COUNCIL
OF FLORIDA
MEDICAL SCHOOL
DEANS

United for Excellence in Medical Education, Research, and Health Care

# Pain Management and Opioid Stewardship Education for Florida Medical Schools


**Framework for Developing Core Competencies & Instructional Guide for Curriculum Development 2018**

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# FORWARD

**Mission:**
To protect, promote & improve the health of all people in Florida through integrated state, county & community efforts.

**Vision:** To be the Healthiest State in the Nation

**Rick Scott**
Governor

**Celeste Philip, MD, MPH**
Surgeon General and Secretary

August 30, 2018

On behalf of the Florida Department of Health (Department), I am grateful to the Council of Florida Medical School Deans for collaboratively overseeing the creation of a comprehensive resource that will help equip Florida Medical Schools to prepare their students to assess and treat pain with the most up-to-date tools and treatment options. The *Framework for Developing Core Competencies on Pain Management and Opioid Stewardship Education* guides Florida Medical Schools on how to enhance their current curriculum to ensure a thorough approach to pain and pain management, as well as highlighting the public health issues related to opioid prescribing practices.

As health care professionals and educators, we have a crucial role in ensuring the best possible care for our patients and communities, including optimal and safe pain management. In 2016, there were more than 42,000 deaths nationwide and nearly 2,800 deaths in Florida attributed to opioid overdoses. Additionally, the National Center for Health Statistics lists overdose as the leading cause of death in the U.S. for those under 50. Given these startling statistics, we must revisit how we educate our future and current health care professionals on pain management and opioid stewardship to align with current understanding and best practices.

Under Governor Rick Scott's leadership, Florida has been committed in the fight against opioid overdoses. In 2017, Governor Scott signed an Executive Order directing a Public Health Emergency across the state for the opioid epidemic, which directed me as the state health officer to issue a standing order for naloxone for emergency responders to help save lives. Further efforts to combat opioid abuse were passed during the 2018 Legislative session, which created the Controlled Substances Act. This law addresses opioid abuse by establishing prescribing limits for acute pain, requiring continuing education on controlled substance prescribing, expanding required use of Florida's Prescription Drug Monitoring Program and more.

Developing this thorough and extensive framework that includes a broad range of non-opioid and non-pharmacologic treatment options was a monumental task and is another important strategy for our state to decrease opioid prescribing when other options can be effective. It will provide far-reaching effects over the next several years as students learn and practice these treatment modalities statewide. The Department values our partnership with the Council of Florida Medical School Deans and looks forward to exploring additional opportunities to improve health together. Thank you for your commitment to solving this national problem that affects so many families and communities in our state.

Sincerely,

Celeste Philip, MD, MPH
Surgeon General and Secretary

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# INTRODUCTION

More than 100 million U.S. adults are burdened by chronic pain, totaling more than diabetes, cancer, and heart disease combined. Acute and chronic pain-related complaints are the most common reason for seeking health care. There has been an upheaval in pain management over the past decade. Initially, there was a period of renewed focus on improving the recognition, assessment and treatment of pain. Reasons for this included emerging research on the neurobiological complexity of pain, recognition of long term consequences of untreated pain, pain-related patient satisfaction scores (HCAHPS), and other factors. Unfortunately, this period was followed by a rapid rise in injudicious opioid prescribing, opioid use disorders, overdoses, and deaths leading to a new emphasis on opioid stewardship, prescribing limits, and non-opioid and non-pharmacologic methods of managing pain. Opioid safety is a top patient safety concern in 2018 and there are new and evolving Joint Commission, regulatory, and legislative pain standards at national and state levels.

In June 2017, the National Academies of Sciences, Engineering and Medicine publication on "Pain Management and the Opioid Epidemic" reported: "Drug overdose is now the leading cause of death from unintentional injury in the United States, and most of these deaths involve an opioid (prescription or illegal nonprescription). The ongoing opioid crisis lies at the intersection of two public health challenges: reducing the burden of suffering from pain and containing the increasing toll of the harms that can arise from the use of opioid medications."

The opioid epidemic has expanded to all socioeconomic classes, with death totals now exceeding those from motor vehicle crashes. The medical community faces the challenge of ensuring safe and effective pain management for those with significant pain (acute; chronic; cancer pain; end of life), while minimizing the abuse and diversion of opioid analgesics. This is further complicated by the new challenge of analgesic medication shortages. Pain management and education must be addressed while being mindful of different types of pain, the uniqueness of individuals with pain, and the broad array of pharmacologic and non-pharmacologic treatment options.

This crisis prompted a CDC Guideline for Prescribing Opioids in 2016 and a CDC opioid website: https://www.cdc.gov/drugoverdose/prescribing/resources.html.

