SCOPE of Pain
Safer/Competent Opioid Prescribing Education

Safer/Competent Opioid Prescribing Education (*SCOPE of Pain*)

Putting the Blueprint into Action

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Personal Disclosure

- I have had no financial arrangement or affiliation or other beneficial interest in the past three years with any products, or firms relevant to today's discussions.

Scope of Pain Disclosure

- This activity is supported by an independent educational grant from the Opioid Analgesic REMS Program Companies. Please see ce.opioidanalgesicrems.com/RpcCEUI/rems/pdf/resources/List_of_RPC_Companies.pdf for a listing of REMS Program Companies. This activity is intended to be fully compliant with the Opioid Analgesic REMS education requirements issued by the US Food and Drug Administration.

Why Accredited CME for REMS?

Accreditation Council for Continuing Medical Education

The hallmark of accredited CME is independence from promotion or marketing

- **Independence of commercial bias** by strict adherence to ACCME Standards for Commercial Support[1]
- **Valid content** that is based on continuously updated scientific best evidence[2]
- The **target audience** is identified according to who is at the frontline of the clinical issue and includes the **inter-professional team**
- **Educational needs** underlying **practice gaps** inform content

1. www.accme.org/accreditation-rules/standards-for-commercial-support
2. www.accme.org/accreditation-rules/policies/cme-clinical-content-validation

Why Accredited CME for REMS?

Accreditation Council for Continuing Medical Education

- **Educational formats** based on adult learning principles designed to be relevant to practice and result in improvements in clinicians' competence, performance, and patient outcomes
- **Evaluation** of changes in learners as a result of the education
- Emphasis on **patient-centered care**

SCOPE of Pain – From the Beginning

- **February 28, 2013:** Launched in response to ER/LA Opioids Analgesic REMS Blueprint funded by first educational grant from the REMS Program Companies

- **March 1, 2019:** Launched updated program in response to September 2018 Opioid Analgesics REMS Blueprint

- As of **November 19, 2020** we have had **203,526 cumulative completions**
  - 69% controlled substance prescribers, 24% non-prescribers, 7% unsure

Independence and Valid Content

- All content developed by course director and faculty independently of the grantor
- Content is continuously updated according to Blueprint modifications, guidelines, peer reviewed literature
- 99.5% (202,549/203,501) of participants detected **NO** commercial bias

Target Audience

- Physicians, nurse practitioners, registered nurses, physician assistants, nurses, dentists, pharmacists, and allied health professionals whose practices manage acute and chronic pain

- Since 2013 BUSM has focused on continuity care providers and as of 2019, added content for episodic care providers who treat acute pain in the post-operative and emergency department settings

Needs Assessment

- Expert clinicians and faculty – led by Daniel P. Alford, MD, MPH
- The Blueprint
- CDC Guideline
- Literature
- Specialty Society Guidelines
- State and national public health data
- Analysis of questions and follow-up survey data from years of Boston University School of Medicine CME activities

Selected Practice Gaps

- Overreliance of opioids for the management of acute and chronic pain
- Prior to opioid prescribing
  - lack of risk stratification for opioid misuse risk
  - low confidence in talking to patients about realistic benefits and potential harm
- During prescribing
  - poor assessment of benefits and harms
  - poor documentation of the assessment and treatment plan
  - poor use of multi-modal care including rationale polypharmacy
  - lack of knowledge and use of universal precautions, eg. monitoring with urine drug testing
  - lack of skill in addressing worrisome opioid taking behaviors
- Lack of skill in knowing when to continue, modify, or discontinue opioids
- Lack of skill in how to discontinue opioids safely

Educational Objectives

At the conclusion of these activities, learners will be better able to:

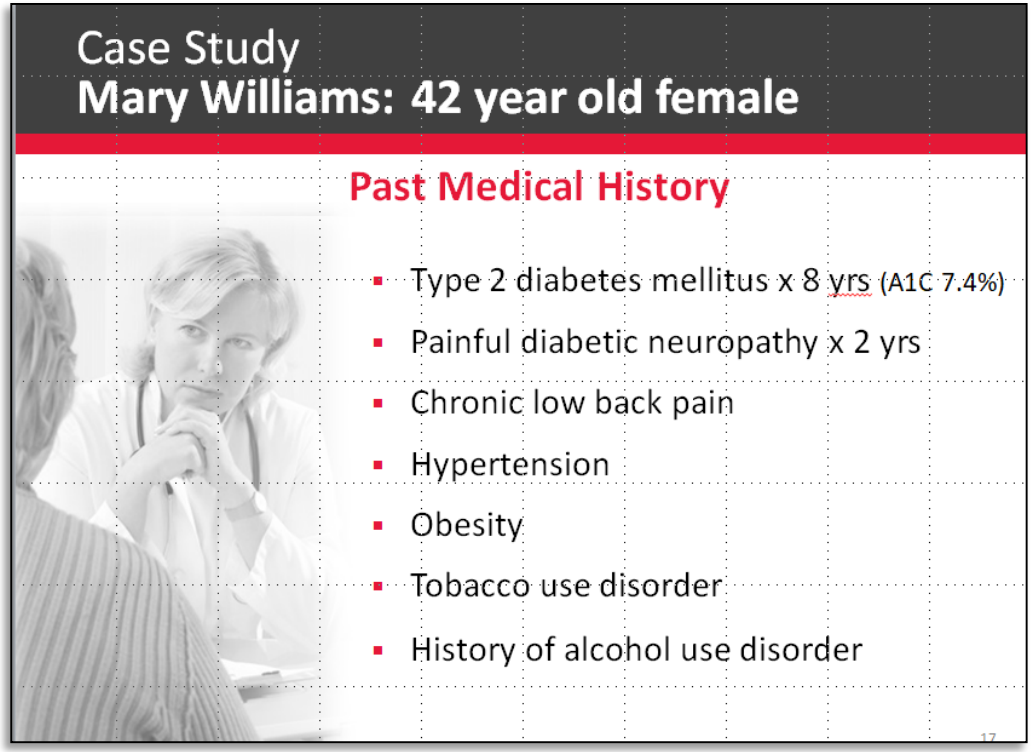
- Optimize safety when prescribing opioids for acute and chronic pain
- Assess pain and prescription opioid misuse risk
- Educate patients about opioid risks and realistic benefits
- Monitor patients on opioid therapy for benefits and harms
- Assess and manage worrisome opioid-taking behaviors
- Safely taper long-term opioid therapy
- Identify and manage patients with an opioid use disorder

Educational Design

How do you address 100 Blueprint elements in educational content that will engage learners and encourage them to sit still for 2-3 hours either in person or in front of a computer? How do you teach them the general principles and where to find specific drug and dosing information when they need it?

2013

- New patient with chronic low back pain and painful diabetic neuropathy on chronic opioid therapy
- 3 visits to primary care, with increasing complexity
- Critical decision points at the end of modules 1 and 2 encouraged completion of the online program through module 3
- 91% completion Module 1 – Module 3

