Compass SHARP

Caring for Patients with Substance Use Disorders in the Perioperative Space

Dr. Rachael Duncan, PharmD, BCPS, BCCCP

June 11th, 2025

Housekeeping

- Who's in the room today? (Name, organization, role)
- To eliminate any background noise during today's presentation your audio has been muted upon entry.
- We encourage questions and open discussion. You can unmute your audio to engage verbally or through the Chat box.
- This event is being recorded.

Compass Healthcare Collaborative
Financial Disclosure, Mitigation of Financial Relationships, Accreditation, & Credit Designation

- The Compass Healthcare Collaborative (Compass) is committed to providing CME that is balanced, objective, and evidenced-based. In accordance with the Accreditation Council for Continuing Medical Education Standards for Integrity and Independence all parties involved in content development are required to disclose all conflicts of interest with ACCME defined ineligible companies.
- Compass Healthcare Collaborative have identified, reviewed, and mitigated all conflicts of interest that speakers, authors, course directors, planners, peer reviewers, or relevant staff disclosed prior to the delivery of any educational activity.
- The CME planning committee who are in a position to control the content of this CME Activity, have no relevant financial relationships with ineligible companies to disclose.
- Compass Healthcare Collaborative have identified, reviewed, and mitigated all conflicts of interest that speakers, authors, course directors, planners, peer reviewers, or relevant staff disclosed prior to the delivery of any educational activity. Remaining persons in control of content have no relevant financial relationships.

Accreditation
This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Iowa Medical Society (IMS). Compass Healthcare Collaborative is accredited by the IMS to provide continuing medical education for physicians.
Credit Designation
Compass Healthcare Collaborative designates this live activity for a maximum of **0.5** *AMA PRA Category 1 Credit™*. Physicians should claim only the credit commensurate with the extent of their participation in the activity.
Commercial Support
This Activity was developed without support from any ineligible company.*The ACCME defines ineligible companies as those whose primary business is producing, marketing, selling, re-selling, or distributing healthcare products used by or on patients. Note: The ACCME does not consider providers of clinical service directly to patients to be commercial interests – unless the provider of clinical services is owned, or controlled by, and ACCME defined ineligible company.
Disclosure: Compass adheres to the Standards for Integrity and Independence in Accredited Continuing Education. The content of this activity is not related to products or the business lines of an ACCME-defined ineligible company. None of the planners or moderators for this educational activity have relevant financial relationships to disclose with ineligible companies whose primary business is producing, marketing, selling, re-selling, or distributing products used by or on patients.

Note: *After participating in our event, you will receive a Certificate of Attendance detailing the number of AMA PRA Category 1 Credits™ you can claim. This certificate does not automatically award continuing education credit, it is provided for self-reporting requirements and must be submitted to your respective state board for license renewal. Thank you for your attention to this matter, and feel free to reach out to Amber Rizzo at rizzoa@compasshcc.org if you have further questions.*

Introducing

Rachael Duncan, PharmD BCPS BCCCP

Senior Consultant

Stader Opioid Consultants

Objectives

Compass SHARP

1. Describe the unique challenges and considerations in managing patients with substance use disorders (SUD) throughout the perioperative period, including pre-operative assessment, intraoperative management, and post-operative recovery.
2. Identify strategies for effectively screening, assessing, and managing patients with SUD undergoing surgical procedures, including addressing withdrawal symptoms, pain management, and potential drug interactions.
3. Discuss ethical and legal considerations related to caring for patients with SUD in the perioperative setting, including patient confidentiality, informed consent, and strategies for reducing stigma and promoting a non-judgmental approach.

Substance Use Disorder

Compass SHARP

- Definition of SUD (DSM-5 criteria)[1]
  - Impaired control
  - Physical dependence
  - Social problems
  - Risky use

1) Hasin DS, et al. Am J Psychiatry. 2013;170(8):834-51.

Prevalence of Substance Use

- Prevalence of "unhealthy substance use" among patients undergoing elective surgery = 40%[2]
  - Illicit drugs (20.1%)
    - Opioids, stimulants, cannabis
  - Alcohol (18.7%)
  - Tobacco (13.7%)
  - Prescription medications (4.5%)
- Associated with higher scores for pain, average overall pain, and mental health scores for anxiety and depression

2) Fernandez AC et al. Ann Surg. 2023;278(4):e740-e744.

