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Quality Medical Care for People Who Use Drugs

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Target Audience

- The overarching goal of PCSS is to train healthcare professionals in evidence-based practices for the prevention and treatment of opioid use disorders, particularly in prescribing medications, as well for the prevention and treatment of substance use disorders.

Disclosures

- Mr. Finegood, Dr. Dhanireddy and Dr. Waters have no financial relationships or conflicts of interest.
- Dr. Tsui's disclosures:
 - Site PI for a Patient Centered Outcomes Research Institute (PCORI) funded study of models of HCV for which medications are provided by Gilead.
 - PI of NIH/NIDA funded studies in partnership with mHealth technology company (emocha) for video-directly observed therapy of methadone and buprenorphine.

*The content 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.*

INTRODUCTION

Brad Finegood,
Strategic Advisor,
Public Health—Seattle & King County



Land Acknowledgement

As we begin our talk, we respectfully acknowledge that our event today (where we are) is taking place on occupied Coast Salish land on the homelands of the Duwamish people.

We pay respect to Coast Salish Elders past and present and extend that respect to their descendants and to all Indigenous people.

To acknowledge this land is to recognize its longer history and our place in that history.

Provider Introduction

- Advancing opportunities for recovery from substance use disorders by providing compassionate care and partnering with harm reduction services providers.
 - Dr. Judith Tsui
 - Dr. Richard Waters
 - Dr. Shireesha Dhanireddy

Quality Medical Care for People Who Use Drugs

Harm reduction is quality medical care.

Educational Objectives

- At the conclusion of this activity participants should be able to:
 - Recognize the importance of harm reduction strategies in the provision of quality medical care.
 - Identify partnership opportunities for physicians and harm reduction providers to provide compassionate care to people who use drugs.
 - Take a substance use history and strategize with patients to use more safely.
 - Recognize how stigma contributes to negative outcomes.
 - Address co-morbidities and social factors.
 - Design patient-centered approaches to care delivery models.
 - Discuss management strategies for non-opioid substances in OUD treatment.
 - Recognize the value in caring for patients who repeatedly start & stop buprenorphine.
 - Approach probable or confirmed medication diversion in a health-centered manner.
 - Understand epidemiology of HIV and STIs in people who inject drugs.

DISCUSSING SUBSTANCE USE AND ADDRESSING COMORBIDITIES

Dr. Judith Tsui
Physician, University of Washington Medicine



What is Harm Reduction?

- “... a pragmatic approach to reduce the harmful consequences of alcohol and drug use... The primary goal of most harm-reduction approaches is to meet individuals where they are at...” (Marlatt GA and Witkiewitz K, 2010)
- It is an approach that is rooted in both pragmatism and compassion (Collins SE and Clifasefi S, 2017)

What is Harm Reduction?

- Focus is on sustaining health and reducing harms associated with use
- Cessation of use/abstinence is not an expectation
 - Reduction of use may or may not be goal
- Priorities/goals are set by patient

Harm Reduction is Patient-Centered Care

- “Patient-centered care is considered to be care that is relationship-based, and makes the patient feel known, respected, involved, engaged and knowledgeable.” (Schottenfeld 2016)
- Providers allow individual values and preferences to shape care.
- Patient-centered care has been shown to be associated with improved health status, treatment adherence and greater efficiency of care. (Stewart M 2000; Zolnierek 2009)

Primary care is full of examples of respecting preferences/reducing harm

- Consider the following scenarios where providers must “meet patients where they are”:
 - Patient is due for repeat colonoscopy for polyps. Says “I’m never doing that again!”
 - Diabetic patient has uncontrolled blood glucose, specialist recommends insulin, but patient refuses, stating “I hate needles”.
 - Patient who had recent cardiac bypass surgery who continues to smoke cigarettes
- Quality, patient-centered care = harm reduction

#1: Use person-first language and a collaborative interview style

Provider stigma impacts patient health

- Stigma is a major reason why patients don't seek care, and they don't remain engaged in care, for substance use disorder (Tsai, 2019)
- Language matters: Clinicians have more negative responses to patients described as “substance abusers” v. “person with a substance use disorder” (Kelly and Westerhoff, 2010)

Use non-stigmatizing, person-first language

SAY

- Substance use disorder
- Person with substance use disorder
- Positive, negative urine test
- Recurrence of use
- Pharmacotherapy, medication for use disorder, agonist therapy

AVOID

- Drug abuse/abuse
- Addict, junkie
- Dirty, clean urine
- Clean, sober
- Relapse/fall off the wagon
- Substitution therapy

Take a good substance use history

- Ask permission to ask sensitive information
- Express gratitude and listen when they share their stories
- Let patients know that your questions are standard, asked the same way for all patients
- Reassure patient that care is not contingent on their responses, your intent is to provide them with help (if desired)
- Frame questions neutrally in a way that doesn't assume non-use

Asking About Substance Use

- Study of 162 patients w/ recent use of alcohol, cocaine, heroin, multiple substances found providers failed to ask in 50% of encounters (Callon JGIM 2016)
- When providers asked, it mattered how they asked whether a patient would disclose use
 - Open-ended and normalizing (“Tell me what’s happening with drugs”)→100% disclosure
 - Closed-ended and leaning toward non-use (“And you haven’t been using any drugs?”)→22-58% disclosure

#2 Strategize how to use safely

Safer drug use strategies

- Carry naloxone
- Avoid using alone, use with people you trust
- Avoid mixing drugs
 - Drugs used together may have greater risk (e.g., stimulants + alcohol, benzos + opioids, etc.)
- Be wary of fentanyl contamination
 - Use fentanyl test strips
 - Use a test dose
- Choose safest mode possible
 - Oral>snort>smoke>inject IV>muscle

Safer injection drug use strategies

- Practice good vein care
 - Rotate injection sites
 - Avoid injecting in neck and groin
 - Clean skin prior to injection
- Avoid sharing any injecting equipment
 - Includes cookers, cottons and rinses
 - Also, don't reuse your own equipment
- Avoid using drugs in settings that can lead to risky sex
- Consider Pre-Exposure Prophylaxis (PrEP) for HIV

**#3 Understand patient's priorities
for care, address co-morbidities
like HCV**

Addressing co-morbidities and social factors

- Important to address patient's key concern
 - If not addressed, patient may never return
- Medical issues may not be the priority
 - Housing, food, transportation, legal issues may take precedence
- Substance use should not be a barrier to address other medical issues: treating co-morbidities can improve substance use
 - Example: treating/curing HCV can be transformative experience that leads to engagement in other domains

Psychological and Behavioral Transformation with HCV Treatment

- “Everything changed. I stopped drug use. I stopped everything because I said if I beat the Hep C, I could beat that too.”
- “With this hepatitis and being clean, when I started [HCV treatment], I guess I started being responsible.”
- “I like to think of it as the Hep C treatment turned me around...”

Conclusions

- Harm reduction is good primary care
- Use person-first language and a collaborative interview style when discussing substance use
- Introduce strategies for safe use, allow patient to set goals
- Discuss care priorities, offer treatment for common co-morbidities like HCV

PRIMARY CARE DELIVERY MODELS FOR PWUD

Dr. Richard Waters
Site Medical Director, Housing & Street Outreach
NeighborCare Health



100% access?

Traditional primary care model:

- Brick-&-mortar clinic
- Predominantly schedule-based
- 15-20-minute visits, high-throughput
- Limitations in addressing SDoH
- Medical milieu
- Works for many, but not all...