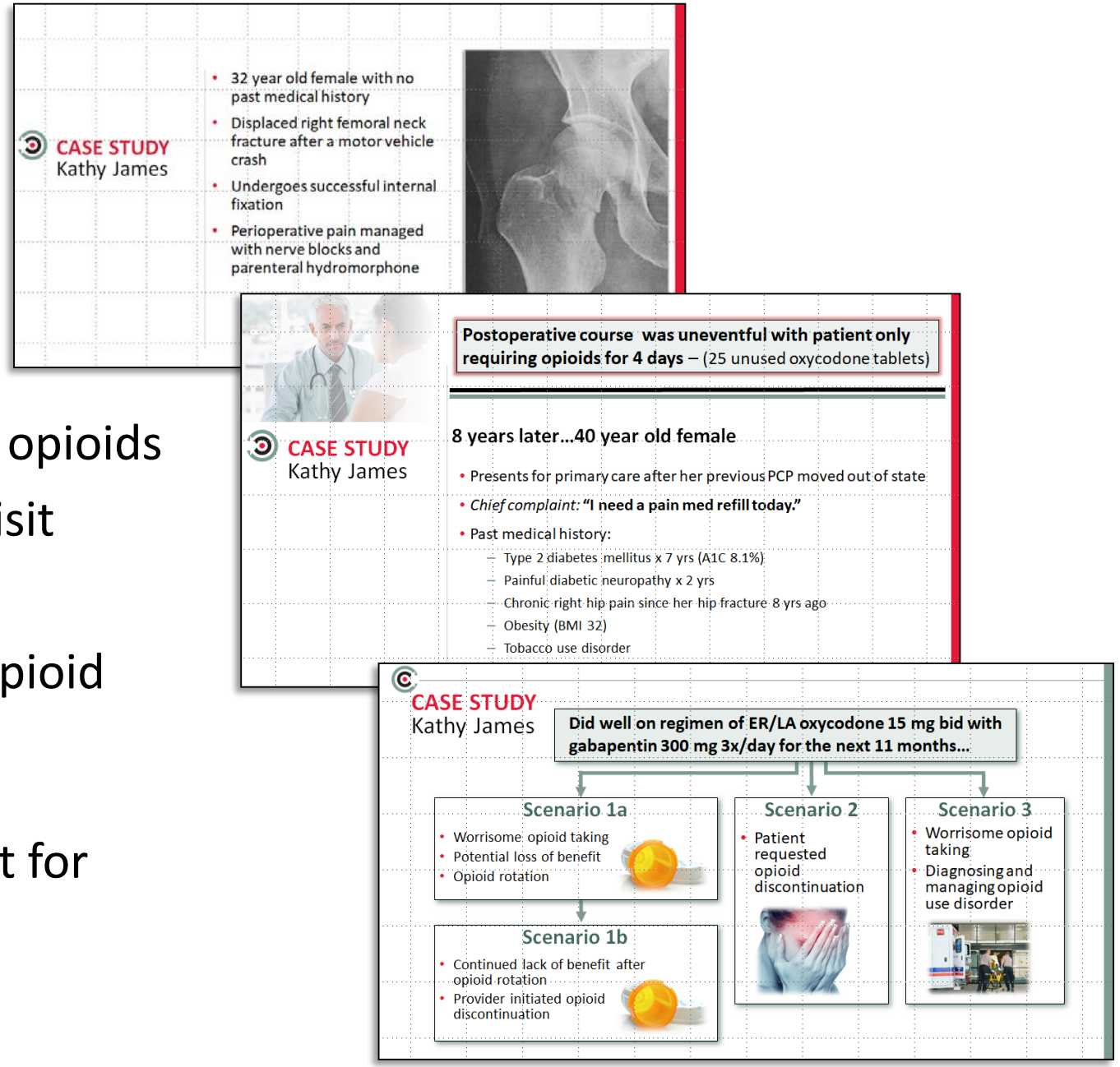


Educational Design

2019 (new case)

- Acute fracture requiring surgery – post-operative pain
- Returns years later with chronic pain on opioids
- Acute pain requiring emergency room visit