Substance Use & Surgical Outcomes

Compass SHARP

- Tobacco[3] → wound complications, infections, pulmonary complications, neurological complications, and Intensive Care Unit (ICU) admission
- Alcohol[4, 5] → infections, wound complication, ICU admission; very heavy use linked to postoperative mortality
- Cocaine[6] → risks for anesthesia, life threatening dysrhythmias and MI posing anesthesia risk
- Opioids[7, 8] → uncontrolled pain, respiratory depression, opioid dose escalation, overdose after surgery
- Cannabis[9, 10] → Cardiovascular (CV) effects, higher pain and opioid use

3) Gronkjaer M, et al. Ann Surg.2014. 259(1): 52-71.
4) Bradley KA, et. J Gen Intern Med. 2011;26(2):162–169.
5) Harris AHS, et al. J Bone Joint Surg Am. 2011;93(4):321–327.
6) Kim ST, et al. Int J Mol Sci. 2019;20(3).
7) Mitra S, et al. Anesthesiology. 2004;101(1):212–227.
8) Ladha KS, et al. JAMA. 2018;320(5):502–504.
9) Goel A, et al. Anesthesiology. 2020;132(4):625–635.
10) McGuinness B, et al. J Vasc Surg. 2021;73(4):1376–1387.e3.

Pre-operative Considerations

- Thorough patient history, including substance use
- Screening tools
  - Alcohol Use Disorders Identification Test (AUDIT)-C, AUDIT-C+2, Drug Abuse Screening Test (DAST)-10, Cut down, Annoyed, Guilty, and Eye-opener (CAGE) questionnaire, Tobacco, Alcohol, Prescription medication, and other Substance use (TAPS)
- Assessing risk of withdrawal
- Anesthesia considerations
- Coordination with addiction specialists if needed

Sample Questionnaires

Compass SHARP

Alcohol

Scoring:
A total of 5+ indicates increasing or higher risk drinking.
An overall total score of 5 or above is AUDIT-C positive.

TOTAL

Questions	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	1 -2	3 - 4	5 - 6	7 - 9	10+	
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

Questions	Scoring system					Your score
	0	1	2	3	4	
How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Have you or somebody else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year	

Scoring: 0 – 7 Lower risk, 8 – 15 Increasing risk, 16 – 19 higher risk, 20+ possible dependence

TOTAL

PTO

The Scale

The following questions concern information about your potential involvement with drugs, **excluding alcohol and tobacco,** during the past **4 weeks**.

When the words "drug abuse" are used, they mean the use of prescribed or over-the-counter medications/drugs in excess of the directions and any non-medical use of drugs. The various classes of drugs may include: cannabis (e.g., marijuana, hash), solvents, tranquilizers (e.g., Valium), barbiturates, cocaine, stimulants (e.g., speed), hallucinogens (e.g., LSD) or narcotics (e.g., heroin). Remember that the questions do not include alcohol or tobacco.

These questions refer to the past 4 weeks.

1. Have you ever used drugs other than those required for medical reasons? A = *Yes* B = *No*	6. Does your spouse (or parents) ever complain about your involvement with drugs? A = *Yes* B = *No*
2. Do you abuse more than one drug at a time? A = *Yes* B = *No*	7. Have you neglected your family because of your use of drugs? A = *Yes* B = *No*
3. Are you always able to stop using drugs when you want to? (If never used drugs, answer "Yes") A = *Yes* B = *No*	8. Have you engaged in illegal activities in order to obtain drugs? A = *Yes* B = *No*
4. Have you had "blackouts" or "flashbacks" as a result of drug use? A = *Yes* B = *No*	9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs? A = *Yes* B = *No*
5. Do you ever feel bad or guilty about your drug use? (If never used drugs, choose "No".) A = *Yes* B = *No*	10. Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding, etc.)? A = *Yes* B = *No*

Scoring the DAST-10

In these statements, the term "drug abuse" refers to the use of medications at a level that exceeds the instructions, and/or any non-medical use of drugs. Patients receive 1 point for every "yes" answer with the exception of question #3, for which a "no" answer receives 1 point.