Community-embedded model:

- Embedded within other community services; where people already are at
- Designed for walk-ins
- Longer visits possible
- Lower volumes often
- Co-located services to address SDoH
- Less likely to evoke prior medical-system traumas

The “why” for newer paradigms of primary care

Status quo isn't working

“Every system is perfectly designed to get the results it gets”
- W. Edwards Deming

Community-embedded models in Seattle

High-value or full primary care services, with OUD focus, embedded within:

- A criminal-legal system diversion program drop-in center for PWUD
- Shelters
- Permanent supportive housing buildings
- A drop-in center for PWUD or are living homeless
- Adjacent to a thrift store
- Syringe-needle exchanges



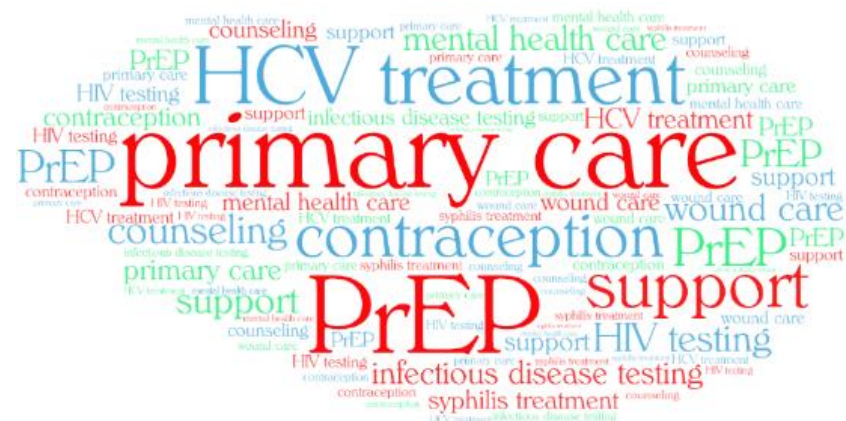
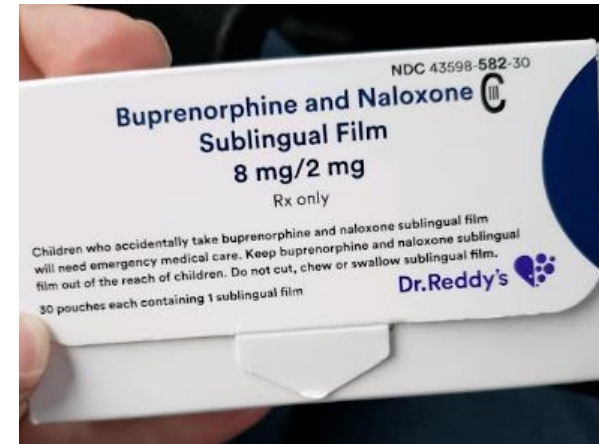
OUD treatment & primary care: “Meds first”, more later

Medication First philosophy of OUD treatment
= pragmatic, outcomes-oriented, patient-centered

(Winograd, Am J Drug Alcohol Abuse 2019)

More primary care often follows:

- Infectious disease testing
- Renal function testing
- HCV treatment
- Pre-exposure prophylaxis for HIV
- Contraception management
- Wound care
- Mental health care



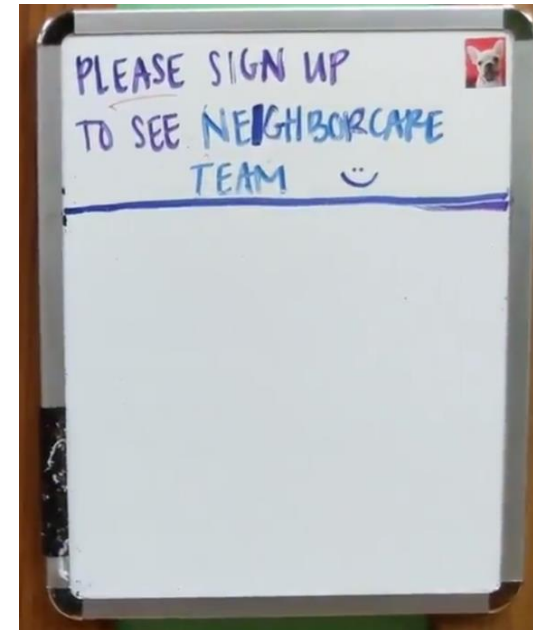
Creating quality care for PWUD

- Community-embedded care if possible
- Regardless of location, focus on:
 - **Structural** adaptations in care delivery
 - **Cultural** adaptations in care delivery

Structural adaptations

How you design workflow & your team

- Easily **accessible** location
- Minimal “**waste**” in value stream of care, from the patient perspective
- Walk-ins / **same-day** buprenorphine starts
- **Microdosing** inductions when needed
- **Flexibility** with follow up
- RN care managers **protocols for refills**
- Coordination with **social services**
- **Peer** supports
- On-site **dispensing**



Structural adaptations: Minimize “waste” to the patient

Minimize “waste” in value stream of care, from the patient perspective

E.g.: If the patient’s only goal is starting buprenorphine for OUD:

- Confirm OUD diagnosis
- Assess for current use of naltrexone, methadone, buprenorphine; PMP check
- Assess for pregnancy *
- Screen, by history, for severe liver dysfunction
- Medication interactions?
- Buprenorphine education (starting, taking, keeping safe, follow up)

Ideal but not necessary at 1st visit: lengthy intake, detailed substance use history, mental health history, vital signs, urine drug screen at times, labs, medication “agreements”

Structural adaptations: Starting buprenorphine

- Bupe can be prescribed in encampments, shelters, mobile vans, etc.
- Default to “wherever you are”-based bupe starts, not office-based
- Discuss “microdosing” starting approach as an option
- Prescribe opioid withdrawal treatment medications
- Partner with case managers on hotel options or short-term medical facilities (e.g., detox) for patients living homeless who struggle with starting process

Structural adaptations: Policies around non-opioid use

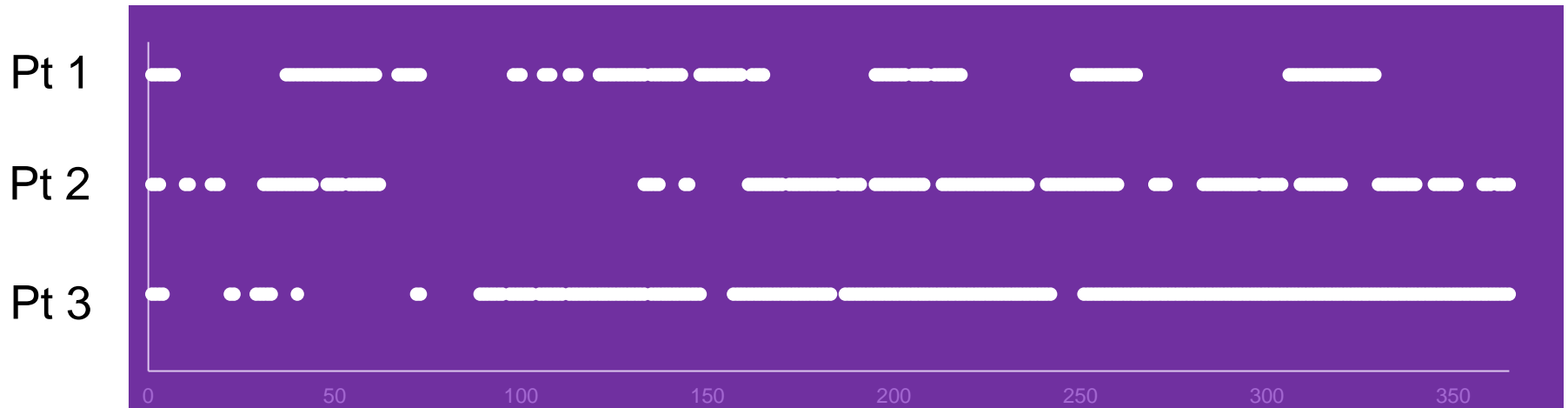
- Mortality risk reduction with agonist therapy for OUD treatment
 - Observational studies = mortality benefit **persists** with polysubstance use
 - Mortality risk reduction of OAT may be **relatively greater** when concurrent alcohol & benzo use exist
 - Non-opioid substance use may hinder OUD treatment retention
- = Ok to start & continue bupe for OUD with concurrent benzo, alcohol, stimulant or other drug use**
- = Offer treatments & supports for other use disorders**

Structural adaptations: Policies around restarting bupe

- 37 year old with OUD, stimulant use disorders & unstable housing repeatedly started & stopped bupe, at **least 10 times over 1.5 years.**
- Prescription lengths were 2-7 days
- Other treatment options discussed. She declined (methadone, bupe daily dosing, therapeutic residential communities)
- Then she stabilized on bupe. **Hope** for reuniting with family was key. Her SUDs have been in remission for nearly 3 years, now working full time, housed, with family.

