Identifying Key Competencies for Opioid Prescriber Education

April 4, 2022 | 1:00-5:00 p.m. ET

April 5, 2022| 1:00-4:10 p.m. ET

FDA U.S. FOOD & DRUG ADMINISTRATION | Duke MARGOLIS CENTER *for* Health Policy

Welcome & Introduction | Day 1

Mark McClellan, MD, PhD

Director, Duke-Margolis Center for Health Policy

Agenda: Day 1

Presentations:

Opening Remarks from FDA

FDA Presentation: Blueprint for Health Care Providers Involved in the Treatment and Monitoring of Patients with Pain: An Overview

SAMHSA Presentation: SAMHSA's Substance Use Disorder Training Initiatives

Panel Discussions:

Examining Core Competencies for Opioid Prescriber Education

Professional Practice Gaps in SUD and Pain Management and Related Gaps in Current Prescriber Education

Agenda: Day 2

Panel Discussions:

Identifying Lessons Learned from Provider Education and Continuing Medical Education Initiatives

Future Directions and Next Steps for Shaping Prescriber Education Efforts

Statement of Independence

The Robert J. Margolis, MD, Center for Health Policy is part of Duke University, and as such it honors the tradition of academic independence on the part of its faculty and scholars. Neither Duke nor the Margolis Center take partisan positions, but the individual members are free to speak their minds and express their opinions regarding important issues.

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Virtual Meeting Reminders

- Attendees are encouraged to contribute throughout the meeting with questions in the Zoom Q&A function.
- This meeting is being recorded, and the recording and slide deck will be posted on the Duke-Margolis event page in the weeks following the meeting.

Opening Remarks from FDA

Patrizia Cavazzoni

U.S. Food and Drug Administration

U.S. FOOD & DRUG ADMINISTRATION

Identifying Key Competencies for Opioid Prescriber Education

Opening Remarks

April 4, 2022

Overdose Crisis

- **The overdose crisis continues to devastate our society as drug overdose deaths reach a record high, with CDC's provisional estimate of over 100,000 drug overdose deaths occurring between October 2020 and October 2021.**

- **The estimated number of opioid prescriptions dispensed in the US has been steadily declining since 2012. Despite this decline in dispensing:**
  - Overall opioid-involved overdose deaths have risen sharply since 2012, with opioids often seen in combination with other substances; and
  - This rise has been driven primarily by a surge in deaths involving illicitly manufactured fentanyl and fentanyl analogues. Although these overdose deaths largely involve illicit substances, many users of illicit opioids are initially exposed to opioids through nonmedical use of prescription opioids.

- **Against this background of a complex and intensifying crisis, FDA is re-examining the role of prescriber education as part of our comprehensive approach to confronting this public health emergency**.

Current Landscape of Opioid Prescriber Education

- **There are many prescriber education programs available.**
  - At a state and institutional level, some are mandatory, and some are voluntary.
  - At a national level, training is not required, and under the Opioid Analgesic REMS program required by FDA, prescriber education is voluntary.
- **There is considerable variation in the content, scope, and depth across the many available education programs.**
  - Potential gaps exist in education across the various options currently available.
  - Consistent core training is not reaching all opioid prescribers, and not required at the national level.
- **While education is available, the current landscape suggests room for improvement.**

FDA Heard from Many Stakeholders

- **Prescriber education is important**
  - Evidence-based
  - Unbiased

- **Duke-Margolis Public Workshop and Open Public Comment October 2021: Key Takeaways Regarding Educational Needs**
  - Education can help prescribers make more informed prescribing decisions.
  - Whether education should be voluntary or mandatory remains unclear.

- **Additional Considerations for Education**
  - Education should ensure core competencies.
  - Education should be tailored to the individual clinician's practice, practice setting, and patient population – not "one size fits all."
  - Education should come from a trusted source, free of industry influence.
  - Education is a start, but prescribers face numerous other barriers that also need to be addressed.

Vision for Prescriber Education

- Core education required for all prescribers nationwide
- Additional considerations:
  - Extension of educational content for all healthcare providers (HCPs)
  - Content that is consistent, science-based, and unbiased.
  - Create meaningful engaging content that promotes adaptive learning
  - An approach that balances core education with potentially additional available training that is:
    - tailored to the needs of different medical specialties; and
    - adaptive to emerging public health needs.

Under the Current Opioid Analgesic REMS

Currently, the Opioid Analgesic REMS:

- requires that training be made available to all HCPs
- allows drug companies to provide unrestricted grants to accredited continuing education (CE) providers
  - CE providers develop training that is based on the Education Blueprint for Health Care Providers Involved in the Treatment and Monitoring of Patients with Pain (Blueprint)
  - FDA developed the Blueprint
- does not require that HCPs take the training in order to prescribe or dispense opioid analgesics

Under the Current Opioid Analgesic REMS

- **FDA would need to implement any requirement for mandatory prescriber education through our REMS, which has potential advantages:**
  - Improves consistency by providing a single, unified core curriculum available at the national level
  - Improves dissemination and reach by requiring through a federal vehicle

- **FDA acknowledges the many concerns experts have expressed about requiring education via REMS, including:**
  - The need for tailored educational content adapted to clinicians' diverse practices
  - The potential additional burden on prescribers and pharmacists
  - The need for an unbiased, trusted source not affiliated with drug companies

Alternative Implementation Vehicles

- **Many have proposed linking education to DEA registration and renewal.**
  - Currently, there are bills proposed in Congress to add opioid prescriber education as part of DEA licensing requirements.
  - None have become law.

- **Recent conversations have explored more collaborative approaches with federal partners, medical societies, and professional organizations.**

Conclusion


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Blueprint for Health Care Providers Involved in the Treatment and Monitoring of Patients with Pain: An Overview

Mark Liberatore

U.S. Food and Drug Administration

Blueprint for Health Care Providers Involved in the Treatment and Monitoring of Patients with Pain:

An Overview

CDR Mark A. Liberatore, PharmD, RAC
Deputy Director for Safety
Division of Anesthesiology, Addiction Medicine, and Pain Medicine (DAAP)
FDA/CDER/OND/ON

Why a *Blueprint?*

- FDA regulates drugs, FDA does not directly regulate CE providers
- FDA authority to require a Risk Evaluation and Mitigation Strategy (REMS):
  - Allows for Elements to Assure Safe Use (ETASU)
  - One element = provider training
- Independent of manufacturers, FDA developed the Blueprint to provide a guide as to what must be covered in the continuing education (CE)
- The Blueprint is part of the REMS, which is required of the application holders, but the **application holders are not the CE providers**
- **Application holders are obligated to abide by the terms of the REMS, but do not develop the CE themselves**
- CE providers can independently develop CE based on this document

2012 and 2018 Blueprint Comparison

2012

- Extended-Release and Long-Acting Opioid Analgesics *only*
- Focused on product-specific information
- Targeted mainly to prescribers

2018

- Expanded to include all opioid analgesics intended for use in the outpatient setting
- Focuses on fundamental concepts of pain management and the role of opioids (but, no longer product-specific)
- Targets *all* health care providers involved in the treatment and monitoring of patients with pain

Why Health Care Provider Education is Important

- Adverse outcomes of addiction, unintentional overdose, and death remain a major public health problem
- Inappropriate prescribing, as well as misuse, and abuse contribute to these outcomes
- Critical that HCPs *and patients* understand the risks associated with opioid analgesics

Blueprint available at:
https://www.accessdata.fda.gov/drugsatfda_docs/rems/Opioid_Analgesic_2019_11_14_FDA_Blueprint.pdf

What is Behind the *Need* for Education

- Millions of Americans suffer from chronic pain
- Many people who use prescription opioids “nonmedically” report obtaining them from friends or family
- Undertreated pain carries with it a lot of adverse consequences
- Proper treatment of pain while using best practices to ensure patient safety is critical
- Having a broad knowledge about how to manage patients with pain (including non-pharmacologic options) can help contribute to national efforts to address and reduce opioid misuse and abuse

Blueprint available at:
https://www.accessdata.fda.gov/drugsatfda_docs/rems/Opioid_Analgesic_2019_11_14_FDA_Blueprint.pdf

Purpose of the REMS Educational Effort

Educating prescribers about…

- Fundamental concepts of pain management
- How to assess patients in pain
- How to identify risk factors for abuse and addiction
- The range of therapeutic options
- How to manage acute and chronic pain, including initiation, titration, and discontinuation (proper tapering) of opioid analgesics
- How to counsel patients
- When to refer to pain specialist
- Fundamental elements of addiction medicine, including identification and management of patients with opioid use disorder

Blueprint available at:
https://www.accessdata.fda.gov/drugsatfda_docs/rems/Opioid_Analgesic_2019_11_14_FDA_Blueprint.pdf

Focus Section 1:
The Basics of Pain Management

- The Need for Comprehensive Pain Education
  - Reinforcement of the purpose
- Definitions and Mechanisms of Pain
  - Taking into consideration biological significance, acute/chronic, nociceptive/neuropathic pain
- Assessing Patients in Pain

Blueprint available at:
https://www.accessdata.fda.gov/drugsatfda_docs/rems/Opioid_Analgesic_2019_11_14_FDA_Blueprint.pdf

Focus Section 2:
Creating The Pain Treatment Plan

I. Components of an Effective Treatment Plan
II. General Principles of Non-pharmacologic Approaches
III. General Principles of Pharmacologic Analgesic Therapy
IV. Managing Patients on Opioid Analgesics
V. Addiction Medicine Primer

Blueprint available at:
https://www.accessdata.fda.gov/drugsatfda_docs/rems/Opioid_Analgesic_2019_11_14_FDA_Blueprint.pdf

III. General Principles of Pharmacologic Analgesic Therapy

Non-opioid Analgesics

- Mechanism of action
- Indications and uses
- Routes of administration
- Initiation, titration, tapering
- Contraindications
- Adverse events
- Drug interactions

Opioid Analgesics

- Knowledge of all the same points covered under non-opioid options, *plus:*
  - Opioid-specific risks (i.e., misuse, abuse, addiction)
  - Respiratory depression, overdose, death
  - Use successfully as a *component* of pain management

Blueprint available at:
https://www.accessdata.fda.gov/drugsatfda_docs/rems/Opioid_Analgesic_2019_11_14_FDA_Blueprint.pdf

III. b. Opioid Analgesic Medications

1. General Precautions
2. Mechanism of Action and Analgesic Effect
3. Types of Opioids (full agonists, partial agonists)
4. Indications and Uses for Pain Management
5. Range of Opioid Analgesic Products Available for Pain Management and their Related Safety Concerns
6. Initial Dosing, Dose Titration, Dose Tapering (when appropriate) for Analgesia
7. Contraindications
8. Adverse Events
9. Drug Interactions
10. Key Safety Strategies for Use with Opioid Medications

Blueprint available at:
https://www.accessdata.fda.gov/drugsatfda_docs/rems/Opioid_Analgesic_2019_11_14_FDA_Blueprint.pdf

IV. Managing Patients on Opioid Analgesics

- Appropriate use
- Acute and chronic pain
- Balance of benefits and risks
- Serious outcomes including overdose and death

Blueprint available at:
https://www.accessdata.fda.gov/drugsatfda_docs/rems/Opioid_Analgesic_2019_11_14_FDA_Blueprint.pdf

IV. Managing Patients on Opioid Analgesics

A. Initiating Treatment with Opioids – Acute Pain
B. Initiating Treatment with Opioids – Chronic Pain
C. Ongoing Management of Patients on Opioid Analgesics
D. Long-term Management
E. How to Recognize and Intervene Upon Suspicion or Identification of Opioid Use Disorder
F. When to Consult a Pain Specialist
G. Medically Directed Opioid Tapering
H. Importance of Patient Education

Blueprint available at:
https://www.accessdata.fda.gov/drugsatfda_docs/rems/Opioid_Analgesic_2019_11_14_FDA_Blueprint.pdf

V. Addiction Medicine Primer

- Knowledgeable about the basic elements of addiction medicine
- Usage of non-stigmatizing language
- Be familiar with:
  - Neurobiology of OUD
  - Use of Screening Tools
  - Management of OUD

Blueprint available at:
https://www.accessdata.fda.gov/drugsatfda_docs/rems/Opioid_Analgesic_2019_11_14_FDA_Blueprint.pdf

Limitations of the Blueprint

- The REMS-compliant CE is funded by industry
- The Blueprint is an outline - it does not contain every detail behind opioid prescribing (e.g., no product-specific information)
- FDA does not have direct control over the content of the CE programs

Possible Blueprint Enhancements

- *Source:* FDA Safety Labeling Changes (SLC)
  - Safe Storage and Disposal
    - Including FDA's *Remove the Risk* Campaign
  - Dose Reductions and Discontinuation (aka: Opioid Tapering)
  - Discuss Naloxone Availability
- *Source:* CDC guidelines
  - Emphasis on individualized patient care
- *Source:* FDA MME workshop
  - Intended to aid in prescribing; treat the patient, not the numbers
- *Source:* 2021 Duke-Margolis Meeting
  - Tailored and targeted training vs. "one-size-fits-all"
  - Whole-person approach to patient care

Morphine Milligram Equivalents: Current Applications and Knowledge Gaps, Research Opportunities, and Future Directions - 06/07/2021 - 06/08/2021 | FDA

Federal Register :: Proposed 2022 CDC Clinical Practice Guideline for Prescribing Opioids

Summary

- The Blueprint is an FDA-approved document designed to facilitate development of continuing educational programs
- The 2018 Blueprint, and CE developed from it, targets all health care providers, not just prescribers
- The Blueprint contains a high-level outline of core educational messages that must be included in CE – *CE can be customized*
- Contains an “addiction medicine primer” so that HCPs are educated on the basic elements of addiction medicine
- Has limitations – FDA does not have oversight of the exact content of the resulting CE
- FDA is looking to enhance the existing Blueprint by exploring today, what core content may need to be added to the document


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SAMHSA's Substance Use Disorder Training Initiatives

Yngvild Olsen

Substance Abuse and Mental Health Services Administration

SAMHSA's Substance Use Disorder Training Initiatives

Yngvild Olsen, MD, MPH
Acting Director, Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services Administration
U.S. Department of Health and Human Services

April 4, 2022

SAMHSA
Substance Abuse and Mental Health Services Administration

Categories of Training Initiatives

1. Grant support

2. Technical Assistance

3. Educational publications and materials

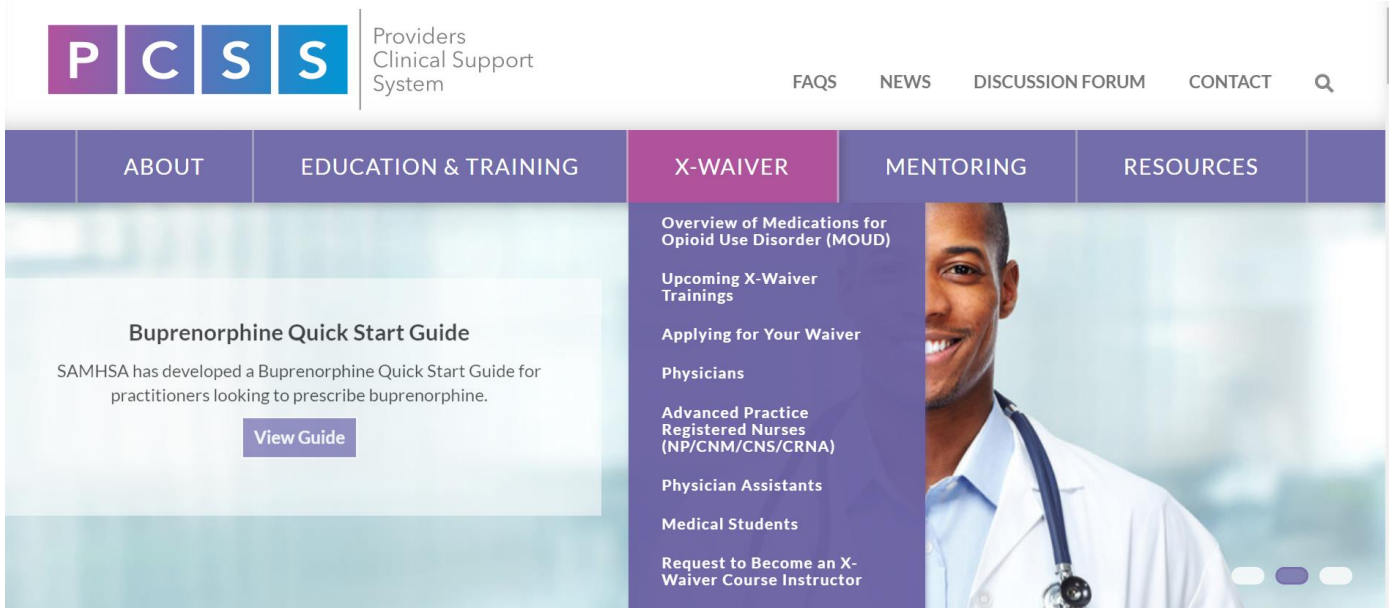
Provider Clinical Support System - Universities

- Grant program focused on academic healthcare professional (HCP) institutions.
- **Goal:** Ensure HCP students graduate able to treat patients with opioid use disorder (OUD) in office-based settings.
- Two grant cohorts
  - 48 universities across 22 states
- Over 1,400 students trained

Provider Clinical Support System

- PCSS provides ***free*** training to HCPs on evidence-based prevention and treatment of OUD/SUDs and treatment of chronic pain

https://pcssnow.org/



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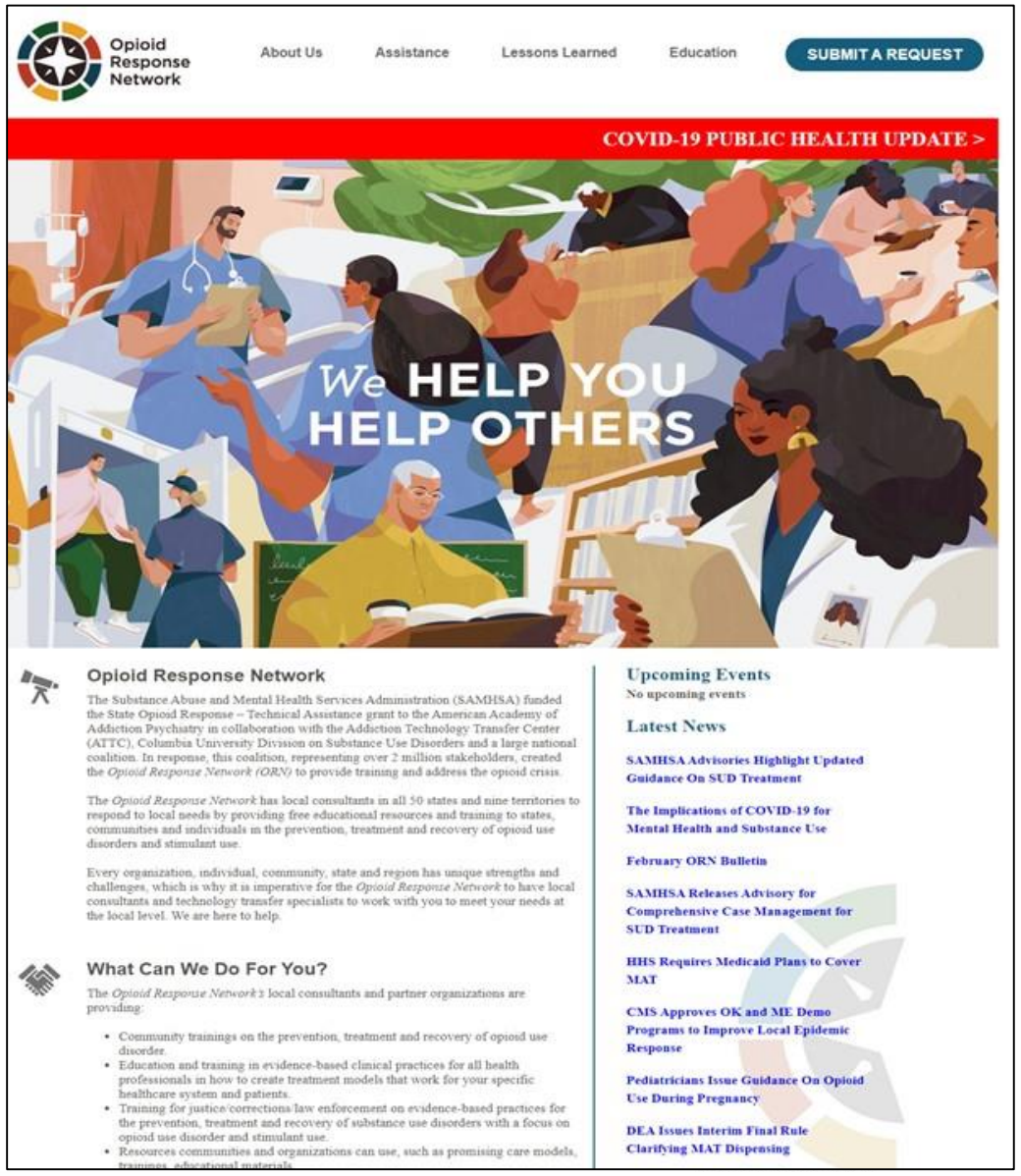
Opioid Response Network (ORN)
State and Tribal Opioid Response – Technical Assistance

https://opioidresponsenetwork.org/

- The ORN has local consultants in all 50 states and nine territories
- Designed to respond to local needs by providing free educational resources and training to states, communities and individuals in the prevention, treatment and recovery of OUD and stimulant use disorder
- Accessible to all communities.

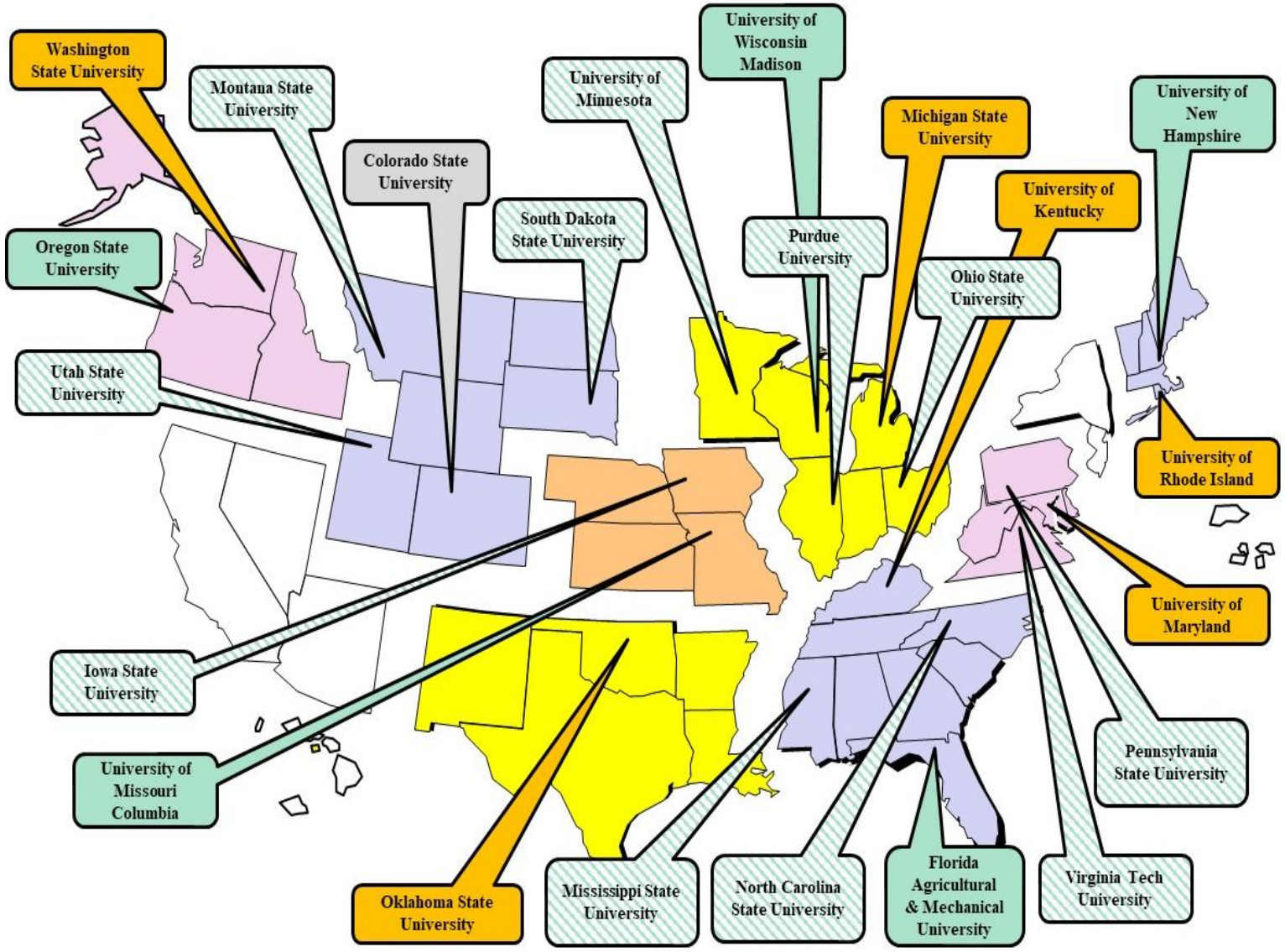


ROTA

Rural Opioid Technical Assistance Program

MISSION: To develop and disseminate training and TA for rural communities addressing opioid and stimulants issues affecting their communities**.**

The ROTA grantees facilitate the identification of model programs, develop and update materials related to the prevention, treatment, and recovery activities for opioid use disorder (OUD), and provides high-quality training.



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Addiction Technology Transfer Centers (ATTCs)

- 13 Centers across the country with one National Coordinating Office
- ATTCs provide an extensive set of educational resources across the SUD continuum
  - Training curricula
  - Accompanying articles, white papers, and reference materials
  - Recorded and live webinars
  - Toolkits, videos
  - Online modular courses

https://attcnetwork.org/

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Evidence-Based Practices Resource Center

www.samhsa.gov/ebp-resource-center

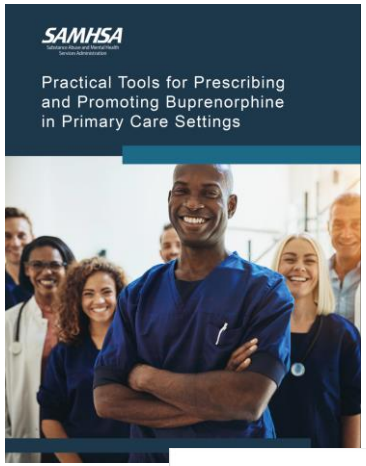
- Repository of EBPs for prevention, treatment, and recovery practices
- Focus on practical implementation tools

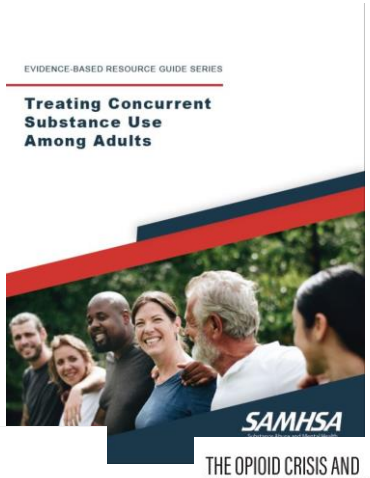
  Examples products:

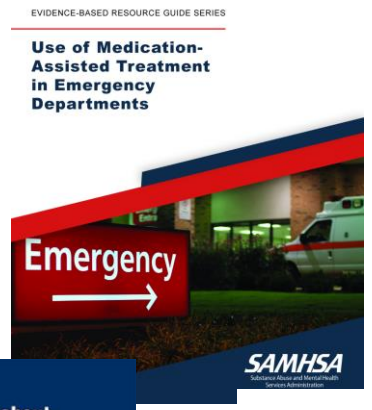
  - MOUD implementation in CJ Settings
  - MOUD Implementation in ED Setting
  - TIP 63 Update

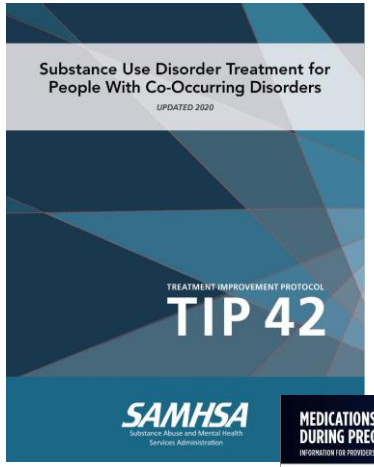
SAMHSA Resources

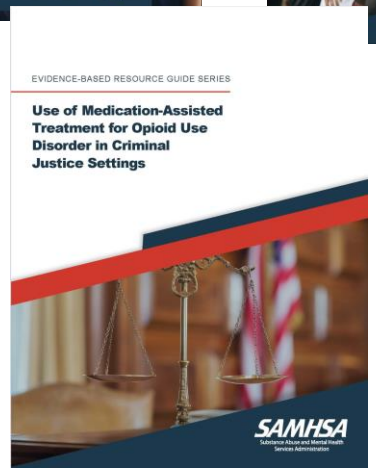
The SAMHSA Store (https://store.samhsa.gov/) contains resources related to best practices for HCPs in the identification and treatment of OUD/SUDs

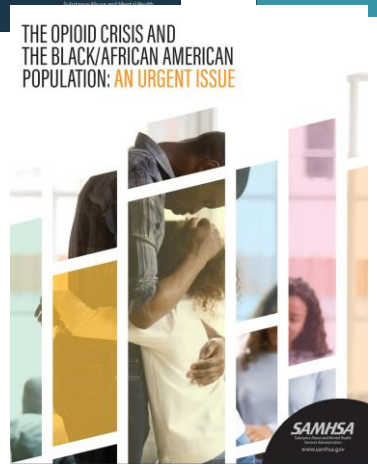


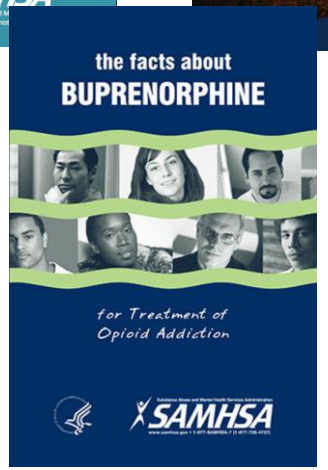












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Thank you!