DAST-10 Score	Degree of Problems Related to Drug Abuse	Suggested Action
0	No problems reported	None at this time
1–2	Low level	Monitor, re-assess at a later date
3–5	Moderate level	Further investigation
6–8	Substantial level	Intensive assessment
9–10	Severe level	Intensive assessment

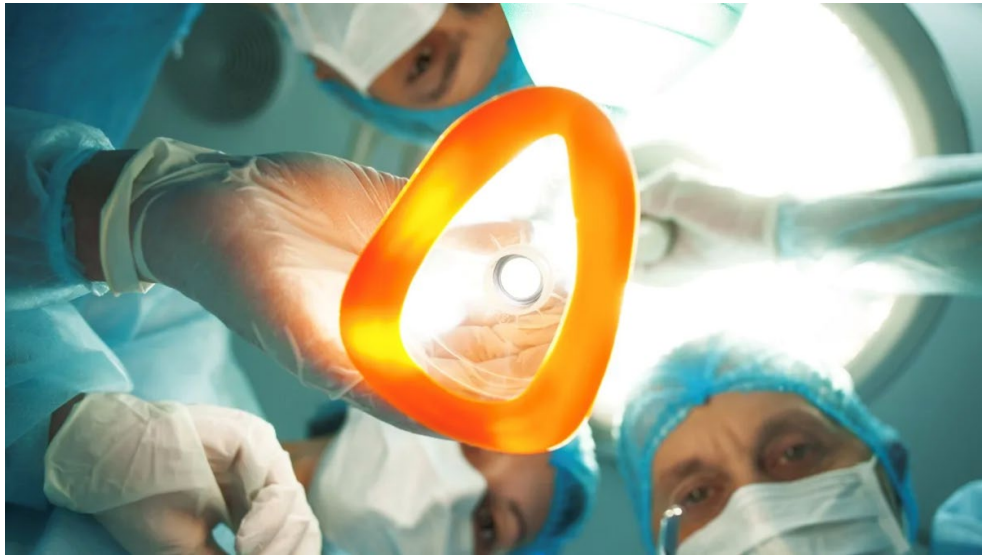
Challenges in Pre-operative Planning

Compass SHARP

- Patient fear or mistrust
- Underreporting of substance use
- Comorbid mental health conditions
- Risk of perioperative complications

Intraoperative Considerations

- Tolerance to anesthetics and opioids
- Drug interactions (e.g., methadone, buprenorphine, naltrexone)
- Altered physiologic responses
- Anesthesia team coordination
- Multimodal analgesia
  - Compass SHARP Guideline
  - Compass SHARP Non-Opioid Medication Dictionary



Perioperative Management of Patients on Opioids (Including MOUD)

Compass SHARP Example Policy

Patient populations:

- Patients with a history of opioid use disorder (OUD) currently being treated with methadone or buprenorphine
- Patients currently taking naltrexone for treatment of alcohol or OUD

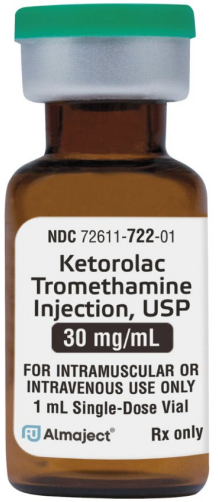
Recommendations:

- Perioperative management of home medications
  - Home Buprenorphine Algorithm
- Management of unanticipated acute pain and nothing by mouth (NPO) diet