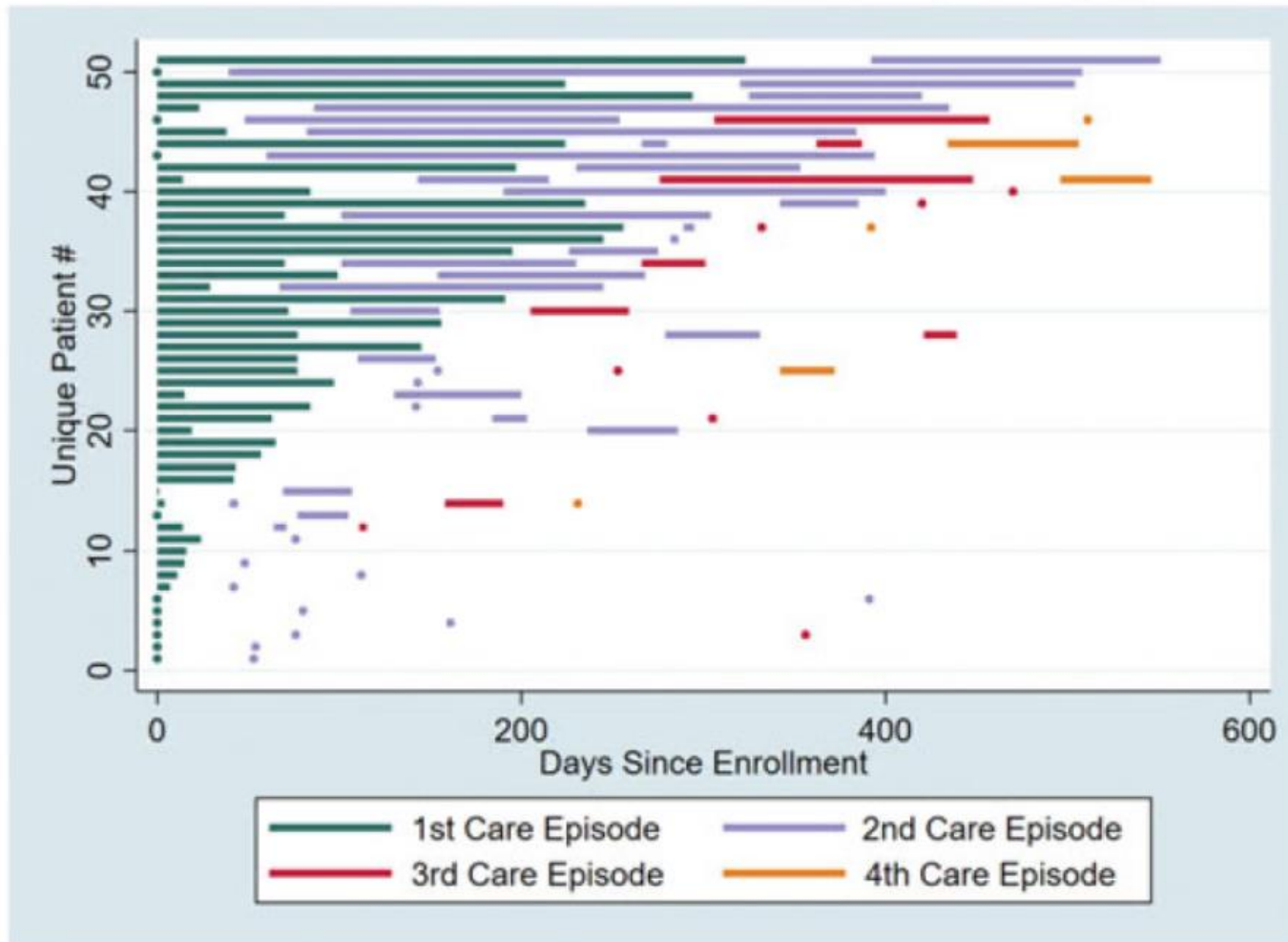
Structural adaptations: Policies around restarting bupe

Days with buprenorphine prescription, based on PDMP data



	Pt 1	Pt 2	Pt 3
Bupe Coverage months 0-3	43%	40%	19%
Bupe Coverage months 4-6	52%	30%	88%
Bupe Coverage months 7-9	44%	78%	89%
Bupe Coverage months 10-12	26%	63%	100%

Structural adaptations: Policies around restarting bupe



Structural adaptations: Policies around restarting bupe

- Milder OUD, more privilege (e.g., social supports, housing status, financial status), lack of legal issues, lack of other SUDs = greater likelihood of quick stabilization on bupe
- If we limit opportunities to re-engage in care, we apply a selective pressure that benefits the (relatively) more privileged, harms the more vulnerable
- Re-engagements = opportunities for other health care

Cultural adaptations

Maximize psychological safety for our patients

“It’s OK to use heroin, let’s minimize the harms”

“Ok, let’s talk about how you can use heroin and stay on bupe”

“Welcome back!” (for 6th re-start)

Creating welcoming spaces for BIPOC, immigrants, LGBTQI+, non-English speakers

Assessing racism & colonialism embedded with our health structures

Addressing urine tampering while keeping patients engaged

Diversion

30 year old returned for bupe care.

- POC urine tox immunoassay = bupe positive
- Confirmation = Bupe >1500 ng/mL, norbupe 106 ng/mL
- She disclosed dipping bupe into urine, diverting half her supply to her partner, taking the remaining bupe.

Goal is to minimize under-treatment while minimizing diversion

Diversion

- Most diverted buprenorphine gets used for treating opioid withdrawals and treating OUD
- Psychological safety = increased likelihood of an honest picture of use of bupe
- Periodic norbuprenorphine confirmations can add clinical value
- Occasional monitored dosing or pill/film counts can be helpful at times if concerns arise

EXCHANGE SEX, HIV, STIS & THE OPIOID EPIDEMIC

Dr. Shireesha Dhanireddy
Physician, University of Washington Medicine
Medical Director of UW's Madison Clinic, Infectious
Diseases Clinic, & SHE Clinic



Patient Story

- 34 year old woman presents to Aurora Commons (community day space)
- She is living homeless, injects methamphetamines and heroin daily
- Reports having exchanged sex with multiple daily partners (oral and vaginal sex)
- Has new boyfriend x 2 months
- Significant mental health issues with h/o psych hospitalization
- She is concerned about her health – has an abscess on her face but also expresses desire to quit using heroin

Patient Story

- She notes she was tested for HIV 2 months prior while in jail and was negative
- She agrees to STI/HIV testing
- **Rapid test for HIV is positive**

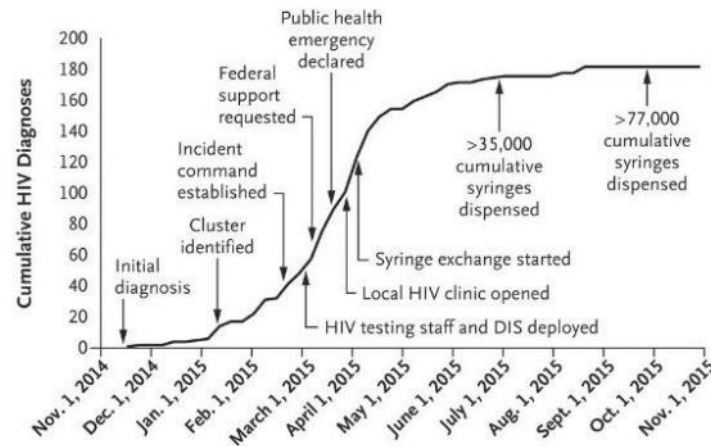
Risk Factors for HIV

Estimated Per-Act Probability of Acquiring HIV from an Infected Source, by Exposure Act*