1-877-SAMHSA-7 (1-877-726-4727) | 1-800-487-4889
(TTY) www.samhsa.gov | @samhsagov

Examining Core Competencies for Opioid Prescriber Education

Eric Holmboe

Accreditation Council for Graduate Medical Education and National Academy of Medicine Action Collaborative on Countering the U.S. Opioid Epidemic

Preparing Health Professionals in Pain Management and Substance Use Disorder

Update on Initiatives of the National Academy of Medicine Action Collaborative

And

Accreditation Council for Graduate Medical Education

NATIONAL ACADEMY OF MEDICINE

ACGME
Accreditation Council for Graduate Medical Education

Disclosures

Eric Holmboe is employed by the ACGME and receives royalties from Elsevier Publishing for a textbook on assessment

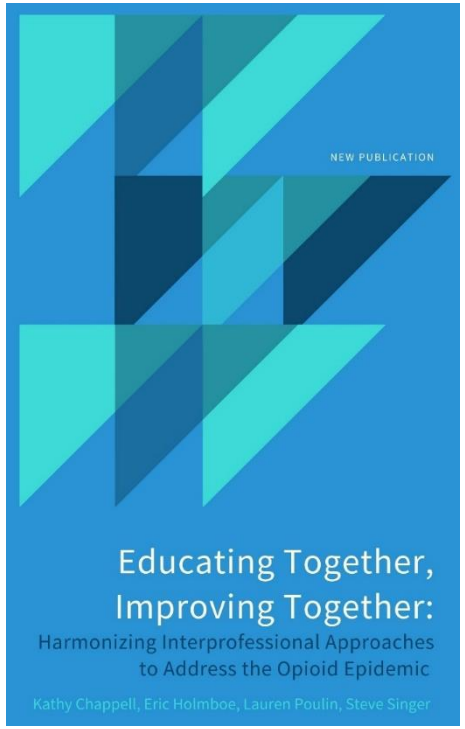
A Note of Thanks

- Aisha Salman and the whole NAM team
- Kathy Chappell and Steve Singer (co-chairs)
- The Education Workgroup

Education and Training Workgroup

Developed a special publication on **professional practice gaps**, existing **regulatory requirements and policy standards**, and identified **five actionable priorities** needed to strengthen coordination and collaboration across the health education system:

1. Establish minimum core competencies for *all health care professionals* in pain management (PM) and substance use disorders (SUDs);
2. Align *accreditors' expectations* for interprofessional collaboration in education for PM;
3. Foster *interprofessional collaboration among licensing and certifying bodies* to optimize *regulatory* approaches and outcomes;
4. Unleash the capacity for continuing education to meet health professional learners where they are
5. Create *partnerships* among organizational stakeholders such as *health care organizations and regulatory agencies* to harmonize practice improvement initiatives



Competency Framework Background And Scope

- The first actionable priority seeks to **inform a minimum level of core competency** across professions to ensure flexibility reflective of scope-of-practice and setting specific needs
- Additionally core competencies will **address critical PPGs** across the health education continuum and re-calibrate the U.S. health care workforce toward **adaptive interprofessional practice** and **improve overall readiness and responsiveness**
- To support this priority, the working group **developed a core competency domains framework** to inform the minimum level of competence needed in pain management and substance use disorder (SUD) care
- The framework is intentionally **broad in scope** to **optimize comprehensiveness and applicability**; of note, the framework describes competency domains and not granular competencies

The C's Competency Framework

- The Cs Framework is intended to inform minimum core competencies where needed and should describe baseline knowledge, skills, behaviors/performance, and attitudinal expectations across health professions.
- The framework must be disseminated to educational systems and their stakeholders for far-reaching and collaborative implementation.
- This framework is not intended to detract from existing or emerging evidence-based, interprofessional competencies for pain management and SUDs, but rather ensure flexibility

Core Competency Domains Framework

- Core competency framework identifies a **foundational set of knowledge, skills, and attitudes** that all health professionals, regardless of profession or level, should have competence in to care for patients with pain and/or SUD
- Overarching goals are to:
  - utilize a **public health approach** that sets a **minimum standard of competence** for *all* practicing clinicians; and
  - provide an **implementable framework** that can used to **catalyze the development of specific competencies** across professions and/or disciplines as needed
- Framework is centered around partnering in care with patients, families, and communities, and describes **three broad domains of performance** that collectively reflect competence in health professionals: **1) Core Knowledge, 2) Collaboration, 3) Clinical Practice**

Core Competency Domains Framework

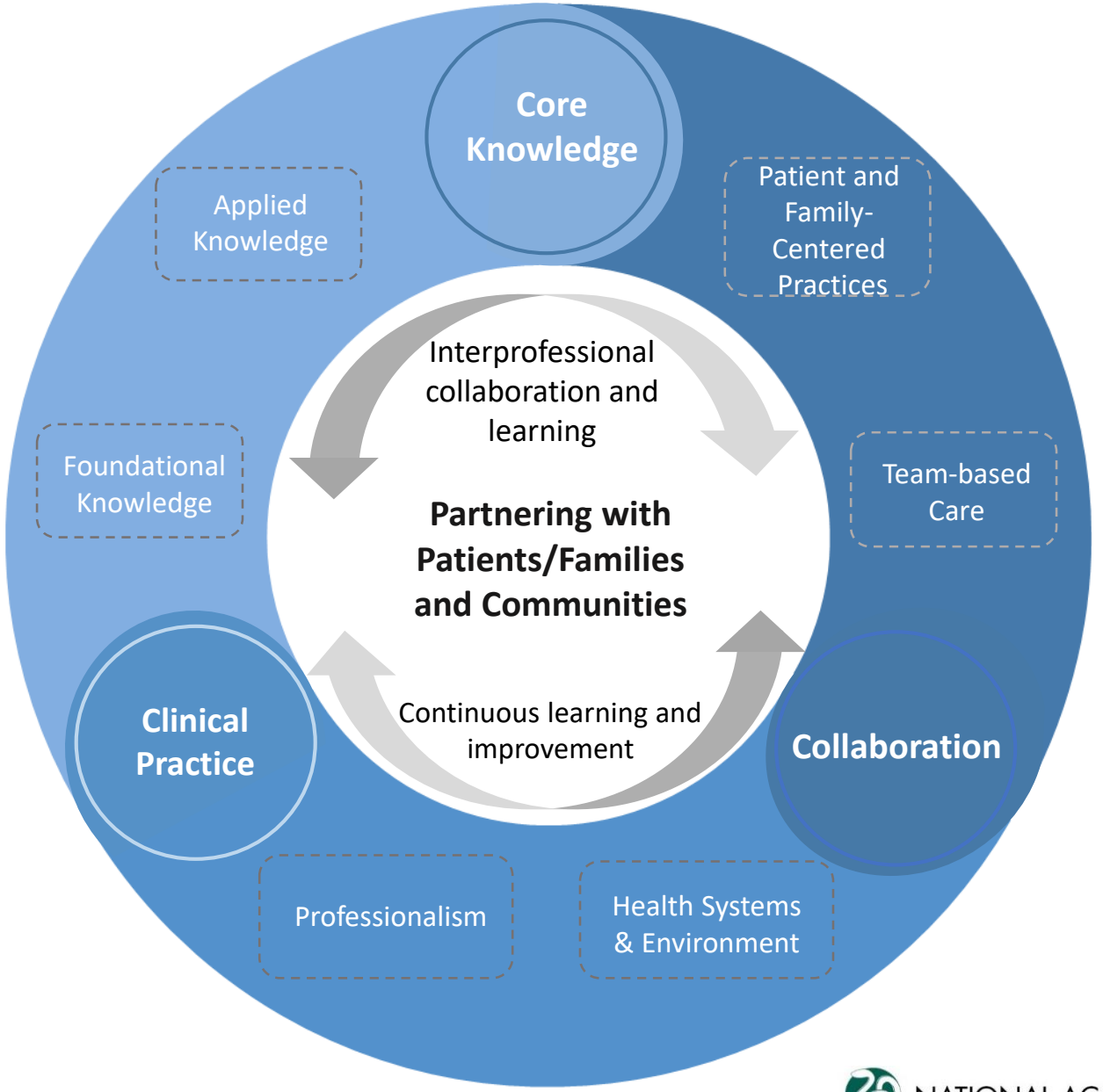
- The **C's Framework** maps to **six core competency domains** and associated subdomains that describe a minimum level of knowledge, skills, and abilities needed for competence

- **Core Competency Domains (and performance domains):**
  1. Baseline Knowledge (Core Knowledge)
  2. Applied Knowledge (Core Knowledge)
  3. Patient-centered Practices (Collaboration)
  4. Team-based Care (Collaboration)
  5. Health Systems and Environment (Clinical Practice)
  6. Professionalism (Clinical Practice)

- Framework includes two important **facilitating factors** needed for success: **interprofessional collaboration and learning, and continuous learning and improvement**

- Framework is undergoing review and will be released as a **publication** through NAM Perspectives

The Core Competency Domains "C Framework"



Core Knowledge: Foundational concepts of pain/SUD and the behaviors, skills and attitudes needed to effectively apply knowledge; Domains and subdomains include:

I. Foundational Knowledge

- Knowledge of pain, SUD, behavioral health, their intersections and discrete concepts
- Knowledge of emotional, mental, and behavioral health and their intersections with pain and SUD
- Recognize the range of and differences among conditions relating to substance use and pain
- Knowledge of stigma related to pain and SUD
- Knowledge of clinical practice guidelines
- Knowledge of treatment options for pain and SUD

II. Applied Knowledge

- Baseline skills for recognizing and assessing signs of pain and SUD
- Baseline skills for determining risks associated with mismanaged/undermanaged pain and SUD
- Ability to translate evidence and data into practice
- Understanding the relationship between stigma and disparities and inequities in pain and SUD care

Collaboration: Core principles of patient and family-centered practices and team-based care, and the behaviors, skills, and attitudes needed for successful collaboration across these groups; Domains and subdomains include:

III. Patient and family-centered Practices

- Respect and appreciate individual and family-level needs and autonomy
- Recognize and eliminate stigma experienced by patients and families
- Encourage patient and family discussions and expectations for functional care goals
- Demonstrate attitudes and behaviors reflecting cultural competency
- Practice effective and evidence-based communication strategies with patients and families, including use of non-judgmental, non-stigmatizing, non-discriminatory language
- Use person-centered, collaborative approaches and decision-making, including motivational interviewing, redirection of an anchored patient, and conflict resolution techniques
- Awareness of trauma informed care practices
- Select and prepare individuals with lived experience to share their experiences and perspectives in educational sessions

Collaboration (cont'd)

IV. Team-based Care

- Knowledge of individual roles and responsibilities within the care team
- Ability to work effectively and collaborate within and across different professions and settings
- Recognize and eliminate stigma against care teams
- Practice effective and evidence-based communication strategies with team members
- Recognize patient and families as members in the interdisciplinary team
- Provide appropriate referral for pain and SUD

Clinical Practice: Baseline awareness needed to understand health systems/environments and exercise professionalism, and the behaviors, skills, and attitudes that facilitate successful integration with practice; Domains and subdomains include:

V. Health Systems and Environment

- Recognize of social determinants of health, high risk populations, and structural barriers affecting pain and SUD care
- Knowledge of clinician level stigma and impact
- Recognize and appreciate the role of health care professionals and the responsibility of providing complex care
- Understand health systems and strategies for navigating practice setting challenges by learning from colleagues
- Awareness/appropriate use of current data/evidence, tools, and resources
- Awareness of current regulations and policies and their relationship to practice
- Knowledge of harm reduction and prevention strategies

Clinical Practice: Baseline awareness needed to understand health systems/environments and exercise professionalism, and the behaviors, skills, and attitudes that facilitate successful integration with practice; Domains and subdomains include:

VI. Professionalism

- Knowledge and use of ethical practices and mediation strategies
- Exercise self-care skills
- Engage in interprofessional education that supports lifelong learning and professional development related to pain and SUD care
- Continually assess and address one's own implicit attitudes and biases
- Exercise resourcefulness and adaptability across practice settings
- Demonstrate compassion, empathy, and support throughout all stages of care, and exercise the ability to "meet patients where they are"

Implementation

To support implementation:

- The framework will be accompanied by a suite of tools:
  - Implementation frameworks,
  - Implementation guidance for different stakeholder groups,
  - Clinical resources mapped to the framework's subdomains.

Next Steps

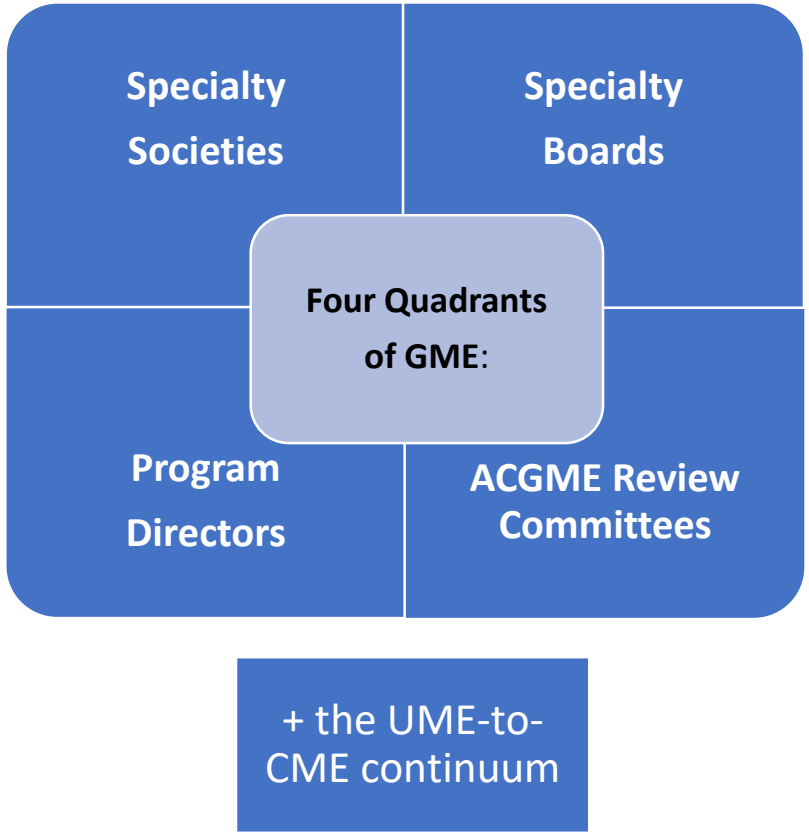
- The C's framework is still in draft form
  - Currently undergoing review and final revisions
  - Anticipate public release later this spring
  - Welcome any advice, help, or guidance on implementation and dissemination strategies

Preparing Residents/Fellows to Manage Pain and Substance Use Disorder

ACGME
Accreditation Council for Graduate Medical Education

Results from a Congress of GME Stakeholders

Congress Attendees



+ the UME-to-CME continuum

- Anesthesia
- Emergency Medicine
- Family Medicine
- Internal Medicine
- Obstetrics And Gynecology
- Orthopaedics
- Pediatrics
- Physical Medicine & Rehabilitation
- Psychiatry
- Surgery

ACGME
Accreditation Council for Graduate Medical Education

General Considerations

Pain Management

- Multi-modal approaches to pain
- Non-opioid and non-pharmacologic treatment of acute and chronic pain
- Pharmacology of both opioid and non-opioid pain medications
- Safe opioid prescribing and management of opioid analgesics, including opioid selection, dosage and duration, and tapering
- Proper assessment of pain

General Considerations

Substance Use Disorder

- Use of medication to treat Opioid Use Disorder (OUD)
- Assessment of individual patient risk for developing a SUD or substance use-related harms
- Understanding of SUDs as brain disorders, not moral failings
- Recognition of SUD and where to refer patients for treatment
- Exposure to patients undergoing successful treatment for SUD

General Considerations

Communication

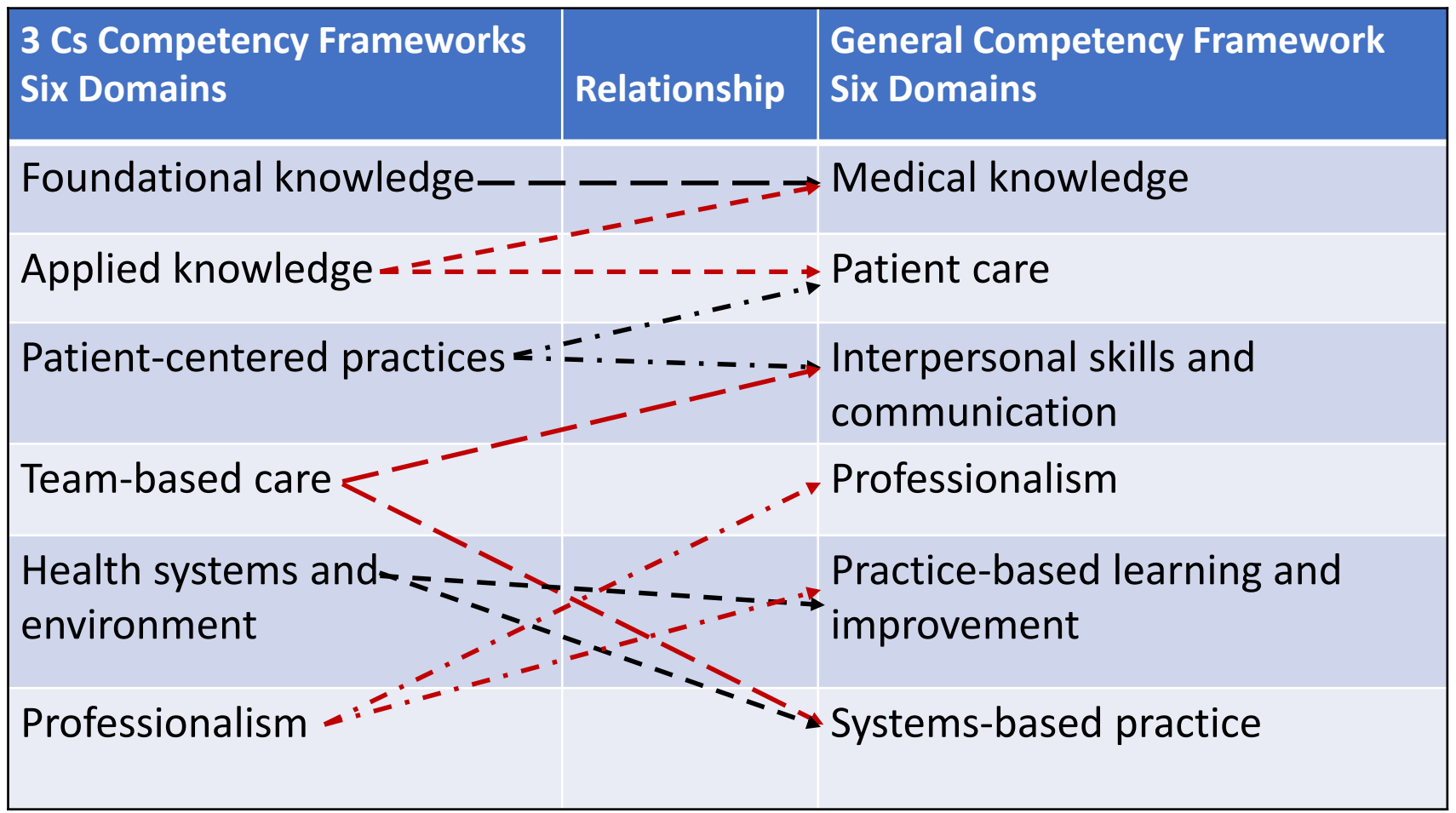
- Value of interprofessional and interdisciplinary approaches to pain management
- Communicating effectively with team members and how to manage handoffs
- How to listen and talk to patients about pain and pain management
- Communicating with patients about:
  - use of opioids
  - potential risks and realistic benefits of opioids and non-opioid or non-pharmacologic treatment methods for pain
  - setting reasonable goals for pain, function, and quality of life
  - communicating with the patient's care team
- Identifying and eliminating:
  - stigma, stereotypes, and bias that foster discrimination against and interfere with appropriate treatment for those with SUDs
  - use of stigmatized language regarding pain and SUD

Specialty-specific Considerations

- Provision of anticipatory guidance for safe opioid use (Emergency Medicine)
- Avenues for communicating with surgeons following pre-op workup and assessment (Family Medicine)
- Preoperative counseling to address patient expectations and concerns (Orthopaedics)
- Cognitive behavioral therapy for managing pain (Psychiatry)
- Communicating a pain plan to the patient and the patient's caregivers (Surgery)

3Cs Framework and General Competencies

3 Cs Competency Frameworks Six Domains	Relationship	General Competency Framework Six Domains
Foundational knowledge		Medical knowledge
Applied knowledge		Patient care
Patient-centered practices		Interpersonal skills and communication
Team-based care		Professionalism
Health systems and environment		Practice-based learning and improvement
Professionalism		Systems-based practice



Patient-centered Practices: Addiction Medicine Milestones

Patient Care 1: Screening, Evaluation, Differential Diagnosis, and Case Formulation of the Patient with or at Risk of Substance Use, Addictive Disorders, and Comorbidities				
Level 1	Level 2	Level 3	Level 4	Level 5
Uses validated screening and assessment tools	Actively engages patients in discussions of screening and assessment results	Addresses inconsistencies in collected information from screening and assessment	Teaches validated screening and assessment tools to other health care professionals	Facilitates or leads screening and patient evaluation activities within an organization
Performs biopsychosocial history and targeted physical examination	Incorporates biopsychosocial history, examination, lab, and collateral data into patient evaluation	Performs comprehensive patient evaluation, including patients with complex presentations, with indirect supervision	Independently performs comprehensive patient evaluation, including for patients with complex presentations	Participates in the ongoing development or evaluation of disease identification and diagnostic criteria
Organizes, summarizes, and presents information and develops an initial differential diagnosis	Uses diagnostic criteria to define differential diagnosis while avoiding premature closure	Develops a case formulation, including diagnosis, readiness to change, risk of withdrawal and relapse, psychiatric and medical comorbidities, and recovery/living environment	Continuously reassesses the patient, adjusting the formulation as new data becomes available	
☐	☐	☐	☐	☐
Comments:			Not Yet Completed Level 1 ☐ Not Yet Assessable ☐	

ACGME

Accreditation Council for Graduate Medical Education

Summary

- The Action Collaborative has identified opportunities for medical education across the continuum to address the current and worsening opioid epidemic.
- The special publication outlines current practice gaps and regulatory opportunities to help address the gaps
- The 3Cs competency framework can supplement the current six general competencies in use by GME programs and help programs
  - Target key practice gaps
  - Reduce stigma
  - Enhance interprofessional collaborative

Examining Core Competencies for Opioid Prescriber Education

Lisa Howley, Association of American Medical Colleges

Bobby Mukkamala, American Medical Association Substance Use and Pain Care Task Force

Paul Moore, University of Pittsburgh School of Dental Medicine (Emeritus)

Melissa Weimer, American Society of Addiction Medicine

Identifying Key Competencies for Opioid Prescriber Education

Bobby Mukkamala, MD
Chair, AMA Board of Trustees
Chair, AMA Substance Use and Pain Care Task Force

April 4, 2022

Drivers of America's drug overdose epidemic

Policy mandates have not helped reduce drug-related overdose or death

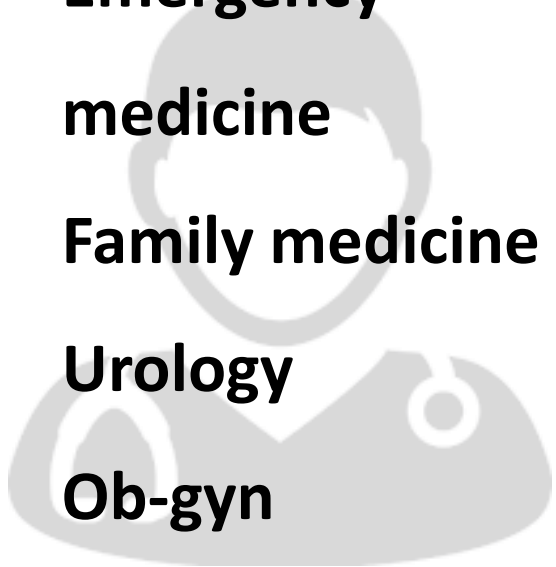
Physicians and other health care professionals have reduced opioid prescriptions and increased use of prescription drug monitoring programs. But the data shows a worsening, more deadly drug-related overdose epidemic - primarily fueled by illicitly manufactured fentanyl and fentanyl analogs.

221,699
Overdose Deaths
YoY Change ▲30.0%

143,390,951
Opioid Prescriptions
YoY Change ▼6.9%

Can one REMS address all patients and physician specialties?

- Ear, nose and throat physicians
- Orthopaedics
- Trauma surgery
- Emergency medicine
- Family medicine
- Urology
- Ob-gyn
- Physiatry
- Pediatrics



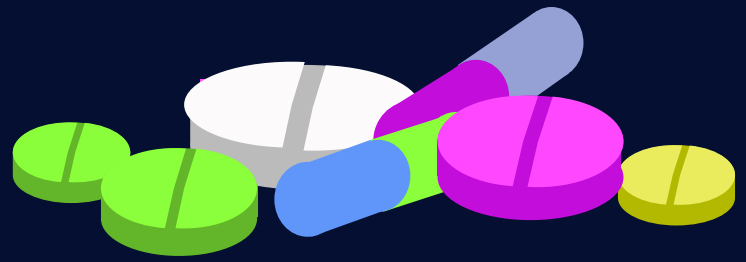
What does the AMA recommend to support evidence-based care for patients with pain?

Access to care	Update policies	Distinguish pain from SUDs	Enhance medical education
Support coverage for, access to, and payment of comprehensive, multi-disciplinary, multi-modal evidence-based treatment for patients with pain.	Finalize the 2022 CDC proposed opioid prescribing recommendations to remove inflexible prescribing thresholds to begin to restore balance and remove stigma for patients with pain.	Distinguish policies and practices for SUDs and pain—this is misleading, stigmatizing, and inappropriately suggests that patients with pain are only one prescription away from becoming an “addict”	Support and encourage undergraduate and graduate medical education to add specific curricula on comprehensive pain care

Physicians' powerful ally in patient care

University of Pittsburgh

The Development of Key Competencies for Opioid Prescriber Education in Dentistry



Paul A. Moore DMD, PhD, MPH
Professor Emeritus
Pharmacology, Anesthesiology, Public Health
University of Pittsburgh
School of Dental Medicine

pam7@pitt.edu

Disclosures: Paul A. Moore

In the last twenty years, Dr. Moore has served as a research consultant to several companies including Dentsply Pharmaceutical, Kodak Dental Systems, Septodont USA, St Renatus, Novalar Inc. and Novocol of Canada Inc. His serves have involved pharmacovigilance of marketed local anesthetic products as well as research protocol development of new local anesthetics for dentistry. Additionally, he has also served as a principal investigator for FDA required Phase II, Phase III and Phase IV clinical research contracts awarded to the University of Pittsburgh by Wyeth Consumer Healthcare, Novocol of Canada Inc. and Novalar Pharmaceutical Inc. He currently has no affiliations with any pharmaceutical company.

Three Domains of Performance

Core Knowledge

Collaboration

Clinical Practice

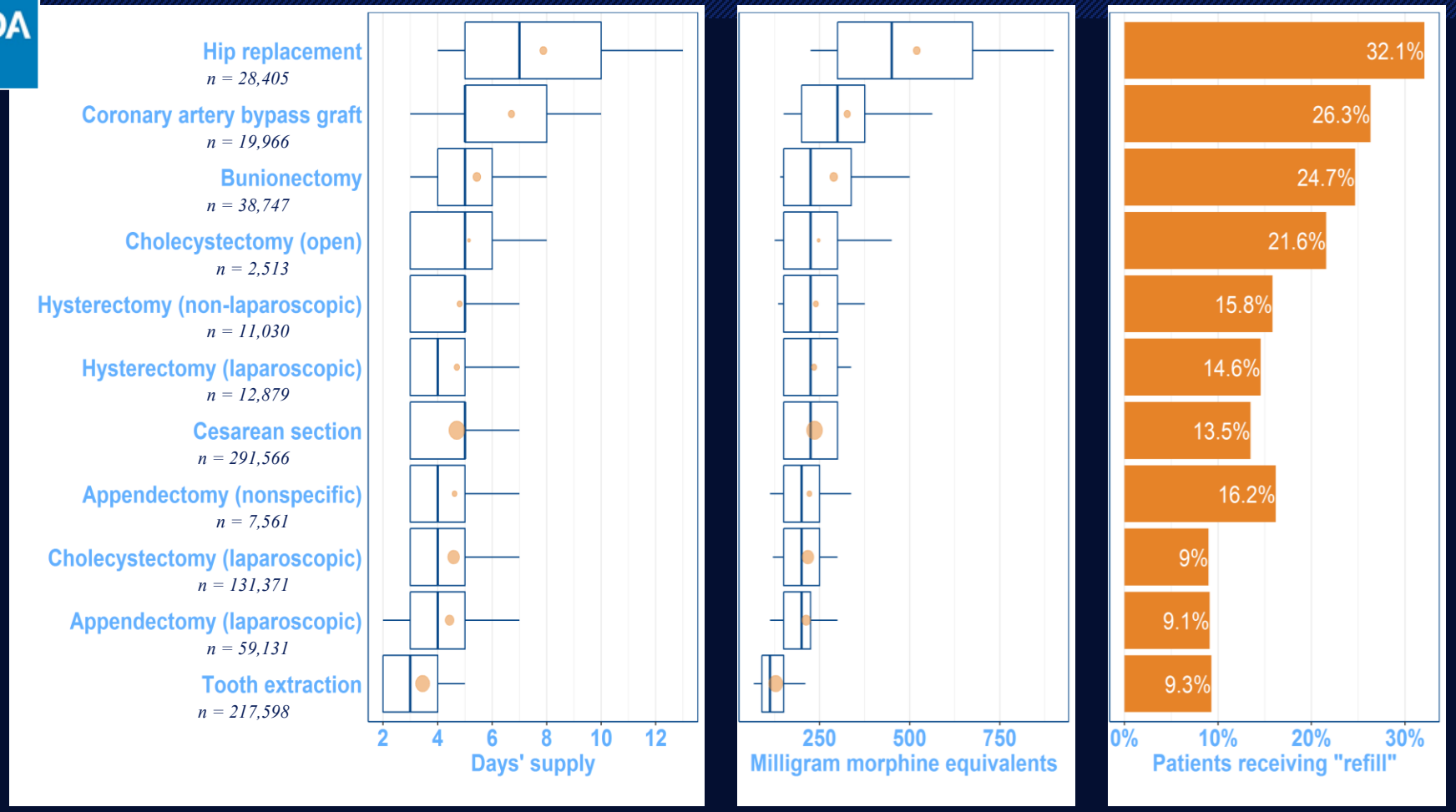
Why Are Dental Practitioners Unique?

- We are extremely risk aversive.
- We manage acute pain almost exclusively.
- Outpatient and solo practice model:

  ”A Culture of Independence”
- Our role in opioid addiction crisis is

  “Primary Prevention”.
- May be first to prescribe to adolescents.

Quantities Dispensed



Bohn J, Mundkur M, et al.: Estimating "Optimal" Durations for Initial Opioid Analgesic Prescription Following Common Surgical Procedures". International Conference on Pharmacoepidemiology & Therapeutic Risk Management (34th ICPE), August 25, 2018.