Post-operative Considerations

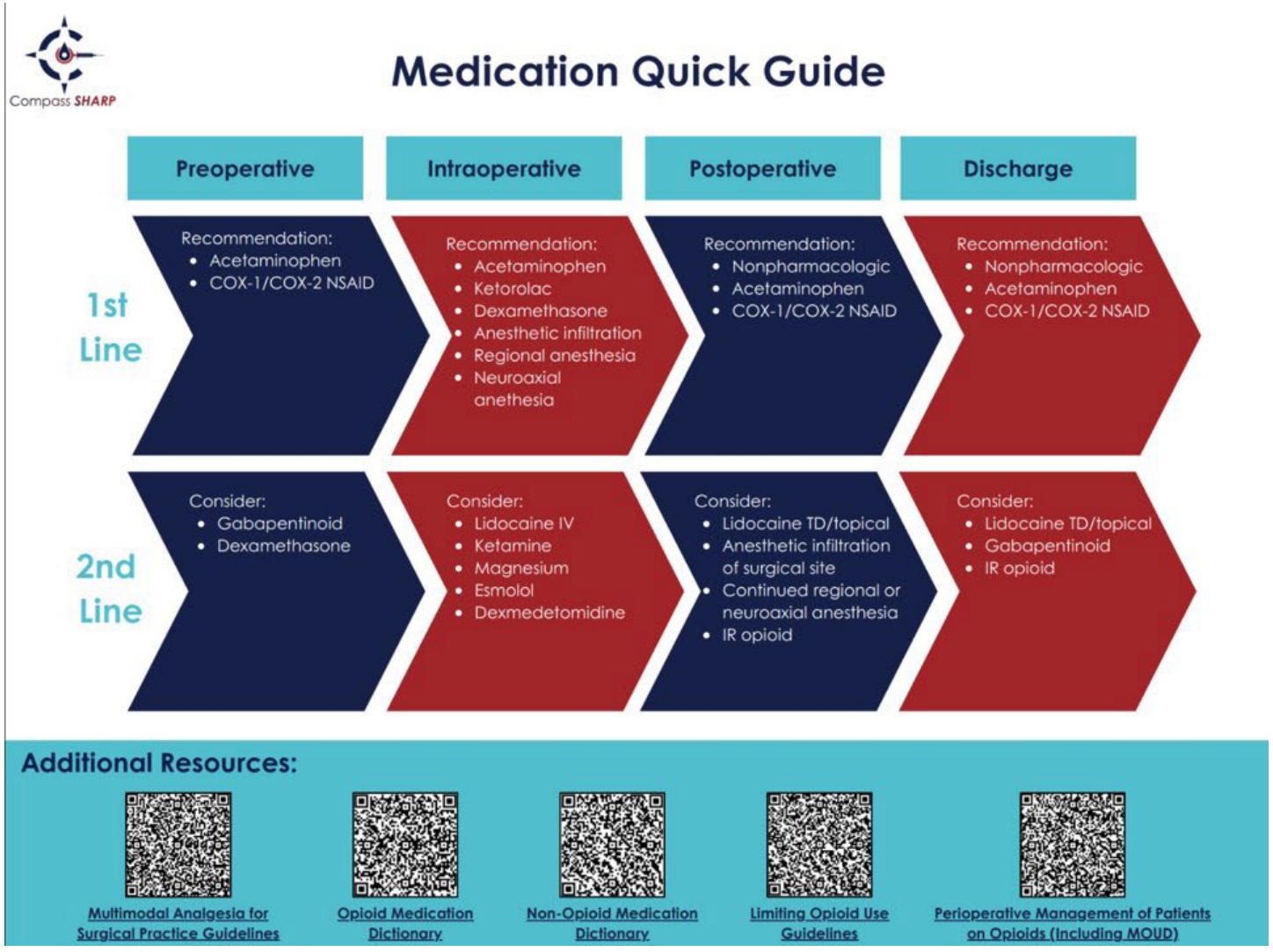
Compass SHARP

- Pain control: multimodal analgesia
- Monitoring for withdrawal symptoms
- Avoiding opioid overuse and relapse
- Involvement of pain and addiction specialists



Medication Quick Guide

Compass SHARP



Managing Withdrawal Symptoms

Compass SHARP

- Substance specific
- Common symptoms: tremors, anxiety, nausea, pain
- Use of medications: benzodiazepines, phenobarbital, clonidine, antiemetics, methadone, buprenorphine
- Importance of scheduled assessments, initiation of standard protocols

Clinical Institute Withdrawal Assessment for Alcohol – revised (CIWA-Ar) scale

Clinical Institute Withdrawal Assessment for Alcohol revised	
Symptoms	**Range of scores**
Nausea or vomiting	0 (no nausea, no vomiting) –7 (constant nausea and/or vomiting)
Tremor	0 (no tremor) – 7 (severe tremors, even with arms not extended)
Paroxysmal sweats	0 (no sweat visible) – 7 (drenching sweats)
Anxiety	0 (no anxiety, at ease) – 7 (acute panic states)
Agitation	0 (normal activity) – 7 (constantly trashes about)
Tactile disturbances	0 (none) – 7 (continuous hallucinations)
Auditory disturbances	0 (not present) – 7 (continuous hallucinations)
Visual disturbances	0 (not present) – 7 (continuous hallucinations)
Headache	0 (not present) – 7 (extremely severe)
Orientation/clouding of sensorium	0 (orientated, can do serial additions) – 4 (Disorientated for place and/or person)

