PCSS Medications for Opioid Use Disorders | Providers Clinical Support System

PCSS-MOUD Online Case-based Learning Collaborative

Session 4: Multidisciplinary Approach to Assessing Opioid Withdrawal

July 15, 2026 | 5:00 – 6:30 PM ET

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Housekeeping

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- PCSS-MOUD aims to increase the knowledge and skills of healthcare and counseling professionals about available evidence-based treatment approaches for substance use disorder (SUD) with a particular focus on opioid use disorder (OUD). PCSS-MOUD provides free training and mentoring to practitioners on the use of medications for OUD (MOUD) and the integration of these services into mainstream health care.

Funding for this initiative was made possible by cooperative agreement no. 1H79TI086770 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.



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Disclosure to Learners

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All disclosures have been reviewed, and there are no relevant financial relationships with ineligible companies to disclose.

All speakers have been advised that any recommendations involving clinical medicine must be based on evidence that is accepted within the profession of medicine as adequate justification for their indications and contraindications in patient care. All scientific research referred to, reported, or used in the presentation must conform to the generally accepted standards of experimental design, data collection, and analysis.



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Participation Ground Rules

- Please participate!
- Everyone's experiences differ: Assume the best intentions.
- Monitor your participation: Everyone is accountable.
- If someone says something that is not your understanding of the evidence, ask questions and do so respectfully.



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Poll:

Which role do you primarily serve in the assessment and management of opioid withdrawal?

Respond in the Zoom poll that will pop up on your screen



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Agenda

1. Welcome & Introduction
2. Didactic Presentations
3. Facilitated Case Discussion
4. Learner Case Discussion & Q&A
5. Wrap-up & Announcements



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Educational Objectives

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

1. Introduce validated tools to assess opioid withdrawal
2. Discuss the role of a clinician, pharmacist, and social worker in assessing opioid withdrawal
3. Define the differences for assessment and scope between inpatient and outpatient settings
4. Discuss case examples of opioid withdrawal syndrome, highlighting common challenges, gaps in evidence, and practical approaches



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Session Panel



Debra Newman, PA C, MPAS, MPH



Emily Casey, PharmD, BCPMP



Elsa Dahan, LSW

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Clinician Role & Perspective

Debra Newman, PA-C, MSPAS, MPH



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Clinician Key Areas of Focus

1. **Screen**
   - Identify disease and withdrawal risk, including signs and symptoms
2. **Assess**
   - Utilize appropriate assessment tools (e.g., COWS)
   - Treat withdrawal symptoms (body aches, GI disturbances, anxiety, insomnia, etc.)
   - Understand clinical risks (polysubstance use, infectious disease, unintentional overdose following withdrawal)
3. **Treat**
   - Employ evidence-based treatment, including medications for opioid use disorder (MOUD)
4. **Ensure**
   - Continuity of care to reduce overdose and save lives.



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Clinician Key Areas of Focus

Failure to recognize and treat withdrawal can lead to serious complications, including overdose and death, so prompt evaluation and treatment are key.

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Clinical Opiate Withdrawal Scale (COWS)

- Validated, clinician-administered tool used to assess the severity of opioid withdrawal based on observable signs and symptoms.
- Helps guide treatment decisions, including initiation and adjustment of medications for opioid use disorder (MOUD).
- Can quantify severity at a given moment; does not replace clinical judgment.

COWS Wesson & Ling, J Psychoactive Drugs. 2003 Apr-Jun;35(2):253-9.
Clinical Opiate Withdrawal Scale