Paul A. Moore

Decrease Opioid Prescribing in Dentistry

- ✓ There was an 40% overall decrease in opioid prescriptions by OMS from 48% of adults undergoing dental surgery in 2012 to 29% in 2019.*

- ✓ Prescribing by general dentists (2012 to 2019) reported a decrease of 45% in number of opioid prescriptions, and a decrease of 59% in the total MME.**

*Okuney I, et al. Trends in National Opioid Prescribing for Dental Procedures among Medicaid Patients. JADA 152:622-630, 2021.

** Yan CH, et al. Trends In opioid prescribing by general dentists and dental specialist in the U.S. 2012-2019. Am J Prev Med 2022.

Decrease Opioid Prescribing by OMS

390,000 MMEs/year by Primary Care Physicians,
112,000 MMEs/year by Medical Surgeons
29,000 MMEs/year by Emergency Physicians

compared to

13,000 MMEs/year prescribed by Oral and Maxillofacial Surgeons

Comparing specialties, oral and maxillofacial surgeons ranked 8th among specialties when prescribing was based on MMEs/year.

Stein, Bradley et al. Change in Per Capita Opioid Prescriptions Filled at Retail Pharmacies, 2008-2009 to 2017-2018. Ann Intern Medicine. 2022 Feb;175(2):299-302

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

Special Issues for Rx in Dentistry

- ✓ Understand the major elements of the ADA 2022 Clinical Practice Guidelines.
- ✓ Provide five examples of Multimodal Pain Management for acute dental pain.
- ✓ Practice screening for risks of misuse and abuse and referral for OUDs.
- ✓ Discuss “Just-in-Case” prescribing and unused opioids.
- ✓ Describe “Doctor Shopping”, Electronic Prescribing and PDMP.
- ✓ Discuss elements of education for adolescents and parents- Third molar extractions and informed consent.
- ✓ Inform patients/parents regarding securing, storage and disposal.

USS Homestead Mill - 1966

Thank you for your attention

http://pgdigs.tumblr.com/

Discussion Questions

1. How would you define the concept of core competencies for all healthcare providers who help manage patients with pain?
2. What are key skills, knowledge, and competencies that should be considered core competencies for opioid prescribers and team members? How have these core competencies shifted with the changing landscape of the opioid and substance use crisis?
3. Are there particular competencies more relevant for certain provider types or specialties? How do these align with or diverge from core competencies that all providers should be taught?
4. Do providers generally have the skills and knowledge necessary for these core competencies? How well do the REMS Blueprint and other prescriber educational content address them?

Break

We will be back momentarily.

The next panel will begin at 3:30 p.m. (U.S. Eastern Time)

Professional Practice Gaps in SUD and Pain Management and Related Gaps in Current Prescriber Education

Kathy Chappell

American Nurses Credentialing Center and National Academy of Medicine Action Collaborative on Countering the U.S. Opioid Epidemic

Current Gaps in Prescriber Education and Their Impact on Professional Practice Gaps in SUD and Pain Management

Kathy Chappell, PhD, RN, FNAP, FAAN
Senior Vice President, Accreditation, Certification, Measurement, Institute for Credentialing Research and Quality Management, and Advanced Practice Initiatives

April 4, 2022

ANCC
AMERICAN NURSES CREDENTIALING CENTER

Innovate. Involve. Inspire.

Disclosure

- I have no conflicts of interest to disclose.

About the Action Collaborative and the Education and Training Working Group

The Action Collaborative is a public-private partnership of over 60 members from the public, private, and non-profit sectors.

Mission: To convene and catalyze public, private, and non-profit stakeholders to develop, curate, and disseminate multi-sector solutions designed to reduce opioid misuse, and improve outcomes for individuals, families, and communities affected by the opioid crisis.

Leadership: Steering Committee co-chaired by NAM, Aspen Institute, HHS, and HCA Healthcare

Four priority focus areas (working groups): Health professional education and training; Pain management guidelines and evidence standards; Prevention, treatment, and recovery services; and Research, data, and metrics needs

Health Professional Education and Training Working Group Co-leads: Kathy Chappell (American Nurses Credentialing Center), Eric Holmboe (Accreditation Council for Graduate Medical Education), Steve Singer (Accreditation Council for Continuing Medical Education)

NAM Special Publication

On December 16, 2021 the Education and Training Working Group released a NAM Special Publication to describe and assess: **professional practice gaps**, existing **regulatory requirements and policy standards**, and identified five **actionable priorities** needed to strengthen coordination and collaboration across the health education system

Literature Review Data

Data Snapshot

- Coding data high level overview and summary
  - 609 articles in search
  - 547 analyzed (62 articles not available in full text)
  - 310 articles met inclusion criteria (57%)
    - Quantitative – 197 (64%)
    - Qualitative – 61 (19%)
    - Mixed methods – 52 (17%)
- Evaluated by:
  - Profession (including specialty if available)
  - Practice environment/setting
  - Domain of practice (as it related to acute or chronic pain management or SUD)
  - Data source
  - Patient population
  - Domains of treatment
  - Source of PPG

Literature Review Data

Coding Results

- Results by health profession
  - Physician (unspecified, MD and DO) – 83%
  - Nursing (unspecified, RN and APRN) – 25%
  - Pharmacy (pharmacist and pharmacy tech) – 14%
  - PA – 9%
  - Dentistry (dentist) – 5%
  - Behavioral health –14%
  - Specialty of one of the above – 43%

- Results for top combinations of 2 or more professions
  - APRN + Physician- 11.9%
  - Physician + Pharmacist- 11.9%
  - Physician + Physician Assistant- 8.7%
  - APRN + Physician Assistant- 7.3%
  - Nursing (unspecified) + Physician- 6.6%
  - Physician + Dentistry (DDS/DMD)-3.5%
  - RN + Physician- 2.8%
  - APRN + RN- 2.1%
  - Nursing (unspecified) + Pharmacist- 2.1%

Literature Review Data

Analysis Results

- Results for domain of practice
  - Chronic pain management- 66%
  - Acute pain management- 36%
  - Substance use disorders- 23%
  - Other practice domain- 5%

- Results for type or stage in care process
  - Treatment: Prescribing or Tapering- 93%
  - Monitoring- 10%
  - Screening/assessment- 8%
  - Treatment: Non-pharmacological- 7%
  - Identification/diagnosis- 4%
  - Treatment: Prescribing non-opioids- 3%
  - Referral- 3%
  - Other type or stage in care process- 9%

Note: n = 310. Percentages do not total 100% because of multiple response options

Literature Review Data

Analysis Results

- Practice gaps organized by theme
  - Clinical knowledge (didn't know best practices)- 40%
  - Attitudes and biases- 30%
  - Use of evidence-informed tools and resources- 26%
  - Communication with patients/families- 13%
  - Constraints in practice settings- 12%
  - Communication with other members of the care team- 6%

Literature Review Data

Analysis Results

Practice gap analysis from qualitative data on restraints in clinical settings

- Healthcare Professional
  - Time (insufficient)
  - Fear of litigation
  - Concern that income and employment would be impacted by low patient satisfaction scores
- Health Care System
  - Insurance related
  - Regulatory restrictions
  - Lack of available referral resources
  - Lack of institutional guidelines or resources
  - Data interoperability
- Patient-Related
  - Patient logistics
  - No provider-patient relationship in setting (e.g. ED)

Literature Review Data

Analysis Results

Practice gap analysis organized by healthcare profession and patient related themes

Healthcare Professionals

- Education and training
  - Competency
  - Lack of evidence
  - Lack of access to existing evidence
- Different prescribing practices between groups but cause unknown
  - Provider type
  - Type of pain
- Attitude/biases
  - Towards patients
  - Interprofessional
  - Interest
  - Lack of trust

Literature Review Data

Analysis Results

Practice gap analysis organized by healthcare profession and patient related themes

Healthcare Professionals (continued)

- Barriers
  - Cite knowledge, training and institutional support as barriers
  - Don't believe opioid treatment agreement between patient and provider prevented opioid misuse; believed they did protect physician

Patients

- Demographic differences
  - Age, race, SES, location
  - Patient type
    - Civilian vs active duty
    - Patient population (geriatric vs orthopedic; surgery vs medical)
  - Past medical history
    - Chronic pain
    - SUD

Literature Review Data

Analysis Results

Practice gap analysis organized by healthcare profession and patient related themes

Patients (continued)

- Comorbidities
- Payer type (private insurance, public insurance, no insurance)
- Patient reported gaps
  - Pain undertreated
  - Use ER for pain management
  - Lack of treatment for substance dependence
  - Physician spent insufficient time educating patient
  - Lack of access to therapy
  - Lack of structured process for tapering dosages
  - Physicians typically do not present alternative pain management options or discuss risks of opioid dependence
  - Fragmented care/treatment plan
  - Not being included in decision-making processes around own pain management
- Discordant goals with provider

Literature Review Results

Quantitative Results and Key Findings

- PPGs were associated with prescribing or tapering opioids (93%), followed by monitoring (10%), screening/assessment (8%), nonpharmacological treatment (7%), identification/diagnosis (4%), prescribing non-opioids (3%), and referral (3%)

- Root causes: clinical knowledge (wasn't aware of best practice; 40%), attitudes and biases (30%), and/or the use of (failure to use/lack of available) evidence-informed tools and resources (26%)

- Communication with patients/families (13%), constraints in the practice setting (12%), and/or communication with other members of the health care team (6%) were also cited as contributing to professional practice gaps

Literature Review Results

Conclusions and Discussion

- Health care providers are struggling as they try to manage multiple and competing priorities. They **lack access to user-friendly tools and resources at the point of care** and **struggle to identify and/or implement evidence-based guidelines** to support patient-care decisions

- **Attitudes and biases** appear to negatively impact patient outcomes.

- **Lack of trust** was an emerging theme, particularly as it related to the subjectivity of pain and pain scales

- **Education should be provided across all health professions.** Additionally, education should be team-based and focused on improving team performance and patient outcomes. Patients and families should participate as members of the health care team

Literature Review Results

Conclusions and Discussion (continued)

- **Health care providers struggle more often treating patients with chronic pain as compared to patients with acute pain**. There is a need for education, tools and resources to support efficacious prescribing practices (particularly for tapering, converting different types of opioids, and how to effectively use non-opioid strategies concurrently with or in lieu of opioids)
- **Differences in prescribing practices between different provider groups and by type of pain** were prevalent in the literature
- **Insurance reimbursement issues were cited as a significant barrier**, including lack of insurance and insurance coverage that did not cover recommended services
- **Inadequate numbers of providers in critical areas** such as mental health, addition or specialty pain management resulted in failure to meet patients' needs
- *Limitations: Evaluating professional practice gaps solely based on the published peer-review literature which could reflect publication biases; studies that relied solely on self-report data; and data that may reflect response biases such as a tendency to attribute blame to a system issue rather than to oneself*

Kathy.chappell@ana.org

Professional Practice Gaps in SUD and Pain Management and Related Gaps in Current Prescriber Education

Janet Keane, Shatterproof

Dania Palanker, National Pain Advocacy Center

Daniel Alford, Boston University School of Medicine

Carolyn Kinney, American Board of Physical Medicine and Rehabilitation

80% of heroin users reported using prescription opioids prior to heroin addiction.

STOP ADDICTION BEFORE IT STARTS

ACUTE PAIN

1. Post-op surgical pain
2. Dental pain
3. Pain treated in the emergency room

USE
ALTERNATIVES TO OPIOIDS

Take programs that have successfully implemented non-opioid alternatives to treat acute pain & replicate those programs across the country

MICHIGAN OPEN
michigan-open.org

- Launched in 2016
- Michigan department of health and human services
- Blue Cross and Blue Shield of Michigan value Partnerships
- Institute of healthcare policy at the University of Michigan
- 22% decrease in opioid prescriptions from 2015-2018.

MICHIGAN OPEN

- Combination of NSAIDS and Acetaminophen round the clock as the first line of treatment for treatment of postoperative pain.
- Pain relief is the same or better than using opioids alone.
- Alleviates the need or significantly reduces the number of opioid pills that need to be prescribed post op.

https://michigan-open.org/wp-content/uploads/2021/05/Non-Opioid-Acute-Care-Pain-Management_Adult.FINAL_.pdf

ALTO IN THE ER (alternatives to opioids)

Launched in 2016 by Dr. Mark Rosenberg at the Saint Joseph's Medical Center in Patterson NJ.

Reduces opioid prescriptions by 82%.

Uses alternatives to opioids to treat specific diagnosis such as kidney stones, musculoskeletal pain, fractures, and headaches/migraines

Recommends specific pathways by diagnosis including doses of medications used.

IMPLEMENTATION

Require providers to take continuing education courses.

https://michigan-open.org/provider-education/

IMPLEMENTATION

Provide additional support and training of staff for offices & hospitals who want to initiate opioid alternative program.

IMPLEMENTATION

Require providers to display brochures in their offices to educate their patients on non-opioid alternatives to pain control.

https://michigan-open.org/patient-community-education/

IMPLEMENTATION

Public service announcements for patients.

UNDERSTANDING PATIENT-CENTERED OPIOID PRESCRIBING COMPETENCIES

Dania Palanker

Margolis-FDA Workshop: Identifying Key Competencies for Opioid Prescriber Education

April 4, 2022

UNDERSTANDING HEALTH COVERAGE LIMITATIONS

- **Limitations vary by payer**
  - (Medicare, state Medicaid program, insurer, different plans offered by an insurer, employer, etc.)
- **Opioid prescribing limits**
  - Quantity and day limits
  - Non-quantitative treatment limits
- **Non-opioid treatments are limited in many plans**
  - Visit limits often combined for rehabilitation services
  - Coverage exclusions
  - Definitions of medical necessity
  - No coverage for care coordination
- **Mental health coverage limitations**
  - Federal and state laws require parity, but…

UNDERSTANDING TAPERING DOS AND DON'TS

- Tapering needs to be voluntary
- Forced tapers are dangerous
- Proper pace to taper
- When to stop tapering
- Caring for new patients in the midst of a forced taper

UNDERSTANDING HEALTH EQUITY

- **Health Equity**: A just opportunity to live as healthy a life as possible
- **Equality**: Having the same opportunities
- **Disparities or Inequalities**: System differences between groups
- **Inequities**: Disparities or inequalities that arise from injustice

STRUCTURAL INEQUITIES WORSEN PAIN

- **Structural inequities**
  - Change the experience of pain
  - Cause pain
  - Reduce Access to pain treatments

- **Inequitable barriers to care**
  - Costs of services
  - Pharmacy locations and not carrying opioids
  - Provider locations
  - Lack of transportation

RECOGNIZING PROVIDER BIAS

- **We all have bias**
  - unconscious, conscious, and in between
- **Bias is everywhere**
  - Race, Ethnicity, Limited English Proficiency
  - Gender, Gender Identity, Sexual Orientation
  - Religion
  - Disability
  - Socioeconomic Status
- **Medical myths**

PROVIDING CULTURALLY COMPETENT PAIN CARE (1)

- **Cultural competency**
  - Understanding and responding to cultural differences
  - Culture is more than ethnicity

- **Assessment of function**
  - What does quality of life mean to the patient?
  - Understanding activities of daily living
  - Patients pushing past capacity, deteriorating function

PROVIDING CULTURALLY COMPETENT PAIN CARE (2)

- **Providing adequate translation**
  - Know legal requirements for providing translation services, including ASL
  - Family members do not translate everything
  - Pain descriptors vary by language and culture
  - Patient-specific communication assistance for disabled patients

- **Cultural competency in talking about pain**
  - Stoicism
  - Gender differences
  - Health literacy
  - Experience of pain
  - Different terminology

UPCOMING CHANGES TO CDC GUIDELINES

- **Unintended consequences of 2016 guidelines**
- **Key proposed changes**
  - Abandons strict day/supply and dose limits from mainline recommendations
  - Cautions against rapid tapers and abrupt discontinuation of medications
  - Emphasizes individualized, person-centered pain treatment
  - Emphasizes collaboration with patients
  - Focuses on disparities in pain care

Professional Practice Gaps in SUD and Pain Management and Related Gaps in Current Prescriber Education

April 4, 2022

Margolis-FDA Workshop

Daniel P. Alford, MD, MPH, FACP, DFASAM

Professor of Medicine

Associate Dean, Continuing Medical Education

Director, Clinical Addiction Research and Education (CARE) Unit

Director, Safer/Competent Opioid Prescribing Education (SCOPE of Pain) Program

Boston University School of Medicine | Boston Medical Center

Boston University School of Medicine

Boston Medical Center

EXCEPTIONAL CARE. WITHOUT EXCEPTION.

Daniel Alford, MD, MPH
Disclosures

- I serve as course director for safer opioid prescribing CME funded by an unrestricted educational grant awarded to Boston University by the REMS Program Companies as part of the FDA's Opioid Analgesic REMS program
- I do not receive any direct payment from industry for these activities

My opinions are based on 20+ years as a…

- General Internist with a primary care practice that includes patients with chronic pain (some taking long-term opioids) and patients with addiction (some with concurrent pain)
- Addiction medicine specialist, former medical director of an opioid treatment program and an office-based addiction treatment program
- Clinician educator with history of NIDA, SAMHSA, CDC and HRSA funding to develop curricula on addiction and pain related topics
- Associate Dean of Continuing Medical Education at BUSM
- Course director of the first and longest running opioid REMS program – BUSM's Safer and Competent Opioid Prescribing Education (SCOPE of Pain) program which as trained approximately 250,000 nationally over 9 years

In my 5-7 minutes of opening remarks…

- **I will not focus on the many systemic gaps** (e.g., lack of adequate insurance coverage) which result in lack of patient access to optimal SUD and pain care

- **I will focus on provider education gaps** which result in practice gaps and suboptimal patient care
  - Despite the many improvements over the past decade in provider SUD and pain management knowledge, there remains many important gaps in knowledge and how to apply this knowledge into clinical practice in a way that optimizes patient care

Substance Use and SUD: Education Gaps

- Implementing universal use of validated screening tools to identifying patients with the full spectrum of unhealthy substance use (risky use to use disorder) as part of routine health care
- Counseling patients with unhealthy substance use in ways that builds motivation to change rather than resistance to change
- Initiating (and maintaining) life-saving medications for treating SUD wherever the patient presents for care, not unlike what is done for other chronic medical conditions
- Creating practice-specific procedures for facilitating patient referrals to specialty addiction treatment and educating patients (and their families) about what to expect
- Treating acute and chronic pain in patients with concurrent SUD
- Using non-judgmental, non-stigmatizing, patient-first language (e.g., “patients with a severe opioid use disorder” rather than “opioid addict” or “opioid abuser”)

Pain Management: Education Gaps

- Recognizing and addressing stigma, biases, mistrust and fear when caring for patients with pain
- Creating procedures for implementing multidimensional assessments (pain, function, quality of life) and appreciating their limitations (i.e., one person's "6" is another person's "10")
- Setting realistic individualized treatment goals (pain, function, quality of life) that are specific to each patient and that change over time
- Initiating and modifying treatment plans based on the subjective (patient-reported) nature of the clinical data (i.e., how much improvement is enough?...10%, 20%, 30%, any?)
- Communicating with patients about the rationale for nonmedication-based therapy and what to expect from that treatment

Pain Management and Opioids: Education Gaps

- Using universal precautions but applying them individually to match the patient's risk
- Shifting from a focus on following procedures (agreements, urine drug tests, PDMP) to using these tools in a meaningful way to improve patient care and safety (e.g., agreements written at the appropriate reading level)
- Assessing and responding to worrisome behaviors (e.g., unexpected urine drug test result) and communicating nonjudgmentally with patients about concerns and next steps
- Distinguishing between "pain-relief-seeking" and "substance-use-seeking" behaviors as both can appear out-of-control and compulsive
- Minimizing opioid dose escalation despite the absence of an analgesic ceiling effect (setting arbitrary maximum doses based on subjective risk and benefit assessments)

Pain Management and Opioids: Education Gaps

- Caring compassionately for patients already on high dose opioids (e.g., the inherited patient, the “opioid orphan”)
- Navigating the prior authorization process for various opioids and opioid doses
- Judging the opioid treatment (i.e., benefits and harms) not the patient, similar to how we assess treatment outcomes for other chronic conditions
- Safely tapering opioid treatment due to lack of benefit or apparent harm with careful monitoring for additional harm during the taper (e.g., suicide, overdose) and avoiding patient abandonment
- Optimizing office systems by educating and utilizing interprofessional teams similar to managing other complex chronic conditions - it cannot just be about educating prescribers
- Collaborating with community pharmacists (sharing information to improve care)

Thank you!

dan.alford@bmc.org

Identifying Gaps in Prescriber Education and Practice

Duke-Margolis Center for Health Policy/U.S. Food and Drug Administration Workshop – April 4, 2022

Carolyn L Kinney, MD

American Board of Physical Medicine and Rehabilitation

Knowledge Acquisition

- What promotes new learning and its long-term retention?
  - Relevance of material to learner
  - Trusted source of material
  - Testing
  - Feedback on (especially) incorrect answers
  - Related assessment “counts” for scoring
  - Regular repetition of material –correction opportunity for previous incorrect answers

Price D, et al. (2018). Longitudinal assessments in continuing specialty certification and lifelong learning. Medical Teacher, 40(9), 917-919.

ABPMR Continuing Certification

- Longitudinal Assessment (LA-PM&R) – “assessment for learning” - quarterly
  - Ability to customize learning experience to what is most valuable to individual physicians
  - Clinically relevant vignettes with associated questions
  - Immediate feedback on answers with the rationale for the correct response
  - Links from each question to additional educational material
  - Items answered incorrectly presented again in future quarters: spaced repetition
  - Physicians know they will receive full credit for correct answer if subsequently answered correctly – powerful motivator
  - Leads to summative decision on 5-year cycle – performance “counts”

Robinson L, et al. Evaluation of Longitudinal Assessment for Use in Maintenance of Certification. Amer J of Physical Medicine & Rehabilitation. May 2020. 99(5): 420-23.

ABPMR Continuing Certification

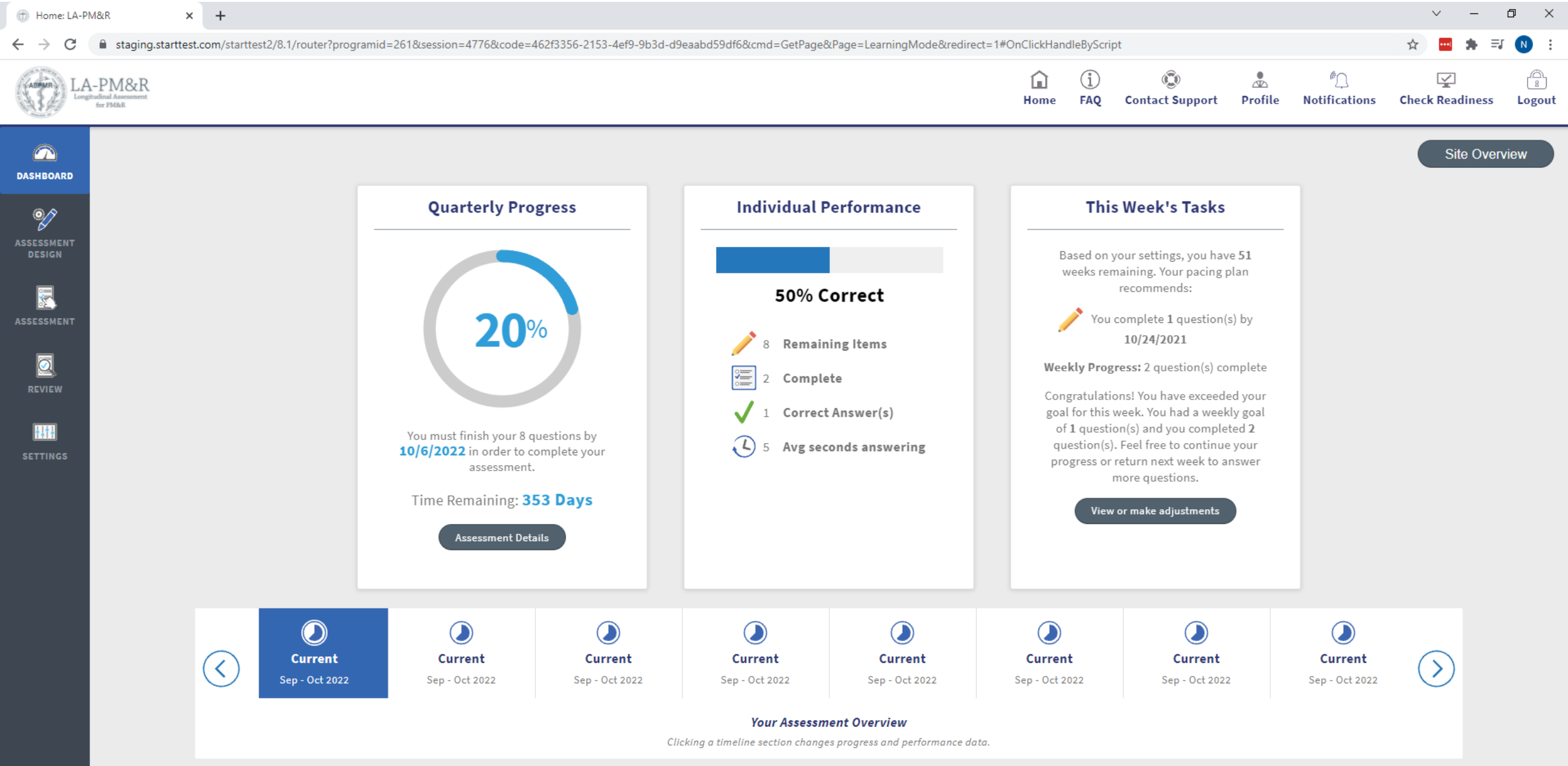
- Longitudinal Assessment (LA-PM&R)

  Over time, **individual** receives accumulated feedback on knowledge gaps

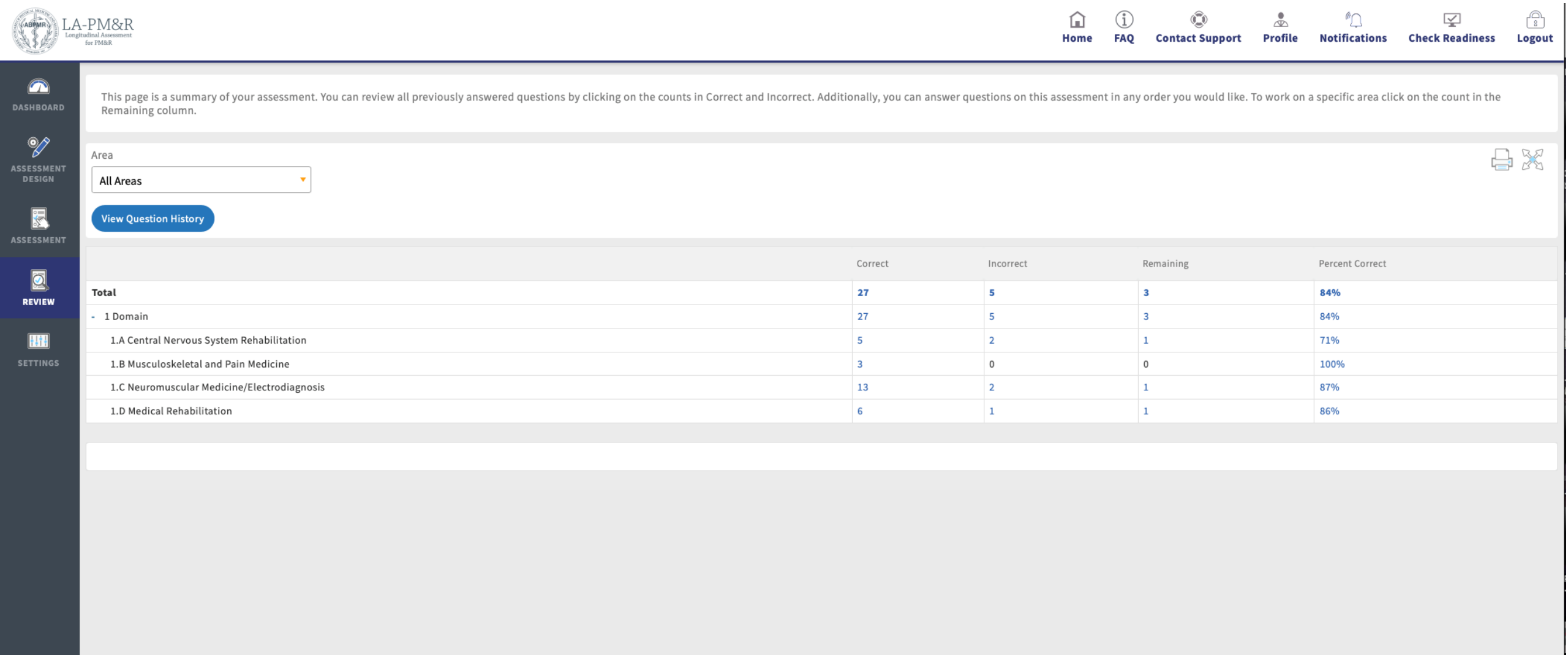
  Over time, **ABPMR** receives specialty feedback on knowledge gaps

  - Can share feedback with specialty society partners for development of educational materials in variety of formats
  - Individuals can receive specific guidance on remediation of knowledge gaps
  - Can present new significant learning quickly – ex: COVID, opioids

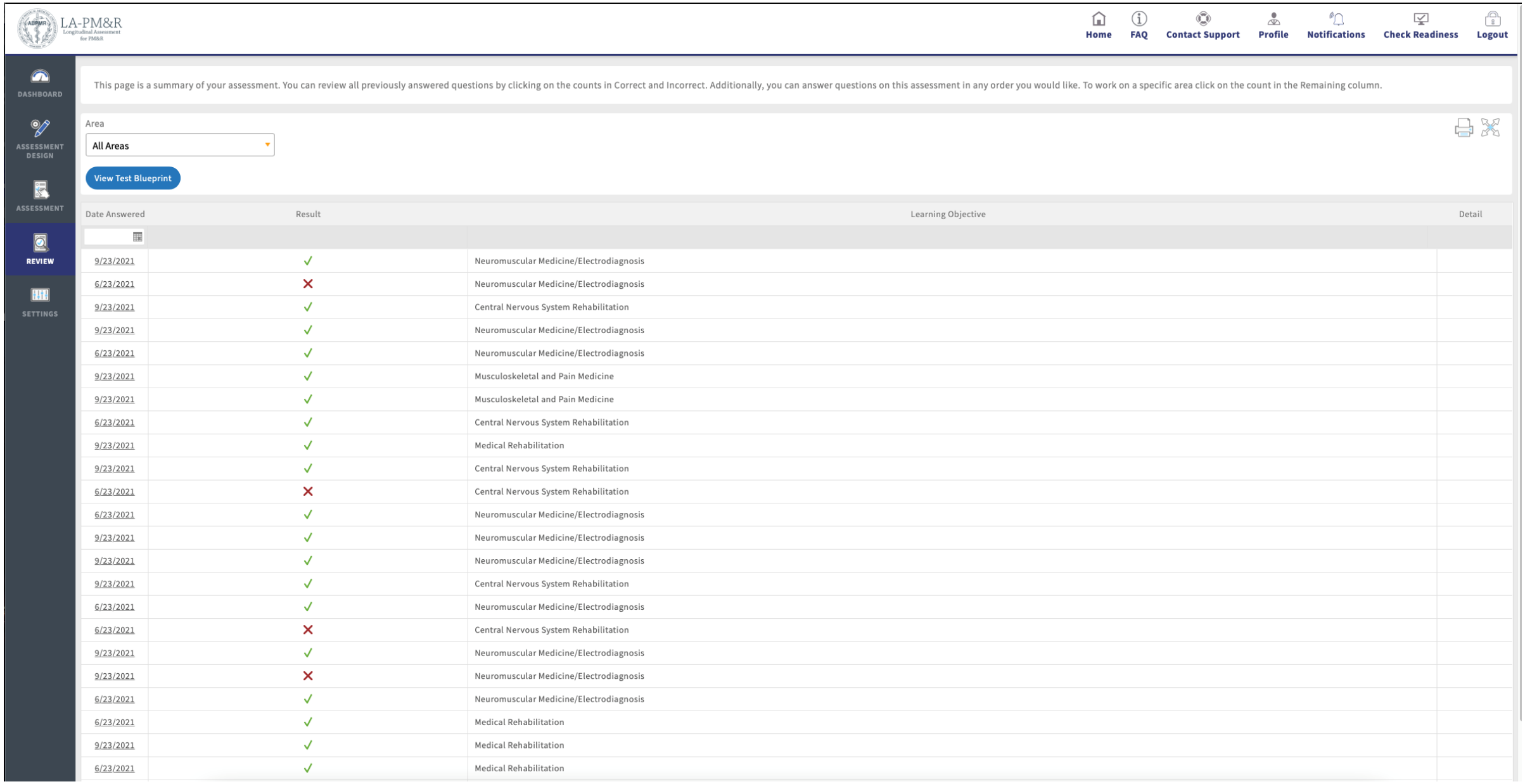
Homepage


Home: LA-PM&R
staging.starttest.com/starttest2/8.1/router?programid=261&session=4776&code=462f3356-2153-4ef9-9b3d-d9eaabd59df6&cmd=GetPage&Page=LearningMode&redirect=1#OnClickHandleByScript
LA-PM&R
Longitudinal Assessment for PM&R
Home
FAQ
Contact Support
Profile
Notifications
Check Readiness
Logout
DASHBOARD
ASSESSMENT DESIGN
ASSESSMENT
REVIEW
SETTINGS
Site Overview
Quarterly Progress
20%
You must finish your 8 questions by 10/6/2022 in order to complete your assessment.
Time Remaining: 353 Days
Assessment Details
Individual Performance
50% Correct
8 Remaining Items
2 Complete
1 Correct Answer(s)
5 Avg seconds answering
This Week's Tasks
Based on your settings, you have 51 weeks remaining. Your pacing plan recommends:
You complete 1 question(s) by 10/24/2021
Weekly Progress: 2 question(s) complete
Congratulations! You have exceeded your goal for this week. You had a weekly goal of 1 question(s) and you completed 2 question(s). Feel free to continue your progress or return next week to answer more questions.
View or make adjustments
Current Sep - Oct 2022
Current Sep - Oct 2022
Current Sep - Oct 2022
Current Sep - Oct 2022
Current Sep - Oct 2022
Current Sep - Oct 2022
Current Sep - Oct 2022
Current Sep - Oct 2022
Your Assessment Overview
Clicking a timeline section changes progress and performance data.