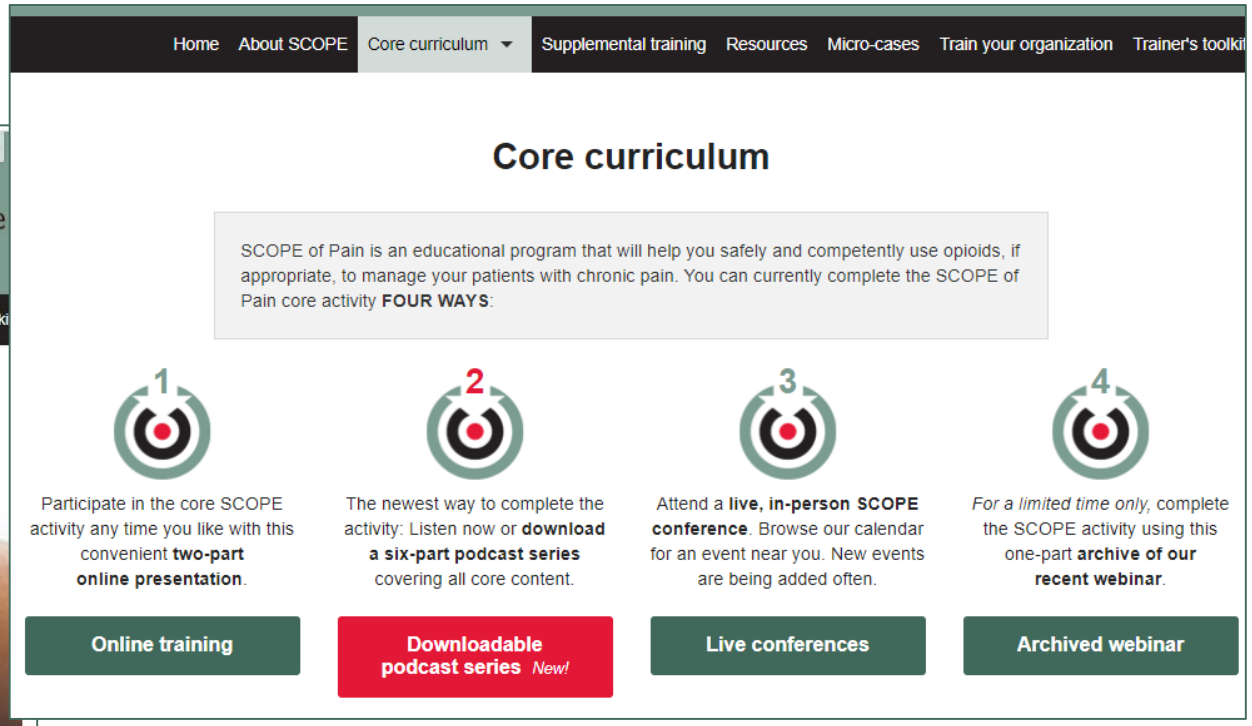
- 4 potential endings covered, including opioid rotation with decrease in morphine mg equivalents, opioid taper (voluntary and involuntary), opioid overdose, treatment for opioid use disorder



The Grid

February 2019 Audit Blueprint Section	Module/Scenario	Post-test Question
Section 1: The Basics of Pain Management		
I. THE NEED FOR COMPREHENSIVE PAIN EDUCATION		Question 2, Question 3, Question 4
The FDA Blueprint was developed with two, competing, U.S. public health concerns in mind, (1) the large number of Americans with acute and chronic pain and (2) the epidemic of prescription opioid abuse.		
1. Providing health care providers (HCPs) with a thorough understanding of the risks associated with opioids can give HCPs the opportunity to consider all pain management options, including nonpharmacologic and pharmacologic options, prescribing opioids only when non-opioid options are inadequate and when the benefits of using an opioid are expected to outweigh the risks.	Module 1	
2. When HCPs have information about the risks of opioid misuse and abuse, they will be better able to create opportunities for patient counseling and other strategies to reduce these risks.		
II. DEFINITIONS AND MECHANISMS OF PAIN		Question 1
Pain can be categorized according to its duration, underlying pathophysiology of the original insult, and whether a central sensitization component has developed. An understanding of these different categorizations can help direct therapeutic decisions.		
When defining, and classifying pain, the following should be taken into consideration		
1. Biological significance of pain (survival value)	Module 1	
2. Relationship between acute and chronic pain	Module 1	
3. Distinction between nociceptive and neuropathic pain	Module 1	
III. ASSESSING PATIENTS IN PAIN		Question 1, Question 5, Question 6
HCPs should be knowledgeable about how to assess each patient when initiating a pain management program. When appropriate, evidence-based, standardized scales and tools can be used to document pain characteristics and guide management decisions throughout treatment, noting the strengths and weaknesses regarding specificity and sensitivity of these scales.		
Important elements of an initial assessment include the following:		
1. Patient History	Module 1	
2. Screening tools to evaluate known risk factors for development of chronic pain after an acute injury or disease.	Module 1	
3. Screening tools to evaluate the known risk factors for opioid use disorder (OUD) or abuse	Module 1	
4. Queries of state prescription drug monitoring programs (PDMPs)	Module 1, Module 2	
5. Pain assessment scales/tools	Module 1	
6. Functional assessment scales	Module 1	
7. Physical Examination	Module 1	
8. Family planning, including information about use of contraceptives, pregnancy intent/status and plans to breastfeed	Module 2	
9. Psychological and social evaluations	Module 1	
10. Diagnostic Studies when indicated	Module 1	

www.scopeofpain.org



Educational Activities to Date

- Online program with multiple updates
- 184 live in-person meetings held in 27 states (offered with state- or institution-specific content)
- 15 webinars - 12 have been archived as enduring materials
- Print monograph
- 6-part podcast series released in April of 2020