On May 3, 2017, Governor Rick Scott issued Executive Order Number 17-146, noting that, "the CDC has declared a national opioid epidemic and found that such epidemic poses a severe threat to the State of Florida." The Executive Order found that in 2015 opioids were responsible for over 33,000 deaths nationwide and nearly 3,900 deaths in Florida. Pursuant to the Executive Order, Florida Surgeon General Celeste Philip, M.D., MPH, declared a statewide public health emergency. As a result, the state was able to immediately draw down more than $27 million in federal grant funding from the United States Department of Health and Human Services to be used for prevention, treatment, and recovery services. In addition, a standing order was issued to ensure that emergency responders have access to naloxone in order to reverse opioid overdoses.

In 2017, a study, *Prescribing Medications for Chronic Pain Management: The State of Education in Florida Medical Schools and Residency Programs*, was conducted by the Florida State University Center for Innovative Collaboration in Medicine and Law. The purpose of the study was to assess the state of chronic, non-cancer pain management education in Florida's medical schools and residency programs. The study found that a majority of medical students

and residents (59.5%), in addition to a majority of medical school faculty (58.1%), agreed or strongly agreed that more clinical time should be dedicated to chronic, non-cancer pain management education in Florida's medical schools and residency programs. Results demonstrated that while Florida's medical schools and residency programs currently provide education on chronic, non-cancer pain management, there remains opportunity for enhancement of our pain management training programs including continuing medical education. The study suggested that increased communication among institutions and standardization of competencies related to pain management might prove beneficial (Florida Public Health Review, 2017; 14, 22-32).

The Council of Florida Medical School Deans (CFMSD) determined a need to proactively consider how Florida's medical schools can work together to assist in ameliorating the opioid epidemic in Florida and improve the education and training of the state's medical students in the area of pain and pain management, with consideration for the emerging changes in Florida and nationally. In early 2017, the CFMSD established a pain management working group comprised of multi-disciplinary representation from Florida's nine allopathic and osteopathic medical schools (see list below). Nova Southeastern University College of Allopathic Medicine joined the CFMSD as well as the working group in 2018. The working group was charged with determining recommendations for Florida's medical schools to enhance the pain and opioid education and curriculum of medical students. The Florida State Surgeon General also participated, and served as a leader, in the activities of the pain management working group.

Florida medical schools represented on the working group:

- Charles E. Schmidt College of Medicine at Florida Atlantic University (FAU)
- Herbert Wertheim College of Medicine at Florida International University (FIU)
- Florida State University (FSU)
- Lake Erie College of Osteopathic Medicine (LECOM), Bradenton
- Dr. Kiran C. Patel College of Osteopathic Medicine at Nova Southeastern University College of Osteopathic Medicine
- University of Central Florida (UCF)
- University of Florida (UF)
- Leonard M. Miller School of Medicine at University of Miami (UM)
- USF Health Morsani College of Medicine, University of South Florida
- Dr. Kiran C. Patel College of Allopathic Medicine at Nova Southeastern University College of Allopathic Medicine

Florida's medical schools recognize the need for a multisystem, multidisciplinary approach to effectively address the statewide and national opioid epidemic. Solutions and efforts at the community/local, state, and national levels require a multifaceted collaboration among numerous stakeholders. While medical schools are only a part of the solution, Florida's medical schools stand poised to educate not only future physicians, but to also provide ongoing continuous medical education to practicing physicians.

Florida is considering the overall topic on many fronts. The state has a statutorily created *Statewide Drug Policy Advisory Council* under the Florida Department of Health. Statewide efforts, particularly related to law enforcement matters, have been led by Attorney General Pam Bondi. Florida Governor Scott's 2017 Executive Order created the opportunity to draw upon federal funding and focused on the "communities" impacted by rising

opioid usage. The Florida Department of Children and Families serves as a lead agency in addressing substance abuse treatment in the state and the lead agency to coordinate the federal funding. The Florida Department of Health has developed a Multidisciplinary Board-Work Group on Controlled Substances; the Florida Medical Association and Florida Osteopathic Medical Association have been leaders in continuing medical education and legislative advocacy related to controlled substances and opioid use. The Board of Governors and the chairs of the boards of trustees of the 12 institutions that comprise the State University System of Florida have established a Drugs, Alcohol and Mental Health Task Force, which is addressing critical matters of drug, alcohol and mental health issues facing students in Florida's state universities. Additionally, health care professional and facility provider groups have led efforts in the state and in their local communities. Florida's law enforcement community and families of individuals impacted by the opioid crisis have also been important leaders. Florida's medical schools opted to focus on the medical education of Florida's future physicians in their collaborative efforts. However, the representatives of the medical schools have also participated in a number of local and statewide initiatives, including, but not limited to those listed above.

In 2018, the topic of opioid use and overdose was a priority of the Florida Legislature. Senator Lizbeth Benaquisto and Representative Jim Boyd spearheaded legislative efforts to pass Senate Bill 21, a bill that increased the regulation, training, and reporting required when controlled substances are prescribed in Florida. On March 19, 2018 Governor Rick Scott signed opioid legislation Chapter 2018-13, Laws of Florida (House Bill No. 21) (aws.flrules.org/files/Ch_2018_013.pdf) effective July 1st.