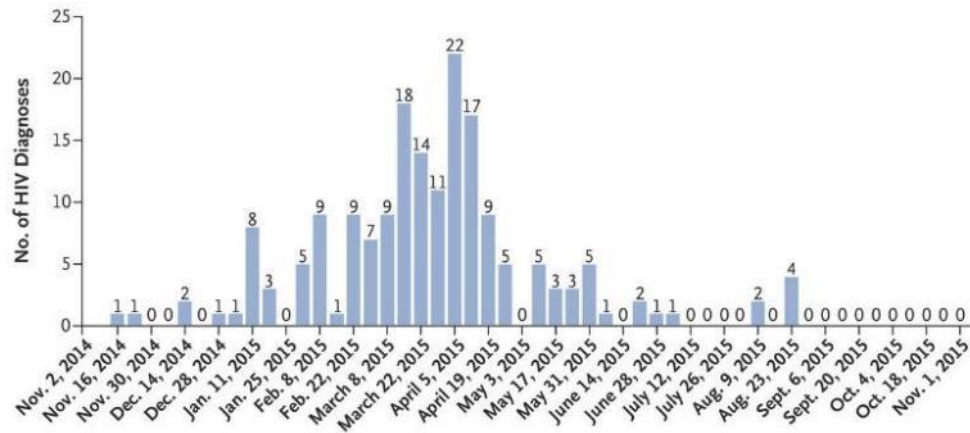
Type of Exposure	Risk per 10,000 Exposures
Parenteral	
Blood Transfusion	9,250
Needle-Sharing During Injection Drug Use	63
Percutaneous (Needle-Stick)	23
Sexual	
Receptive Anal Intercourse	138
Insertive Anal Intercourse	11
Receptive Penile-Vaginal Intercourse	8
Insertive Penile-Vaginal Intercourse	4
Receptive Oral Intercourse	Low
Insertive Oral Intercourse	Low

Outbreak of HIV Infection in Southeast Indiana

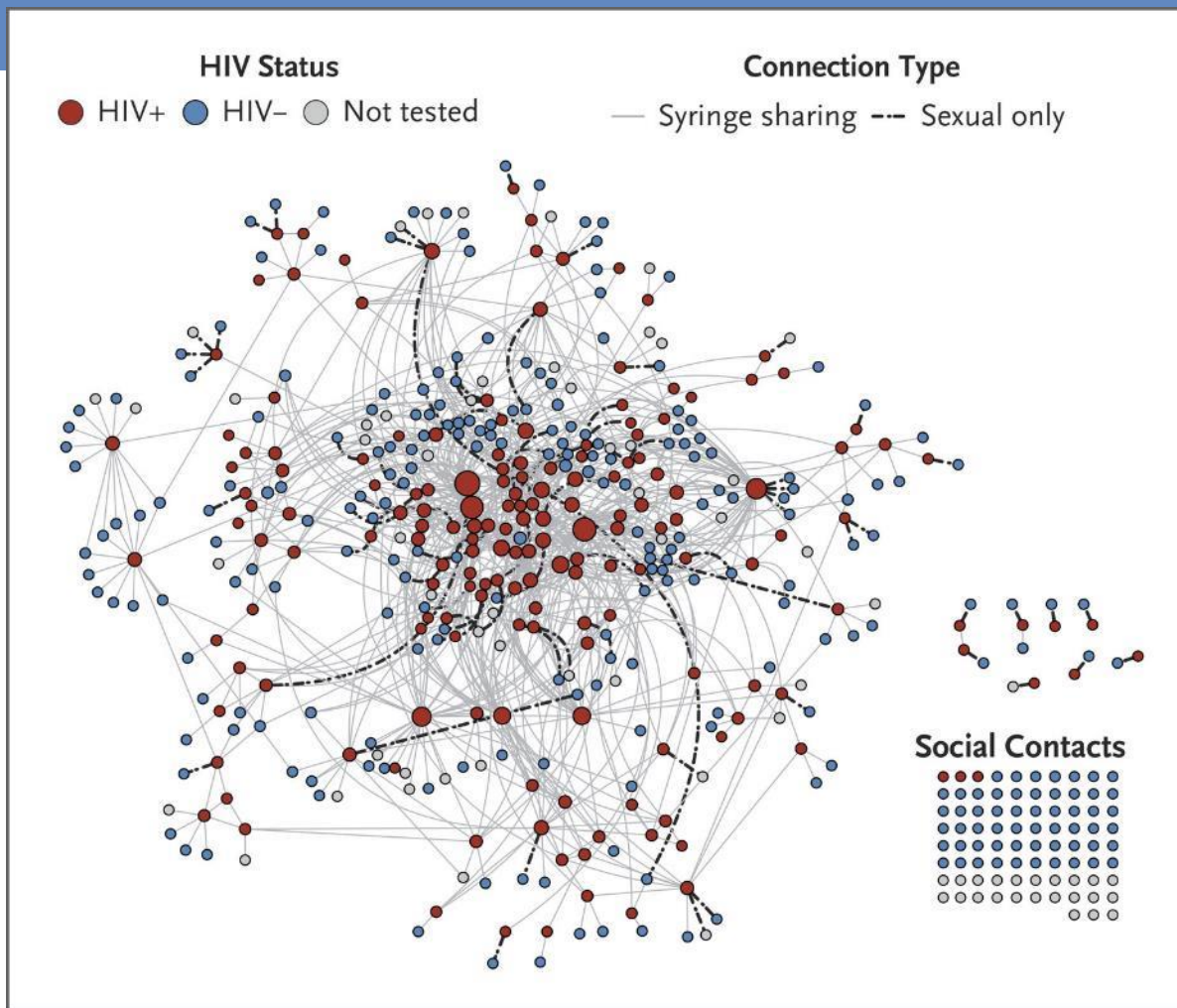
A Cumulative HIV Diagnoses and Public Health Response