- Supplemental content including
  - Trainers' Toolkit (8 communication videos, skills practice, guided case discussion)
  - Additional online modules (opioid tapering, implementation strategies)
  - 19 Micro-cases podcast series (< 4 minute audio scenarios that illustrate clinical pearls)

Beyond Knowledge Acquisition: Teaching Communication Skills

Communication Videos

Aberrant opioid taking behavior
Video • PDF

Lack of opioid benefit and excessive risk
Video • PDF

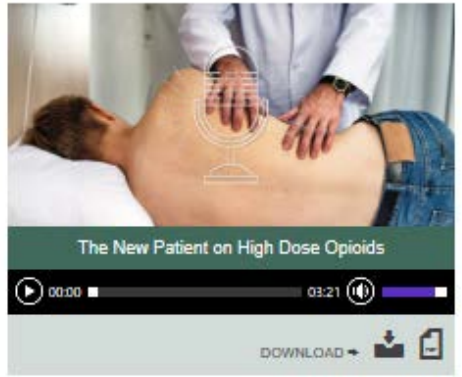
Illicit drug use in a patient on chronic opioid therapy
Video • PDF

PDMP questionable activity in an established patient
Video • PDF

Micro-cases

The Challenge: Unexpected Urine Drug Test Result

The Challenge: High-Risk Patients



CME Evaluation

The Moore, Green, and Gallis model describes 7 outcome levels[3]

- Level 1 Participation
- Level 2 Satisfaction
- Level 3A Learning: Declarative Knowledge (Knows)
- Level 3B Learning: Procedural Knowledge (Knows How)
- Level 4 Learning: Competence (Shows How)
- Level 5 Performance (Does)
- Level 6 Patient Health
- Level 7 Community Health

3. Moore D, Green J, Gallis H. *Journal of Continuing Education in the Health Professions.* 2009

Assessment – case based knowledge and competence

1. **Richard is a 72-year-old veteran with a history of end-stage bilateral knee osteoarthritis. He underwent right total knee arthroplasty (TKA) 3 days ago. He is currently taking oxycodone 5 mg with ibuprofen 800 mg three times daily for moderate post-op pain. He has a history of major depression that includes high levels of anxiety symptoms (anxious depression) which is treated with citalopram 20 mg daily and quetiapine 300 mg daily.**

   Which of the following is a risk factor for chronic persistent postsurgical knee pain in Richard?

   - ○ His age
   - ○ His male gender
   - ○ His history of anxious depression
   - ○ His continued use of oxycodone on postoperative day 3

2. **Which of the following is a risk factor for long-term opioid use in Richard?**

   - ○ His history of mental illness
   - ○ His type of surgery
   - ○ His continued use of oxycodone on postoperative day 3
   - ○ His prior military service

3. **A national survey on drug use and health found that which of the following represented the greatest source of misused prescription opioids?**

   - ○ Prescriptions from multiple health care providers
   - ○ Prescriptions from a single health care provider
   - ○ A drug dealer or other stranger
   - ○ Given by, bought, or taken from a friend or relative

4. **Which of the following statements regarding national trends in opioid prescribing and opioid overdose deaths is correct?**

   - ○ Since 1992, opioid prescriptions have continued to increase
   - ○ Since 1992, high dose opioid prescriptions have continued to increase
   - ○ Since 2016, the majority of opioid overdose deaths are due to illicitly manufactured fentanyl or other synthetic opioids
   - ○ Since 2011, the majority of opioid overdose deaths are due to commonly prescribed opioids

5. **Which of the following tools would be best suited to assess chronic pain in a busy primary care setting?**

   - ○ Pain, Enjoyment, General activity (PEG) scale
   - ○ Numeric Rating Scale (0 to 10)
   - ○ McGill Pain Questionnaire
   - ○ Brief Pain Inventory

6. **Beth is a 53-year-old woman who has had severe chronic low back pain for the past 5 years secondary to spinal stenosis. For the past year, she has been taking a combination of immediate-release oxycodone 5 mg with acetaminophen 325 mg every 8 hours. She is an unemployed single mother. She has a history of tobacco use disorder smoking one pack per day for over 30 years. She denies a personal or family history of substance use disorder or history of mental illness.**

   Which of the following would be a risk factor for her to develop prescription opioid misuse?