Florida's medical schools laud the recent collaborative efforts of the medical schools in Massachusetts, the Massachusetts Department of Public Health, and the Massachusetts Medical Society, and the collaborative efforts of the medical schools in Pennsylvania and Michigan and their respective state agencies, as well as the work of the International Association for the Study of Pain (IASP). Their publications and materials have served as a foundation to provide valuable models for the activities of Florida's pain management working group.

The CFMSD's pain management working group determined the importance of considering factors beyond opioid misuse and substance use disorders. The group opted to focus on the core principles of pain and pain management as the primary subject matter and to include the basics of pain assessment and treatment and the challenges of treating special patient populations, such as patients with co-occurring psychiatric disorders and past or current substance use disorders. The group recognized the influence that various biological, psychological, and social issues have on pain and its management and determined their inclusion as vital to ensuring a comprehensive approach to education and training, as well as to ensuring patient safety and quality patient care. The group also recognized that there are likely some overlapping considerations among these topics.

The *Framework for Developing Core Competencies on Pain Management and Opioid Stewardship Education* is based on a compilation of existing materials and research regarding the areas noted above, particularly the work and joint efforts of the medical schools in Massachusetts, Michigan, and Pennsylvania with their respective departments of health; individually created material, and the opinions of the authors regarding the needs in the State of Florida. In addition, the *Framework for Developing Core Competencies on Pain Management and Opioid Stewardship Education* references the 2018 "Curriculum Outline on Pain for Medicine" recommended by the International Association for the Study of Pain (see also Appendix A).

The *Framework for Developing Core Competencies on Pain Management and Opioid Stewardship Education* is not intended to provide a statewide standard or mandated curriculum, but instead to provide a set of core competencies to guide individual medical schools in incorporating this material into their existing curricula as each school deems appropriate and necessary to address the needs of patients experiencing pain, as well as the public health concerns related to opioid abuse. The *Framework for Developing Core Competencies on Pain Management and Opioid Stewardship Education* developed by the pain management working group serves as a "tool kit" for educators, who may choose to use it for various levels of medical education and training.

The *Framework for Developing Core Competencies on Pain Management and Opioid Stewardship Education* addresses four (4) general domains. Each domain includes the key areas of learning that were identified as necessary to assure a thorough and inclusive approach to educating medical students on pain and pain management. The domains addressed are:

Domain I: The Multidimensional Nature of Pain
Domain II: Assessment and Measurement of Pain
Domain III: Interprofessional and Multidisciplinary Approaches to Treatment
Domain IV: Other Considerations Related to Pain and Pain Management

The *Framework for Developing Core Competencies on Pain Management and Opioid Stewardship Education* also includes additional resources, including potential assessment tools, and bibliographical references that might be helpful in developing each school's coursework and training experiences. The landscape of pain management, literature and regulations are changing on a monthly basis and schools will need an ongoing method of updating pain and opioid related resources and references.

On August 4, 2018, The CFMSD formally adopted and signed "A Commitment to Pain Management Education in Florida's Medical Schools. This commitment includes seven general principles of understanding, recognizing that the strength of, and collective knowledge gained through collaborative efforts among Florida's medical schools. The Pain Management and Opioid Stewardship Education for Florida Medical Schools: Framework for Developing Core Competencies and Instructional Guide for Curriculum Development 2018 reflects the joint efforts of representatives from Florida's medical schools. However, the CFMSD understands that the commitment of the CFMSD does not limit in any way a medical school's ability to provide services and education unique to its own students in a manner desired by that respective medical school, nor to interfere in any manner with any medical school's relationship with its parent university, community, or accrediting body.

# FRAMEWORK FOR DEVELOPING CORE COMPETENCIES

# FLORIDA MEDICAL SCHOOLS 2018

## DOMAIN I: THE MULTIDIMENSIONAL NATURE OF PAIN

### 1.1 The Basic Science of Pain: Introduction to Defining and Understanding Pain

| POTENTIAL LEARNING OBJECTIVES | POTENTIAL AREAS OF STUDY | *Content location in curriculum* | *Method(s) of Assessment* |
|---|---|---|---|
| ***1.1.1 Definition of Pain*** | | | |
| A. Identify and recognize the different classifications of pain.<br>B. Identify and understand the multidimensional influences on pain perception.<br>C. List and define common pain terms. | ▪ Biological significance of acute pain (survival value)<br>▪ Relationship between acute pain, acute recurring pain, and chronic pain; acute pain superimposed on chronic pain<br>▪ Distinction between nociceptive, neuropathic and inflammatory pain<br>▪ Relationship and distinction between physical pain and emotional pain; emotional pain superimposed on physical pain<br>▪ Distinction between cancer and non-cancer pain<br>▪ Pain and substance use disorders as a public health problem/emergency<br>▪ Pain epidemiology: societal consequences<br>▪ Multifactorial determinants of pain: age, genetics, gender, race and culture, socioeconomic status, co-occurring medical and/or psychiatric illness<br>▪ Terms for common pain symptoms (spontaneous or evoked):<br>o allodynia<br>o analgesia<br>o dysesthesia<br>o hyperalgesia<br>o hyperesthesia<br>o hyperpathia<br>o hypoalgesia<br>o hypoesthesia | | Examples:<br>➢ Preceptor ratings<br>➢ Written test–MCQ<br>➢ Essay<br>➢ Simulation<br>➢ Standardized or simulated patients<br>➢ MiniCEX<br>➢ Chart audits<br>➢ Direct observation of encounters<br>➢ Other |
| ***1.1.2 Neuroanatomy and Neurophysiology of Pain*** | | | |