B HIV Diagnoses According to Week of Testing

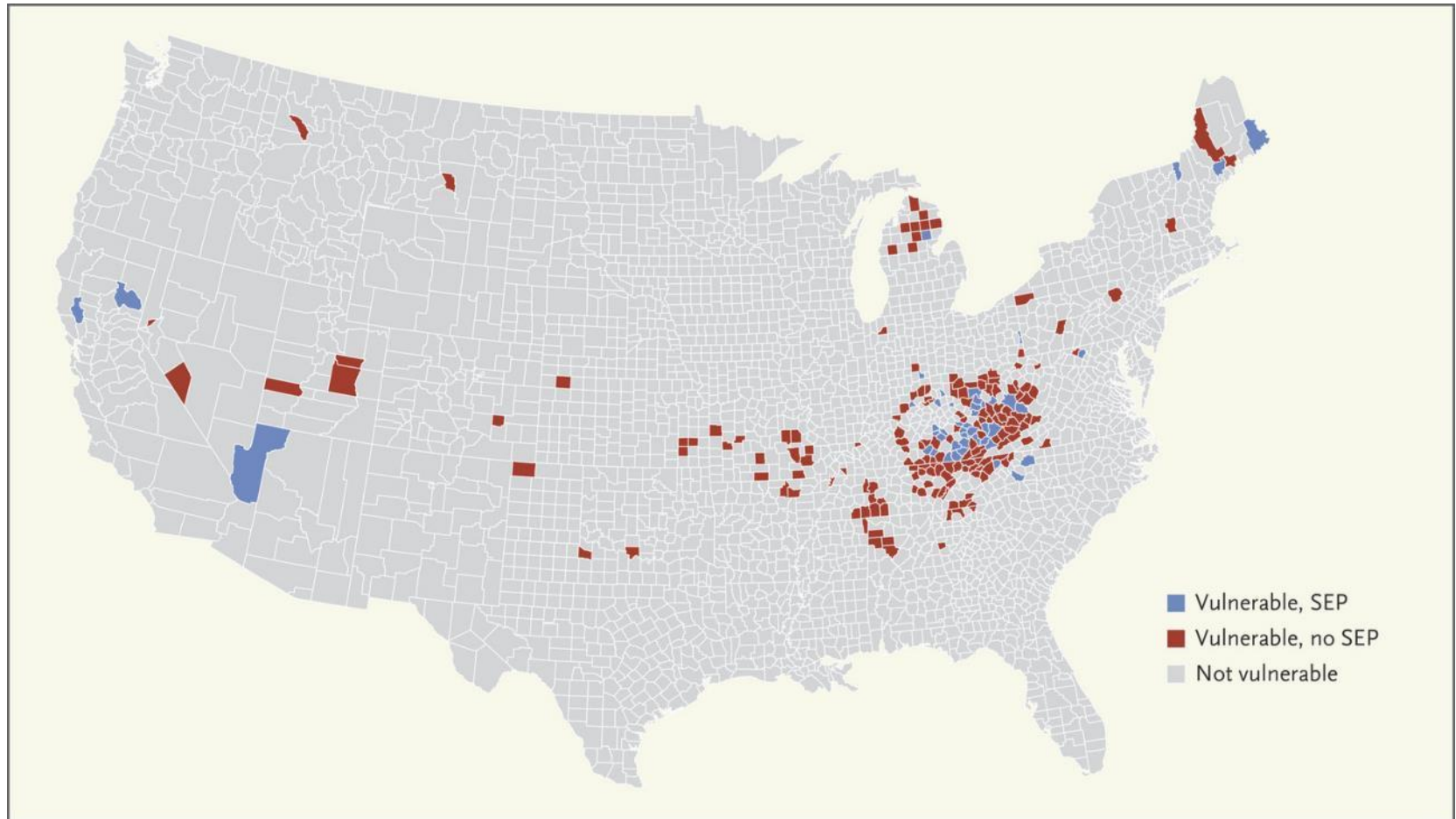


Syringe-Sharing Network



Syringe-sharing Network of Persons with Newly Diagnoses HIV Infection in Indiana Outbreak

County Vulnerability to HIV & HCV and Syringe-Exchange Status

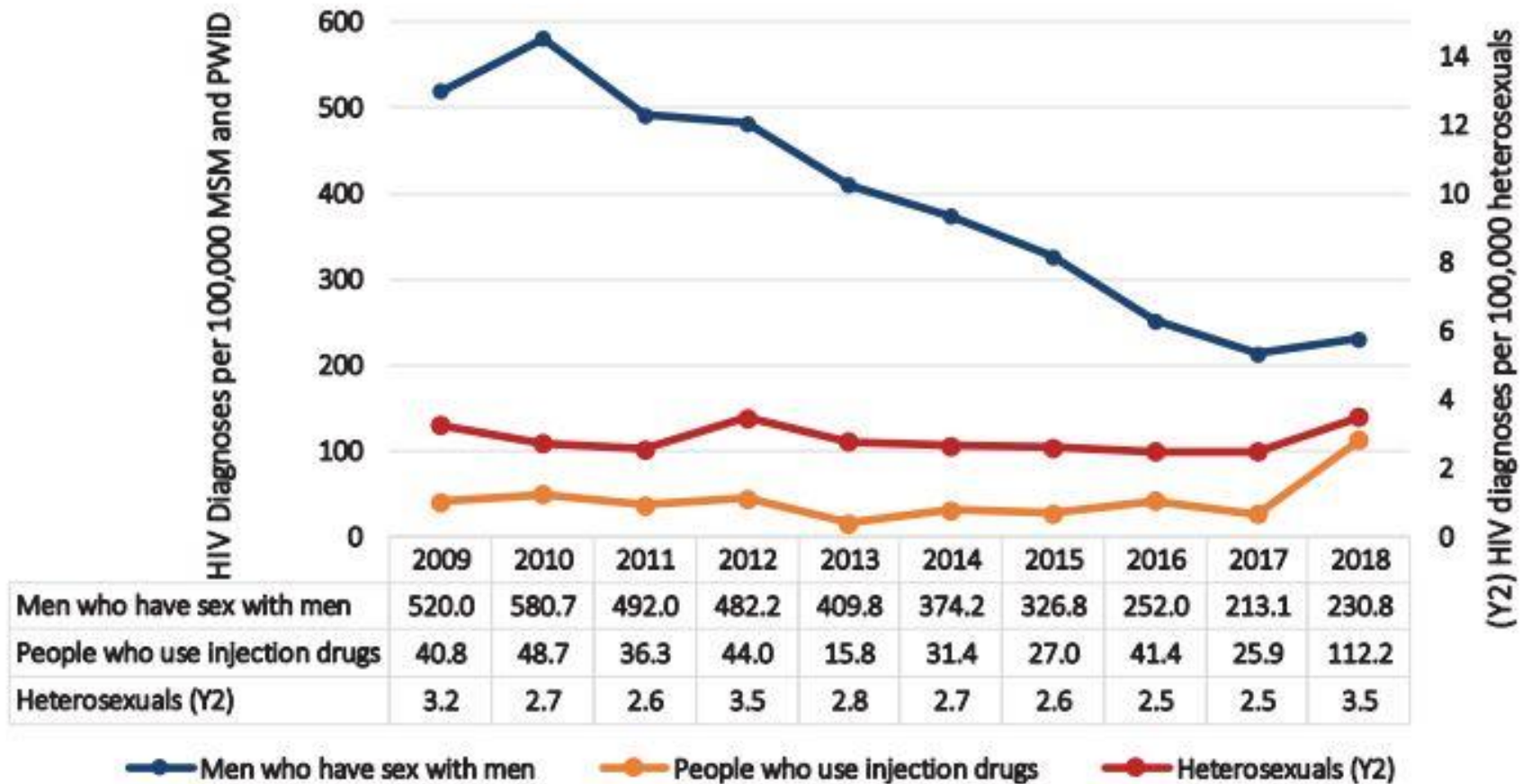


US Counties' Vulnerability to HIV and HCV Outbreaks and Their Syringe-Exchange Program (SEP) Status

Lessons Learned from Indiana

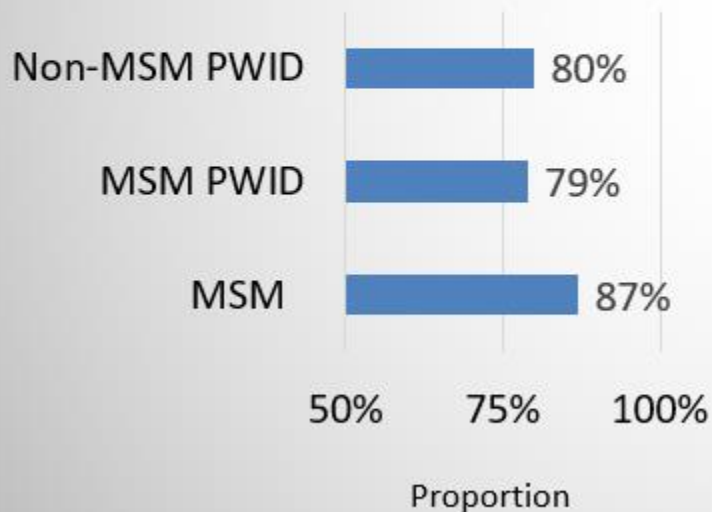
- Need for more rapid response to HIV
- Need for syringe exchange services
- Expanded use of buprenorphine and other opiate agonist therapy