- Score grading:
  - less than 8 indicate mild withdrawal,
  - 8–15 indicate moderate withdrawal (marked autonomic arousal)
  - and >15 indicate severe withdrawal and are also predictive of the development of seizures and delirium
- Score interpretation:
  - if CIWA-Ar score is <8 pharmacological treatment is not necessary
  - if CIWA-Ar score 8-15 pharmacological treatment may be appropriate to prevent the progression to more severe forms of AWS
  - pharmacological treatment is strongly indicated in patients with CIWA-Ar score >15

Pain Management Strategies

- Balanced analgesia: Nonsteroidal anti-inflammatories (NSAIDs), acetaminophen (APAP), regional anesthesia
- Nonpharmacologic methods
- Communication about expectations, healing trajectory, and care plans

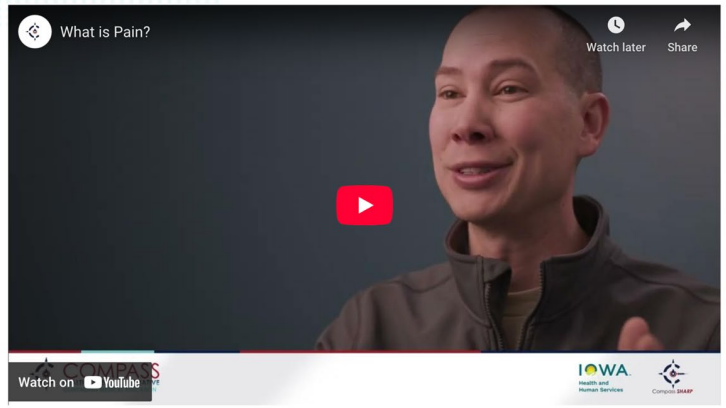
PATIENT RESOURCES

1. Making Sense of Pain
2. Managing Pain After Surgery
3. Preparing For Surgery

PROCEDURE SPECIFIC POST-OP INSTRUCTION RESOURCES

Laparoscopic Cholecystectomy	Joint Replacement Surgery	Orthopedic and Sports Medicine
Sinus Surgery	Hernia Repair	General Abdominal Surgery

PATIENT RESOURCE VIDEO SERIES



We want your feedback on this video: Survey link

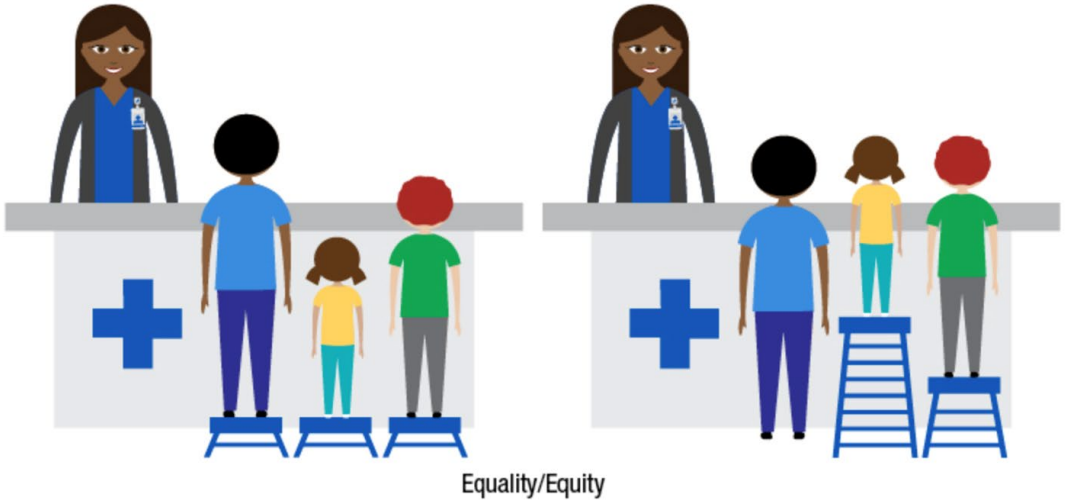
Interdisciplinary Team Approach

Compass SHARP

- Role of nurses, anesthesiologists, surgeons, pharmacists, social workers
- Discharge planning and linkage to addiction services

