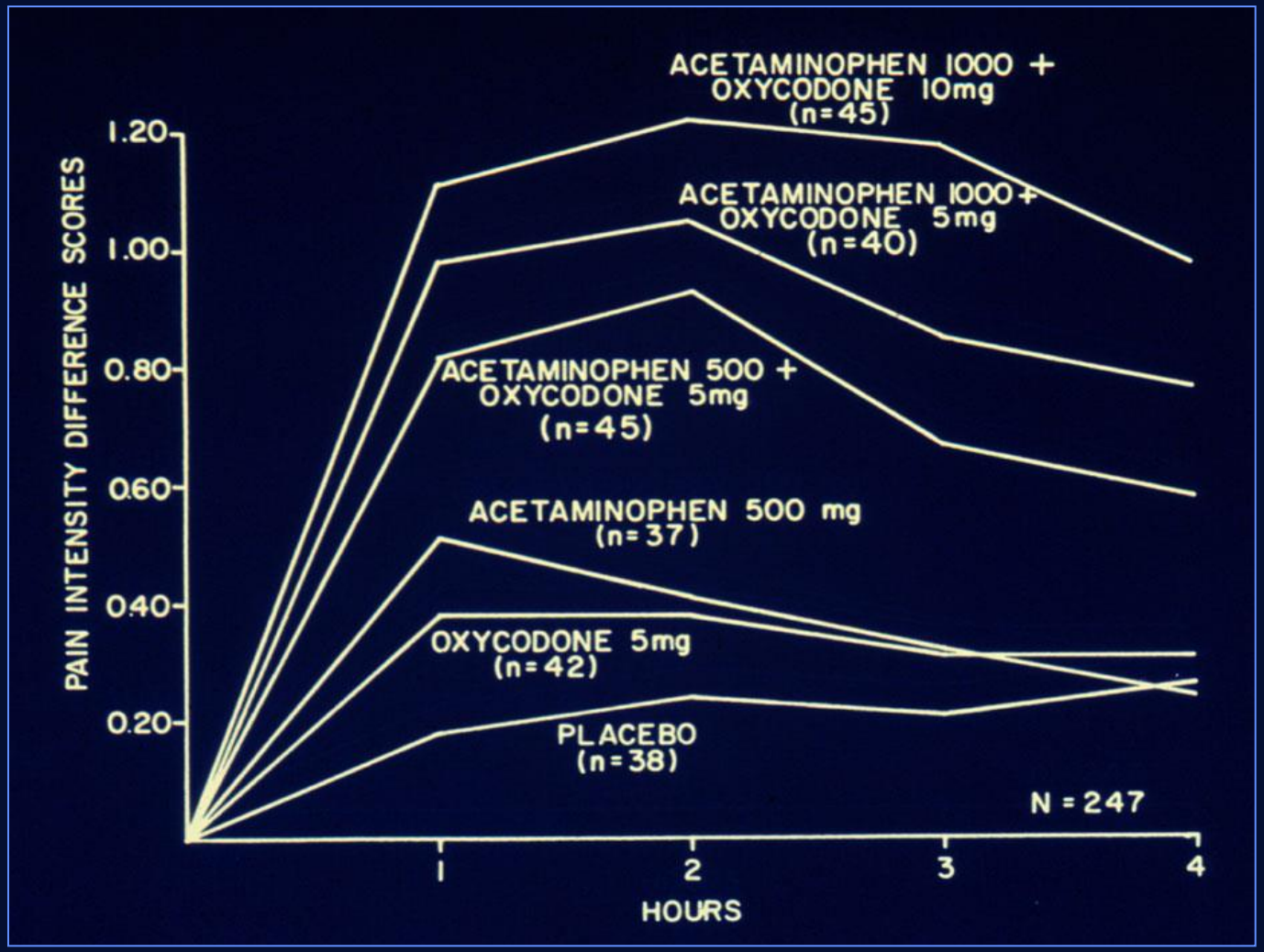
Oral Surgery Model: Opioid Combinations



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