Resting Pulse Rate: _____beats/minute *Measured after patient is sitting or lying for one minute* 0 Pulse rate 80 or below 1 Pulse rate 81-100 2 Pulse rate 101-120 4 Pulse rate greater than 120	GI Upset: *over last 1/2 hour* 0 No GI symptoms 1 Stomach cramps 2 Nausea or loose stool 3 Vomiting or diarrhea *5* Multiple episodes of diarrhea or vomiting
Sweating: *over past 1/2 hour not accounted for by room temperature or patient activity.* 0 No report of chills or flushing 1 Subjective report of chills or flushing 2 Flushed or observable moistness on face 3 Beads of sweat *on* brow or face 4 Sweat streaming off face	Tremor *observation of outstretched hands* 0 No tremor 1 Tremor can be felt, but not observed 2 Slight tremor observable 4 Gross tremor or muscle twitching
Restlessness *Observation during assessment* 0 Able to sit still 1 Reports difficulty sifting still, but is able to do so 3 Frequent shifting or extraneous movements of legs/arms *5* Unable to sit still for more than a few seconds	Yawning *Observation during assessment* 0 No yawning 1 Yawning once or twice during assessment 2 Yawning three or more times during assessment 4 Yawning several times/minute
Pupil size 0 Pupils pinned or normal size for room light 1 Pupils possibly larger than normal for room light 2 Pupils moderately dilated *5* Pupils so dilated that only the rim of the iris is visible	Anxiety or irritability 0 None 1 Patient reports increasing irritability or anxiousness 2 Patient obviously irritable anxious 4 Patient so irritable or anxious that participation in the assessment is difficult
Bone or Joint aches *If patient was having pain previously, only the additional component attributed to opiates withdrawal is scored* 0 Not present 1 Mild diffuse discomfort 2 Patient reports severe diffuse aching of joints/ muscles 4 Patient is rubbing joints or muscles and is unable to sit still because of discomfort	Gooseflesh skin 0 Skin is smooth 3 Piloerrection of skin can be felt or hairs standing up on arms *5* Prominent piloerrection
Runny nose or tearing *Not accounted for by cold symptoms or allergies* 0 Not present 1 Nasal stuffiness or unusually moist eyes 2 Nose running or tearing 4 Nose constantly running or tears streaming down cheeks	Total Score _____ The total score is the sum of all 11 items Initials of person completing Assessment:_____

Score: 5-12 mild; 13-24 moderate; 25-36 moderately severe; more than 36 = severe withdrawal

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Subjective Opiate Withdrawal Scale (SOWS)

- Validated, self-administered scale for grading intensity of opioid withdrawal symptoms
- Higher summed scores indicate greater withdrawal severity.
- Commonly used in outpatient settings

Subjective Opiate Withdrawal Scale (SOWS)

Instructions: We want to know how you're feeling. In the column below today's date and time, use the scale to write in a number from 0-4 about how you feel about each symptom right now.

Scale: 0 = not at all 1 = a little 2 = moderately 3 = quite a bit 4 = extremely

DATE						
TIME						
SYMPTOM		SCORE	SCORE	SCORE	SCORE	SCORE
1	I feel anxious					
2	I feel like yawning					
3	I am perspiring					
4	My eyes are tearing					
5	My nose is running					
6	I have goosebumps					
7	I am shaking					
8	I have hot flushes					
9	I have cold flushes					
10	My bones and muscles ache					
11	I feel restless					
12	I feel nauseous					
13	I feel like vomiting					
14	My muscles twitch					
15	I have stomach cramps					
16	I feel like using now					
TOTAL						

Mild Withdrawal = score of 1 – 10
Moderate withdrawal = 11 – 20
Severe withdrawal = 21 – 30

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Pharmacist Role & Perspective

Emily Casey, PharmD, BCPMP



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Pharmacist Key Areas of Focus

Complex Medication Management

- Acute polysubstance withdrawal
- Pain management in patients with substance use
- Review of medication profile for drug-drug and drug-disease interactions
- Medication adjustments based on renal and hepatic function

Direct Patient Care

- Assessment of withdrawal severity
- Counseling for new medications
- Initiation of long-acting injectable MOUD



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Pharmacist Key Areas of Focus

- **Drug Shortages**
  - Frequent shortages of opioids and benzodiazepines
  - Stewardship
  - Substitutions
- **Transitions of Care**
  - Dependent on inpatient vs outpatient role
  - Ensure inpatient medications are covered by prescription plan & accessible
  - Communicate with providers and pharmacies
- **Guideline and Policy Writing**
  - Align across community to ensure best practices are implemented



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Social Worker Role & Perspective