Ethical Considerations

- Non-maleficence vs autonomy
- Managing pain vs. risk of relapse
- Shared decision making
- Equity in access to care



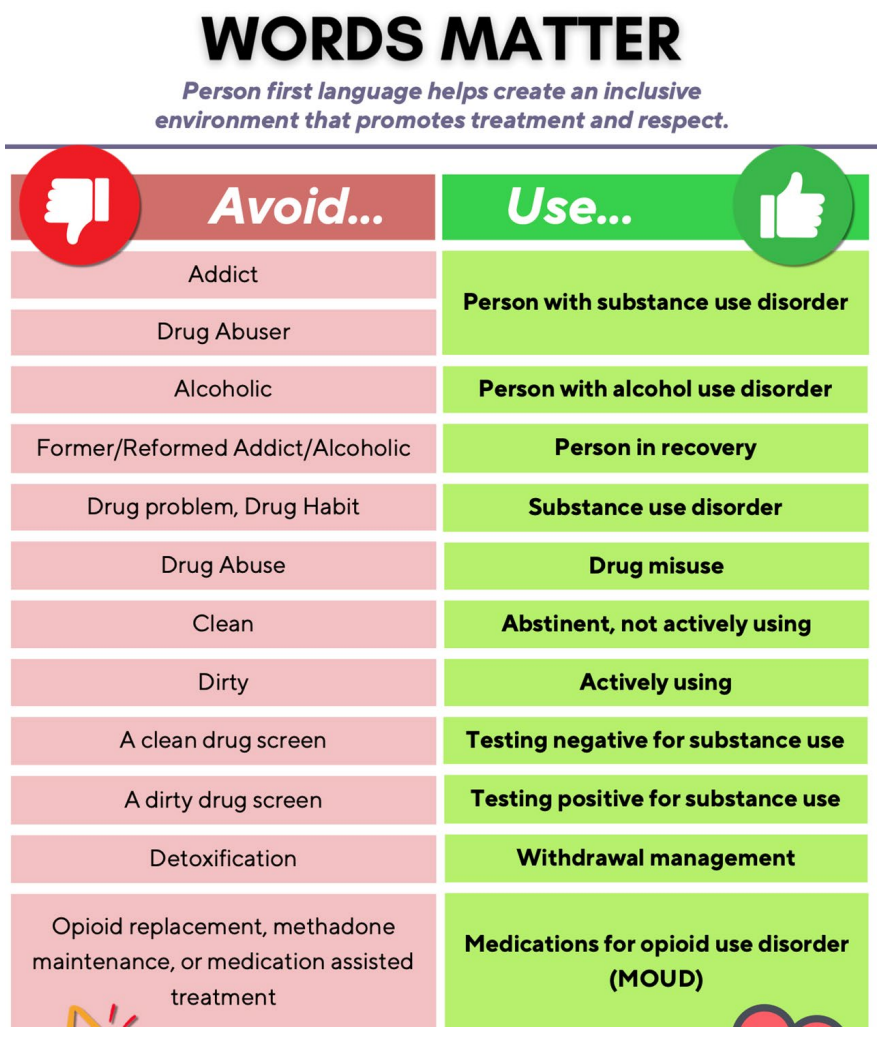
Equality/Equity

Legal Considerations

- Confidentiality and Health Insurance Portability and Accountability Act (HIPAA)
- SUD typically falls under behavioral health, so Title 42 of the Code of Federal Regulations (42-CFR) applies
- Documentation of informed consent
  - Toxicology testing
- Reporting requirements (when applicable)

Reducing Stigma

- Language matters → use person-first language
  - "Person with opioid use disorder" vs "addict"
  - Think, speak, document
  - Hold co-workers accountable
- Avoid stigmatizing terms
  - "junky" "clean vs dirty urine toxicology screening (Utox)"
- Implicit bias training
  - Do you know anyone affected by a SUD?
- Creating a judgement-free environment



Discharge Considerations

- Continue multimodal analgesia
  - APAP + NSAID
  - Lidocaine topical/patches
- Tailor discharge opioid prescription (RX) to patient-specific needs
  - Balance risk/benefit
  - Shared decision making
  - Safe storage and disposal
  - Prescribe/dispense naloxone
- Follow up appointments with pain and addiction specialists

Case Study 1

52-year-old female on long-term Suboxone for OUD presents for pre-op appointment

- Elective right total knee replacement (TKR) next week

Worried about pain control:

- Do I keep taking my Suboxone?
- I don't want any opioids - I'm scared I'll relapse.
- Will you be able to control my pain without opioids?