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| A. Identify and recognize the neuroanatomy associated with the process of pain.<br>B. Recognize and describe the neurophysiological functioning of pain. | ▪ Neuroembryology<br>▪ Evolutionary biology of pain (biological significant of pain/survival value)<br>▪ Peripheral receptors, afferent fibers, transduction and transmission, peripheral sensitization<br>▪ Spinal terminations and spinal processing of nociceptive information, spinal reflexes, ascending tracts, neurotransmitters (peptides and amino acids)<br>▪ Brainstem mechanisms of pain (autonomic reflexes, ascending reticular activating system)<br>▪ Thalamic nuclei, nociceptive cortical network, cortical reorganization<br>▪ Descending control of nociceptive information and pain modulation<br>▪ Central pain/central sensitization<br>▪ Modulation and transmission of pain<br>▪ Neuroplasticity<br>▪ Genetics in relation to pain mechanisms and medications | | |
| ***1.1.3 Neuropathology of Pain*** | | | |
| A. Recognize the pathophysiology of pain.<br>B. List the differences between the 3 classifications of pain.<br>C. Describe the differences between the 3 classifications of pain. | ▪ Nociplastic pain<br>▪ Neuropathic pain<br>▪ Nociceptive pain | | |
| ***1.1.4 Biochemistry of Pain*** | | | |
| A. Recognize the mechanisms of action involved in pain.<br>B. Describe the pathways of pain and the transmitters involved. | ▪ Neurotransmitters<br>▪ Opioid receptors<br>▪ Opioid transmitters | | |
| ***1.1.5 Psychology of Pain*** | | | |
| A. Recognize the biopsychosocial model of health/illness.<br>B. Identify and recognize psychological and psychosocial processes and factors that influence the expression and experience of pain.<br>C. Identify and recognize the co-occurring psychiatric disorders that are commonly associated with pain (e.g. bipolar, depression, anxiety, and trauma-stressor-related disorders, substance use disorders). | ▪ Affective, cognitive, behavioral, and developmental aspects of pain, including personality variables<br>▪ Prior learning, pain attribution, self-esteem, self-efficacy, and perceived self- control<br>▪ Interpersonal issues, the role of the family and/or caregivers, occupational/academic issues, job dissatisfaction<br>▪ Health beliefs, sick role, illness behavior (normal and abnormal)<br>▪ Principles of psychiatric diagnosis | | |

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| D. Recognize the bidirectional relationship between psychiatric disorders and substance use disorders. | ▪ History of trauma and adverse childhood experiences (ACEs)<br>▪ Denial of pain; amplification, or catastrophizing of pain; secondary gain and malingering<br>▪ Cultural differences in pain, pain expression, meaning of pain/suffering, and treatment approaches<br>▪ The influence of political, governmental, and social welfare programs<br>▪ Pain as a coded message of psychosocial distress | | |
| ***1.1.6 Sociological and Anthropological Factors Related to Pain*** | | | |
| A. Describe the socioeconomic, racial, ethnic, cultural and familial factors that influence the expression and experience of pain in various patients. | ▪ Access to care/treatment<br>▪ Healthcare disparities<br>▪ Patient reports of pain<br>▪ Patient response to pain<br>▪ Patients' experience of pain<br>▪ Patients' experience of suffering<br>▪ Acceptance of pharmacological treatment approaches<br>▪ Acceptance of non-pharmacological treatment approaches<br>▪ Role and influence of family and other caregivers | | |