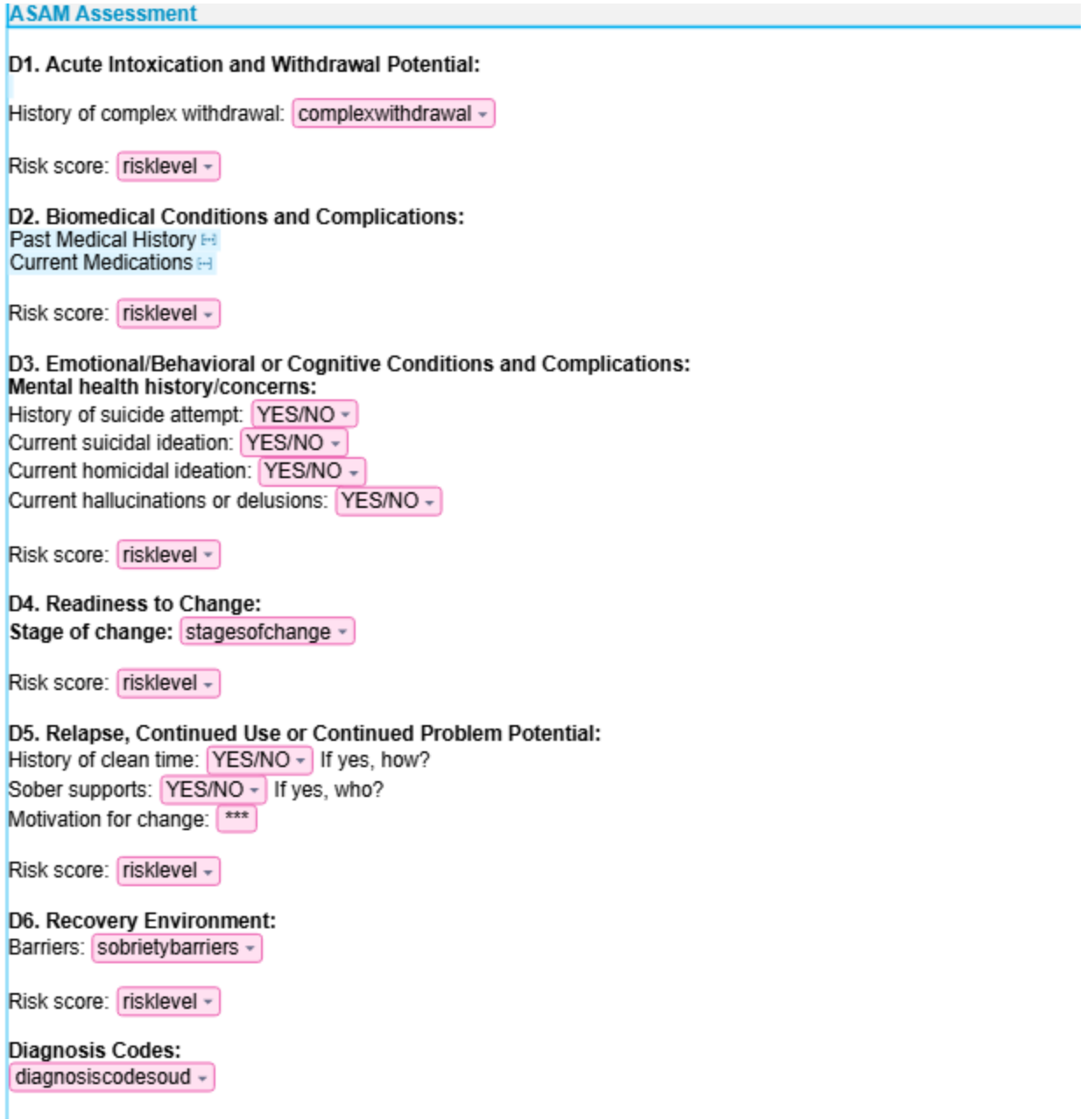
Elsa Dahan, LSW



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Social Work Key Areas of Focus

- **Psychosocial assessment with ASAM lens**
  - Acute intoxication and withdrawal potential
  - Biomedical conditions and complications
  - Emotional/Behavioral
  - Readiness to change
  - Relapse/Continued Use or Continued Problem potential
  - Recovery Environment



ASAM Assessment

D1. Acute Intoxication and Withdrawal Potential:

History of complex withdrawal: complexwithdrawal

Risk score: risklevel

D2. Biomedical Conditions and Complications:
Past Medical History
Current Medications

Risk score: risklevel

D3. Emotional/Behavioral or Cognitive Conditions and Complications:
Mental health history/concerns:
History of suicide attempt: YES/NO
Current suicidal ideation: YES/NO
Current homicidal ideation: YES/NO
Current hallucinations or delusions: YES/NO

Risk score: risklevel

D4. Readiness to Change:
Stage of change: stagesofchange

Risk score: risklevel

D5. Relapse, Continued Use or Continued Problem Potential:
History of clean time: YES/NO If yes, how?
Sober supports: YES/NO If yes, who?
Motivation for change: ***

Risk score: risklevel

D6. Recovery Environment:
Barriers: sobrietybarriers

Risk score: risklevel

Diagnosis Codes:
diagnosiscodesoud

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Social Work Key Areas of Focus

- **Key areas of focus for discharge planning**
  - Discharge dispositions and factors considered
    - Inpatient rehab: typically 30 days if covered by medicaid, patient will stay at facility and participate in groups and get support with their MAT and recovery housing after they leave rehab
      - Medical complexity
      - Patient preference (city vs outside of city, past experiences etc)
    - Home with MAT
      - Methadone vs. Suboxone
      - Insurance
    - Skilled Nursing Facility:
      - Wound care/IV antibiotics/PT/OT
      - Insurance and MAT