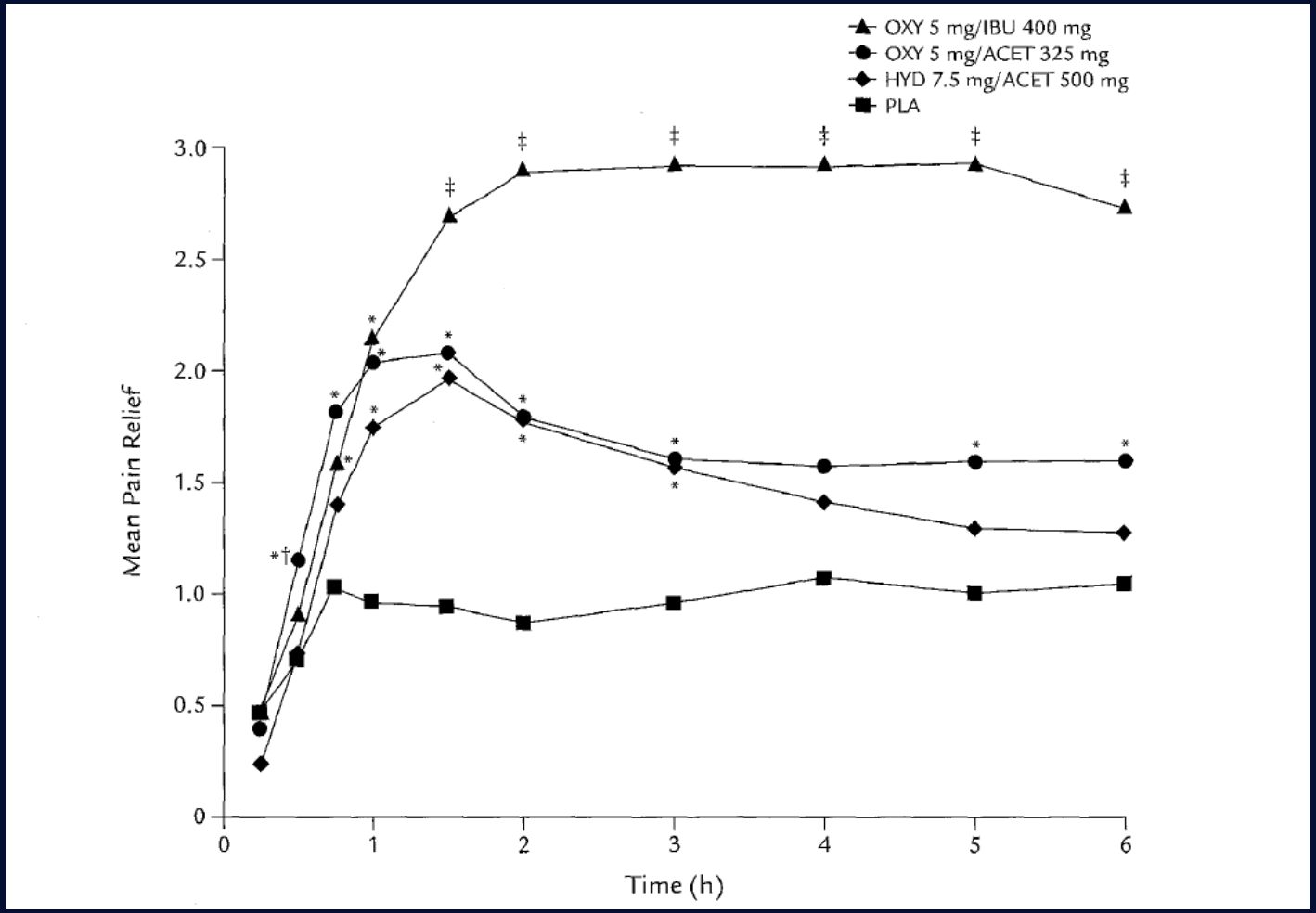
Ibuprofen-Opioid Combination



Litkowski LJ, et al. Clin Therap 2005;27(4):418-429.