Review Screen



Question History



Rationale and References

Answered: 10/12/2021 **Response:**

Key Point: Treatment of tendon pain

Provide Feedback

Rationale:

Wrist and hand pain occur in 48-64% of people with a spinal cord injury (SCI). De Quervain tenosynovitis affects the abductor pollicis longus and extensor pollicis brevis in the first dorsal compartment of the wrist. In patients with an SCI, this can be associated with the repetitive gripping of the wheelchair pushrim. Tenosynovitis is inflammation of a tendon and its enveloping synovial sheath. This condition can be related to piano playing, typing, golfing, pinching, or texting. It typically presents with a gradual onset of pain and stiffness in the lateral wrist with grasp and thumb extension along with a history of chronic overuse of the wrist and hand. Pain can be so severe that the hand becomes nonfunctional, making dressing difficult. There is no associated sensory abnormality. On examination, there can be tenderness to palpation and swelling around the radial styloid. De Quervain tenosynovitis is a clinical diagnosis. Finkelstein test (pain reproduction with grasping the patient's thumb and quickly abducting the hand in ulnar deviation) is pathognomonic; however, radiographs should be done to rule out other causes. Grip, pinch, and other manual muscle testing findings may be decreased secondary to pain. In cases of nondiagnostic clinical findings, bone scan, ultrasound, or injection can be considered to assist. Mild symptoms may be temporarily responsive to thumb spica splinting. The initial treatment is injections as there is no evidence that conservative treatment (ice, nonsteroidal anti-inflammatory drugs [NSAIDs], heat, orthoses, strapping, rest, or massage) is effective. Up to an 83% cure rate has been described with a local anesthetic and corticosteroid injection into the first extensor compartment. The addition of ultrasound-guided injections has increased improvement to 97%.

References:

Frontera WR, Silver JK, Rizzo Jr. TD. Essentials of Physical Medicine and Rehabilitation. 4th ed. Philadelphia PA: Elsevier; 2019:149-152.

Kirshblum SC, Lin VW. Spinal Cord Medicine. 3rd ed. New York, NY: Demos Medical; 2019:442-444.

Frontera WR, Silver JK, Rizzo Jr. TD, eds. Essentials of Physical Medicine and Rehabilitation. 3rd ed. Philadelphia, PA: Elsevier Saunders; 2015:138.

Kirshblum SC, Campagnolo DI, eds. Spinal Cord Medicine. 2nd ed. Philadelphia, PA: Wolters Kluwer/Lippincott Williams & Wilkins; 2011:298-300.

Transition from learning to action

- Feedback promotes self- motivation
  - Comparison with peers
  - Individual – could include patient feedback, information re: prescribing practices
  - Facilitation to change practices

- Natural – and necessary - link with Quality Improvement
  - ABMS boards will require partnering with related medical societies and other institutions do to develop data-driven approaches with performance feedback.

- Navathe A, et al. The Effect of Clinician Feedback Interventions on Opioid Prescribing. Health Affairs; 2022; 41(3):424-33.
- Starr M, et al. Impact of Standardized Prescribing Guidelines on Postoperative Opioid Prescriptions after Ophthalmic Surgery. Ophthalmology. April 2020; 127(11)

ABPMR Quality Improvement Projects

SOAPP-R for Opioid Management

Literature suggests that early identification of opioid abuse potential improves the outcome of patients with painful medical conditions. Identify whether your practice uses the Screener and Opioid Assessment for Patients with Pain-Revised (SOAPP-R) or a similar tool. Consider this project if the SOAPP-R tool is not administered consistently or the results of the screener are not used effectively to manage a patient's risk of opioid misuse.

BEGIN THIS PROJECT

ABPMR Quality Improvement Projects

Opioid Management: Physician Drug Monitoring Program to Identify Multiple Opioid Prescriptions and Contraindicated Drugs

Physicians prescribing or renewing prescriptions for opioids may not be aware that patients are obtaining opioids from multiple providers or being prescribed other substances. The Centers for Disease Control recommends that physicians consider checking their state's Physician Drug Monitoring Program (PDMP) to monitor their patients' prescriptions. Consider this project to help assess how often you're checking the PDMP when prescribing and renewing opioid prescriptions.

BEGIN THIS PROJECT

Discussion Questions

1. Based on your experience, what necessary knowledge and skills related to pain management and opioid analgesics might prescribers and other providers be lacking? How might these differ by provider type or by specialty?
2. Does current prescriber education reflect the latest best practices for opioid analgesic prescribing and care for OUD and SUDs? Are providers generally familiar with these best practices?
3. How do gaps in prescriber and provider knowledge and practice affect patients? Do prescribers have sufficient training and skills in communicating with patients, and communicating inter-professionally with other providers about pain care options, including opioid analgesic medications, and treatments for OUD?
4. What can be done to improve providers' abilities to recognize and address practice gaps? How can prescriber education be a part of a culture of quality improvement?

Closing Remarks | Day 1

Mark McClellan, MD, PhD

Director, Duke-Margolis Center for Health Policy

Thank You!

Contact Us

healthpolicy.duke.edu

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dukemargolis@duke.edu

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Identifying Key Competencies for Opioid Prescriber Education

April 4, 2022 | 1:00-5:00 p.m. ET

April 5, 2022| 1:00-4:10 p.m. ET

FDA U.S. FOOD & DRUG ADMINISTRATION | Duke MARGOLIS CENTER for Health Policy

Welcome & Introduction | Day 2

Mark McClellan, MD, PhD

Director, Duke-Margolis Center for Health Policy

Overview: Day 1

Presentations:

Opening Remarks from FDA

FDA Presentation: Blueprint for Health Care Providers Involved in the Treatment and Monitoring of Patients with Pain: An Overview

SAMHSA Presentation: SAMHSA's Substance Use Disorder Training Initiatives

Panel Discussions:

Examining Core Competencies for Opioid Prescriber Education

Professional Practice Gaps in SUD and Pain Management and Related Gaps in Current Prescriber Education

Agenda: Day 2

Panel Discussions:

Identifying Lessons Learned from Provider Education and Continuing Medical Education Initiatives

Future Directions and Next Steps for Shaping Prescriber Education Efforts

Statement of Independence

The Robert J. Margolis, MD, Center for Health Policy is part of Duke University, and as such it honors the tradition of academic independence on the part of its faculty and scholars. Neither Duke nor the Margolis Center take partisan positions, but the individual members are free to speak their minds and express their opinions regarding important issues.

For more details on relevant institutional policies, please refer to the Duke Faculty Handbook, including the Code of Conduct and other policies and procedures. In addition, regarding positions on legislation and advocacy, Duke University policies are available at http://publicaffairs.duke.edu/government.

Virtual Meeting Reminders

- Attendees are encouraged to contribute throughout the meeting with questions in the Zoom Q&A function.
- This meeting is being recorded, and the recording will be posted on the Duke-Margolis event page in the weeks following the meeting.

Identifying Lessons Learned from Provider Education and Continuing Medical Education Initiatives

Jan Losby, Centers for Disease Control and Prevention

Kathryn Cates-Wessel, Providers Clinical Support System

Julianne Himstreet, U.S. Department of Veterans Affairs

Joanna Katzman, Project ECHO

Margot Savoy, American Association of Family Physicians

CDC's Prescriber Education Trainings and Resources

Jan Losby, PhD, MSW

Branch Chief, Health Systems and Research Branch

Division of Overdose Prevention

FDA Workshop

April 5, 2022

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

Webinars:
To Support the Uptake, Use, and Understanding of the 2016 CDC Guideline for Prescribing Opioids for Chronic Pain

Webinar Topics:

1. Overview of Guideline
2. Nonopioid Treatments for Chronic Pain
3. Assessing Benefits and Harms of Opioid Therapy
4. Dosing and Titration of Opioids
5. Opioid Use Disorder—Assessment and Referral
6. Risk Mitigation Strategies
7. Effective Communication with Patients

- ✓ CDC's Clinical Outreach and Communication Activity (COCA)
- ✓ Free online training webinars for clinicians
- ✓ Case-based content
- ✓ Physicians, nurses, and other health professionals can receive free continuing education for each training

Available at:
https://www.cdc.gov/opioids/providers/training/webinars.html

Training Modules:
To Support the Uptake, Use, and Understanding of the 2016 CDC Guideline for Prescribing Opioids for Chronic Pain

Training Series Topics/Modules:

1. Addressing the Opioid Epidemic: Recommendations from CDC
2. Treating Chronic Pain Without Opioids
3. Communicating with Patients
4. Reducing the Risk of Opioids
5. Assessing and Addressing Opioid Use Disorder
6. Dosing and Titration of Opioids: How Much, How Long, and How and When to Stop
7. Determining Whether to Initiate Opioids for Chronic Pain
8. Implementing CDC's Prescribing Guideline into Clinical Practice
9. Opioid Use and Pregnancy
10. Motivational Interviewing
11. Collaborative Patient-Provider Relationship in Opioid Clinical Decision Making
12. A Nurse's Call to Action for Safer Opioid Prescribing Practices
13. Using the Prescription Drug Monitoring Program to Promote Patient Safety in Opioid Prescribing and Dispensing
14. Addressing the Opioid Overdose Epidemic in the Emergency Department

- ✓ Free online training modules for clinicians
  Interactive online training series
- ✓ Stand-alone modules
- ✓ Self-paced
- ✓ Patient scenarios, videos, knowledge checks, tips, and resources
- ✓ Physicians, nurses, and other health professionals can receive free continuing education for each training

Available at:
www.cdc.gov/opioids/providers/training/interactive.html

CDC Resources

Clinician webinars:
https://www.cdc.gov/opioids/providers/training/webinars.html

Clinician training modules:
www.cdc.gov/opioids/providers/training/interactive.html

Creating a culture of safety for opioid prescribing:
https://www.cdc.gov/opioids/healthcare-admins/executive-handbook.html

Opioid overdose prevention website:
www.cdc.gov/drugoverdose

Quality improvement & care coordination:
https://www.cdc.gov/opioids/healthcare-admins/qi-cc.html
https://www.cdc.gov/opioids/healthcare-admins/videos.html

Resources for patients:
https://www.cdc.gov/drugoverdose/patients/index.html

Resources for providers:
https://www.cdc.gov/drugoverdose/providers/index.html

Contact Information:
Jan Losby
JLosby@cdc.gov

Disclaimer: *The findings and conclusions in this presentation are those of the author and do not necessarily represent the official position of the Centers for Disease Control and Prevention.*

American Academy of Addiction Psychiatry

Translating Science. Transforming Lives.

Lessons Learned Training Health Professionals

Kathryn Cates-Wessel
CEO, American Academy of Addiction Psychiatry

PCSS Providers Clinical Support System

Overall Mission: *provide training, educational resources and mentoring at no cost for health professionals in evidence-based practices in the prevention, identification, and treatment of opioid use disorders and other substance use disorders (SUD*).

Since 2008, nearly a half million clinicians have participated in PCSS trainings.

Funding for this initiative was made possible (in part) by grant no. 1H79TI081968 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.

PCSS Providers Clinical Support System

PCSS is a SAMHSA-funded 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 Mental Wellbeing
American Osteopathic Academy of Addiction Medicine	The National Judicial College
American Psychiatric Association	Physician Assistant Education Association
American Psychiatric Nurses Association	Society for Academic Emergency Medicine

PCSS Providers Clinical Support System

PCSS is here to help

The *Providers Clinical Support System*, funded by the Substance Abuse and Mental Health Services Administration, has the resources and expertise to support health professionals' needs to overcome barriers to address substance use disorders with a focus on opioid use disorder and stimulant use. All resources are provided at no cost.

Funding for this initiative was made possible (in part) by grant no. 1H79TI081968 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.

LIVE AND ON-DEMAND WEBINARS
An array of topics pertaining to substance use disorders (SUD) and opioid use disorder (OUD).

MENTORING
Online discussions. Submit questions to clinical experts. Be matched with clinician to answer questions and discuss clinical cases.

ROUNDTABLES
Zoom call to discuss a specific topic with clinical expert. Submit clinical cases in advance of Zoom to expert to consider for discussion.

PCSS X-CHANGE
A course targeting prescribers and other allied health professionals in how to prescribe medications for treating OUD.

PCSS IMPLEMENTATION
Teams work with a clinical site to develop a system for treatment for OUD into their clinical practice.

SUD 101: Course on basics of identifying and treating SUDs.
Chronic Pain:
Course discusses treatment of OUD and the treatment of chronic pain.

PCSS Highlights

Webinars

884 webinars and online modules
247,588 participants

X-Waiver Trainings

177,355 physicians, PAs, and advanced practice nurses

More than 18,533 participants

CLINICAL ROUNDTABLES

201 mentors and 1,297 mentees

MENTOR PROGRAM

PCSS offers online X-waiver training, Half and Half waiver trainings with 4-hour live webinar and 4-hour self-paced training, and live 8-hour and in-person trainings. Online courses for MDs, DOs, PAs, Advanced Practice Nurses, and Medical Students available.

What We Have Learned

- Stigma, stigma, stigma
- Training all staff from front desk, admin, clinical and CEO
- Health professionals need more education in the basics of SUD
- Access to behavioral health treatment
- Systems have to be integrated into clinical practice to include SUD
- Must address SUD and co-occurring psychiatric disorders concurrently.
- Clinicians need to be trained treating with all three FDA-approved medications for treating OUD: methadone, naltrexone and buprenorphine

Preparing the Future Workforce

Expansion of Interprofessional Practitioner Substance Use Disorder Education

- Pilot program to expand the integration of SUD education into the standard curriculum of relevant healthcare and health services education programs.

REACH—Recognizing and Eliminating disparities in Addiction through Culturally informed Healthcare

- REACH's Goals are to:
  - (1) Increase the overall number of racial and ethnic underrepresented minority (URM) addiction specialists in the Addiction Psychiatry and Addiction Medicine workforce, and
  - (2) increase the number of addiction physician specialists adequately trained to work with racial and ethnic URM patients with substance use disorders (SUD).

Funding for these initiatives was made possible (in part) by grant nos. 1H79TI083343 and 5H79TI081358 and 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, organizations imply endorsement by the U.S. government.

Opioid Response Network

ORN is funded through a SAMHSA grant awarded to the **American Academy of Addiction Psychiatry** in collaboration with the **Addiction Technology Transfer Center Network at the University of Missouri-Kansas City, Columbia University Division on Substance Use Disorders** and a coalition of over 40 national professional organizations **representing over 2 million constituents.**

Funding for this initiative was made possible (in part) by grant no. 1H79TI083343 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.

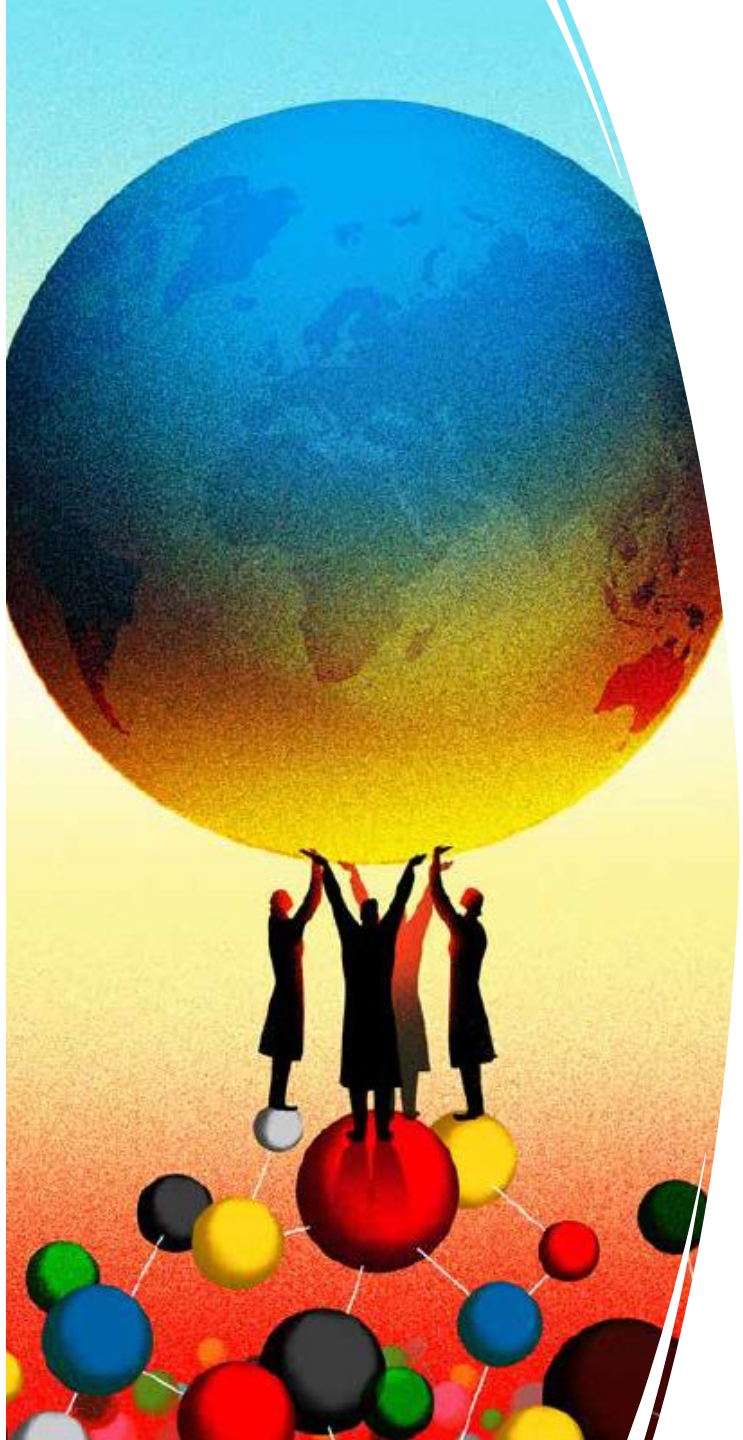
Opioid Response Network

ORN provides training and education in evidence-based practices in the prevention, treatment and recovery of opioid and stimulant use disorders with local *ORN* consultants in every US state and territories to meet locally identified needs—all at *no cost to the requestor.*

Thus far, *ORN* has responded to 3,794 requests for education and training and **trained more than 76,000 individuals.**

ORN Partners

- American Academy of Family Physicians (AAFP)
- American Academy of Pediatrics (AAP)
- American Association for the Treatment of Opioid Dependence (AATOD)
- American College of Emergency Physicians (ACEP)
- American College of Medical Toxicology (ACMT)
- American Heart Association (AHA)
- American Medical Association (AMA)
- American Osteopathic Academy of Addiction Medicine (AOAAM)
- American Pharmacists Association (APhA)
- American Psychiatric Association (APA)
- American Psychiatric Nurses Association (APNA)
- Association of American Indian Physicians (AAIP)
- Association for Multidisciplinary Education and Research in Substance use and Addiction (AMERSA)
- Boston Medical Center (BMC)
- Boston Children's Hospital (BCH)
- Community Anti-Drug Coalitions of America (CADCA)
- C4 Innovations
- Coalition of Physician Education (COPE)
- Council on Social Work Education (CSWE)
- Faces and Voices of Recovery (FAVOR)
- Major County Sheriffs of America (MCSA)
- National Alliance for HIV Education and Workforce Development (NAHEWD)
- National Association of Community Health Centers (NACHC)
- National Association of State Alcohol and Drug Abuse Directors (NASADAD)
- National Association of Social Workers (NASW)
- National Council of Juvenile and Family Court Judges (NCJFCJ)
- National Center for State Courts (NCSC)
- National Sheriff's Association (NSA)
- National Council for Mental Wellbeing
- Northwest Portland Area Indian Health Board (NPAIHB)
- National Judicial College (NJC)
- Partnership to End Addiction
- Physician Assistant Education Association (PAEA)
- Police Assisted Addiction and Recovery Initiative (PAARI)
- Recovery Research Institute (RRI)
- RTI International



Our Target Audience

- **Everyone!** Our audience includes states, cities, organizations, community groups, health professionals, the justice system, law enforcement and even individuals.

- **Our goal is the goal of the requester.** All education and training is locally relevant, culturally responsive and tailored to the individual’s, community's or organization's specific need.

Examples of ORN Requests

In California, trained more than 600 corrections staff in Motivational Interviewing

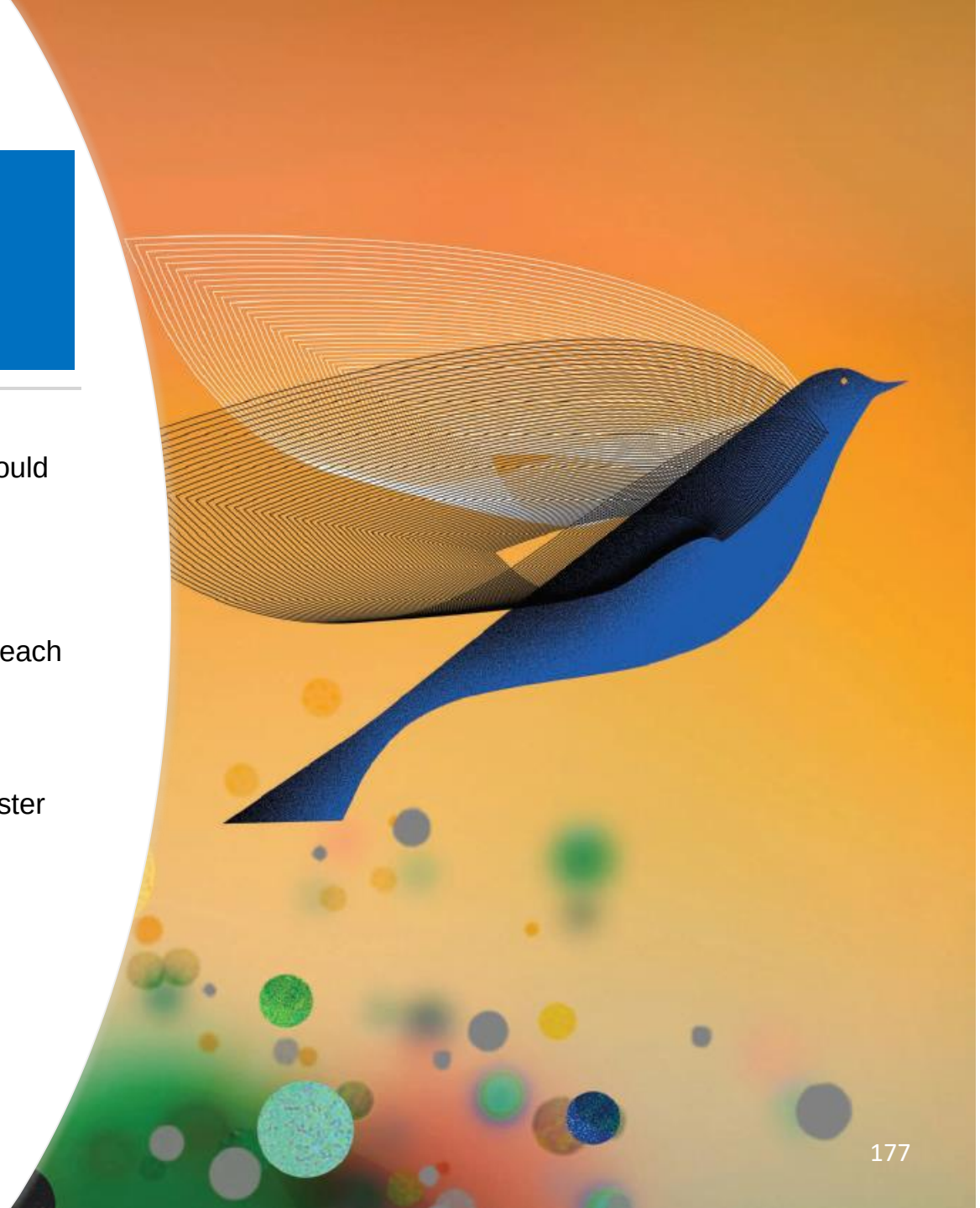
Worked with 10 North Carolina counties to provide guidance in creating sustainable community prevention programs

Host a biweekly teleconference for 75 Texas FQHC clinics and other providers in the state, serving over 1.4 million people

Worked with an alliance of recovery homes in Georgia to identify 133 additional homes to help strengthen the network

How to Submit a Request

- Those seeking education and training should submit a request via a form at www.OpioidResponseNetwork.org.
- Requests are forwarded to a designated Technology Transfer Specialist (TTS) for each state/territory. The TTS is the requester's point person.
- Once the request is submitted, the requester is contacted within one business day to discuss their needs and next steps.
- **Not sure what you need? Email orn@aaap.org.**



Together We CAN Make a Difference

www.OpioidResponseNetwork.org

www.PCSSnow.org

www.aaap.org

Opioid Safety and Academic Detailing

Julie Himstreet, Pharm.D., julianne.himstreet2@va.gov

National Clinical Program Manager

VA PBM Academic Detailing Service

April 2022

Overview

- Knowledge Translation through Academic Detailing
- Overview resources from Academic Detailing Service
  - Pain/Opioid Safety
  - Opioid Overdose Prevention and Naloxone Distribution (OEND)
- Impact of Academic Detailers around Opioid Safety

The Flood of Information

- Information overload creates a service need for addressing the flood of latest published research
- Healthcare providers go from wading to drowning in information trying to making right decision

Life-Boat Needed

- Academic Detailing provides the life-boat to give providers balanced information and empowering evidence-based options to care for their patients
- Meeting individually with providers gives detailers the opportunity to learn what is happening in the provider's practice, objections they may have, barriers they may be experiencing, and a forum to help them overcome these obstacles

Multifaceted Approach

Engage the whole team

Modify the interaction to meet needs

Provide resources

Bridge the gap between professional silos

Identify system barriers

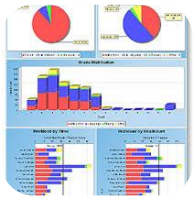
Engage leadership

Academic Detailing Service Interventions

Training: Standardized training to assist AD in conducting their outreach visits to target the prescribing habits of providers

Educational Materials: Create educational materials for both providers and patients

Data Tools: Created suite of data tools to assist in identifying high risk patients



Workload Recording: Utilized software to ensure workload was tracked to document topics covered, time, # of providers/visits, etc.