# DOMAIN II: ASSESSMENT AND MEASUREMENT OF PAIN

## 2.1 Evaluation of the Patient and their Pain

| POTENTIAL LEARNING OBJECTIVES | POTENTIAL AREAS OF STUDY | *Content location in curriculum* | *Method(s) of Assessment* |
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| ***2.1.1 Initial Assessments/Intake*** | | | |
| A. Identify and assess the patient and their pain.<br>B. Identify key areas required for appropriate documentation of assessment, findings, and patient reports.<br>C. Recognize that a comprehensive pain evaluation is essential to developing an effective treatment plan.<br>D. Evaluate a patient's pain using gender, age, and culturally appropriate evidence-based methodology.<br>E. Identify the patient who is experiencing pain<br>F. Demonstrate the unassisted taking of a specific structured pain history based on the clinical situation and population.<br>G. Identify common co-occurring mental health and substance use disorders that are commonly associated with pain (e.g. bipolar, depression, anxiety and trauma-stressor-related disorders, substance use disorders).<br>H. Recognize the bidirectional relationship between psychiatric disorders and substance use disorders<br>I. Identify and discuss the impact that concurrent mental health disorders and social history can have on successful referral and treatment for substance use disorders.<br>J. Recognize and identify your own and the societal stigmatization and biases against individuals with substance use disorders and associated evidence-based medication-assisted treatment. | ▪ Reason(s) for seeking assessment/treatment at this time<br>▪ Requirements per Florida law<br>  ○ patient history<br>  ○ physical exam<br>  ○ laboratory<br>  ○ imaging<br>  ○ informed consent/treatment agreement<br>  ○ treatment plan<br>▪ Limitations of pain reported pain intensity<br>▪ Tools for assessing pain- see also section 2.2<br>▪ Recent/past medical and/or physical symptoms<br>▪ Recent/past treatments (pharmacologic, non-pharmacologic, complementary and alternative medicine); effectiveness of treatments<br>▪ Past medical history: diagnoses, treatments, surgeries hospitalizations etc.<br>▪ Recent/past review of medications (including OTC medications)<br>▪ Allergies to medications<br>▪ Obtain a complete social history<br>▪ Current/past psychiatric history: diagnoses, treatments, etc.<br>▪ Current/past history use of substances including:<br>  ○ caffeine and/or energy drinks/products<br>  ○ tobacco products<br>  ○ over-the-counter medications and/or products<br>  ○ prescription medications<br>  ○ alcohol<br>  ○ illicit substances<br>  ○ marijuana<br>▪ Biopsychosocial history including-quality of life:<br>  ○ current living status/arrangements<br>  ○ educational background<br>  ○ academic/occupational status/history<br>  ○ relationship status/history | | |

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| | ○ level of family support/relationships<br>○ social support network/activities<br>○ economic status/concerns<br>○ religious/cultural influences<br>○ general quality of life/exercise/sleep/nutrition/sexual<br>▪ Obtain a family history including medical illnesses, substance use disorders and other psychiatric disorders<br>▪ Obtain a comprehensive review of symptoms<br>▪ Complete physical examination including a mental status examination and recognition of non-verbal signs of pain<br>▪ Diagnostic testing<br>○ general laboratory tests<br>○ radiographic imaging<br>▪ Consider the use of screening tools such as PHQ-9 (for depression), GAD-7 (for anxiety disorders) and Beck Depression Inventory (BDI) | | |
| ***2.1.2 Follow-Up Visits and Reassessing Pain*** | | | |
| A. Re-assess the patient and their pain<br>B. Identify areas of change:<br>i. Improvement<br>ii. Decline<br>iii. No change<br>C. Identify key areas required for appropriate documentation of assessment, findings, and patient reports. | ▪ Pain assessment: measure of any changes in pain intensity and experience<br>▪ Any changes in current and/or recent medical and/or physical symptoms<br>▪ Any changes in current and/or recent medical diagnoses/treatments<br>▪ Any changes in psychiatric symptoms, diagnoses, and/or treatments.<br>▪ Any changes in biopsychosocial areas:<br>○ current living status/arrangements<br>○ educational background<br>○ academic/occupational status/history<br>○ relationship status/history<br>○ family history<br>- medical<br>- psychiatric including substance use disorders<br>○ level of family support<br>○ social support network<br>○ economic status/concerns<br>○ religious/cultural influences<br>○ general quality of life<br>▪ Physical examination, including a mental status examination<br>▪ Repeat and/or follow-up diagnostic testing<br>○ specific laboratory tests<br>○ imaging studies | | |

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| | ▪ Functional assessment of pain: Measure of any changes in the overall impact pain has on patient, functional abilities, and quality of life, including:<br>o affect, mood, sleep<br>o school/work<br>o relationship/family<br>o social and recreational activities<br>o activities of daily living (ADLs; e.g., eating, sleeping, exercise)<br>▪ Assessment of adherence with pharmacological treatment plan<br>▪ Assessment of obstacles and/or challenges to achieving full adherence<br>▪ Assessment of adherence with non-pharmacological treatment plan<br>▪ Assessment of obstacles and/or challenges to achieving full adherence<br>▪ Assessment of side effects or adverse reactions to pharmacological treatments<br>▪ Assessment of misuse and/or aberrant use of pharmacological treatments<br>▪ Revision of treatment goals | | |