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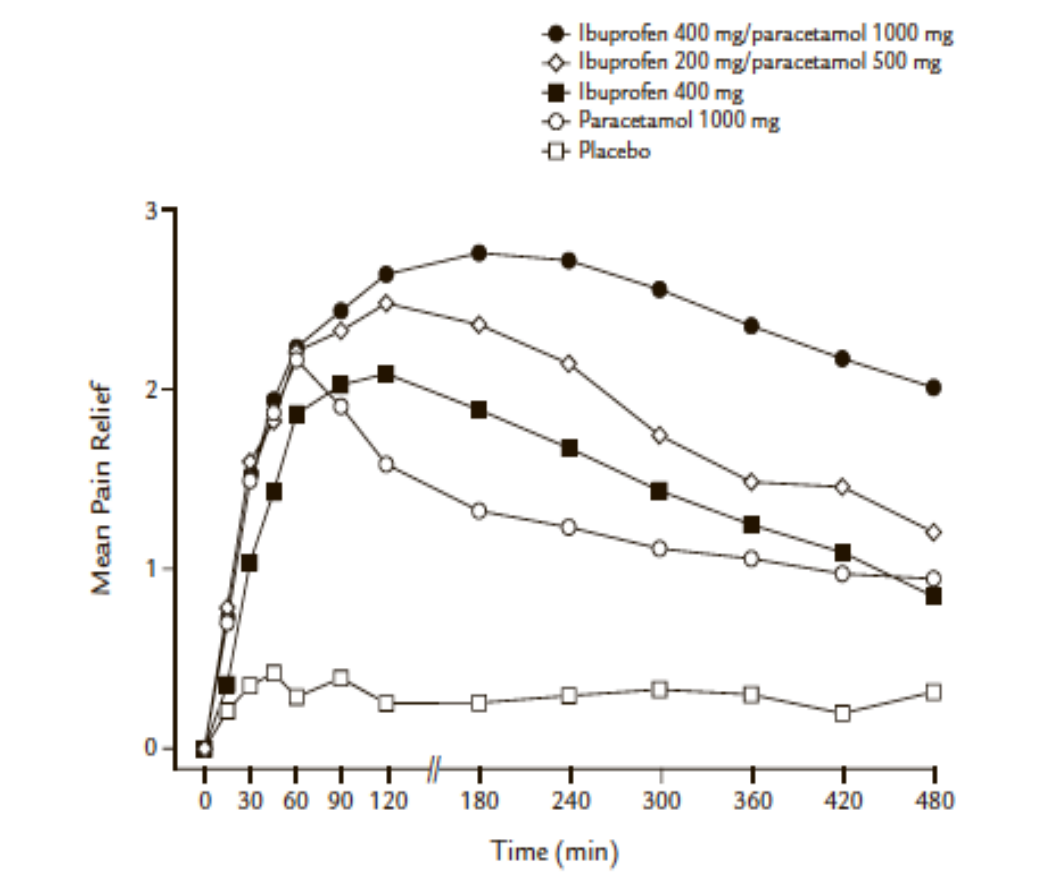
Ibuprofen and APAP



Paracetamol and APAP (Acetaminophen) are chemical names for Tylenol)

Mehlisch DR, Aspley S, Daniels SE, Bandy DP. Clin Ther 2010;32(5):882-895.