What are your next steps?

Case Study 1 Cont'd

Phone a friend

- Consult pain/addiction medicine
- Consult clinical pharmacist
- Consult behavioral specialist

Does your hospital have a guideline or clinical pathway?

Clarify her Suboxone dose

- Suboxone 8mg-2mg sublingual (SL) twice a day (BID)

Talk to the patient about options

Table 6. Perioperative Management of Home Buprenorphine Algorithm

For all patients, continue sublingual buprenorphine (Subutex) or buprenorphine/naloxone. (Suboxone, Zubsolv) throughout the perioperative period, by following these steps:

Step 1: Determine the total 24-hour home dose of buprenorphine (regardless of any naloxone component):

- If the home dose is **≤ 8 mg per day: Continue the home dose** throughout the perioperative period. Do not discontinue prior to surgery; end at this step of algorithm.
- If the home dose is **> 8 mg per day,** proceed to step 2 (excludes obstetric patients)

Step 2: Determine anticipated opioid requirements/ pain after surgery:

Anticipated post-operative opioid requirements	Timeframe		
	Before surgery	**On the day of surgery and throughout hospital stay**	**Preparing for discharge**
Moderate to High Opioid Requirements	**If home dose >16 mg** • **Consider titrating dose down** so that **on the day before surgery**, total buprenorphine dose is 16 mg daily (i.e. on day prior to surgery preferably drop down to 8 mg BID vs 16 mg as a single dose) • **May consider continuing home dose** if reliable continuous regional anesthesia techniques are available or based on patient and clinician preference.	**If home dose >16 mg** • Consider decreasing to **buprenorphine 8 mg per day on day of surgery** (preferably 4 mg BID vs. 8 mg daily) • **Anticipate need for higher opioid agonist dose requirement**, similar to opioid tolerant patients maintained on methadone. • **Use additional opioid agonists as needed.**	**If home dose >16 mg** • Provide a **post-discharge taper plan** for full agonist opioids. • Ideally, **increase back to buprenorphine home dose** at time of discharge. • **Transition care back to patient's outpatient buprenorphine prescriber** for ongoing care with plan to increase back to original home buprenorphine dose.
	If home dose ≤ 16 mg **Consider continuing home dose** if reliable continuous regional anesthesia techniques are available and based on patient and clinician preference.		
Low Opioid Requirements	**Continue home regimen** Do not discontinue prior to surgery and continue home dose throughout the perioperative period.		

Case Study 1 Continued

Compass SHARP

Continue her Suboxone 8mg-2mg SL BID

- Split dosing to 0.5 film (4mg-1mg) SL four times a day (QID)

Use femoral and adductor canal blocks

- Explain how these work to block pain
- Consider use of a longer acting local anesthetic

Use non-opioid agents

- APAP + NSAID
- Intravenous (IV) ketamine, lidocaine patches

What is the plan if she has unanticipated acute pain?

- Increase Suboxone dose (give additional 2mg SL doses as needed (prn))
- Use high-affinity opioid. Close monitoring.
- Goal to not be discharged with opioid rx.

Discuss healing timeline expectations afterward and physical therapy/occupational therapy (PT/OT)

Case Study 2

61-year-old male admitted through the Emergency Department (ED) for laparoscopic cholecystectomy

- Admits to heavy alcohol (EtOH) use
- Blood alcohol level (BAL) = 140

What are next steps?

- AUDIT-C
- Notify anesthesia team
- Communicate across transitions of care
- Watch for signs and symptoms (s/s) of withdrawal → Clinical Institute Withdrawal Assessment for Alcohol (CIWA)

Alcohol

Scoring:
A total of 5+ indicates increasing or higher risk drinking.
An overall total score of 5 or above is AUDIT-C positive.