Evaluation: Evaluation of workload and outcomes

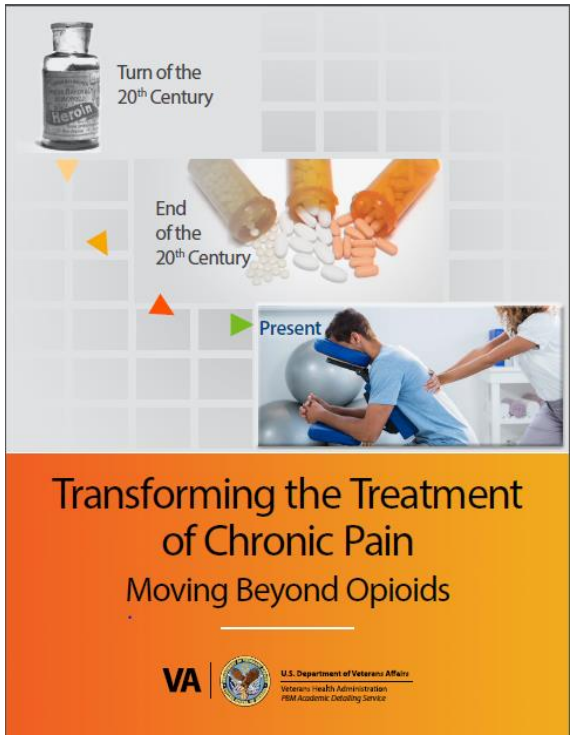
Training

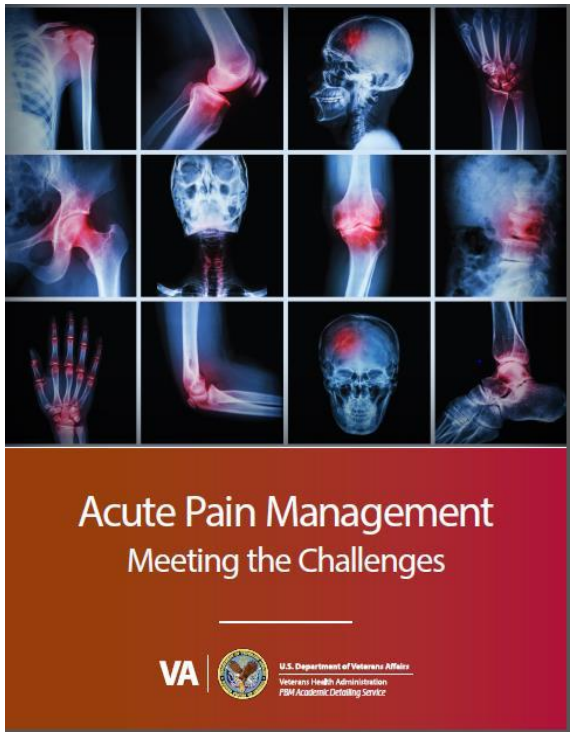
127 academic detailers recording outreach visits in Q1FY22

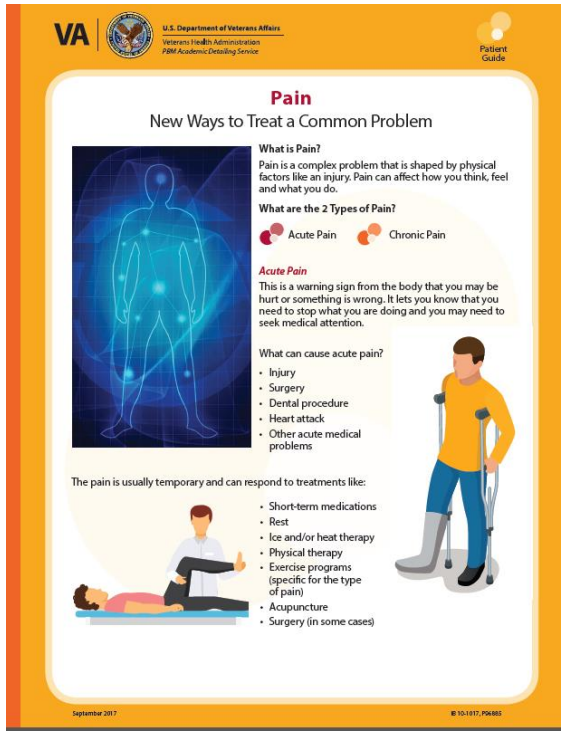
New academic detailers are initially trained in the communication techniques used by detailers to promote behavior change

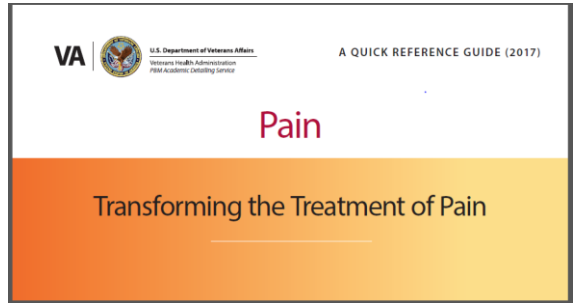
Advanced skills trainings are offered multiple times a year for detailers to improve their skills and practice detailing on new campaign topics

Educational Materials for Providers and Patients









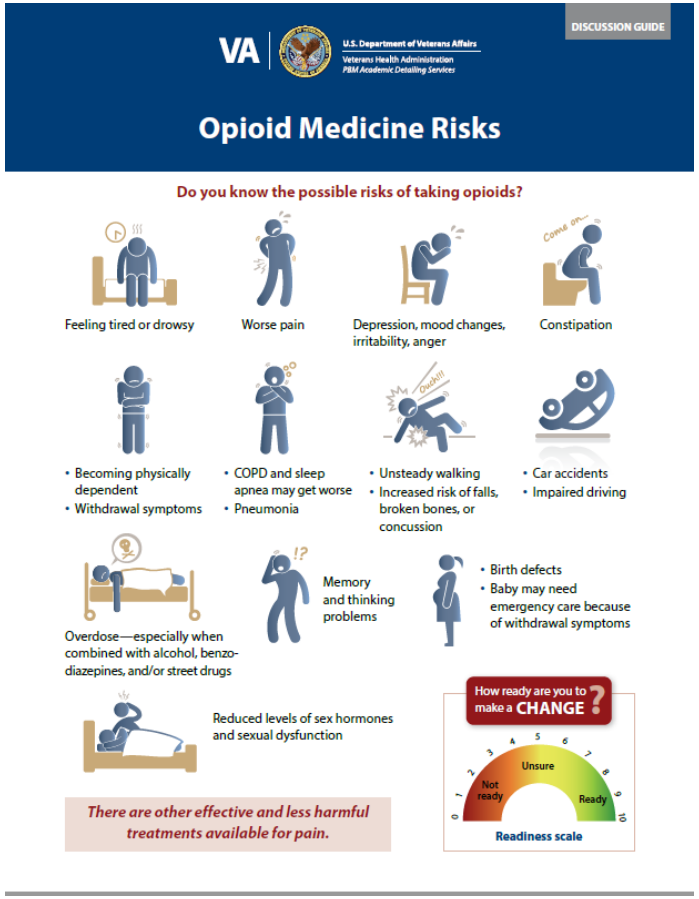
Pain Module – Acute and Chronic Pain

[Opioid Safety - VHA Pain Management (va.gov)]

Link to ADS Public Site:
https://www.pbm.va.gov/PBM/academicdetailingservicehome.asp

Considering Reducing Opioid Doses?
Starting The Discussion

- VA tools to start the discussion about opioid tapering
  - Opioid Risk Discussion tool
    - Assists providers in reviewing opioid risks
    - Prompts discussion of alternative therapies
  - Slowly Stopping Opioids Patient Handout
    - Reviews how tapering is done
    - Possible side effects
    - Encourages slow tapers



DISCUSSION GUIDE

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Opioid Medicine Risks

Do you know the possible risks of taking opioids?

Feeling tired or drowsy

Worse pain

Depression, mood changes, irritability, anger

Constipation

- Becoming physically dependent
- Withdrawal symptoms

- COPD and sleep apnea may get worse
- Pneumonia

- Unsteady walking
- Increased risk of falls, broken bones, or concussion

- Car accidents
- Impaired driving

Overdose—especially when combined with alcohol, benzodiazepines, and/or street drugs

Memory and thinking problems

- Birth defects
- Baby may need emergency care because of withdrawal symptoms

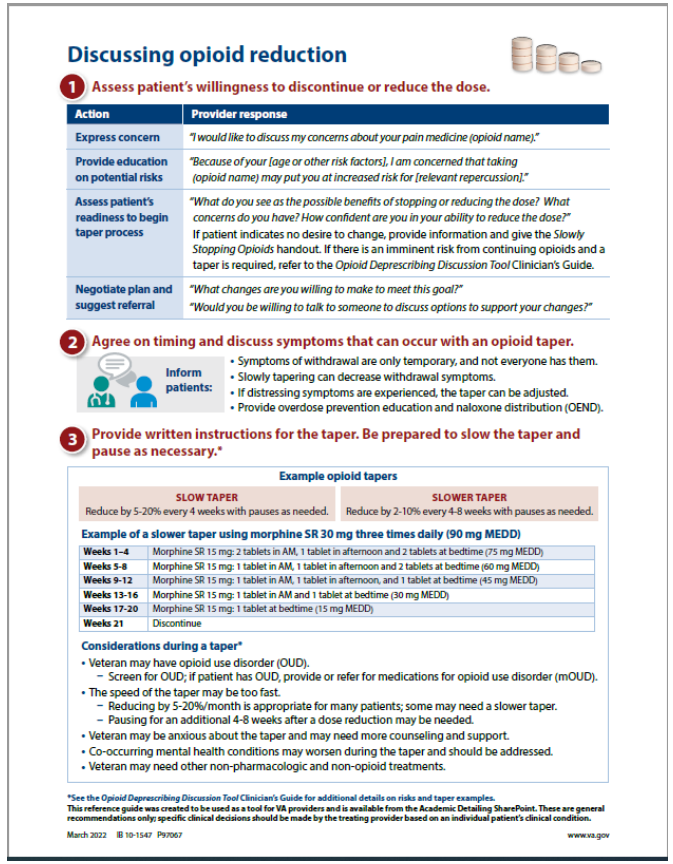
Reduced levels of sex hormones and sexual dysfunction

There are other effective and less harmful treatments available for pain.

How ready are you to make a CHANGE?

Not ready | Unsure | Ready

Readiness scale



Discussing opioid reduction

1 Assess patient's willingness to discontinue or reduce the dose.

Action	Provider response
Express concern	*"I would like to discuss my concerns about your pain medicine (opioid name)."*
Provide education on potential risks	*"Because of your [age or other risk factors], I am concerned that taking (opioid name) may put you at increased risk for [relevant repercussion]."*
Assess patient's readiness to begin taper process	*"What do you see as the possible benefits of stopping or reducing the dose? What concerns do you have? How confident are you in your ability to reduce the dose?"* If patient indicates no desire to change, provide information and give the *Slowly Stopping Opioids* handout. If there is an imminent risk from continuing opioids and a taper is required, refer to the *Opioid Deprescribing Discussion Tool* Clinician's Guide.
Negotiate plan and suggest referral	*"What changes are you willing to make to meet this goal?"* *"Would you be willing to talk to someone to discuss options to support your changes?"*

2 Agree on timing and discuss symptoms that can occur with an opioid taper.

Inform patients:
- Symptoms of withdrawal are only temporary, and not everyone has them.
- Slowly tapering can decrease withdrawal symptoms.
- If distressing symptoms are experienced, the taper can be adjusted.
- Provide overdose prevention education and naloxone distribution (OEND).

3 Provide written instructions for the taper. Be prepared to slow the taper and pause as necessary.*

Example opioid tapers

SLOW TAPER	SLOWER TAPER
Reduce by 5-20% every 4 weeks with pauses as needed.	Reduce by 2-10% every 4-8 weeks with pauses as needed.

Example of a slower taper using morphine SR 30 mg three times daily (90 mg MEDD)

Weeks 1–4	Morphine SR 15 mg: 2 tablets in AM, 1 tablet in afternoon and 2 tablets at bedtime (75 mg MEDD)
Weeks 5–8	Morphine SR 15 mg: 1 tablet in AM, 1 tablet in afternoon and 2 tablets at bedtime (60 mg MEDD)
Weeks 9–12	Morphine SR 15 mg: 1 tablet in AM, 1 tablet in afternoon, and 1 tablet at bedtime (45 mg MEDD)
Weeks 13–16	Morphine SR 15 mg: 1 tablet in AM and 1 tablet at bedtime (30 mg MEDD)
Weeks 17–20	Morphine SR 15 mg: 1 tablet at bedtime (15 mg MEDD)
Weeks 21	Discontinue

Considerations during a taper*
- Veteran may have opioid use disorder (OUD).
  - Screen for OUD; if patient has OUD, provide or refer for medications for opioid use disorder (mOUD).
- The speed of the taper may be too fast.
  - Reducing by 5-20%/month is appropriate for many patients; some may need a slower taper.
  - Pausing for an additional 4-8 weeks after a dose reduction may be needed.
- Veteran may be anxious about the taper and may need more counseling and support.
- Co-occurring mental health conditions may worsen during the taper and should be addressed.
- Veteran may need other non-pharmacologic and non-opioid treatments.

*See the *Opioid Deprescribing Discussion Tool* Clinician's Guide for additional details on risks and taper examples.
This reference guide was created to be used as a tool for VA providers and is available from the Academic Detailing SharePoint. These are general recommendations only; specific clinical decisions should be made by the treating provider based on an individual patient's clinical condition.

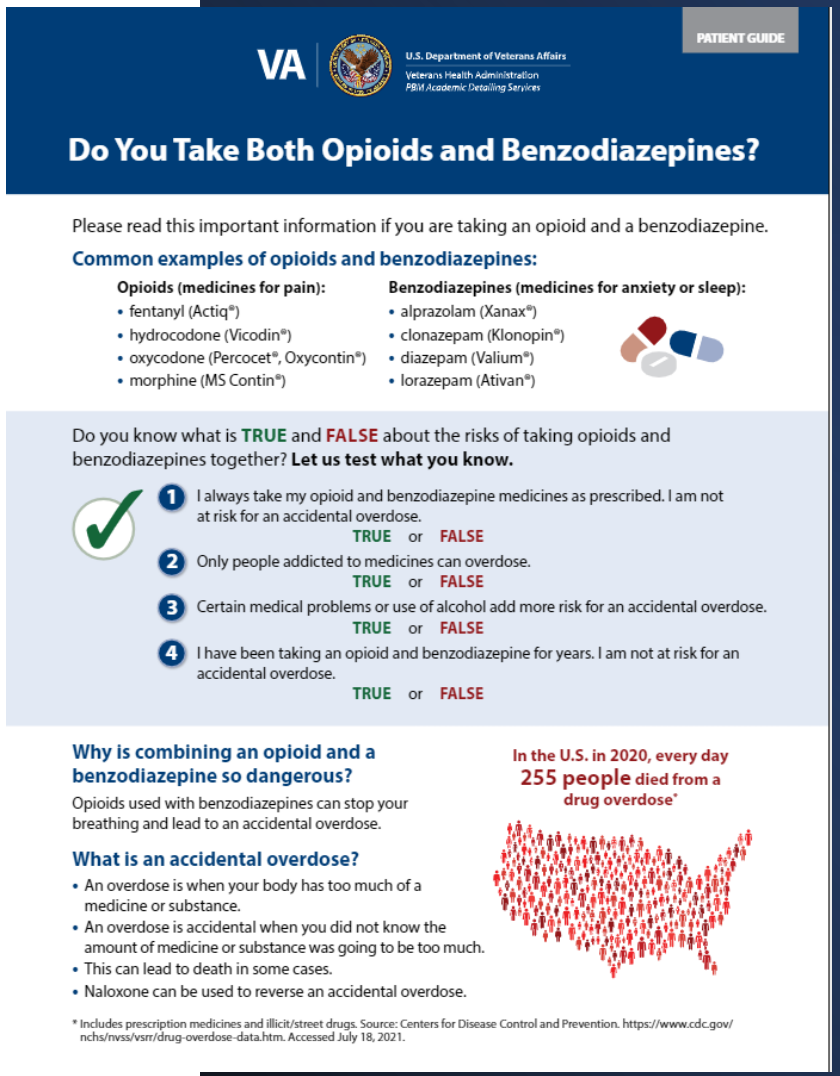
March 2022 IB 10-1547 P97067 www.va.gov

Opioid Deprescribing– How to do it

- Opioid Deprescribing Tool*
  - To help providers determine which patients may be good candidates for opioid taper
  - Highlights that not all patients will be candidates for opioid tapers
  - Reviews how to approach the taper, how to discuss tapering with patients, provide example tapers, and recommended follow up schedules
  - Emphasizes screening for OUD and providing treatment with mOUD.

Opioid and Benzodiazepine Direct to Consumer Brochure

- Update to the tri-fold handout
- Direct to consumer (DTC) handouts can be used to help Veterans understand why they might be at risk for an overdose and could benefit from having naloxone
- When using DTC handouts, it is recommended to send these to patients who have an appointment in the next 2-4 weeks
- Meet with providers and other team members before sending DTC handouts to Veterans and have their buy-in



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PATIENT GUIDE

Do You Take Both Opioids and Benzodiazepines?

Please read this important information if you are taking an opioid and a benzodiazepine.

Common examples of opioids and benzodiazepines:

Opioids (medicines for pain):
- fentanyl (Actiq®)
- hydrocodone (Vicodin®)
- oxycodone (Percocet®, Oxycontin®)
- morphine (MS Contin®)

Benzodiazepines (medicines for anxiety or sleep):
- alprazolam (Xanax®)
- clonazepam (Klonopin®)
- diazepam (Valium®)
- lorazepam (Ativan®)

Do you know what is **TRUE** and **FALSE** about the risks of taking opioids and benzodiazepines together? **Let us test what you know.**

1. I always take my opioid and benzodiazepine medicines as prescribed. I am not at risk for an accidental overdose.
   TRUE or FALSE
2. Only people addicted to medicines can overdose.
   TRUE or FALSE
3. Certain medical problems or use of alcohol add more risk for an accidental overdose.
   TRUE or FALSE
4. I have been taking an opioid and benzodiazepine for years. I am not at risk for an accidental overdose.
   TRUE or FALSE

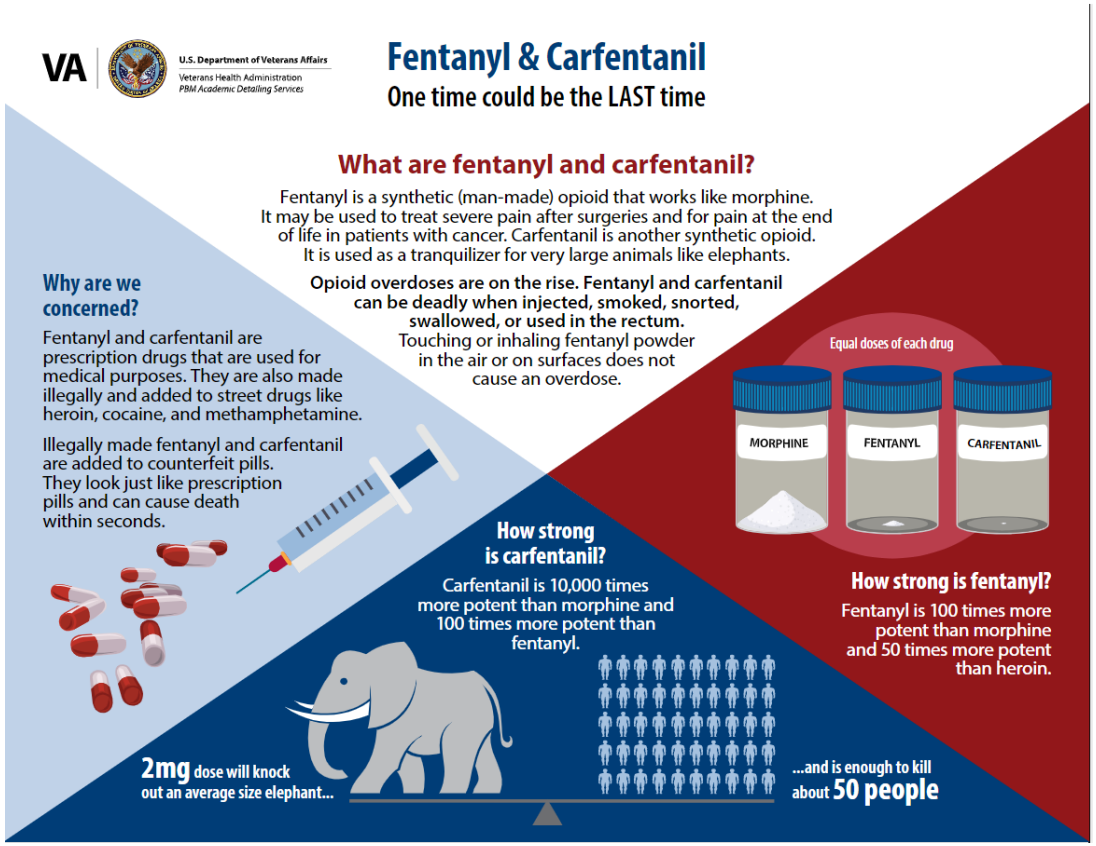
Why is combining an opioid and a benzodiazepine so dangerous?

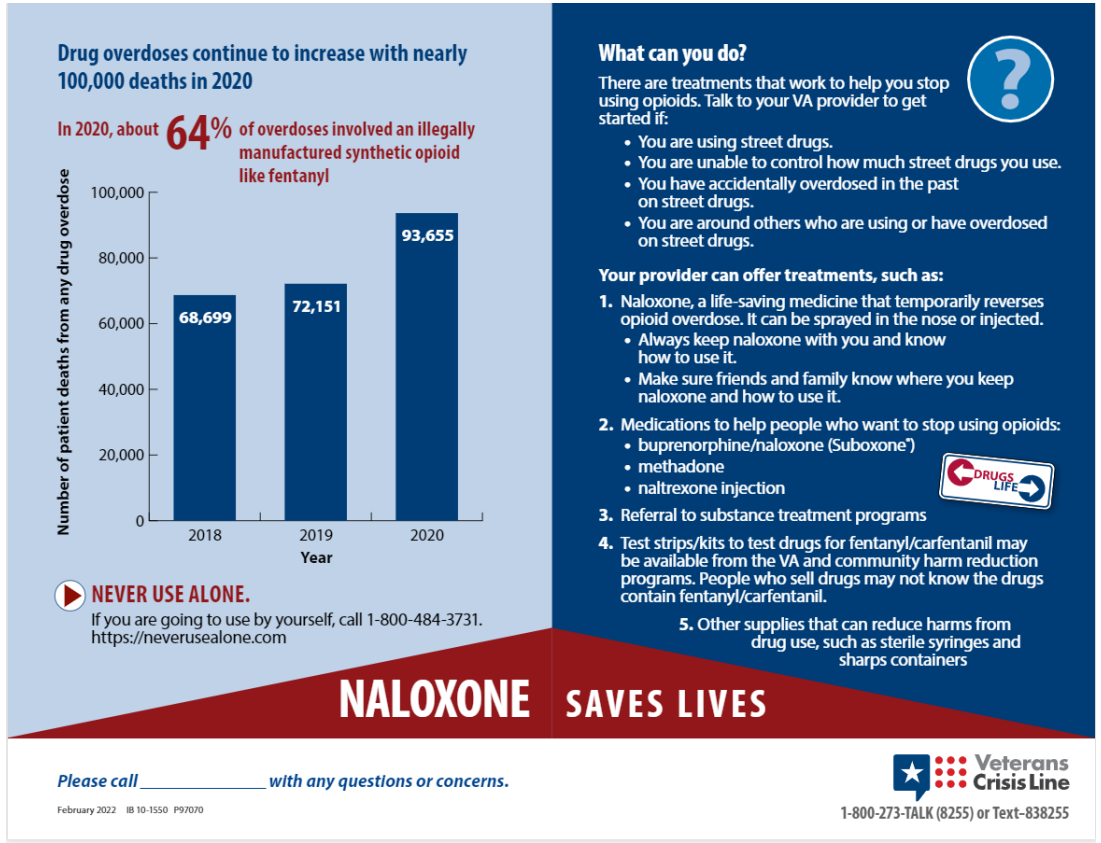
Opioids used with benzodiazepines can stop your breathing and lead to an accidental overdose.

What is an accidental overdose?
- An overdose is when your body has too much of a medicine or substance.
- An overdose is accidental when you did not know the amount of medicine or substance was going to be too much.
- This can lead to death in some cases.
- Naloxone can be used to reverse an accidental overdose.

In the U.S. in 2020, every day 255 people died from a drug overdose*

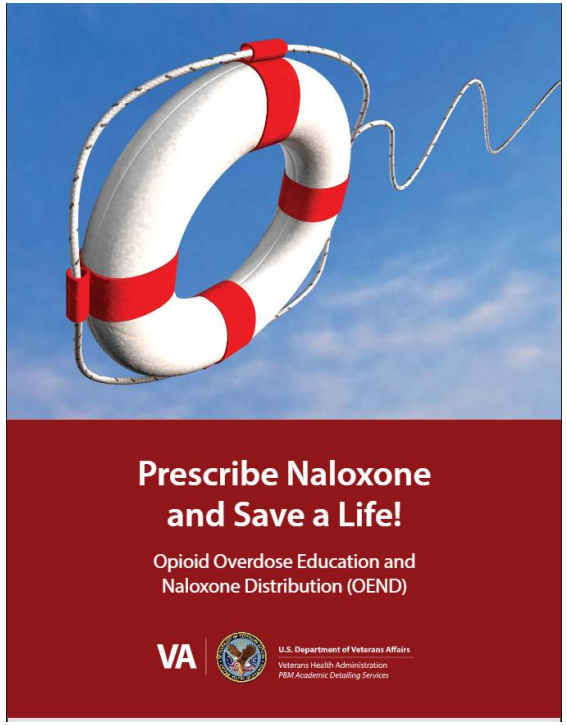
* Includes prescription medicines and illicit/street drugs. Source: Centers for Disease Control and Prevention. https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm. Accessed July 18, 2021.

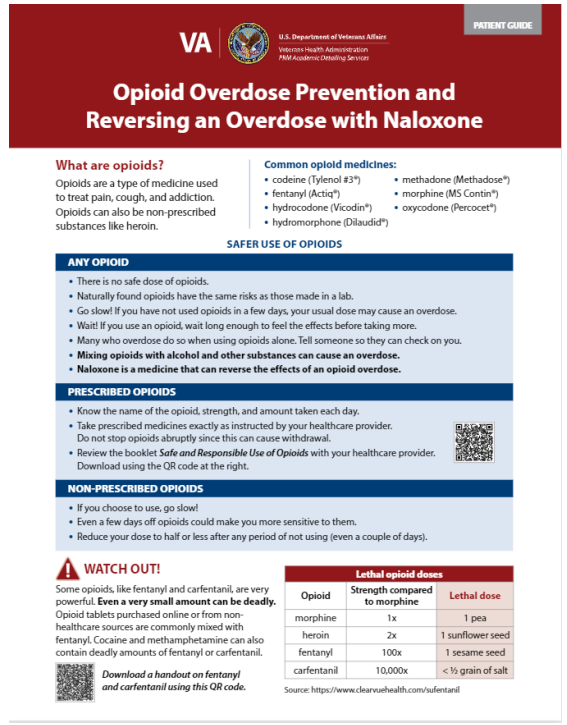


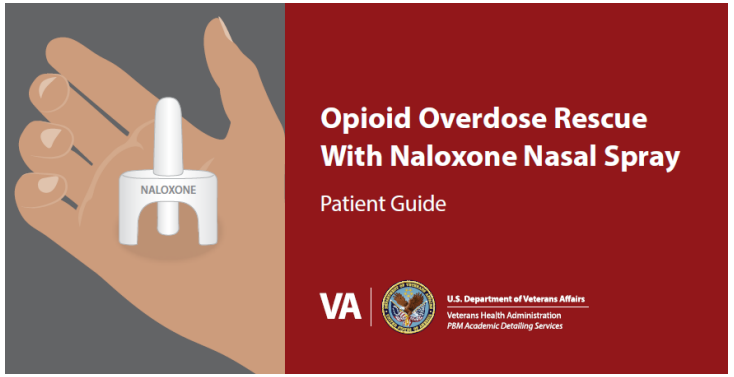


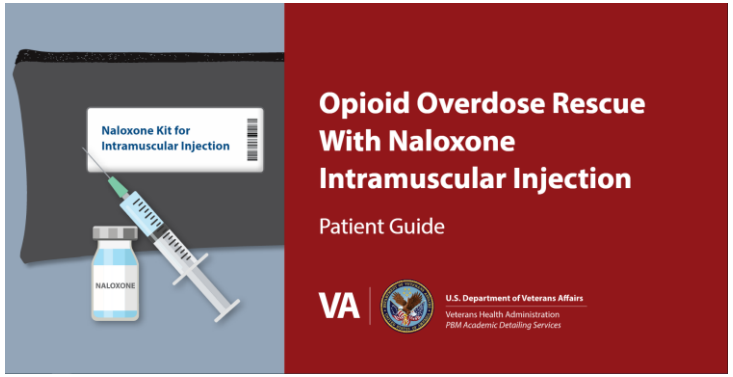
Fentanyl and Carfentanil Patient Handout

Opioid Overdose Education and Naloxone Distribution (OEND)



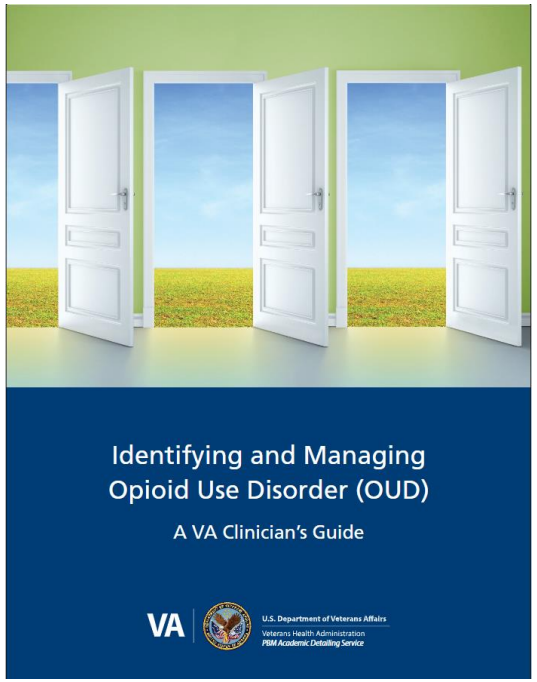


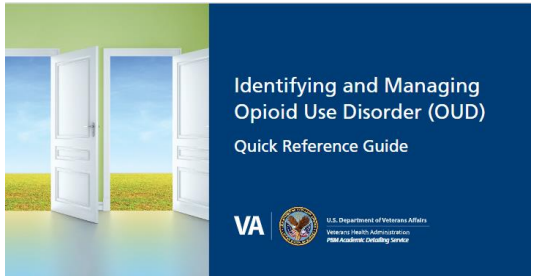


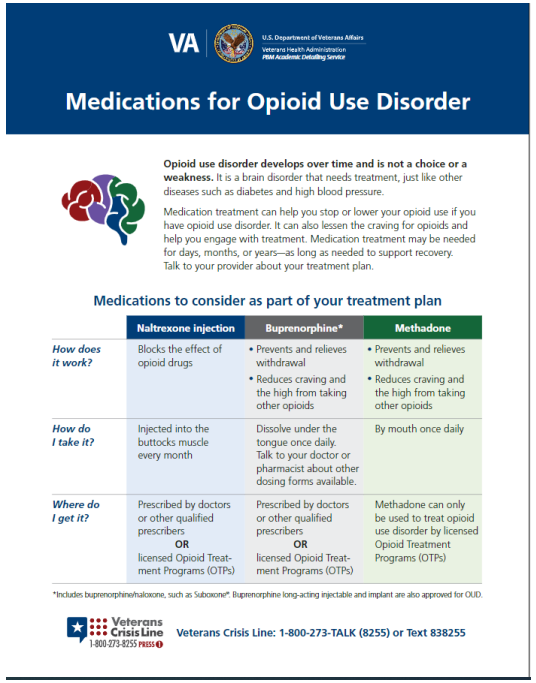


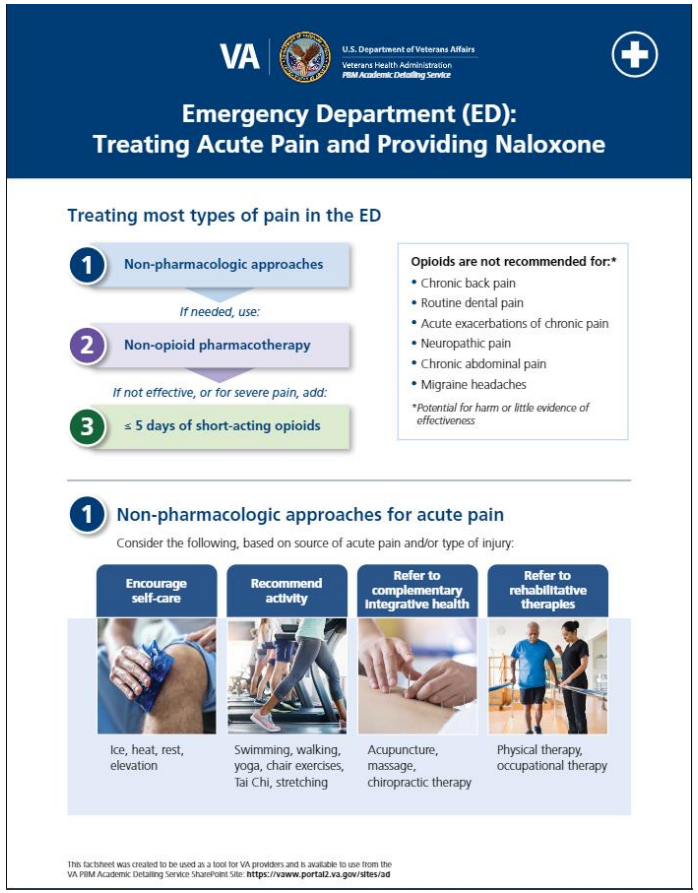
Opioid Use Disorder (OUD)