   - ○ Severe chronic low back pain
   - ○ Unemployed single mother
   - ○ Tobacco use disorder
   - ○ Taking immediate-release oxycodone every 8 hours as prescribed

7. **Which of the following statements regarding opioid and nonopioid treatment efficacy for chronic pain is true?**

   - ○ There is no evidence that opioids, compared with placebo, are effective for treating chronic pain up to 3 months
   - ○ Opioids are superior to non-opioids for improving musculoskeletal pain over 12 months
   - ○ There is evidence that opioids improve chronic pain and function compared with placebo in the short-term (up to 6 months)
   - ○ There is long-term evidence (over 3 years) that both pharmacologic and nonpharmacologic treatments are effective for chronic pain and function compared with placebo

Evaluation and Commitment to Change (CTC)

7. **Do you plan to make any changes in your practice based on what you learned in this activity?**

- (●) Yes
- ( ) No

If "Yes," please select at least one change that you plan to make in practice as a result of this activity: (you may check all that apply)

- [ ] Implement or improve Patient Provider Pain "Agreements" (contracts) with patients
- [ ] Implement or improve urine drug testing for monitoring opioid adherence and misuse
- [ ] Implement or improve pill counts for monitoring opioid adherence and misuse
- [ ] Implement or improve use of your Prescription Drug Monitoring Program for monitoring opioid adherence and misuse
- [ ] Implement or improve patient education or communication relating to opioids
- [ ] Improve documentation in patient medical records relating to opi
- [ ] Implement or improve policies and procedures for opioid prescrib
- [ ] Implement or improve policies and procedures for opioid prescrib
- [ ] Implement or improve a multi-disciplinary team approach for safe
- [ ] Implement or improve office-based treatment for opioid use disor
- [ ] Other

If "Yes," what challenges, if any, do you anticipate encountering as you make changes in your practice? Please select most significant challenge:

- ( ) Institutional resistance to make these changes
- ( ) Other providers' resistance to make these changes
- ( ) Patient resistance to change
- ( ) Lack of support staff to help make these changes
- ( ) Not a priority, given limited time
- ( ) Payer restrictions
- ( ) Lack of access to multi-modal treatment options
- ( ) I do not anticipate any challenges
- ( ) Other

What do CTC statements tell us and why do we care?