TOTAL 10

Questions	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week	4
How many units of alcohol do you drink on a typical day when you are drinking?	1 -2	3 - 4	5 - 6	7 - 9	10+	3
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	3

Questions	Scoring system					Your score
	0	1	2	3	4	
How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	3
How often during the last year have you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	2
How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	3
How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	3
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	2
Have you or somebody else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year	4

Scoring: 0 – 7 Lower risk, 8 – 15 Increasing risk, 16 – 19 higher risk, 20+ possible dependence

TOTAL 17

PTO

Case Study 2 Cont'd

- Continue scoring CIWA postoperatively
- Initiate EtOH withdrawal symptom-based pathway
- Maximize non opioid pain management strategies
- Monitor closely for drug-drug interactions with postoperative opioids + benzos
- Weigh risk/benefit of a discharge opioid rx → naloxone!
- Rely on APAP + NSAID + lidocaine patch on discharge

Summary & Key Takeaways

- Effective perioperative management in a patient with SUD requires preparation, compassion, and coordination
- Understand withdrawal, pain, and ethical/legal aspects
- Foster non-judgemental care environments

Resources and References

- Multi Organizational consensus to define guiding principles for perioperative pain management in patients with chronic pain, preoperative opioid tolerance, or substance use disorder here
- Support for Hospital Opioid Use Treatment (SHOUT) guidelines (OUD specific) here
- Institutional protocols, policies, and order sets
- Compass SHARP Provider Resource page here

Questions & Discussion

Compass SHARP

- Have you had a recent patient case you'd like to share?
- What challenges do you face at your institution in caring for perioperative patients with SUD?

Upcoming Events

Compass SHARP

Postoperative Management
July 9th, 12:10 - 12:50 pm CT

Intraoperative Considerations: Regional and Neuraxial Anesthesia
August 13th, 12:10 - 12:50 pm CT

Perioperative Continuation of Chronic Opioids and Buprenorphine
September 10th, 12:10 - 12:50 pm CT

Resources

Compass SHARP

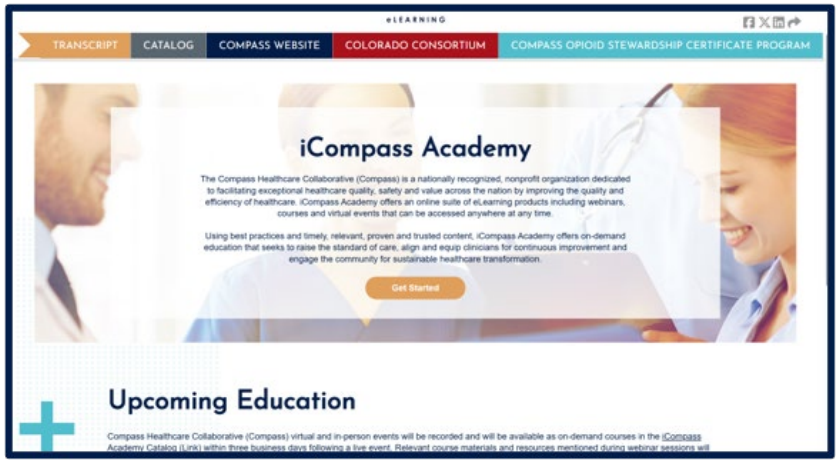
Access provider and patient resources on the Compass SHARP webpage by scanning the QR code below.

Subscribe to the monthly *On Point* Compass SHARP newsletter by scanning the QR code below.

Access the May edition

iCompass Academy

- **This webinar will be recorded and be available on iCompass Academy**
- **What is iCompass Academy?**
  - iCompass Academy offers an online suite of free eLearning products including webinars, courses and virtual events that can be accessed anywhere at any time.
- Scan the QR code for **iCompass Academy**



Follow Compass

Compass SHARP

LinkedIn

Facebook

X (Twitter)

Reach The Program

Compass SHARP

Jillian Schneider, MHA, CPPS
Program Director
Compass Healthcare Collaborative
schneiderj@compasshcc.org

Sharmie Russell, ACEA
Project Support Specialist
Compass Healthcare Collaborative
russells@compasshcc.org

Melissa Perry, MSW, LCSW
Project Coordinator
Compass Healthcare Collaborative
perrym@compasshcc.org

Amanda Donlon, BSN, RN, CDCES, CPHQ, CPPS
Clinical Improvement Consultant
Compass Healthcare Collaborative
donlona@compasshcc.org

Thank you

Compass *SHARP*