Provider and Patient Materials









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Emergency Department (ED): Treating Acute Pain and Providing Naloxone

Treating most types of pain in the ED

1. Non-pharmacologic approaches

If needed, use:

2. Non-opioid pharmacotherapy

If not effective, or for severe pain, add:

3. ≤ 5 days of short-acting opioids

Opioids are not recommended for:*
- Chronic back pain
- Routine dental pain
- Acute exacerbations of chronic pain
- Neuropathic pain
- Chronic abdominal pain
- Migraine headaches

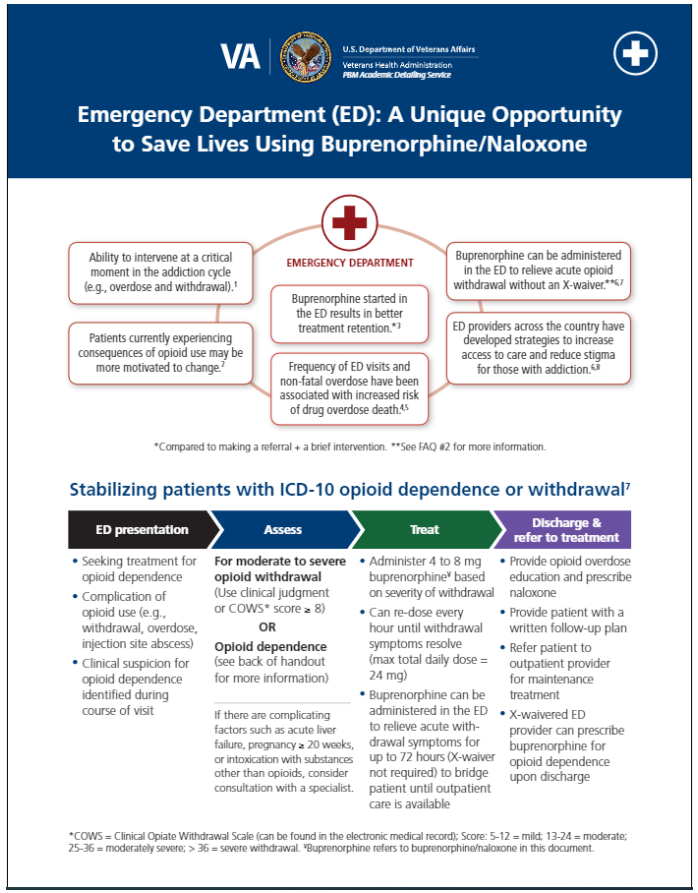
**Potential for harm or little evidence of effectiveness*

1 Non-pharmacologic approaches for acute pain

Consider the following, based on source of acute pain and/or type of injury:

Encourage self-care	Recommend activity	Refer to complementary integrative health	Refer to rehabilitative therapies
Ice, heat, rest, elevation	Swimming, walking, yoga, chair exercises, Tai Chi, stretching	Acupuncture, massage, chiropractic therapy	Physical therapy, occupational therapy

This factsheet was created to be used as a tool for VA providers and is available to use from the VA PBM Academic Detailing Service SharePoint Site: **https://vaww.portal2.va.gov/sites/ad**



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Emergency Department (ED): A Unique Opportunity to Save Lives Using Buprenorphine/Naloxone

EMERGENCY DEPARTMENT

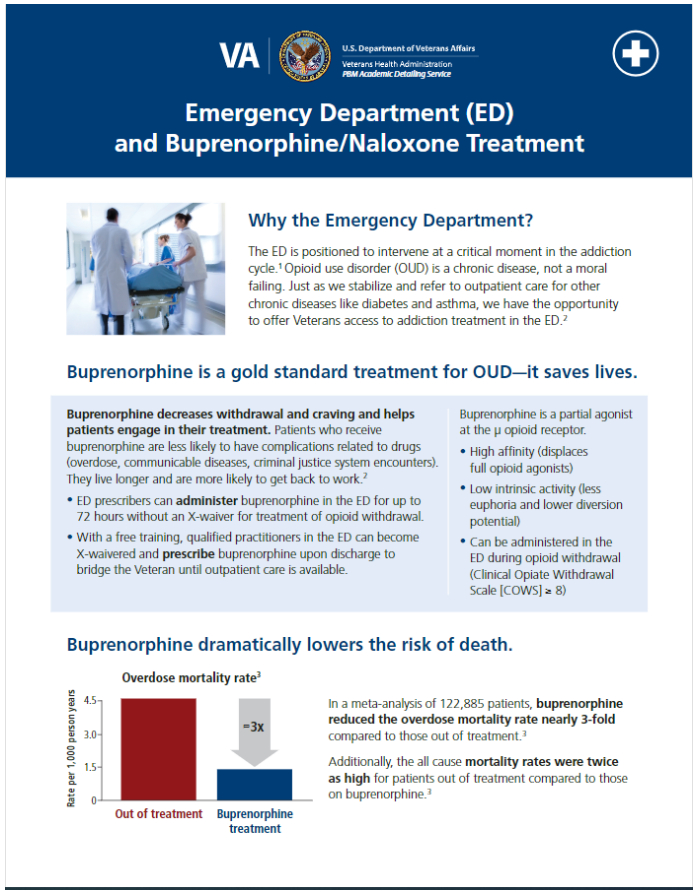
- Ability to intervene at a critical moment in the addiction cycle (e.g., overdose and withdrawal).[1]
- Patients currently experiencing consequences of opioid use may be more motivated to change.[2]
- Buprenorphine started in the ED results in better treatment retention.*[3]
- Frequency of ED visits and non-fatal overdose have been associated with increased risk of drug overdose death.[4,5]
- Buprenorphine can be administered in the ED to relieve acute opioid withdrawal without an X-waiver.**[6,7]
- ED providers across the country have developed strategies to increase access to care and reduce stigma for those with addiction.[6,8]

*Compared to making a referral + a brief intervention. **See FAQ #2 for more information.

Stabilizing patients with ICD-10 opioid dependence or withdrawal[7]

ED presentation	Assess	Treat	Discharge & refer to treatment
• Seeking treatment for opioid dependence • Complication of opioid use (e.g., withdrawal, overdose, injection site abscess) • Clinical suspicion for opioid dependence identified during course of visit	**For moderate to severe opioid withdrawal** (Use clinical judgment or COWS* score ≥ 8) **OR** **Opioid dependence** (see back of handout for more information) If there are complicating factors such as acute liver failure, pregnancy ≥ 20 weeks, or intoxication with substances other than opioids, consider consultation with a specialist.	• Administer 4 to 8 mg buprenorphine[4] based on severity of withdrawal • Can re-dose every hour until withdrawal symptoms resolve (max total daily dose = 24 mg) • Buprenorphine can be administered in the ED to relieve acute withdrawal symptoms for up to 72 hours (X-waiver not required) to bridge patient until outpatient care is available	• Provide opioid overdose education and prescribe naloxone • Provide patient with a written follow-up plan • Refer patient to outpatient provider for maintenance treatment • X-waivered ED provider can prescribe buprenorphine for opioid dependence upon discharge

*COWS = Clinical Opiate Withdrawal Scale (can be found in the electronic medical record); Score: 5-12 = mild; 13-24 = moderate; 25-36 = moderately severe; > 36 = severe withdrawal. †Buprenorphine refers to buprenorphine/naloxone in this document.



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Emergency Department (ED) and Buprenorphine/Naloxone Treatment

Why the Emergency Department?

The ED is positioned to intervene at a critical moment in the addiction cycle.[1] Opioid use disorder (OUD) is a chronic disease, not a moral failing. Just as we stabilize and refer to outpatient care for other chronic diseases like diabetes and asthma, we have the opportunity to offer Veterans access to addiction treatment in the ED.[2]

Buprenorphine is a gold standard treatment for OUD—it saves lives.

Buprenorphine decreases withdrawal and craving and helps patients engage in their treatment. Patients who receive buprenorphine are less likely to have complications related to drugs (overdose, communicable diseases, criminal justice system encounters). They live longer and are more likely to get back to work.[2]

- ED prescribers can **administer** buprenorphine in the ED for up to 72 hours without an X-waiver for treatment of opioid withdrawal.
- With a free training, qualified practitioners in the ED can become X-waivered and **prescribe** buprenorphine upon discharge to bridge the Veteran until outpatient care is available.

Buprenorphine is a partial agonist at the μ opioid receptor.

- High affinity (displaces full opioid agonists)
- Low intrinsic activity (less euphoria and lower diversion potential)
- Can be administered in the ED during opioid withdrawal (Clinical Opiate Withdrawal Scale [COWS] ≥ 8)

Buprenorphine dramatically lowers the risk of death.

In a meta-analysis of 122,885 patients, **buprenorphine reduced the overdose mortality rate nearly 3-fold** compared to those out of treatment.[3]

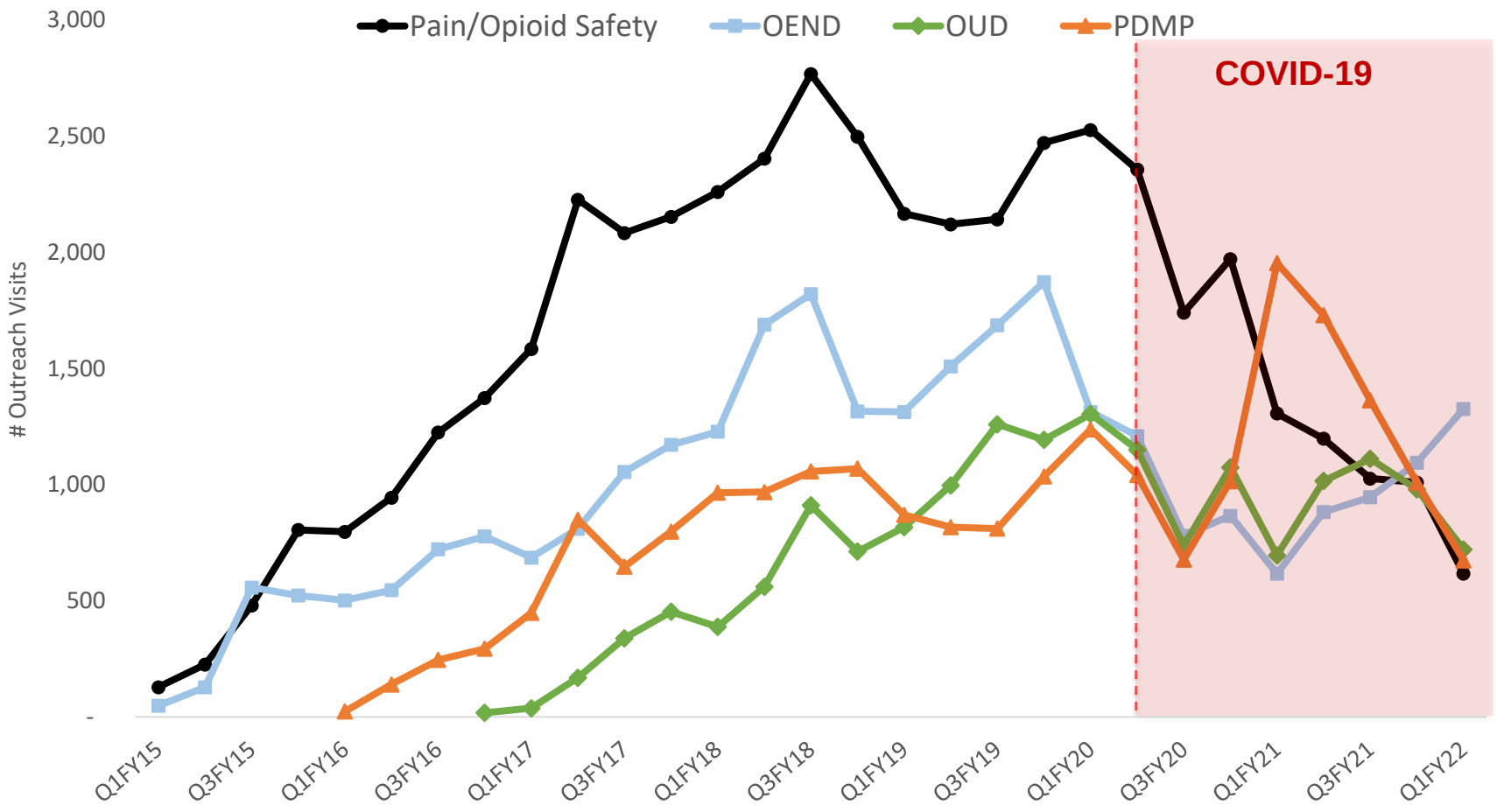
Additionally, the all cause **mortality rates were twice as high** for patients out of treatment compared to those on buprenorphine.[3]

Emergency Department- Opioid Safety Initiative

Data Resource Use by Academic Detailers

- Goal: Leverage data to increase efficiency and effectiveness of Academic Detailing visits
- Uses by Detailers
  - Find priority providers
  - Tailor detailing based on actionable patient population
  - Educate providers how to find actionable patients
  - Provide context to data

Academic Detailing Workload Tracking



76,109 OSI / OEND / OUD / PDMP visits with 33,199 staff

AD Outcomes/Evaluation

Trends in Naloxone Prescriptions Prescribed After Implementation of a National Academic Detailing Service in the Veterans Health Administration: A Preliminary Analysis

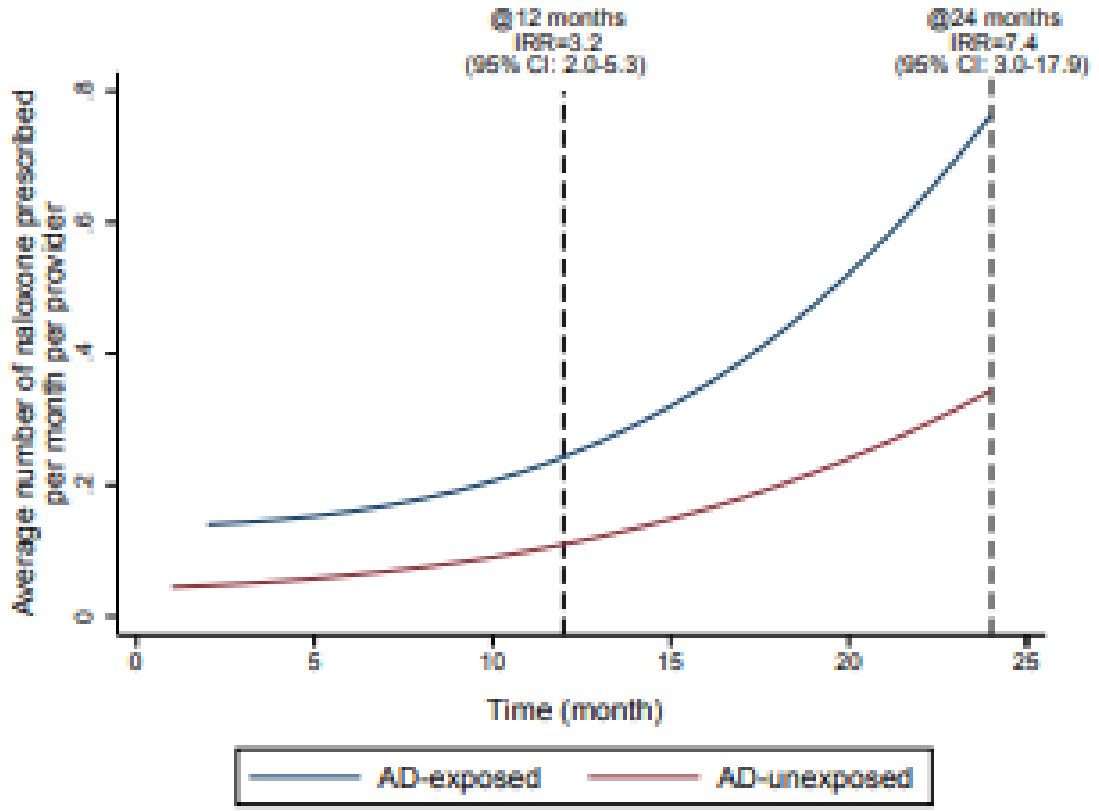


Figure 1. Naloxone kits monthly prescribing rates from October 2014 to September 2016.

At 1 year, the average number of naloxone prescriptions per month was 3-times greater in AD-exposed providers compared with AD-unexposed providers (95% CI 2.0-5.3)

At 2 years, the average number of naloxone prescriptions was 7-times greater (95% CI 3.0-17.9).

Bounthavong M, Harvey MA, Wells DL, Popish SJ, Himstreet J, Oliva EM, Kay CL, Lau MK, Randeria-Noor PP, Phillips AG, Christopher MLD. Trends in naloxone prescriptions prescribed after implementation of a National Academic Detailing Service in the Veterans Health Administration: A preliminary analysis. J Am Pharm Assoc (2003). 2017 Mar-Apr;57(2S):S68-S72. doi: 10.1016/j.japh.2016.11.003. Epub 2017 Jan 11. PMID: 28089521.

Questions?
Contact Us:

VHAPBM Pharmacy Academic Detailing Program Office:
PharmacyAcademicDetailingProgram@va.gov

Public Website:
https://www.pbm.va.gov/PBM/academicdetailingservicehome.asp

Project ECHO: Lessons Learned with Provider Education and CME

JOANNA G KATZMAN, MD, MSPH

PROFESSOR, DEPARTMENT OF NEUROSURGERY

MEDICAL DIRECTOR, PUBLIC HEALTH INITIATIVES, PROJECT ECHO

DIRECTOR, PAIN CENTER

UNIVERSITY OF NEW MEXICO HEALTH SCIENCES CENTER

No Conflicts or Disclosures

Project ECHO

Project ECHO is a lifelong learning and guided practice model that revolutionizes medical education and exponentially increases workforce capacity to provide best practices specialty care and reduce health disparities through its hub-and-spoke knowledge sharing networks

People need access to specialty care for complex conditions

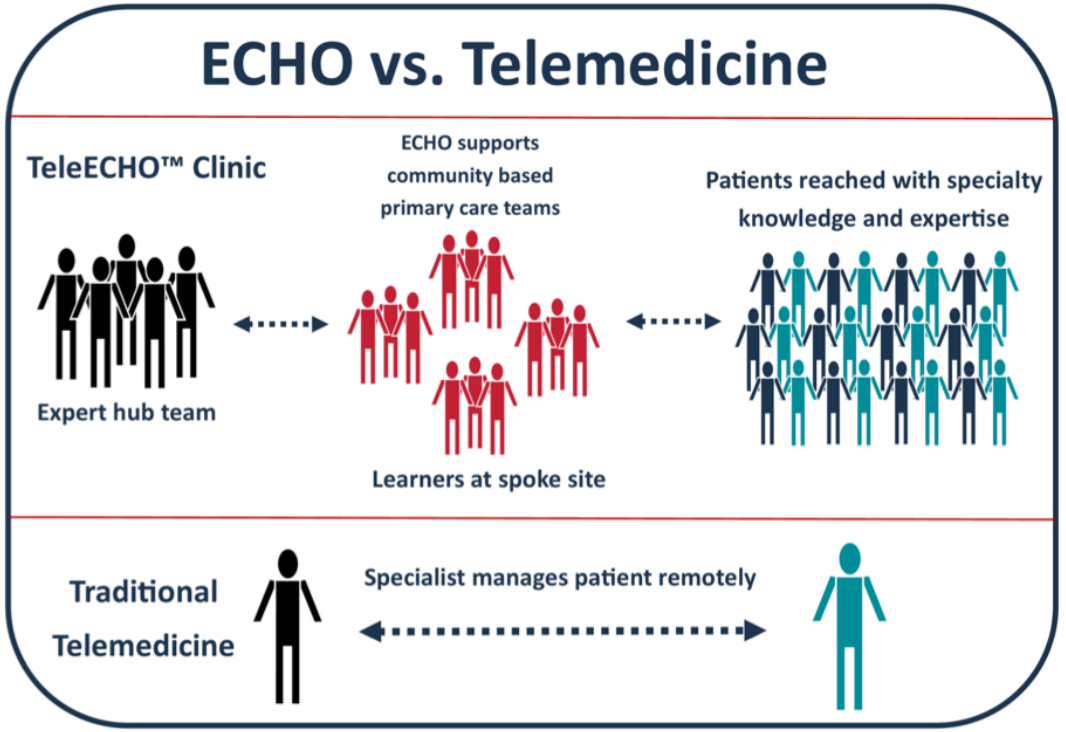
Not enough specialists to treat everyone, especially in rural India

ECHO® trains primary care clinicians to provide specialty care services

Patients get the right care, in the right place, at the right time.

ECHO moves knowledge, not people

Project ECHO® is a lifelong learning and guided practice model that revolutionizes medical education and exponentially increases workforce capacity to provide best practice specialty care and reduce health disparities through its hub-and-spoke knowledge sharing networks

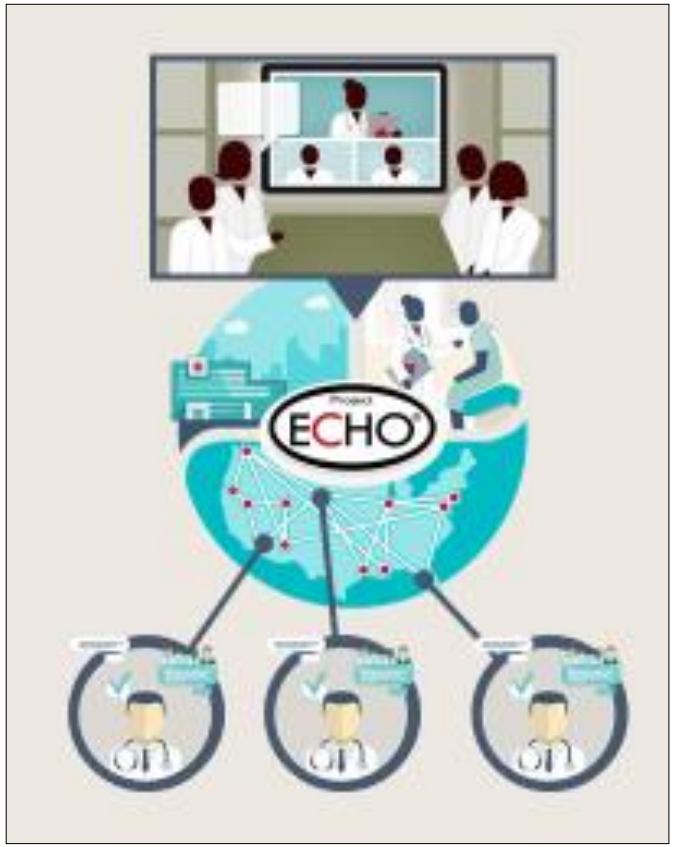


ECHO model **is not 'traditional telemedicine'**

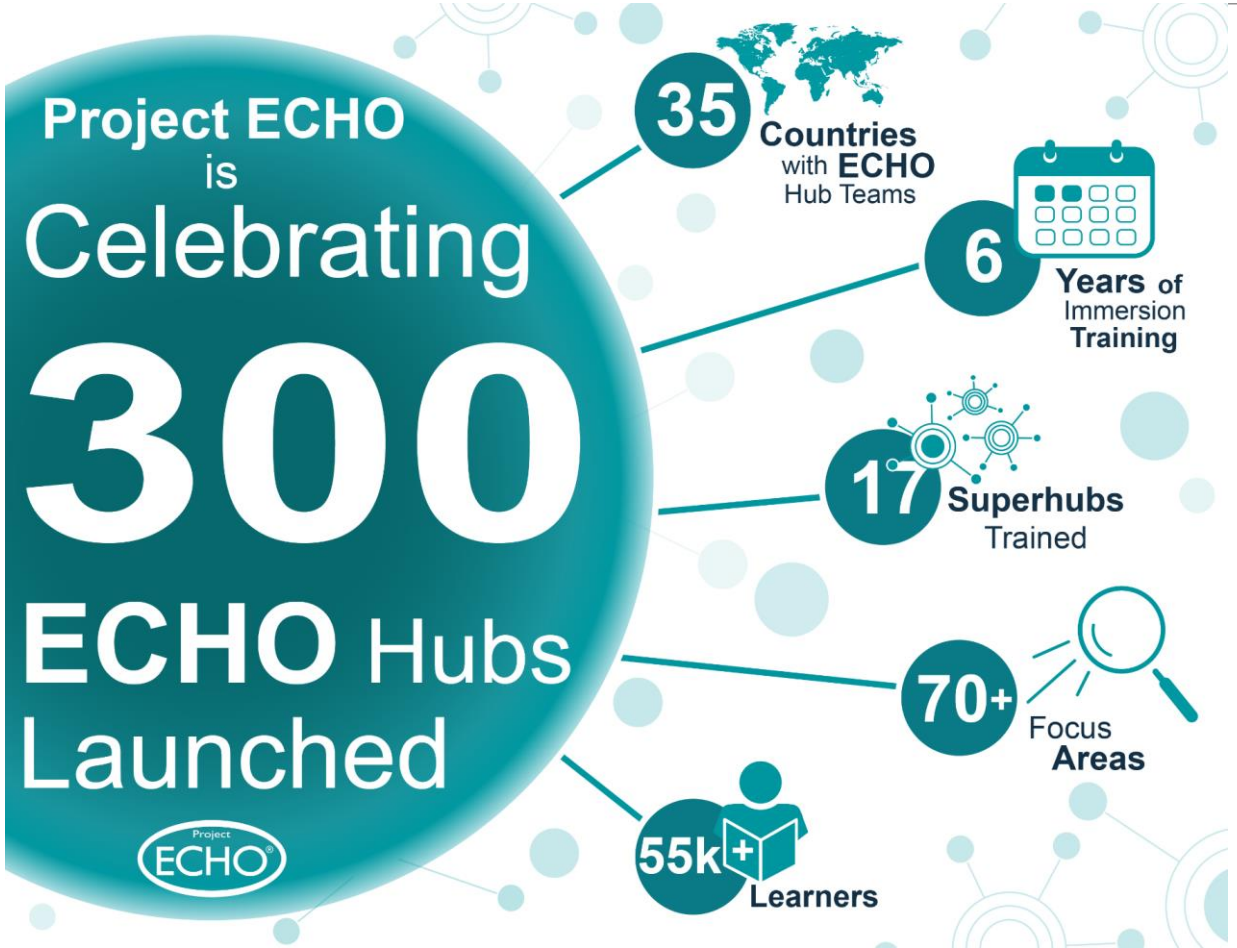
The treating provider retains responsibility for managing their patient.

Hub and Spoke Model

- ECHO links specialist teams at an academic “hub” with primary care providers in local communities – the “spokes” of the model
- “Hubs” and “spokes” participate in weekly online teleECHO™ sessions
- Sessions combine patient or system case presentations with didactic learning and mentoring



ECHO Impact



Project ECHO has nearly 200 program partners in the United States, with hubs operating in 49 states, and local spokes in all 50 states.

ECHO Pain and Opioid Management

Tools: ECHO Pain and Opioid Management

Education of primary care providers and other allied health professionals in pain management & safe opioid prescribing

- Weekly teleECHO program is delivered through Zoom- a videoconferencing platform
- Curriculum- didactics and demonstrations that build upon each other
- Case-based learning
- Workplace learning – multi-disciplinary team learning
- Mini-residency, 2-day trainings
- No cost CME
- ECHO Chronic Pain and Opioid Management curriculum is offered many times throughout the year and fulfills the New Mexico requirements for CME

ECHO Pain Curriculum: Balancing Mandated Continuing Education With the Needs of Rural Health Care Practitioners

Brian M. Shelley, MD; Joanna G. Katzman, MD, MSPH; George D. Comerci, Jr, MD; Daniel J. Duhigg, DO, MBA; Cynthia Olivas, MSN, RN; Summers Kalishman, PhD; Rebecca Monette, BS; Melissa Britt, BS; Lainey Flatow-Trujillo, BS; Sanjeev Arora, MD

Abstract: Chronic pain is a common problem in the United States. Health care professions training at the undergraduate and graduate levels in managing chronic pain is insufficient. The Chronic Pain and Headache Management TeleECHO Clinic (ECHO Pain) is a telehealth approach at Project ECHO (Extension for Community Healthcare Outcomes), which supports clinicians interested in improving their knowledge and confidence in treating patients with chronic pain and safe opioid management. It is a vehicle for educating practicing clinicians (at the "spoke") based on work-place learning with cases selected by participants from their patient panels combined with short lectures by experts (at the "hub"). ECHO Pain has designed an innovative, interprofessional longitudinal curriculum appropriate for individual and team-based clinicians which includes relevant basic and advanced pain topics. The specific design and delivery of the curriculum enhances its relevance and accessibility to busy clinicians in practice, yet also satisfies statutory requirements for CME in New Mexico. Specific features which balance hub-and-spoke needs are presented in this descriptive article, which is intended to serve as a guide to other clinician educators interested in developing or implementing similar telehealth curricula.