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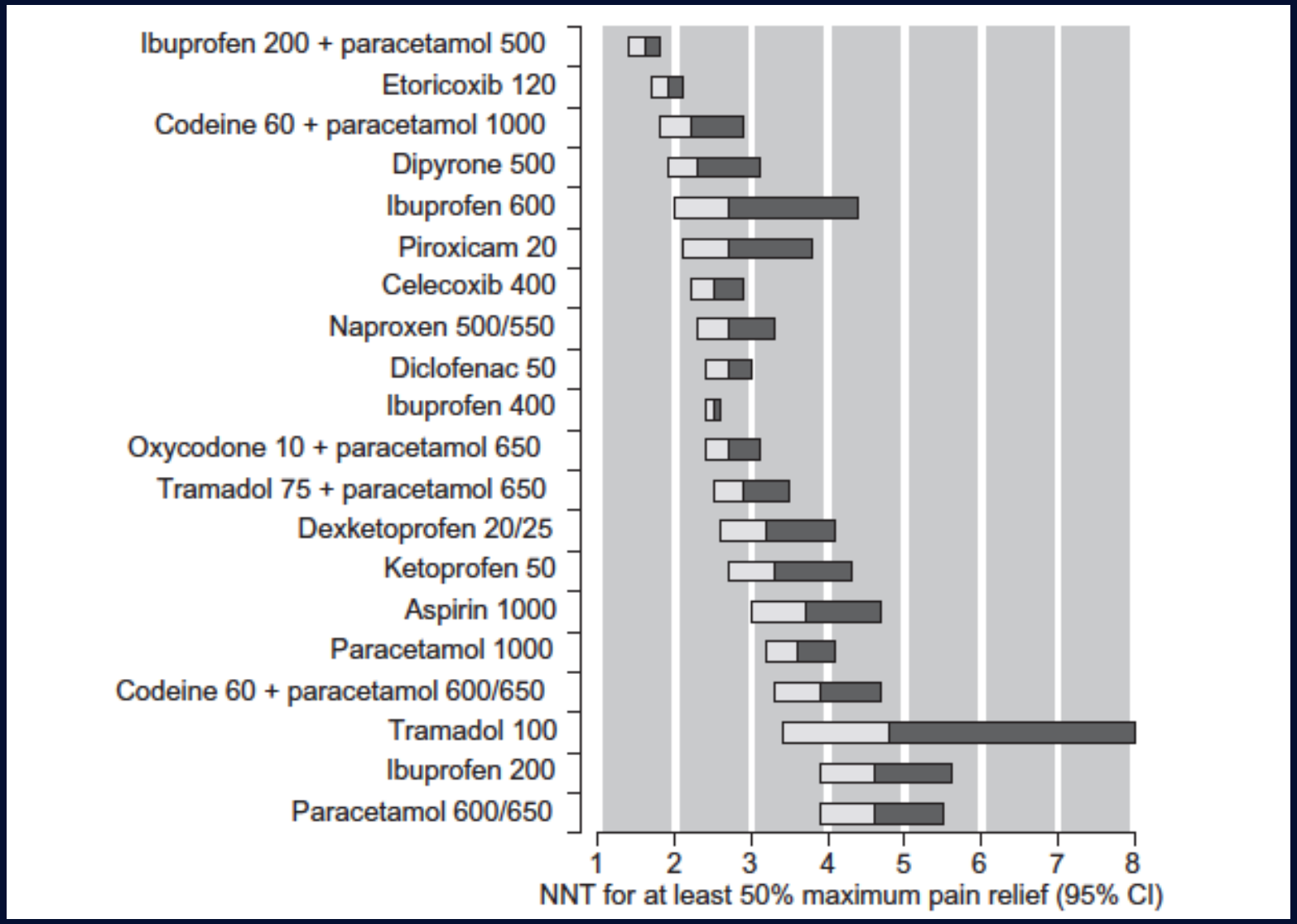
NNTs for Analgesic Agents



NNTs for Dental Analgesics

Drug Formulation	Trials/Subjects	NNT (C.I.)
Aspirin 600/650 mg	45/3581	4.5 (4.0-5.2)
Aspirin 1,000 mg	4/436	4.2 (3.2-6.0)
Acetaminophen 1,000 mg	19/2157	3.2 (2.9-3.6)
Ibuprofen 200 mg	18/2470	2.7 (2.5-3.0)
Celecoxib 400 mg	4/620	2.5 (2.2-2.9)
Ibuprofen 400 mg	49/5428	2.3 (2.2-2.4)
Oxycodone 10 mg plus Acetaminophen 650 mg	6/673	2.3 (2.0-6.4)
Codeine 60 mg plus APAP 1000 mg	26/2295	2.2 (1.8-2.9)
Naproxen 500/550 mg	5/402	1.8 (1.6-2.1)
Ibuprofen 200 mg plus Acetaminophen 500 mg	2/280	1.6 (1.4-1.8)

Stepwise Guidelines

Mild Pain

Ibuprofen 200-400 mg
q 4-6 hours: as needed (p.r.n.) pain

Mild-Moderate Pain

Ibuprofen 400-600 mg
q 4-6 hours: fixed interval for 24 hours

Moderate - Severe Pain

Ibuprofen 400-600 mg plus APAP 500 mg
q 6 hours: fixed interval for 24 hours

Severe Pain

Ibuprofen 400 mg plus APAP 650/hydrocodone 10 mg
q 6 hours: fixed interval for 24-48 hours

Moore PA and Hersh EV. Combining Ibuprofen and Acetaminophen for Acute Postoperative Pain Management: Translating Clinical Research to Dental Practice. J Am Dent Assoc 2013;144(8):898-908.