## 2.2 Use of Standardized Instruments and Tools in Assessing Pain

| **POTENTIAL LEARNING OBJECTIVES** | **POTENTIAL AREAS OF STUDY** | ***Content location in curriculum*** | ***Method(s) of Assessment*** |
|---|---|---|---|
| A. Recognize the importance of utilizing a validated pain assessment tool.<br>B. Describe a variety of validated tools.<br>C. Recognize when their individual use is indicated.<br>D. Discuss the advantages and disadvantages of various pain assessment tools. | ▪ Useful mnemonics for assessing pain<br>o OPQRST<br>o SOCRATES<br>o QISS TAPED<br>▪ Verbal rating scales<br>▪ Visual analogue scales and graphic rating scales<br>▪ Numerical rating scale<br>▪ Picture or face scales<br>▪ Descriptor Differential Scale of Pain Intensity (DDSI)<br>▪ Pain Body Map<br>▪ Defense and Veterans Pain Rating Scale (DVPRS)<br>▪ DIRE: diagnosis, intractability, risk, efficacy<br>▪ Screening, Brief Intervention, and Referral to Treatment (SBIRT)<br>▪ STAR: screening tool for addiction risk<br>▪ PEG scale (CDC checklist, 2016)<br>o Pain<br>o Enjoyment of life | | |

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| | ○ General activity | | |

## 2.3 Documentation of Findings

| POTENTIAL LEARNING OBJECTIVES | POTENTIAL AREAS OF STUDY | *Content location in curriculum* | *Method(s) of Assessment* |
|---|---|---|---|
| A. Demonstrate skills in documentation of assessments conducted and treatments provided using appropriate SOAP and/or EHR formats in patient medical records.<br>B. Recognize the value of standardized documentation tools available in pain management. | ▪ Results of pain management strategies already used by the patient and their effectiveness and tolerance<br>▪ Documentation of 4 A's for opioid therapy<br>○ Analgesia<br>○ Activities<br>○ Adverse effects<br>○ Aberrant drug-related behaviors<br>▪ History, physical findings, and results of imaging and laboratory studies relevant to the pain condition<br>▪ Rationale for medical decisions and recommendations including:<br>○ decisions of whether or not to prescribe or recommend medications<br>○ alternative treatment and/or therapies<br>▪ Documentation of comprehensive pain management plan including:<br>○ pain assessment<br>○ orders for any diagnostic testing<br>○ provision of advice/education about management of pain symptoms<br>○ prescription for a new pain medication<br>○ change in dose or schedule of existing pain medication<br>○ new non-pharmacologic pain treatment (e.g., specialty or therapist referral for pain management, office procedure, order for prosthetics)<br>▪ Pain Assessment and Documentation Tool (PADT)<br>▪ Assessment of risks and benefits of current analgesic plan including:<br>○ functional level<br>○ acceptability of analgesia<br>○ patient mood and affect<br>○ adverse effects of medications<br>▪ Documentation of comprehensive pain management plan as required by Florida Statute including:<br>○ complete history, including pain and substance use disorder histories | | |

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| | ○ complete physical examination<br>○ pain assessment<br>○ results of diagnostic tests<br>○ treatment objectives<br>○ discussion of risks and benefits<br>○ instructions and agreements<br>○ provision of advice/education about management of pain symptoms<br>○ prescription for a new pain medication<br>○ change in dose or schedule of existing pain medication<br>○ new non-pharmacologic pain treatment (e.g., specialty or therapist referral for pain management, office procedure, order for prosthetics)<br>○ periodic review of management plan | | |

## 2.4 Physician-Patient Relationship and Communications

| **POTENTIAL LEARNING OBJECTIVES** | **POTENTIAL AREAS OF STUDY** | ***Content location in curriculum*** | ***Method(s) of Assessment*** |
|---|---|---|---|
| A. Recognize the role of the physician as member of healthcare team.<br>B. Demonstrate the inclusion of patient and others, as appropriate, in the education and shared decision-making process creating comprehensive pain management plan.<br>C. Recognize the role of the physician in behavioral change.<br>D. Recognize primary factors influencing patient adherence.<br>E. Identify and discuss core components of effective communication in healthcare, including appropriate empathy.<br>F. Recognize component of informed consent and medical decision-making.<br>G. Identify and demonstrate adequate use of the core components of Patient-Centered Interviewing<br>H. Identify and demonstrate the use of the basic components of Motivational Interviewing<br>I. Identify core components of developing an appropriate physician-patient rapport and relationship | ▪ Barriers to effective communication in special patient populations such as:<br>○ language illiteracy<br>○ health illiteracy<br>○ intellectually disabled<br>○ low/poor educational background<br>○ non-English speaking (English as a Second language-ESL)<br>○ Sight-impaired<br>○ hearing impaired<br>○ other verbal or nonverbal barriers<br>○ cognitive or thought disturbances and/or impairments<br>▪ Intoxicated or under the influence of mind-altering substances<br>▪ Core communication skills components to develop an appropriate patient-physician relationship:<br>○ active listening<br>○ verbal and non-verbal clues<br>○ open-ended and closed-ended questions<br>○ empathic responses<br>○ clarification<br>○ summarization<br>▪ Factors that help develop the patient-physician relationship:<br>○ respect<br>○ attentiveness<br>○ communication | | |