Keywords: Project ECHO, telehealth, chronic pain, curriculum, opioids, interprofessional education, problem-based/case-based learning, program planning/curriculum development

DOI: 10.1097/CEH.0000000000000165

Managing patients with chronic pain is a daunting challenge of the current generation of clinicians, and the increasing prevalence of this problem is well documented in the literature. It is estimated that up to 100 million people in the United States have some type of chronic pain.[1] However, undergraduate and graduate level training in the health professions does not match the scope of the problem, and most clinicians learn chronic pain management skills on the job. For clinicians in rural areas with little ancillary support, this can be an overwhelming task.[2,3]

In addition to the challenge of access to additional evidence-based training in chronic pain that clinicians face, the passive learning associated with traditional continuing professional development pedagogy is less than optimal and has been associated with only small improvements in knowledge, skill, or evidence-based clinical practice among most clinician participants.[4,5] Pedagogy that incorporates active learning using methods such as interactive case-based learning, team learning, iterative practice with feedback has been associated with sustained improvements in clinicians' knowledge, skills, and clinical performance.[6,7]

Project ECHO (Extension for Community Healthcare Outcomes) relies on several theories of learning integrated into each of its continuing professional development evidence-based curricula and uses them in planning and development of the curricula, feedback, and practices it facilitates in chronic pain and other ECHO-supported telehealth programs. Among these theories are Bandura's self-efficacy and social cognitive theory, Vygotsky's situated learning theory, and especially Lave and Wenger's theory of community of practice, and there is evidence of their successful inclusion in ECHO.[8–11]

ECHO uses a hub-and-spoke model: the hub is a regional center where a multidisciplinary team of subject matter experts for a teleECHO clinic is located, and the spoke is a community partner site at which an individual or a team of learners is located and connects to hub through teleECHO clinics. This hub-and-spoke model is an adaptation of the train the trainer, one to many model used in ongoing health care educational settings, including public health and performance improvement, to scale effective training and dissemination of evidence-based practice.[12–14]

Project ECHO is a novel telehealth approach to support practicing clinicians in their management of chronic and

Disclosures: The authors declare no conflict of interest.

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Group name: Faculty and Staff of the Chronic Pain and Headache Management TeleECHO Clinic.

All authors made substantial contributions to designing and implementing the curriculum, writing and revising the article, and provided final approval of the version to be published.

Supplemental digital content is available for this article. Direct URL citations appear in the printed text and are provided in the HTML and PDF versions of this article on the journal's Web site (http://www.joehp.org).

Correspondence: *Brian M. Shelley, MD, UNM Pain Center, MSC10-6000, 1 UNM, Albuquerque, NM 87131-0001; e-mail: bshelley@salud.unm.edu.*

Anatomy of an ECHO

Table 1. Example of a Mock ECHO Anatomy of an ECHO Guide

1. Introductions a. Telephone participants b. VTC participants c. Hub Site and ECHO Core Group
2. Announcements a. Updates b. Audience questions and concerns
3. Question and Answer from last ECHO session
4. Patient Case Presentation a. Hub/ECHO Core Group introduces the presenter b. Presenter briefs the case c. Hub/ECHO Core Group summarizes presentation d. Hub/ECHO Core Group ensures with presenter the summary is accurate
5. Hub/ECHO asks audience for questions a. There are no recommendations for diagnosis or treatment at this point b. Differential diagnosis c. VTC participants d. Telephone participants e. Hub/ECHO Core Group
6. Hub/ECHO asks audience for recommendations and impressions a. Diagnosis or further workup b. Non-pharmacological recommendations c. Pharmacological recommendations d. Interventional recommendation
7. Hub/ECHO summarizes recommendations and consensus on diagnosis and treatment plan a. Asks presenter if his or her questions have been adequately addressed b. Hub/ECHO Core Group invites presenter to present again in the future and sets a tentative date for a follow-up presentation

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Routledge
Taylor & Francis Group

EDUCATIONAL CASE REPORTS

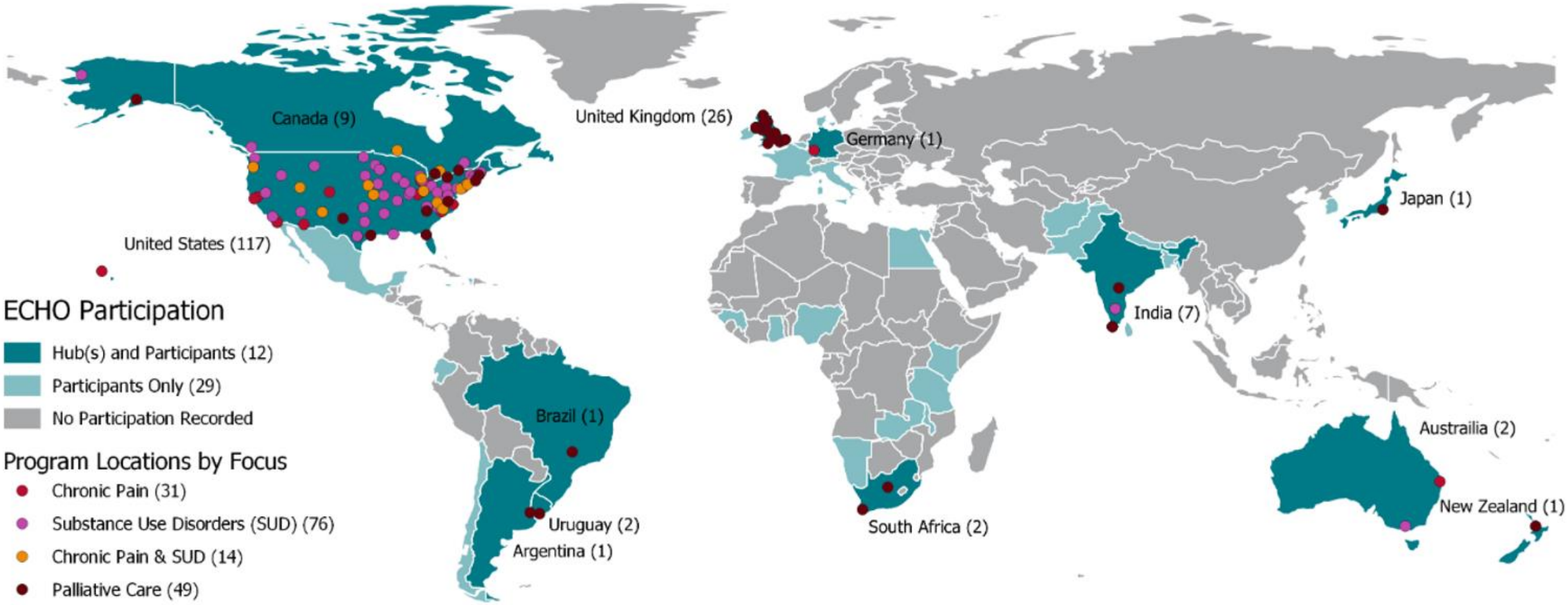
Mock ECHO: A Simulation-Based Medical Education Method

Rebecca C. Fowler[a], Joanna G. Katzman[b], George D. Comerci Jr.[c], Brian M. Shelley[d], Daniel Duhigg[e], Cynthia Olivas[f], Thomas Arnold[b], Summers Kalishman[f], Rebecca Monnette[g], and Sanjeev Arora[h]

Sample Chronic Pain and Opioid Management TeleECHO (ECHO Pain) Curriculum for New Mexico

SCHEDULE	TOPIC
	1. Opioid Overdose Epidemic: A Public Health Crisis
7/5/2018	HOLIDAY
7/12/2018	Opioid Prescribing Trends in New Mexico
7/19/2018	Epidemiology of the Opioid and Overdose Co-Epidemics in New Mexico
7/26/2018	Illegal Drug Use in New Mexico: Substances, Trafficking, Trends
	2. Chronic Pain Basics
8/2/2018	Opioid Use Disorders and Pain
8/9/2018	Lumbar MRI Interpretation Pearls
8/16/2018	Pain Self-Management Strategies
	3. Addiction, Multidimensional Nature of Pain and Rheumatological Conditions
8/23/2018	Introduction to Substance Use Disorders
8/30/2018	Opioid Use Disorder
9/6/2018	Multi-Dimensional Nature of Pain
9/13/2018	Painful Rheumatological Conditions
9/20/2013	Fibromyalgia
	4. Hands-On Pain Skills
9/27/2018	Chiropractic Exam
10/4/2018	Myofascial Exam
10/11/2018	Trigger Point Injection Workshop
10/18/2018	Community Acupuncture
10/25/2018	Taping Methods
11/1/2018	Physical Therapy Exam
11/8/2018	Neurological Exam
	5. Native American Health and Wellness
11/15/2018	Pain and Native American Culture
11/22/2018	HOLIDAY
11/29/2018	Historical Trauma and Chronic Pain
12/6/2018	Native American Healing
12/13/2018	Substance Use Disorder in Native American Communities
12/20/2018	Native American Palliative Pain Care
	6. Chronic Pain and Substance Use Disorders Across the Lifespan
12/27/2018	HOLIDAY
1/3/2019	Pain and Addiction During Pregnancy
1/10/2019	Pediatric Pain
1/17/2019	Adolescent Addiction
1/24/2019	Geriatric Pain
1/31/2019	Medication-Assisted Treatments through the Lifespan
	7. Pain, Mental Health and Substance Use Disorders
2/7/2019	Buprenorphine and Benzodiazepines in a Primary Care Setting
2/14/2019	Opioid and Substance Management in the Setting of Depression & Suicidality
2/21/2019	Office Based Screening Tools for Depression, Anxiety, and Substance Use Disorder in the Chronic Pain Patient
2/28/2019	Depression, Anxiety, and Chronic Pain
3/7/2019	The Role of Trauma in Chronic Pain
3/14/2019	HOLIDAY

	8. Pharmacotherapy of Medications Used for Pain, Psychiatry, and Substance Use Disorders
3/21/2019	Pharmacology I
3/28/2019	Pharmacology II
4/4/2019	Opioid Risks: Drug Disease and Drug-Drug Interactions
4/11/2019	Use of Opioids for Palliative Pain Care
4/18/2019	Naloxone Co-Prescribing with Opioids
4/25/2019	Advances in Migraine Management
	9. Integrative Pain Care
5/2/2019	What Are Best Practices for Integrative Pain Care?
5/9/2019	Botox for Migraine Management
5/16/2019	Acupuncture Best Practices
5/23/2019	Pathophysiology of Kinesiological Taping
	10. Emerging Treatments for Chronic Pain
5/30/2019	New Migraine Treatments
6/6/2019	Botox for Chronic Migraine
6/13/2019	Medical Cannabis
6/20/2019	Herbal Medications
6/27/2019	Buprenorphine for Pain Treatment



To see database used for map creation: https://echo.unm.edu/doc/ECHOPainAndOpioidTelementoringProgramList.xlsx

Project ECHO 2022: All US States and > 85 Countries

https://academic.oup.com/painmedicine/article/21/2/220/5698295

Army and Navy ECHO Pain Telementoring Improves Clinician Opioid Prescribing for Military Patients: an Observational Cohort Study

Joanna G. Katzman, MD, MSPH[1], Clifford R. Qualls, PhD[2], William A. Satterfield, PhD[3,4], Martin Kistin, MD[1], Keith Hofmann, BS[5], Nina Greenberg, MS, MPH[6], Robin Swift, MPH[1], George D. Comerci Jr, MD, FACP[7], Rebecca Fowler, MPH[8], and Sanjeev Arora, MD, MACP, FACG[1]

[1]ECHO Institute, University of New Mexico, Albuquerque, NM, USA; [2]Department of Statistics, University of New Mexico School of Medicine, Albuquerque, NM, USA; [3]Defense Health Agency, Falls Church, VA, USA; [4]University of New Mexico, Albuquerque, NM, USA; [5]Kennell and Associates, Falls Church, VA, USA; [6]Department of Mathematics, University of New Mexico, Albuquerque, NM, USA; [7]Department of Internal Medicine, University of New Mexico School of Medicine, Albuquerque, NM, USA; [8]Department of Psychiatry and Behavioral Sciences, University of New Mexico School of Medicine, Albuquerque, NM, USA.

BACKGROUND: Opioid overdose deaths occur in civilian and military populations and are the leading cause of accidental death in the USA.

OBJECTIVE: To determine whether ECHO Pain telementoring regarding best practices in pain management and safe opioid prescribing yielded significant declines in opioid prescribing.

DESIGN: A 4-year observational cohort study at military medical treatment facilities worldwide.

PARTICIPANTS: Patients included 54.6% females and 46.4% males whose primary care clinicians (PCCs) opted to participate in ECHO Pain; the comparison group included 39.9% females and 60.1% males whose PCCs opted not to participate in ECHO Pain.

INTERVENTION: PCCs attended 2-h weekly Chronic Pain and Opioid Management TeleECHO Clinic (ECHO Pain), which included pain and addiction didactics, case-based learning, and evidence-based recommendations. ECHO Pain sessions were offered 46 weeks per year. Attendance ranged from 1 to 3 sessions (47.7%), 4–19 (32.1%, or >20 (20.2%).

MAIN MEASURES: This study assessed whether clinician participation in Army and Navy Chronic Pain and Opioid Management TeleECHO Clinic (ECHO Pain) resulted in decreased prescription rates of opioid analgesics and co-prescribing of opioids and benzodiazepines. Measures included opioid prescriptions, morphine milligram equivalents (MME), and days of opioid and benzodiazepine co-prescribing per patient per year.

KEY RESULTS: PCCs participating in ECHO Pain had greater percent declines than the comparison group in (a) annual opioid prescriptions per patient (− 23% vs. − 9%, $P < 0.001$), (b) average MME prescribed per patient/year (−28% vs. −7%, $p < .02$), (c) days of co-prescribed opioid and benzodiazepine per opioid user per year (−53% vs. −1%, $p < .001$), and (d) the number of opioid users (−20.2% vs. −8%, $p < .001$). Propensity scoring transformation–adjusted results were consistent with the opioid prescribing and MME results.

CONCLUSIONS: Patients treated by PCCs who opted to participate in ECHO Pain had greater declines in opioid-related prescriptions than patients whose PCCs opted not to participate.

KEY WORDS: clinician education; project ECHO; telementoring; opioids; opioid overdose deaths; benzodiazepines.

J Gen Intern Med
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INTRODUCTION

An estimated 100 million Americans suffer from chronic pain.[1] In the USA, prescriptions for opioid analgesics quadrupled between 1999 and 2012.[2] Prescribing behaviors associated with increased overdose risk include co-prescribing benzodiazepines and opioids and exceeding a daily dose of 50 morphine milligram equivalents (MME).[3, 4] Approximately 175 people die everyday from drug-related deaths.[5] Drug overdose deaths surpass injury deaths caused by motor vehicle accidents and firearms.[6] The public health epidemics of chronic pain and drug overdose affect both civilian and military populations.[7–10]

Chronic pain, opioid use disorder (OUD), and post-traumatic stress disorder (PTSD) frequently occur together. Preventing these conditions is a high priority for the Department of Defense (DoD).[10–15] Pain is a leading reason patients seek medical care and primary care clinicians (PCCs) are often the first points of contact.[16, 17] Pain management and safe opioid prescribing education for civilian pre-licensure students and PCCs is not universally required, but is required for MHS clinicians.[18–21]

Electronic supplementary material *The online version of this article (https://doi.org/10.1007/s11606-018-4710-5) contains supplementary material, which is available to authorized users.*

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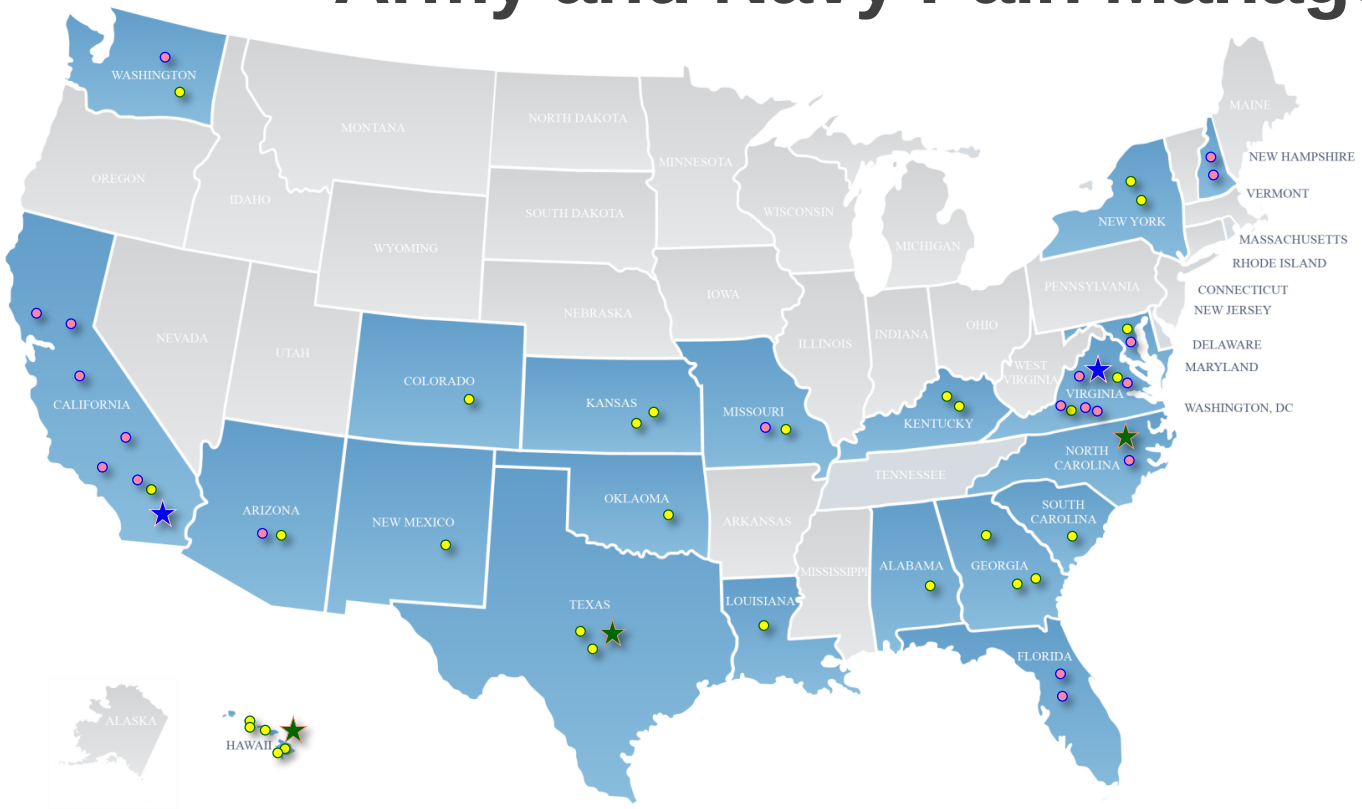
Army and Navy Pain Management ECHO Clinics



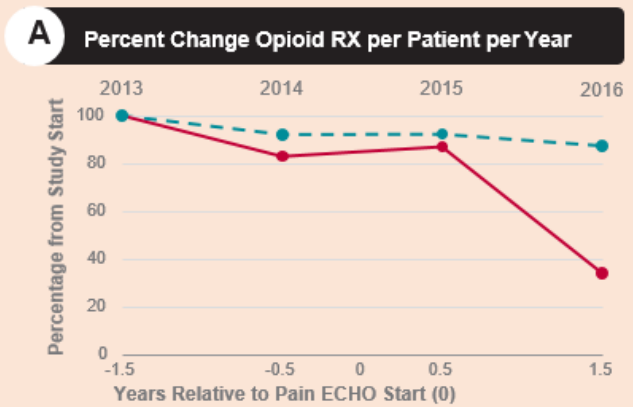
★ **Army ECHO Hubs:** Regional Health Command-Europe (RHC-E) – Landstuhl, Germany | Regional Health Command-Central (RHC-C)-Joint Base San Antonio-Brook Army Medical Center – TX | Regional Health Command-Pacific (RHC-P)-Tripler Army Medical Center – HI | Regional Health Command-Atlantic (RHC-A) – Ft. Bragg, NC

- **Belgium:**
  - Brussels
  - Supreme Headquarters Allied Powers Europe (SHAPE)
- **Germany:**
  - Grafenwoehr
  - Hohenfels
  - Katterbach
  - Landstuhl Regional Medical Center (LRMC)/FHC
  - LRMC/IMC
  - Stuttgart
  - Wiesbaden
  - Vilseck
- **Italy:**
  - Livorno
  - Vicenza
- **Japan:**
  - Camp Zama
- **South Korea:**
  - Camp Casey
  - Camp Humphreys
  - Camp Carroll
  - Camp Walker
  - Brian Allgood Army Community Hospital/ 121st Combat Support Hospital
- **Alabama:**
  - Redstone Arsenal
- **Arizona:**
  - Fort Huachuca
- **California:**
  - Fort Irwin
- **Colorado:**
  - Colorado Springs
- **Georgia:**
  - Fort Gordon
  - Fort Benning
  - Ft. Stewart
- **Hawaii:**
  - Schofield Barracks (Family Medicine and Troop Medical Clinic)
  - Adult Medicine Patient Centered Medical Home (PCMH) Tripler
  - Family Medicine PCMH Tripler
  - Warrior Ohana PCMH
  - VA Pain Clinic
- **Kansas:**
  - Fort Leavenworth
  - Fort Riley
- **Kentucky:**
  - Fort Knox
  - Fort Campbell
- **Louisiana:**
  - Fort Polk
- **Maryland:**
  - Fort Meade
- **Missouri:**
  - Fort Leonard Wood
- **New Mexico:**
  - White Sands Missile Range
- **New York:**
  - Fort Drum
  - West Point
- **Oklahoma:**
  - Fort Sill
- **South Carolina:**
  - Fort Jackson
- **Texas:**
  - Fort Bliss
  - Fort Hood
- **Virginia:**
  - Joint Base Langley-Eustis
  - Fort Lee
- **Washington:**
  - Madigan Army Medical Center

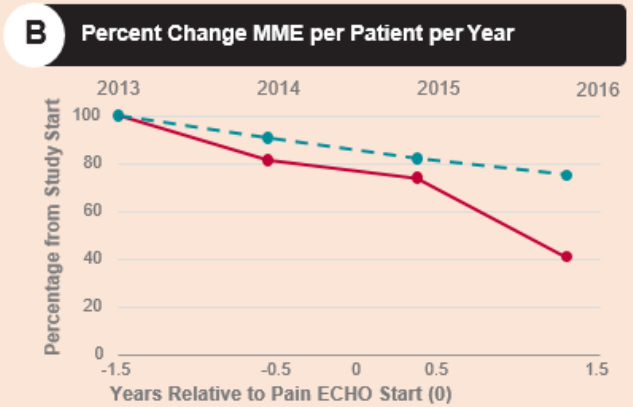
★ **Navy ECHO Hubs:** Navy Medicine East (NME)- Naval Medical Center (NMC) Portsmouth, VA | Navy Medicine West (NMW)- Naval Medical Center San Diego (NMCSD), CA

- **Arizona:**
  - NH Yuma
- **California:**
  - NMCSD Naval Training Center
  - NH Lemoore
  - NH Twentynine Palms
  - NH Camp Pendleton
  - Naval Air Facility El Centro
  - Naval Air Station North Island
- **Florida:**
  - Naval Hospital (NH) Jacksonville
  - Naval Air Station Jacksonville
- **Maryland:**
  - NHC Pax River
- **Missouri:**
  - Behavioral Health Clinic (BHC) Boone
- **North Carolina:**
  - NH Camp LeJeune
- **New Hampshire:**
  - BHC Portsmouth NH
  - Navy Safe Harbor
- **Virginia:**
  - NMC Portsmouth (Case Management, Pain Clinic, Physiatry, Internal Medicine)
  - BHC Oceana
  - TriCare Prime Clinic (TPC) Chesapeake
  - TPC Virginia Beach
  - 633rd Medical Group-Langley

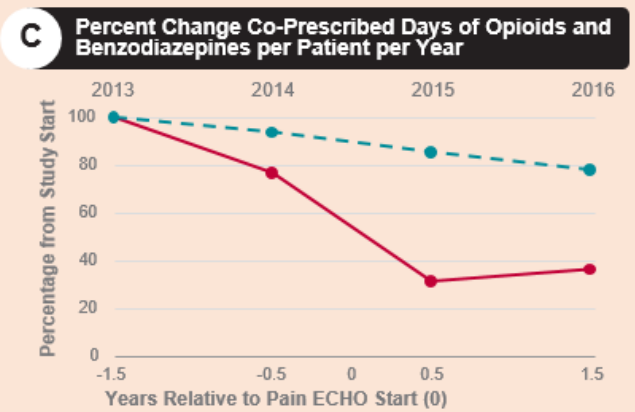
Percent Change of Opioid Prescriptions, Opioid Dose and Co-Prescription of Opioids and Benzodiazepines for Patients whose Clinicians Participate in ECHO Pain



Baseline Comparison = 0.86
Baseline Pain ECHO = 0.31
P = 0.004



Baseline Comparison = 363.95
Baseline Pain ECHO = 171.57
P = 0.02



Baseline Comparison = 0.54
Baseline Pain ECHO = 0.36
P < 0.001

Comparison Group ----------

ECHO Group ——————

Katzman, J, Qualls, C, Satterfield, W, Army and Navy ECHO Pain Telementoring Improves Clinician Opioid Prescribing for Military Patients, 2018, J Gen Intern Med

CDC Opioid Rapid Response Team (ORRT) ECHO 16-Week Curriculum

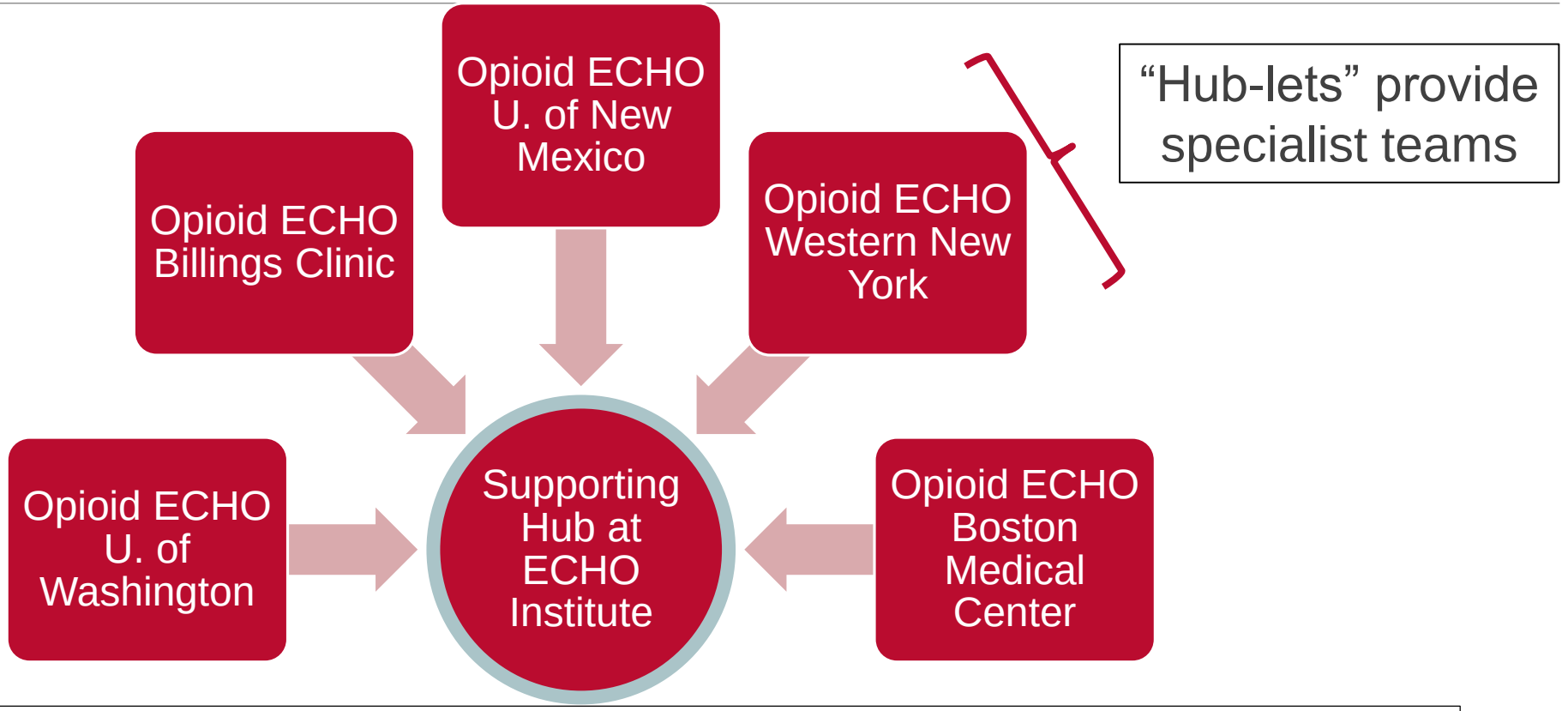
Week	Topic
1	Chronic Pain, Substance Use Disorder, Mental Health and Suicide in US
2	Patient-Centered Approaches to Care: Introduction to Motivational Interviewing
3	Assessing the Patient with Chronic Pain using Functional Goals
4	Initiating Opioid Therapy for Chronic Pain
5	Validated Screening Tools for Depression, Anxiety and Use Disorders
6	Understanding and Managing Challenging Behaviors
7	Referral to Treatment including Medication-Assisted Treatment Using Motivational Interviewing to Enhance Readiness
8	Safety Issues: Street drugs, Prescription of Naloxone, Safe Storage, Blood Borne infections
9	Identifying Depression and Suicide Risk
10	Monitoring Sleep, Depression and Worsening Pain
11	Things to Avoid in Treating Chronic Pain, Substance Use Disorder, and Alcohol Use Disorder Patients
12	Non-Pharmacologic Strategies for Managing Chronic Pain
13	Non-Opioid Pharmacotherapy for Chronic Pain
14	How to Taper Opioid Analgesics
15	How to Taper Benzodiazepines
16	Project ECHO as a Community Resource

Presenter: Joanna Katzman, MD , Snehal Bhatt, MD, Vanessa Jacobsohn, MD, James Sacco, MSW		
Patient information		
Age: 33yo		Gender: Female
Height: 73	Weight: 142	BMI: 17.7
History of presenting illness:		33 year-old female with severe right-sided atypical facial pain which began after a rock-climbing accident and fall. For pain control, patient has tried a multimodal approach including medications (tricyclics, SNRIs, carbamazepine, and opioid analgesics), along with non-interventional trials of physical therapy, behavioral health and hypnosis. In additional, patient has tried sphenopalatine ganglion and supraorbital nerve blocks without benefit.
Past Medical History:		Right sided atypical facial pain, anxiety, insomnia, mild depression
Past Surgical History:		None
Relevant social history:		Grew up in a family with 2 alcoholic parents, no contact with biological family. Unmarried, lives with supportive boyfriend, drinks 1-3 glasses of wine most nights, denies illicit substances; quit tobacco age 22
Physical Examination		33 year old female in obvious pain. Vital signs stable. Pertinent exam findings: exquisite tenderness to very light touch in the V1, V2, V3 distribution of R- Trigeminal Nerve of face. Remainder of Cranial nerves intact. HEENT- o/p-moist, no evidence of temporal mandibular join dysfunction.
Current medications:		Long-acting oxycodone 30 mg tid oxycodone/acetaminophen 5/325, q 6 hours prn breakthrough pain Naloxone – auto injector Temazepam (Restoril) 15-30 mg qhs – sleep/insomnia- nightly
UDS:		Positive for oxycodone and temazepam
Tests/Imaging:		N/A
PDMP:		No issues