Case #1: Inpatient Setting

45-year-old man

Unhoused, history of incarceration

Fentanyl, smoking, up to 2g daily, using for 10 years

OUD diagnosis, no other medical conditions

Frequently admitted for withdrawal, declines treatment

Veteran, history of psychiatric trauma from service and ACES, unresolved, never been in treatment for trauma

Does not want buprenorphine, diversion risk (sells it), methadone works for him

Has not shown at intake appointments, previously insured outside of state



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Discussion question:

From your role's perspective, how would you assess and treat this patient?

Put your role (PA-C, MD, SW, etc) in chat along with your response



Case #2: Outpatient Setting

32-year-old woman

Uses non-prescribed opioids, ~60 mg OxyContin daily for 2 to 3 years

Works full-time in hotel housekeeping, motivated to remain functional and continue working

Prior buprenorphine treatment was helpful, requests to restart buprenorphine

Avoids hospital care due to prior negative experiences and prefers outpatient management



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Discussion question:

From your role's perspective, how would you assess and treat this patient?

Put your role (PA-C, MD, SW, etc) in chat along with your response



Case #3: Outpatient Setting + Custody

56-year-old man

In custody at a county correctional facility, transferred to an outpatient facility for opioid withdrawal management, custody staff report increasing agitation, poor sleep, and repeated requests for care

15-year history of OUD, heroin IV injection, ~8–10 bags daily for the past 5 years, intermittent cocaine use several times per week

Last opioid use ~36 hours before admission, shortly before arrest, reports severe cravings and inability to tolerate symptoms

Several overdoses requiring naloxone in the community in the past month

Has been on methadone and buprenorphine in the past, no longer motivated for MOUD (e.g., belief MOUD is trading one drug for another, MOUD more addictive than fentanyl and heroin, etc.).



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Discussion question:

From your role's perspective, how would you assess and treat this patient?

Put your role (PA-C, MD, SW, etc) in chat along with your response



Case #4: Inpatient Setting with Surgical Need

36-year-old woman

Fentanyl, smoking, up to 1g daily, using for 3 years

OUD diagnosis, admitted for treatment of acute withdrawal and endocarditis

Interested in buprenorphine, has a period of 4 years in remission from OUD in the past when on buprenorphine

Endocarditis treatment will include valve replacement which will require median sternotomy



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Discussion question:

From your role's perspective, how would you assess and treat this patient?

Put your role (PA-C, MD, SW, etc) in chat along with your response



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Wrap-up

- ✓ **Evaluation:** Please complete this quick evaluation: https://ttc-gpra.org/P?s=630853
- ✓ **Claim CE:** Complete a quick post-test and claim your 1.5 CE https://elearning.asam.org/p/PCSSMOUD_Session4_07152026
- ✓ **Recording:** The recording will be available at: https://elearning.asam.org/oud-learning-collaboratives

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Watch the Recordings of the Rest of this Series on Opioid Withdrawal!

ASAM-hosted PCSS-MOUD Online Case-based Learning Collaboratives:

Session 1	**Strategies to Effectively Manage Opioid Withdrawal** *Recording Available*
Session 2	**Strategies to Effectively Manage Complicated Opioid Withdrawal in the Emergency Department or Hospital Setting** *Recording Available*
Session 3	**Managing Opioid Withdrawal in the Era of Medetomidine** *Recording Available*

- *Free!*
- *1.5 CE each*
- *Watch the recordings*



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PCSS-MOUD Steering Committee

- PCSS-MOUD is led by the American Academy of Addiction Psychiatry (AAAP), in collaboration with a coalition of national professional and healthcare organizations.

Learn more about the Steering Committee and its partner organizations: **https://pcssnow.org/about/steering-committee/**



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PCSS-MOUD Mentoring Program

- Designed to offer general information to clinicians about evidence-based clinical practices in prescribing medications for opioid use disorder (MOUD).
- Supported by a national network of providers with expertise in addictions, pain, and evidence-based treatment, including MOUD.
- Three mentoring options are available to meet your needs.
- No cost to participate.