HIV Diagnoses, King County PWID, 2009-18

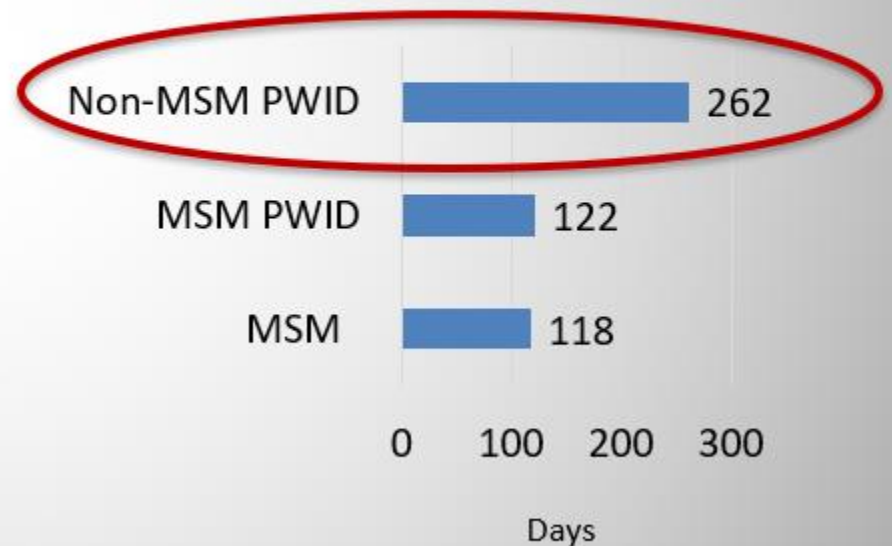


Low Viral Suppression among PWID?

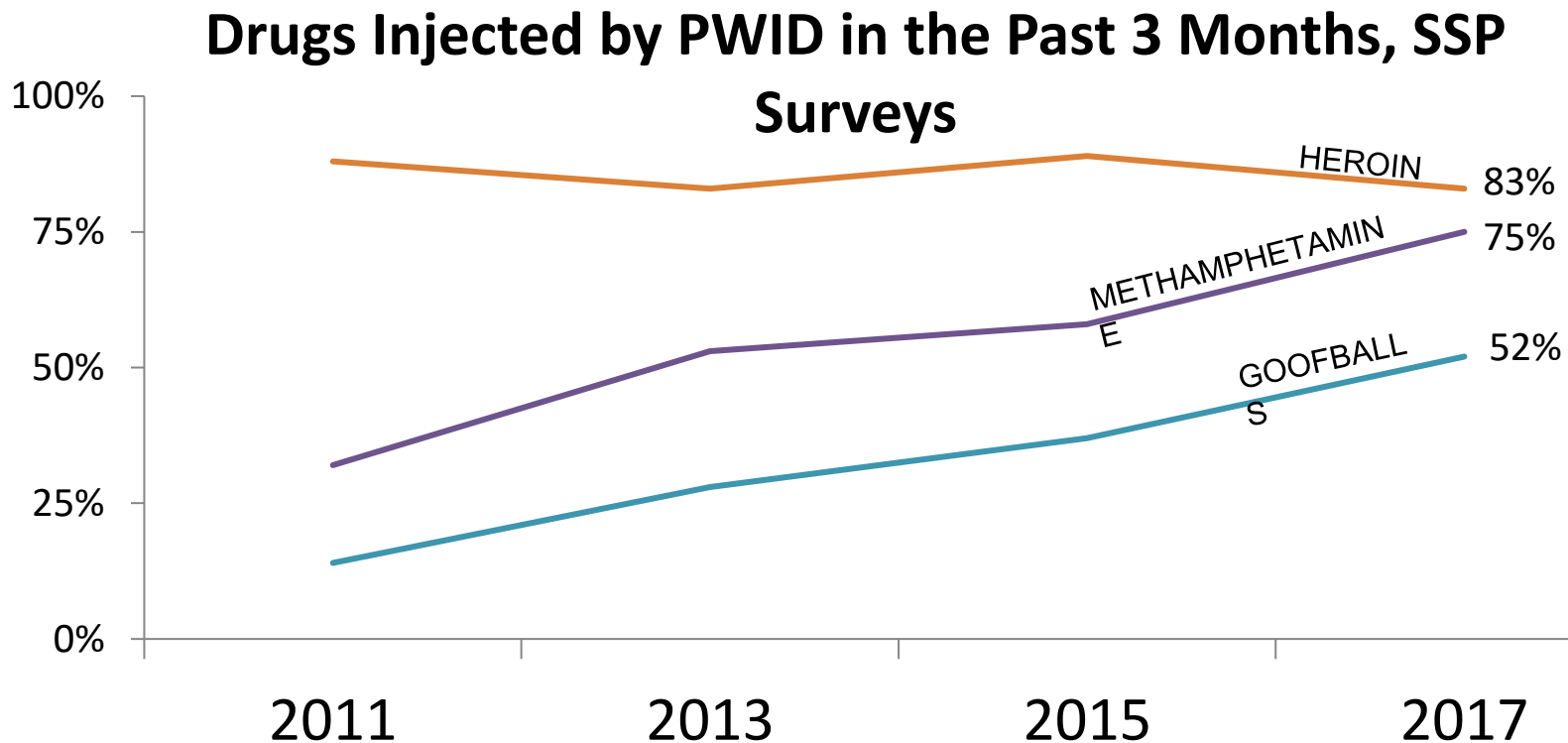
HIV Viral Suppression, 2017



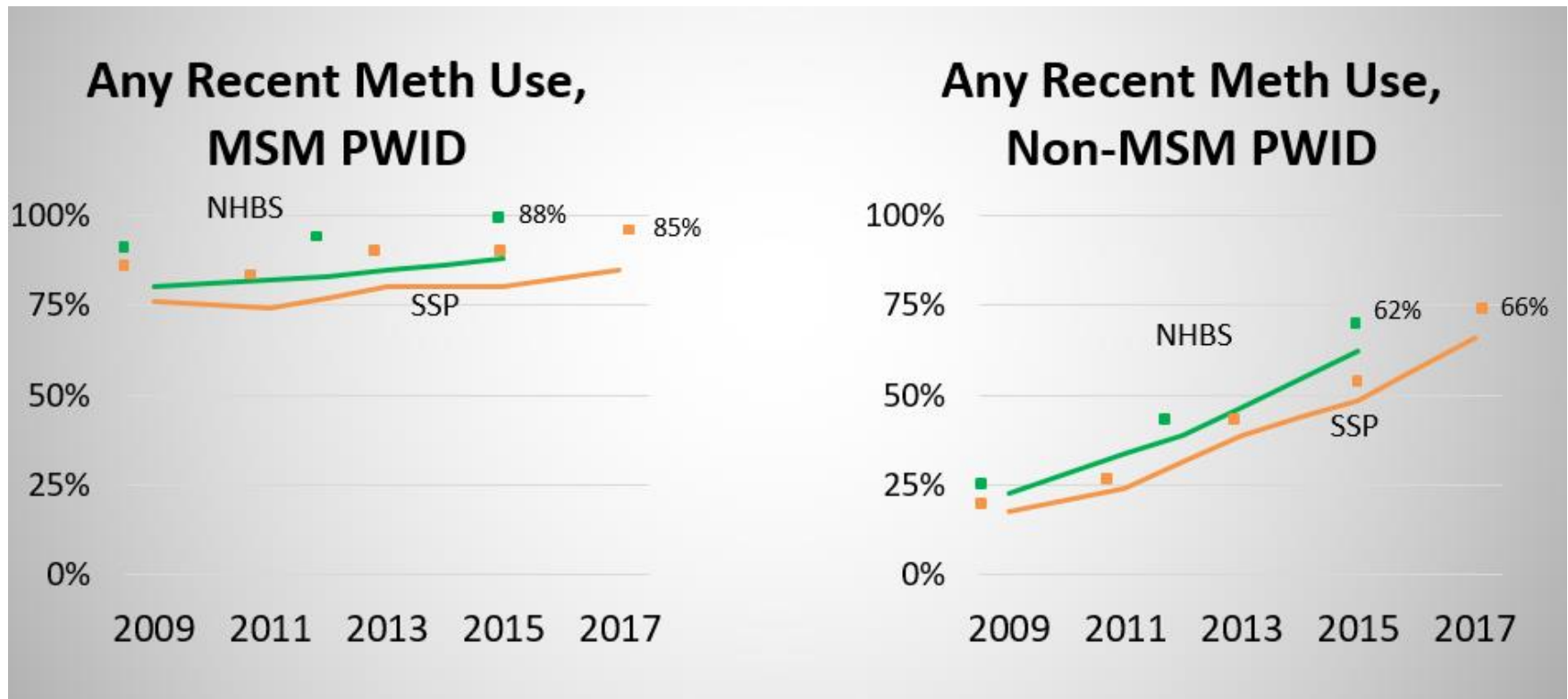
Mean Days to HIV Viral Suppression, 2013-2016