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| J. Recognize and discuss factors influencing effective communications between patients and healthcare providers.<br>K. Identify and discuss barriers to effective communication in special patient populations.<br>L. Recognize influence of diversity factors on the physician-patient relationship and their impact on assessment and treatment of pain.<br>M. Explain the importance of treating the patient with dignity, respect, and a nonjudgmental manner when discussing substance use disorders. | ○ shared-decision making<br>○ comfort and trust<br>○ informed<br>○ cultural competence<br>▪ Use of SPIKES protocol and/or similar methods to communicate difficult/serious news to patients.<br>▪ Implicit bias | | |

# DOMAIN III: INTERPROFESSIONAL AND MULTIDISCIPLINARY APPROACHES TO TREATMENT

## 3.1 Ensuring Quality Pain Care

| POTENTIAL LEARNING OBJECTIVES | POTENTIAL AREAS OF STUDY | *Content location in curriculum* | *Method(s) of Assessment* |
|---|---|---|---|
| A. Recognize the physician's responsibility to promote and enable self-care as the starting point of treatment.<br>B. Demonstrate the ability to develop a comprehensive pain management plan that is individualized to each patient.<br>C. Identify key information available to assist physicians in promoting quality health care and ensuring that evidence-based care as related to pain is provided to all patients.<br>D. Interpret and apply this information to individuals experiencing pain.<br>E. Identify the non-pharmacological interventions available to treat pain.<br>F. Recognize the importance of interprofessional collaboration when managing patients in pain. | ▪ Evidence-Based Clinical Guidelines<br>○ National Guideline Clearinghouse (NGC)<br>○ Cochrane reviews<br>○ Agency for Healthcare Research and Quality (AHRQ)<br>▪ Quality Standards and Measures/Accreditation<br>○ The Joint Commission (TJC)<br>○ National Quality Measures Clearinghouse (NQMC)<br>○ National Quality Forum (NQF)<br>○ American College of Surgeons: Commission on Cancer (ACS COC)<br>○ American Society of Clinical Oncology Quality Oncology Practice Improvement Initiative (ASCO QOPI)<br>▪ Quality Improvement Organizations/Initiatives<br>○ Institute for Healthcare Improvement<br>○ Hospital Consumer Assessment of Healthcare Providers and Systems (HCAPS)<br>○ Center for Healthcare Research and Transformation (CHRT)<br>○ Advancing Excellence in America's Nursing Homes | | |

## 3.2 Evidence-Based Treatment Approaches

| LEARNING OBJECTIVES | POTENTIAL AREAS OF STUDY | *Content location in curriculum* | *Method(s) of Assessment* |
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| ***3.2.1 General Medicine and Related Approaches*** | | | |
| A. Identify general medicine and related approaches that may be a component of a treatment plan based on a thorough assessment of the patient.<br>B. Identify multidisciplinary team members to work collaboratively employing a patient-centered approach.<br>C. Describe how health promotion and self-management strategies are essential to the management of pain. | ▪ Physical therapy<br>○ muscle strengthening<br>○ heat/cold<br>○ hydrotherapy<br>○ ultrasound<br>○ transcutaneous electrical nerve stimulation (TENS)<br>○ stretching<br>○ active rehabilitation-oriented therapies<br>▪ Massage therapy<br>▪ Exercise- based treatments<br>▪ Osteopathic manipulation | | |

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| | ▪ Chiropractic care<br>▪ Manual therapy<br>▪ Physical (sensory) interventions:<br>  o comfort positioning<br>  o cutaneous stimulation,<br>  o nonnutritive sucking, pacifier +/- sucrose solution<br>  o pressure<br>  o massage<br>▪ Acupuncture | | |
| ***3.2.2 Psychological and Behavioral Approaches*** | | | |
| A. Identify psychosocial and behavioral interventions for chronic pain, including self-management approaches.<br>B. For each intervention:<br>  i. Identify core principles for its usefulness in pain<br>  ii. Identify strength of evidence<br>  iii. Identify advantages/disadvantage<br>  iv. Identify self-management strategies | ▪ Individual, family, and/or group psychotherapy<br>▪ Psychoeducation<br>▪ Cognitive-behavioral therapy (CBT)<br>▪ Acceptance and commitment therapy (ACT)<br>▪ Relaxation techniques<br>  o guided imagery<br>  o diaphragmatic breathing<br>  o hypnotherapy<br>▪ Meditation<br>▪ Biofeedback/neurofeedback<br>▪ Stress management; operant approach<br>▪ Treatment of co-occurring psychiatric disorders<br>▪ Treatment of co-occurring substance use disorders<br>▪ Self-management training<br>  o pain diaries/journaling<br>  o sleep/rest hygiene<br>  o emotional regulation<br>  o appropriate use/adherence of pain medications<br>  o healthy eating/appropriate nutrition<br>▪ Assistance from transition care nurses, appropriately trained health coaches, or counselors. | | |
| ***3.2.3 Pharmacology of Pain*** | | | |
| A. Identify and recognize the different pharmacologic approaches to managing pain<br>B. Describe the advantages and disadvantages of using each class.<br>C. Describe the World Health Organization (WHO) analgesic ladder<br>D. Identify the following for each class of medication:<br>  i. Mechanism of action | ▪ Non-opioid analgesics<br>  o non-steroidal anti inflammatory<br>  o acetaminophen<br>  o local anesthetics<br>▪ Opioids<br>  o agonists<br>  o partial agonists<br>  o agonists/antagonists | | |