CSA signed?	yes
Screenings:	GAD-7__11__ PHQ-9__8___ Suicidality__n/a___
Patient's functional goals:	1. Reduce pain 2. "I want to go rock climbing again without anxiety"
Assessment and Plan	1. Do not use benzodiazepines and opioid analgesics together (decreased respiratory drive) - Benzodiazepine taper 2. Do not combine alcohol with opioid analgesics and/or benzodiazepines (decreased respiratory drive) 3. Avoid long-acting opioids (better to begin with short-acting opioids, less risk of decreasing respiratory drive) 4. Behavioral health referral to address depression and anxiety

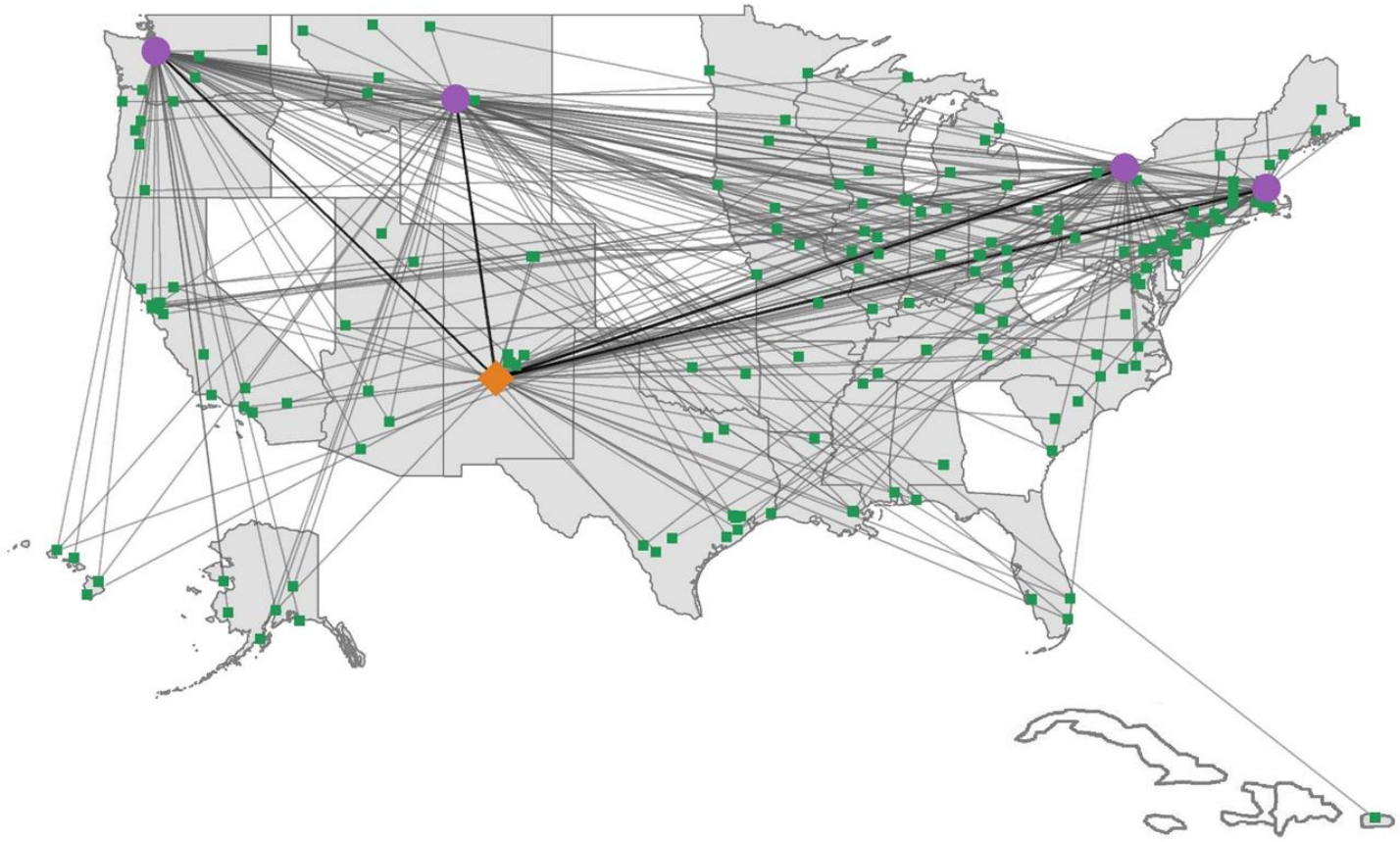
Abbreviations: CSA – Controlled substance agreement; PDMP – Prescription Drug Monitoring Program; SNRIs - Serotonin and norepinephrine reuptake inhibitors; UDS – Urine drug screen

ECHO Shared Services Model



Supporting hub leads the development of curriculum; provides IT, evaluation, and admin support; and participant recruitment for all hubs

HRSA National Opioid ECHO Programs



AIM: Train HRSA-funded health center prescribers in Medication-Assisted Treatment (MAT) for opioid use disorder (OUD)

PARTICIPATION: 429 learners from 192 HRSA-funded health centers

MODEL: Project ECHO provided core support and coordination services for 5 national hub sites

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Discussion Questions

1. What are key components or lessons learned from successful provider education efforts at the national, state, or health system level related to opioids, pain management, and SUD?
2. Building on yesterday's discussion on professional practice gaps, how have these initiatives helped address professional practice gaps identified in Day 1?
3. What have been challenges and barriers to scaling effective educational interventions?
4. What are the types of policy, legal, or operational efforts are needed to support the goals of prescriber education? How can we think about prescriber education from a systems perspective?
5. Have lessons learned from these efforts been shared between organizations? Are there further opportunities for interprofessional and intergovernmental collaborations to improve provider education?

Break

We will be back momentarily.

The next panel will begin at 2:40 p.m. (U.S. Eastern Time)

Future Directions and Next Steps for Shaping Prescriber Education Efforts

Travis Rieder, Johns Hopkins University

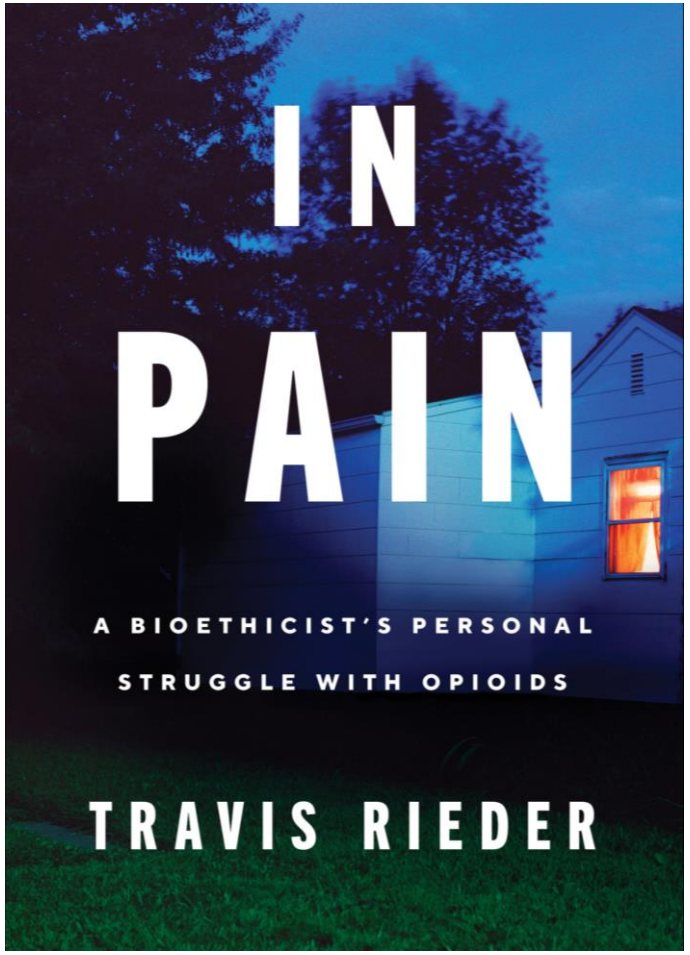
Graham McMahon, Accreditation Council for Continuing Medical Education

Lisa Robin, Federation of State Medical Boards

Marie-Michèle Léger, American Academy of PAs

Alister Martin, Harvard Medical School

Sean Mackey, Stanford Pain Medicine



REFRAMING OPIOID PRESCRIBING GOALS

April 5, 2022

Travis N. Rieder, PhD
Berman Institute of Bioethics
Johns Hopkins University
trieder@jhu.edu
@TNREthx

JOHNS HOPKINS
BERMAN INSTITUTE
of BIOETHICS

I have no relevant disclosures.

JOHNS HOPKINS
BERMAN INSTITUTE
of BIOETHICS

Let's talk about *responsible* opioid prescribing.

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RESPONSIBLE PRESCRIBING:

1. Appropriate initiation

2. Appropriate management

3. Appropriate discontinuation

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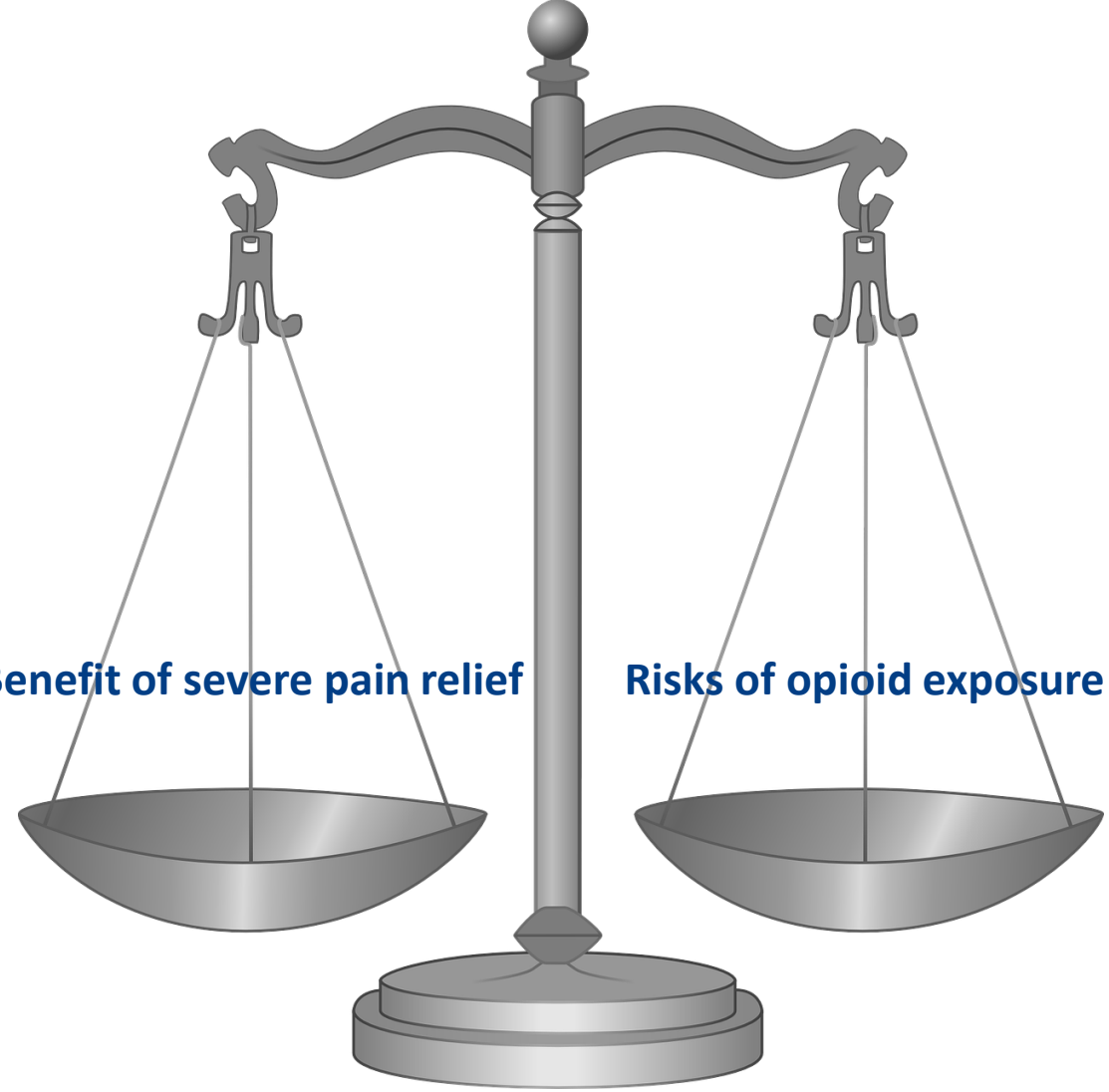

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RESPONSIBLE PRESCRIBING:

1. Appropriate initiation
2. **Appropriate management**
3. Appropriate discontinuation

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The era of prescribe and forget is over. Appropriate management requires:

- Regular checking in, perhaps with behavioral health assessments.
- Screening for not only signs of misuse and developing use disorder, but also physical dependence.
- Checking for understanding concerning the long-term challenges.

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Don't fly a plane if you don't know how to land.

-David Juurlink, MD

How to Taper Opioids

Recommendations for adults 18+ excluding active cancer, palliative, or end-of-life care. Refer clients with suspected or known addiction to addiction services.

Step 1 Explain individual reasons for the need to taper (e.g. risk or side effects of opioids)

Step 2 Communicate that you will stick with the patient through entire taper process and that the taper can be slowed or stopped if needed

Step 3 Optimize adjuvant non-opioid analgesics and non-drug treatments (e.g. CBT, physiotherapy).

Step 4 Consolidate all opioid therapy into a single long-acting medication if feasible.

Step 5 Partner with client in decision on rate of taper.

Step 6 Decrease the opioids by 10% of the original dose per week. It may require 10% per month, depending on length of opioid treatment, if the client is anxious about tapering, or cardiorespiratory conditions exist. Faster tapers may be used if serious adverse effects are present. Slow or pause tapering to manage withdrawal symptoms. See reverse side for treatment of withdrawal symptoms.

Step 7 Once 1/3 of the original dose is reached, slow the taper to half of previous rate.

Step 8 Once the smallest available dose is reached, extend the interval.

Step 9 Consider discontinuation when dosing is less than once per day. The patient may maintain at a lower opioid dose if unable to complete the taper.

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Withdrawal Symptoms and Treatment

Many of these symptoms may not be seen with gradual taper

Opioid Type	Short-acting	Long-acting
Withdrawal Onset	8-12 hours	1-3 days
Peak	24-48 hours	3-8 days
Duration	5-7 days	10-14 days

Early symptoms may include:

- anxiety and restlessness
- runny nose, tearing eyes
- rapid short respirations
- dilated reactive pupils

Late symptoms may include:

- runny nose, tearing eyes
- rapid breating, yawning
- tremor, diffuse muscle spasms/aches
- pilo-erection (goose bumps)
- nausea and vomiting; diarrhea
- abdominal pain
- fever, chills
- increase in white blood cells (if sudden withdrawal)

Prolonged symptoms may include:

- irritability, fatigue; hormonal related
- decreased body temperature
- bradycardia (slower heart rate)

Early = hours to days
Late = days to weeks
Prolonged = weeks to months

Some people with chronic pain will find that symptoms such as fatigue and general well-being are improved over time with tapering of the opioid. In such cases, gradual gains in function will be possible and should be explored.

Symptoms	Pharmacological Treatment
Sweating / Tachycardia	Clonidine 0.1mg BID-QID (test dose 0.1mg and monitor HR and BP; taper after 5-10 days)
Anxiety / Lacrimation / Runny Nose	Hydroxyzine 25-50mg TID prn
Aches / Pains / Myalgia	NSAID 2-4x/day; APAP 650-1000mg q6h prn
Diarrhea	Loperamide 4mg, then 2mg after each loose stool, do not exceed 16mg/day
Nausea and Vomiting	Ondansetron 4 mg every 6 hours as needed OR prochlorperazine 5-10mg q6h
Insomnia	Sleep hygiene; trazodone 25-100mg HS, amitriptyline 10-25mg HS, doxepin 10mg HS

Journal of Gerontological Nursing 2018; 44(1): 9-14 Pocket Guide: Tapering Opioids for Chronic Pain. Centers for Disease Control and Prevention. | NPS MedicineWise: Victoria State Government. Recommendations for Deprescribing or Tapering Opioids. May 2016. | American Society of Addiction Medicine. The National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use. 2015. | Veterans Health Administration. Opioid Taper Decision Tool. October 2016.
"I'm Not Gonna Pull the Rug out From Under You": Patient-Provider Communication About Opioid Tapering | J Pain. 2017 Nov; 18(11): 1365–1373.

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KEY RECOMMENDATIONS FOR CONTINUING EDUCATION FOR THE FDA REMS PROGRAM

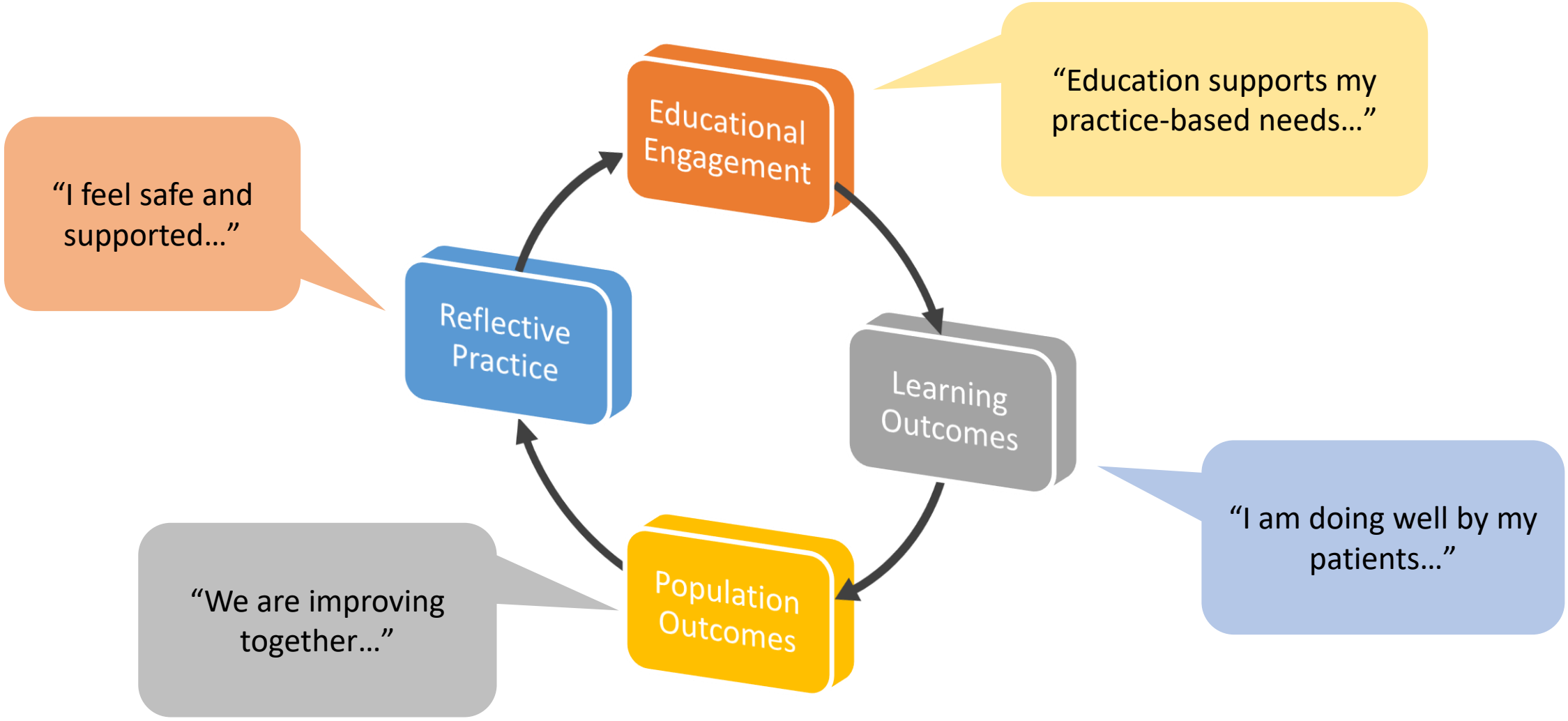
Accreditation Council™
for Continuing Medical Education
learn well

Graham McMahon, MD MMSc
President & CEO, ACCME
gmcmahon@accme.org

Key Problems

- Confidence-Competence Gap
  - prescribers think they know what they're doing when they often don't
  - this results in complacency and errors, low motivation to engage
- No identification of individual performance gaps
- Ineffective use of millions of $$ of annual RPC funds
  - Grant applicants are the same consistent group – not engaging the distributed accredited providers incl those in rural and underserved communities
  - Check-box completions that create appearance of efficacy
  - Requirements that drive information transfer rather than competency development
  - Each activity must cover FDA blueprint leading to inability to customize to learner or group

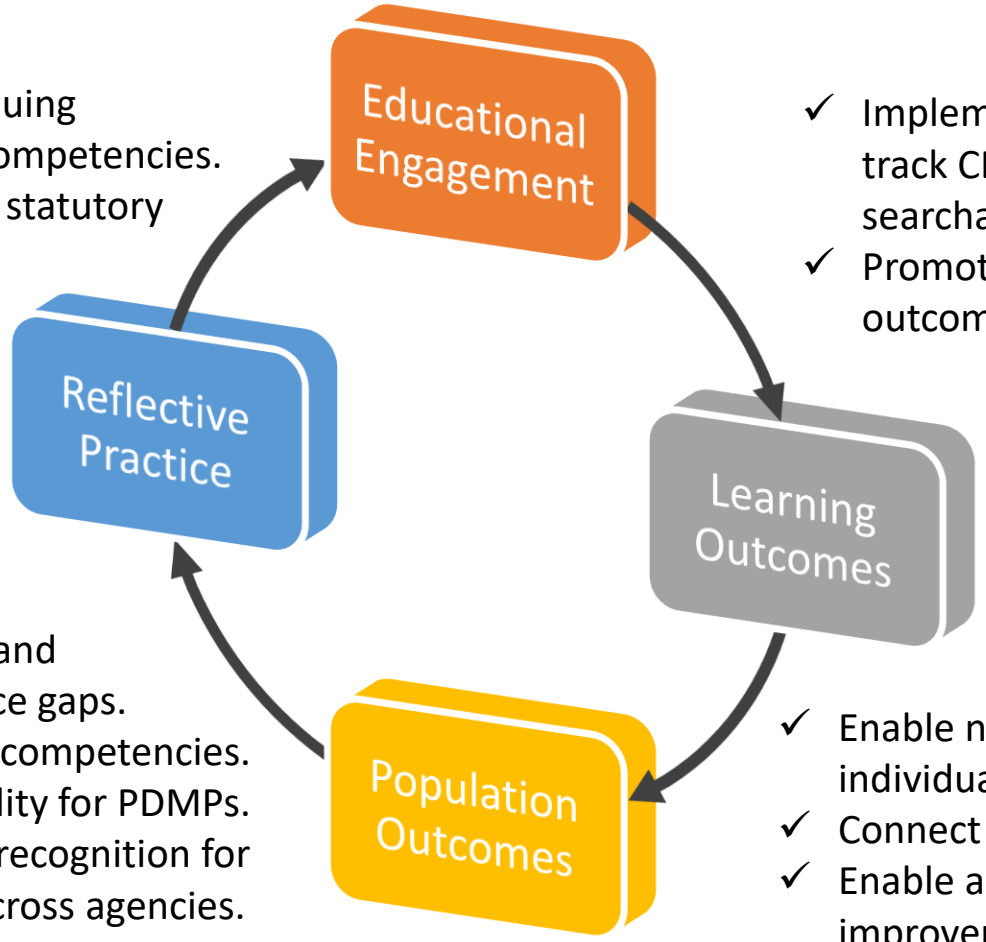
Implementing the Key Priorities*



*Key Priorities from **Educating Together, Improving Together: Harmonizing Interprofessional Approaches to Address the Opioid Epidemic.** *NAM Special Publication.* Washington, DC: National Academy of Medicine, 2021.

Implementing the Key Priorities*

- ✓ Integrate interprofessional continuing education (IPCE) based on core competencies.
- ✓ Harmonize CE requirements with statutory requirements and programs.



- ✓ Implement a data monitoring system to track CE engagement that provides a searchable national database.
- ✓ Promote investment in CE innovation and outcomes research.

- ✓ Enable national tracking of competencies for individuals and/or interprofessional teams.
- ✓ Connect competencies with quality metrics.
- ✓ Enable accredited CE to fulfill federal practice improvement initiatives.

- ✓ Support research to study and disseminate priority practice gaps.
- ✓ Establish minimum IP core competencies.
- ✓ Promote data interoperability for PDMPs.
- ✓ Develop system of mutual recognition for regulatory requirements across agencies.

*Key Priorities from **Educating Together, Improving Together: Harmonizing Interprofessional Approaches to Address the Opioid Epidemic.** *NAM Special Publication.* Washington, DC: National Academy of Medicine, 2021.

Recommended Solutions

- Educators have demonstrated their flexibility, efficacy and innovation in CPD. Let them do their work and flourish
- FDA
  - Require RPC to
    - respect the determinations of the JA independent grant review committee &
    - make their funding amounts and decisions transparent
  - eliminate requirement to fulfill entire blueprint;
  - expect competency specific outcomes (not pre-post tests) that accreditors can audit for
  - allow test-outs
  - Require learner completion data is reported centrally
- ACCME & ACCREDITORS:
  - Manage learner completion data in the centralized PARS dataset.
  - Continue the independent grant review work.
  - Audit activities for compliance
- STATE LICENSING BOARDS:
  - Agree to recognize REMS-compliant completions in the central data system as meeting their (currently diverse) requirements
  - Collaborate to aggregate PDMPs
- OTHERS
  - Create collaborative research effort to identify practice gaps, harmonize data, and product an annual report

THANK YOU

Contact me:
gmcmahon@accme.org

Federation of State Medical Boards (FSMB)

Lisa Robin
Chief Advocacy Officer
Federation of State Medical Boards
www.fsmb.org
lrobin@fsmb.org

OPIOIDS AND PAIN MANAGEMENT

Overview

FEDERAL GOVERNMENT RESOURCES

CDC Guideline for Prescribing Opioids for Chronic Pain

CDC Statement Regarding Misapplication of Guideline

CDC Opioid Data Analysis

HHS Pain Management Best Practices

SAMHSA Federal Guidelines For Opioid Treatment Programs

SAMHSA 2018 National Survey on Drug Use and Health (NSDUH) Report

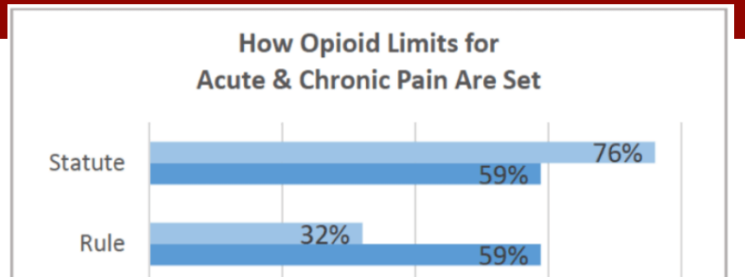
OPIOIDS AND PAIN MANAGEMENT

The United States' escalating opioid epidemic, with drug overdose deaths on the rise since 1999, has led to a wave of laws, regulations, and guidelines implemented at the federal and state level in an effort to curb substance use disorder.

The FSMB supports its member boards through policy analysis and development on key issues impacting medical regulation, including opioid prescribing and pain management. FSMB's official public policies are intended to give guidance and encourage consistency among state medical boards in order to protect the public and improve the quality, safety, and integrity of health care.

STATE OPIOID POLICIES

Federation of State Medical Boards



Opioid Regulatory Collaborative

- A collaboration of the American Association of Dental Boards, Federation of State Medical Boards, National Association of Boards of Pharmacy, and the National Council of State Boards of Nursing…regulating more than 5 million health care professionals

- **Goals**:
- Share resources and strategies to reduce opioid substance use disorder among the public and health care professionals
- Seek better alignment of state policy guidance across health regulatory boards
- Partner with and support initiatives of other healthcare organizations aimed at the opioid epidemic including the National Academy of Medicine's Action Collaborative on Countering the U.S. Opioid Epidemic

- **Dedicated Website**:
- www.curbopioidmisuse.org

ORC Invitational Summit

- March 7-8 at NAM's Keck Center in Washington, DC
- Board Governance of FSMB, NCSBN, NABP, AADB

- **Featured Speakers**:
  - Rahul Gupta, MD, MPH (Director, NDCP)
  - Joshua Sharfstein, MD (Johns Hopkins Bloomberg SPH)

- **Program Topics**:

✓ Strategies to Advance Effective and Individualized Education
✓ Risk Reduction and Accountability
✓ Protecting Patients and Practitioners: New Trends in Opioid Addiction Treatment

ORC Invitational Summit

- **Opportunities Identified**:

✓ Improving harmonization of policy and CE requirements
✓ Addressing stigma
✓ Increasing access to care and support for MOUD
✓ ORC will continue to identify focus areas and commit to action on identified opportunities

- **ORC Moving Forward**
- Publish a commentary and call to action based on Summit discussions
- Continue quarterly meetings
- Participate in FSMB's upcoming project to revise its pain and addiction policies

Thank you

Discussion Questions

1. As the nature of the opioid and substance use crisis has changed, what gaps in prescriber education and practice have become more critical and what core competencies have become more relevant? How have stakeholder organizations worked to adapt to these changes?
2. What existing interprofessional and intergovernmental collaborations are working to improve opioid prescriber education?
3. Where are there further opportunities for alignment and harmonization in the content of prescriber education initiatives, especially as telehealth expands providers' abilities to deliver care across state lines?
4. How can FDA most effectively further efforts to harmonize and improve prescriber education?

Closing Remarks | Day 1

Mark McClellan, MD, PhD

Director, Duke-Margolis Center for Health Policy

Thank You!

Contact Us

healthpolicy.duke.edu

Subscribe to our monthly newsletter at
dukemargolis@duke.edu

1201 Pennsylvania Avenue, NW, Suite 500
Washington, DC 20004

DC office: 202-621-2800
Durham office: 919-419-2504

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