Increasing Methamphetamine Use?



Increasing Methamphetamine Use?

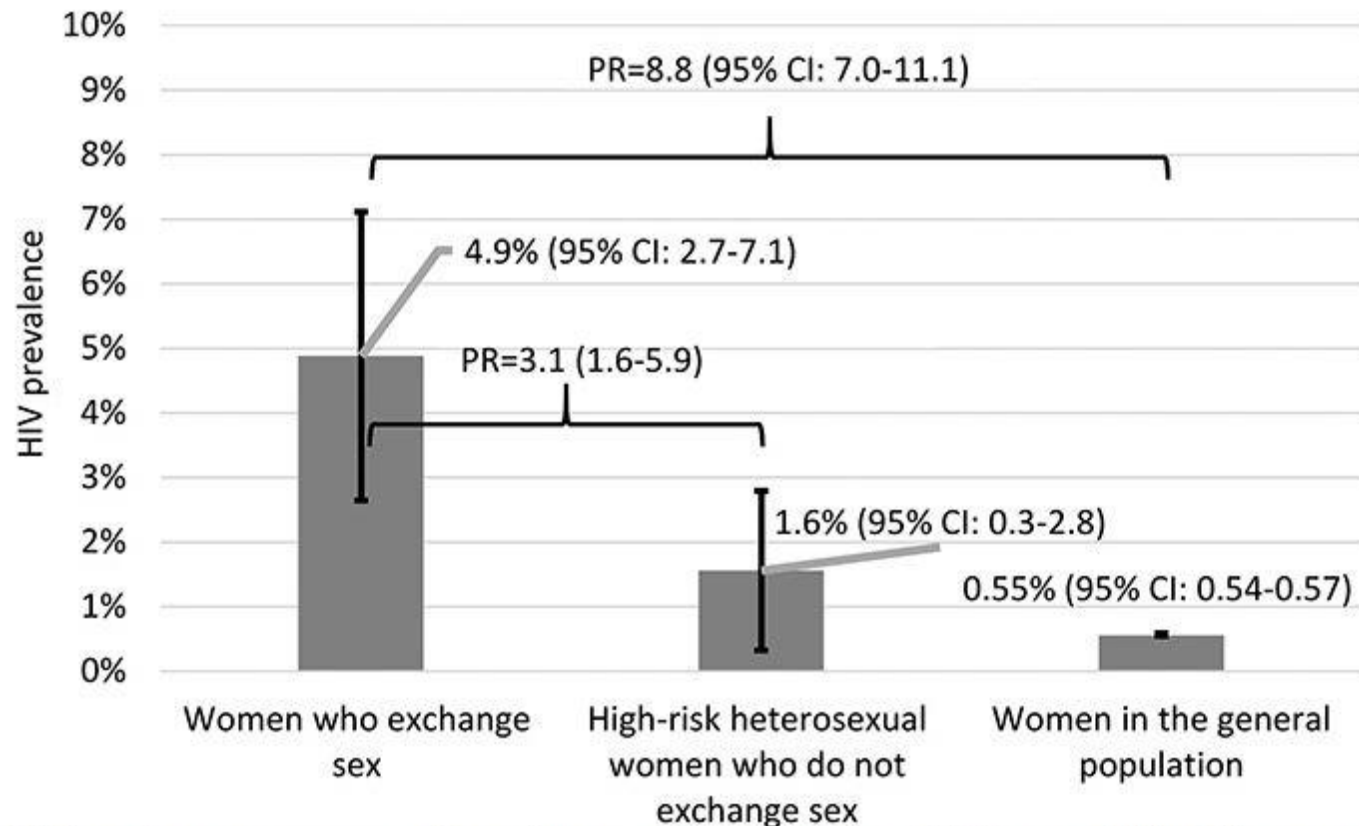


Evidence of Equipment Sharing

PWID who Report Injecting Meth and Sharing Injection Equipment (2009-2015)

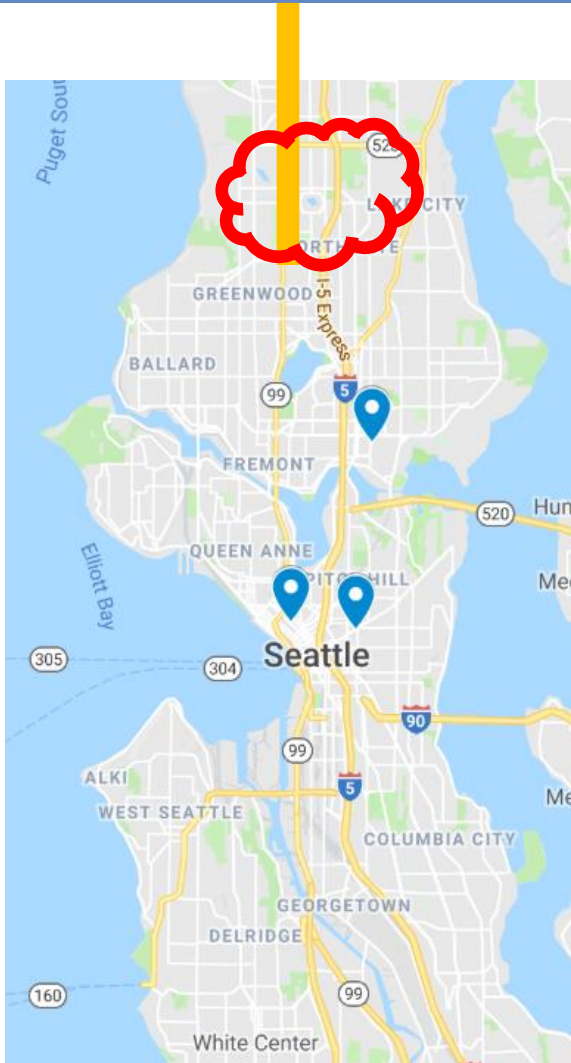


Exchange Sex & HIV



HIV prevalence among women who exchange sex for money or drugs (2016), among high risk heterosexual women who do not exchange sex (2013), and among women in the general population (2015)—Chicago, Detroit, Houston, and Seattle.