Issues in Opioid Pain Therapeutics

- ✓ Changes in drug therapy for post-operative dental pain management.
  - No longer prescribing Darvocet.
  - Limiting dose of APAP in combination analgesics.
  - Long-acting local anesthetics i.e. Marcaine
  - High efficacy of NSAIDs in dental post-op pain.
  - Steroids as an antiemetic and an anti-inflammation.
  - Prophylactic NSAID's.
  - APAP-Ibuprofen alternative.
- ✓ Balancing pain Tx and potential misuse.

National Issues in Opioid Therapeutics

- ✓ Expand take-back programs.
- ✓ Educational requirements for DEA registration and State licensure.
- ✓ REMS: Risk Evaluation and Mitigation Strategies.
- ✓ Expand dental school accreditation curriculums in anesthesia and pain control.
- ✓ PDMPs: Electronic State sponsored prescription drug monitoring programs.
- ✓ Revise opioid formulation DEA scheduling.

Checklist: Opioid-Sparing Strategies

- ✓ Preventive NSAIDs (naproxen sodium 550 mg, or ibuprofen 600 mg)
- ✓ Long-acting local anesthesia/analgesia: 0.5% bupivacaine with 1:200,000 epinephrine.
- ✓ Corticosteroids (dexamethasone 8 mg i.m. or i.v.)
- ✓ Reliance on NSAIDs analgesics as the first-line of therapy. (ADA)
- ✓ Consider the combination of ibuprofen (400 mg) and acetaminophen (500 mg) as an opioid alternative.
- ✓ A two or three day supply of opioids analgesics is usually sufficient. (CDC)

CDC Guidelines for Opioids in Chronic Pain

The CDC expert panel recognized that long-term opioid use often begins with treatment of acute pain.

"Three days or less will often be sufficient; more than seven days will rarely be needed."

Extended release and long-acting opioids, such as methadone, fentanyl patches, or extended release versions of opioids such as oxycodone, oxymorphone, or morphine, should not be prescribed for the treatment of acute pain.

Dowell D, Haegerich TM, Chou R. CDC Guideline for Prescribing Opioids for Chronic Pain - United States, 2016. MMWR Recomm Rep 2016;65:1–49.

ADA Statement for Opioids in Acute Pain

The American Dental Association revised its statement on the Use of Opioids in the Treatment of Dental Pain.*

"Dentists should consider nonsteroidal anti-inflammatory analgesics (NSAIDs) as the first-line therapy for acute pain management.

*Adopted by the House of Delegates 2016.

Available at ADA.org

ADA Statement for Opioids in Acute Pain

The American Dental Association revised its statement on the Use of Opioids in the Treatment of Dental Pain.*

"Dentists should consider coordination with other treating doctors, including pain specialists when prescribing opioids for management of chronic orofacial pain."

*Adopted by the House of Delegates 2016.

Available at ADA.org

Provider Issues in Opioid Therapeutics

- ✓ Assessing patients at risk for opioid misuse.
- ✓ Limiting prescriptions to fewer units of opioids. (No refills, 8 units?, 20 units?, 40 units?)
- ✓ Educate parents and patients of dangers.

  This may be our most important "teaching opportunity for first time users of anesthetics and analgesic drugs"
- ✓ With adolescents, parent responsibility as the "gatekeeper" to monitor pain and analgesia needs.
- ✓ Recommend strategies to secure prescriptions.
- ✓ Indicate DEA drug take-back programs.
- ✓ Describe procedures for disposal of unused drug.

Changing Professional Responsibilities

- Antibiotic Stewardship
  - Narrow spectrum
  - D/C after 2-3 days symptom free
  - Definitive bacterial infections only
- Mercury Waste: EPA/ADA requirements
  - Amalgam separators
  - Prohibits flushing into water supplies
  - Avoid bleach and chorine cleaners
- Opioid Prescribing: ADA guidelines
  - Explain your expectation for postoperative pain.
  - History of abuse or mental illness.
  - Respiratory depression with alcohol and drug interactions.
  - Limit dose and numbers when prescribing opioids.
  - Discuss possible side effects: nausea / vomiting and constipation.
  - Counseling for misuse of unused opioid medications.

Questions / Comments

Providers' Clinical Support System Training

PCSS is a collaborative effort led by the 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.pcssnow.org

For questions, email: pcss@aaap.org

Visit us on Twitter: @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.

Webinar Evaluations (Post and 30-Day)

Each PCSS partner organization is asked to distribute a post and 30-day evaluation to participants for their completion.

Participants in today's webinar will be emailed the link to complete their evaluations.

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