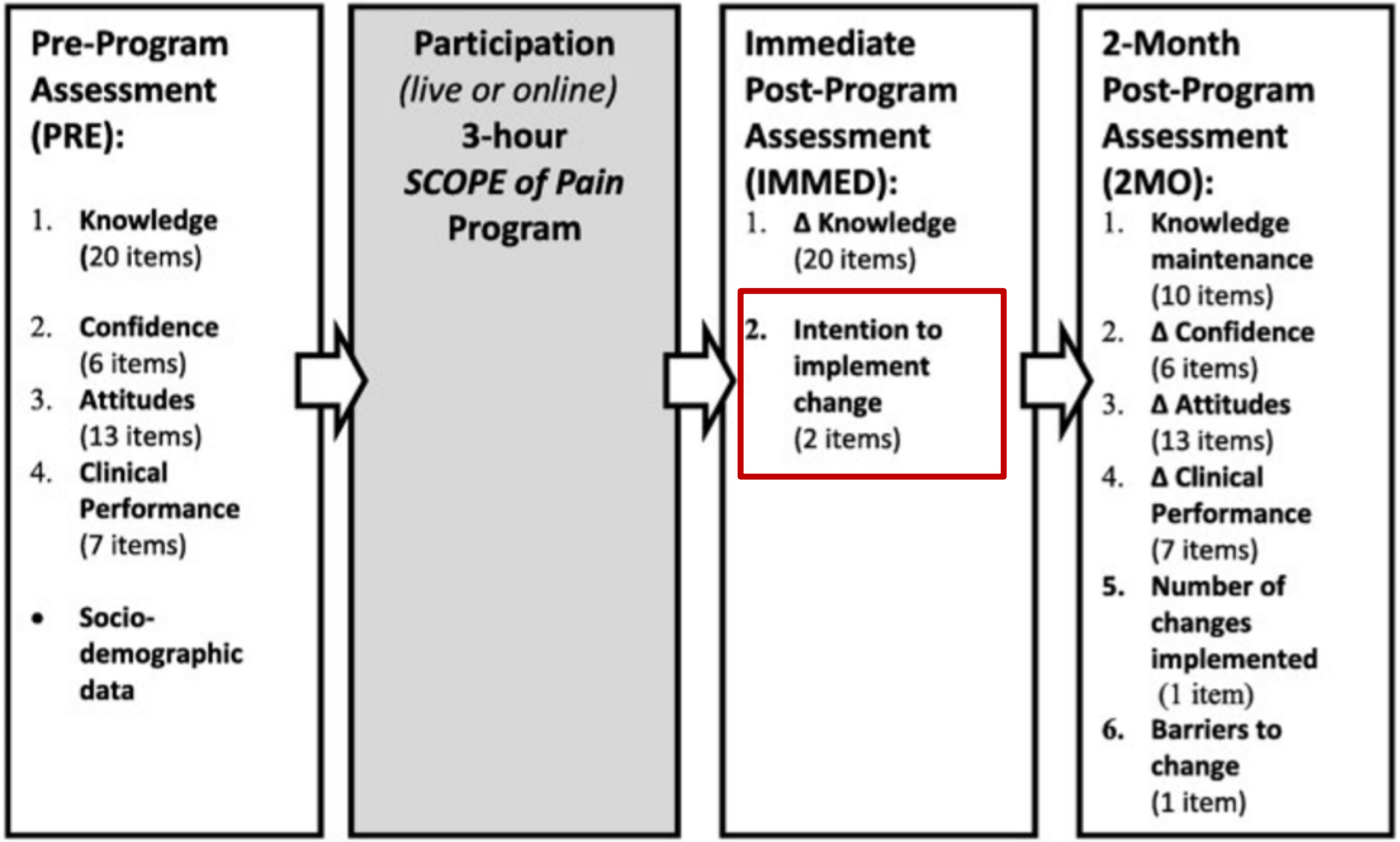
- Clinicians are expected to deliver safe, effective, cost-effective, compassionate care, based on best practice and evidence. ***Accredited CME helps make that happen.***[4]

- "Making commitments, whether selecting them from a predefined list or generating them spontaneously, is positively associated with practice change." [5] CTC Predicts behavior.

- CME supports and facilitates the change process. [6]

4. www.accme.org/why-accredited-CME-matters
5. Domino FJ, Chopra S, Seligman M, et al. *Medical Teacher* 2011
6. Olson CA, Tooman TR *Advances in Health Science Education Theory and Practice* 2012

SCOPE of Pain Evaluation



Original Research Article

SCOPE of Pain: An Evaluation of an Opioid Risk Evaluation and Mitigation Strategy Continuing Education Program

- **Immediate post-program** (n=2,850)
  - 87% with intention to change toward guideline-based care
- **2-month post program** (n=476 [17% response rate but no significant differences in demographics to the entire sample])
  - Significant increase in correct responses to knowledge questions
  - 67% increased confidence in applying safe opioid prescribing care
  - 86% reported implementing practice changes
  - Improvement in alignment of desired attitudes toward safe opioid prescribing[7]

7. Alford DP, Zisblatt L, Ng P et al. *Pain Med* 2016

Looking Ahead

Research
Guidelines
Opinions
Beliefs
Legislation
Regulations
National trends
Time pressures
Clinical uncertainties
Payer restrictions
Competing priorities
Complex patient communication

SCOPE of Pain

Adheres to the FDA curricular blueprint and aligns with the CDC guideline

Any Questions?