Women in Need



- Homelessness
- Exchange sex
- Lack of services
- Stigma



Licton Springs Tiny House Village (photo Seattle Times)

Exchange Sex and HIV

- Overlap of injection drug use and exchange sex increases risk of STIs and HIV
- Increasing number of women engaging in transactional sex in the Seattle area
- Impact of backpage shutdown – higher risk sex

Women of North Aurora

- Qualitative interviews of exchange sex workers on North Aurora found the following
 - All surveyed were opiate dependent
 - Nearly all did not have medical home/PCP
 - Prior interactions with healthcare system were felt to be judgmental and stigmatizing

Women of North Aurora

- Medical needs assessment performed in 2017
 - Most of the women surveyed wanted full primary care
 - Contraception
 - Vaccines
 - Cancer screening
 - Mental health care
 - Buprenorphine-naloxone
 - STI testing/treatment
 - HIV testing
 - HCV testing and treatment
 - Most had not heard of PrEP

S.H.E. Clinic



SHE Clinic Model

- Began 7/2018
- Walk-in
- Partnership with PSCC, AC, WA DOH, PHPDA (Health Equity Fund)
- Primary care clinic for female-identifying persons on North Aurora Avenue
- MD, RN, full time medical case manager

SHE Clinic

Evaluation of the first 50 patients

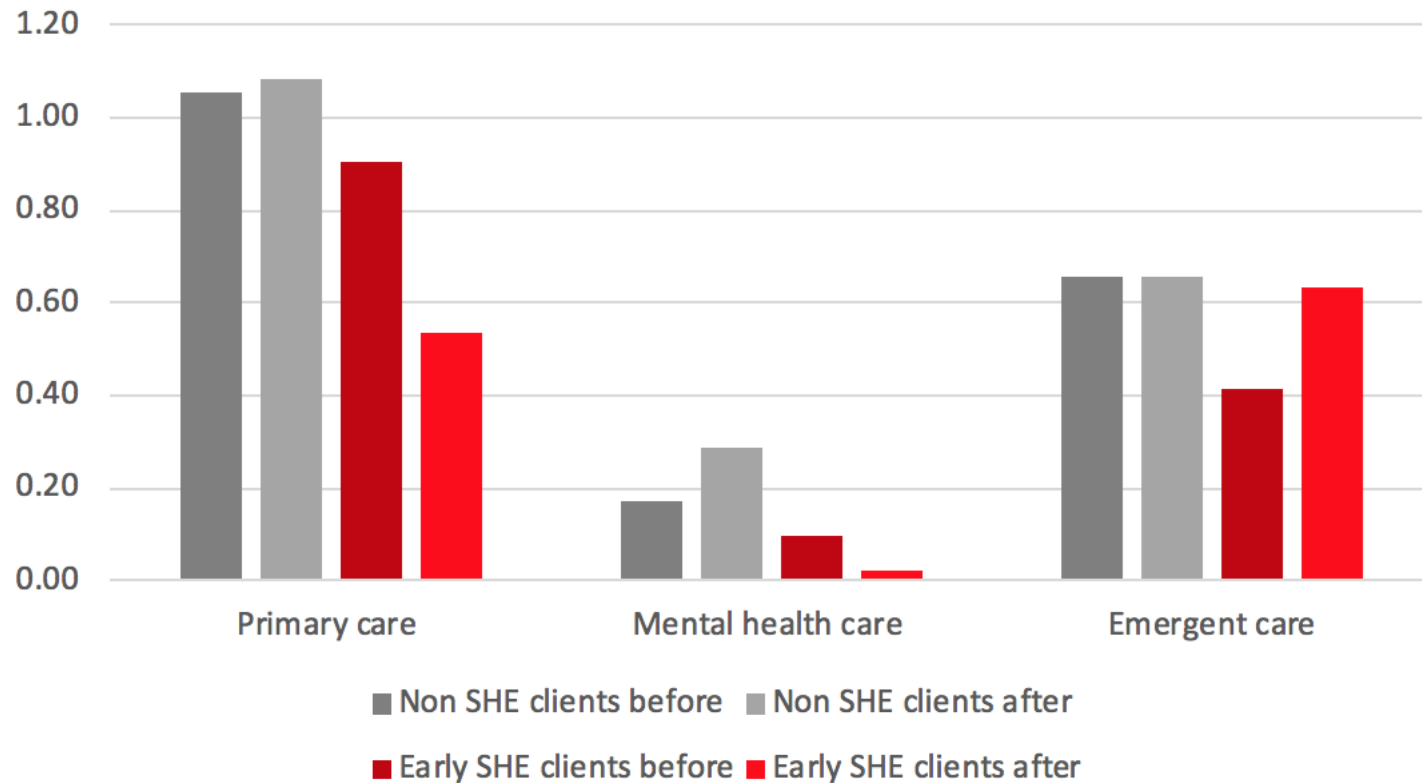
- High STI risk yet none had been tested within 3 months of initial SHE clinic visit
- 29% of women reported condom use
- 50% of women tested were positive for trichomonas
- None reported planning for pregnancy, but 4 with new dx of pregnancy (now up to > 20)
- 42/50 tested for HIV
 - 17 of the HIV negative women initiated PrEP at first visit
- 12 HIV positive women have accessed SHE clinic services but only 3 are in consistent care and on treatment

SHE Clinic – First 50 Patients

Characteristics	Percent Asked About Characteristic or Tested (n)	% Positive (n)
Average age (IQR)	37 (34, 40)	
Racial identity	98.0 (49)	
White		69.4 (34)
Black		22.5 (11)
Native American/Alaskan		2.0 (1)
Asian		0
Other		6.1 (3)
Unstable housing	94.0 (47)	95.7 (45)
Injection drug use	90.0 (45)	80.0 (36)
Transactional sex	90.0 (45)	68.9 (31)
Pregnancy	78.0 (39)	10.3 (4)
Trichomoniasis	46.0 (23)	47.8 (11)
Chlamydia	56.0 (28)	17.9 (5)
Gonorrhea	54.0 (27)	18.5 (5)
Syphilis	26.0 (13)	0
HIV	84.0 (42)	8.5 (4)
Hepatitis C	76.0 (38)	39.5 (15)

SHE Clinic Implementation: Reduction in ED Visits

Visits per woman by complaint and patient group in the 6 months before and after first SHE clinic visit or reference date



Back to Patient Story

- Now 20 months since her diagnosis
- She obtained housing 6 months ago
- Still using meth and heroin daily, but smoking not injecting (and intermittently on buprenorphine/naloxone)
- But, engaged in SHE Clinic and last HIV RNA is undetectable!

Conclusions



- Women living unhoused and exchanging sex are at high risk for HIV and STIs and have frequent contact with ED providers
- In conjunction with a trusted safe space, a co-located clinic model can provide non-judgmental low barrier HIV, STI, and primary care and lead to decreased ED visits

Next Steps



- Expansion of SHE
- Continue to offer low barrier buprenorphine and optimize delivery
- Partnership with Hepatitis Education Project to assist with HCV treatment adherence support
- STI control – point-of-care testing with expedited partner therapy
- Explore fertility desire – need for in depth qualitative exploration of concepts of motherhood and resistance to LARC



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DOH

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Lahai

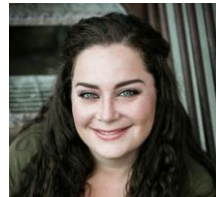
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THANK YOU
to all the
women of
North Aurora



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Questions?

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PCSS Mentoring Program

- PCSS Mentor Program is designed to offer general information to clinicians about evidence-based clinical practices in prescribing medications for opioid use disorder.
- PCSS Mentors are a national network of providers with expertise in **addictions, pain, evidence-based treatment including medications for addiction 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:

<https://pcssNOW.org/mentoring/>

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

Addiction Technology Transfer Center	American Society of Addiction Medicine
American Academy of Family Physicians	American Society for Pain Management Nursing
American Academy of Pain Medicine	Association for Multidisciplinary Education and Research in Substance use and Addiction
American Academy of Pediatrics	Council on Social Work Education
American Pharmacists Association	International Nurses Society on Addictions
American College of Emergency Physicians	National Association for Community Health Centers
American Dental Association	National Association of Social Workers
American Medical Association	National Council for Behavioral Health
American Osteopathic Academy of Addiction Medicine	The National Judicial College
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