For more information visit:
https://pcssNOW.org/mentoring/

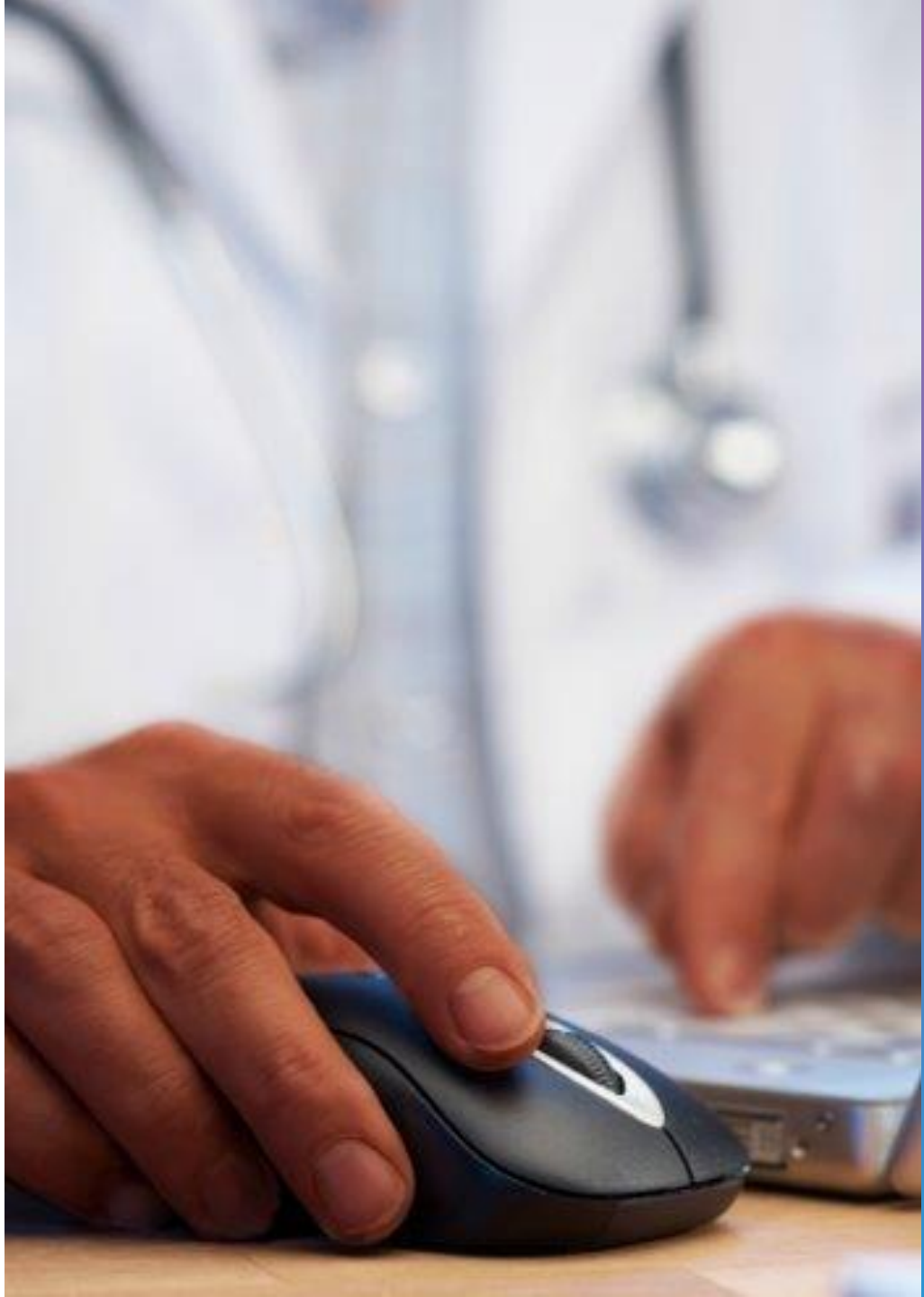
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1: Discussion Forum

- An online discussion forum moderated by addiction specialists where health professionals can post questions and receive answers from clinical experts and other colleagues.

Register here at no cost!

For more information visit:
https://pcssNOW.org/mentoring/



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2: Ask a Clinical Question

- A simple and direct way to receive an answer related to Substance Use Disorder, Opioid Use Disorder, and other related topics. Designed to provide a prompt response to clinical questions via email.

Submit your clinical question

For more information visit:
https://pcssNOW.org/mentoring/



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3: One-on-One Mentoring

- Provides individualized, one-on-one guidance via email, phone, or in-person (if feasible), to discuss specific clinical issues. Members are “matched up” with one of our mentors in their region. This is the most in-depth of the three PCSS-MOUD mentoring tools. Please contact **pcssmentoring@aaap.org** to receive a mentor request form.

Browse our Mentors

For more information visit:
https://pcssNOW.org/mentoring/



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