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| ii. Indications and contraindications<br>iii. Adverse effects<br>iv. Drug interactions<br>v. Route(s) of administration<br>vi. Dosing and frequency of administration<br>vii. Onset of action and duration of effect<br>viii. Appropriate monitoring<br>ix. Relative potency (within class)<br>x. Proper formulation selection<br>xi. Considerations for use in special populations, including renal and hepatic dose adjustments or considerations<br>E. Identify available resources and references containing detailed information on individual medications.<br>F. Identify medications used for managing the side effects associated with the use of pharmacologic agents for pain.<br>G. Identify the following for each class of medication used for managing the side effects associated with the use of pharmacologic agents for pain.<br>i. Mechanism of action<br>ii. Indications<br>iii. Contraindications<br>iv. Adverse/side effects<br>v. Drug interactions<br>vi. Route(s) of administration<br>vii. Dosing and frequency of administration<br>viii. Onset of action and duration of effect<br>ix. Required monitoring<br>x. Relative potency (between and within each class)<br>xi. Proper formulation selection<br>H. Identify considerations for use in special populations including renal and hepatic dose adjustments or considerations. | ○ pure antagonists<br>▪ Ketamine<br>▪ Co-analgesics (drugs whose primary indication is not for pain, but can help)<br>○ antidepressants<br>○ anticonvulsants<br>○ muscle relaxants<br>○ glucocorticoids<br>○ cannabinoids<br>○ serotonin agonists<br>○ dihydroergotamine<br>▪ Medications to manage side effects<br>○ antiemetics<br>○ antihistamines<br>○ laxatives<br>○ anticholinergics<br>○ gastric acid inhibitors<br>○ psychostimulants | | |
| ***3.2.4 Pharmacological Approaches*** | | | |
| A. Demonstrate the ability to choose the appropriate medication based on:<br>i. Type of pain<br>ii. Etiology of pain<br>iii. Response to prior medications | ▪ Analgesic dosing strategies<br>○ World Health Organization (WHO) analgesic ladder<br>○ dosing in opioid naïve and non-naïve patients<br>○ routes of administration<br>○ dosage escalation and de-escalation | | |

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| iv. Conditions and comorbidities of the patient<br>v. Benefits outweigh the risks<br>B. Demonstrate the ability to anticipate and manage side effects.<br>C. Describe the difference and utility of scheduled versus as needed (PRN) dosing.<br>D. Demonstrate the ability to apply dosage escalation and de-escalation based on clinical scenario.<br>E. Describe the relative potencies of opioids and other analgesics.<br>F. Describe the concept and value of opioid rotation.<br>G. Recognize the role of pharmacogenetics in pain management prescribing. | ○ pharmacogenetics<br>○ pharmacokinetics and pharmacodynamics<br>○ relative opioid potencies and conversion calculations<br>○ opioid rotation<br>○ scheduled versus as needed (PRN) dosing<br>▪ The 5 Rs of prescribing<br>○ Right analgesic<br>○ Right route<br>○ Right dose (Lowest effective dose)<br>○ Right dosing interval<br>○ Right message (Importance of self-care/management)<br>▪ Key considerations for opioid prescribing:<br>○ educate patients about their responsibility for adherence<br>○ patients agree to obtain medications from only one physician<br>○ agreement for periodic drug testing<br>○ do not mix with alcohol or other central nervous system depressants<br>○ medications should be kept in a secure location<br>▪ Nonsteroidal anti-inflammatory agents and antipyretics<br>▪ Systemic and spinal opioids<br>▪ Local anesthetics<br>▪ Medicines indicated for neuropathic pain<br>▪ Other medicines active against neuropathic pain (e.g., anticonvulsants, antidepressants)<br>▪ Medications used to counter the side effects of pharmacologic agents for pain | | |
| ***3.2.5 Interventional Approaches*** | | | |
| A. Demonstrate the ability to choose the appropriate interventional approach based on:<br>i. Type of pain<br>ii. Etiology of pain<br>iii. Response to prior treatment<br>iv. Conditions and comorbidities of the patient<br>v. Benefits outweigh the risks<br>B. Demonstrate the ability to anticipate and counsel patients regarding common side effects and/or complications related to these interventional approaches. | ▪ Trigger point injections<br>▪ Epidural/facet steroid injections<br>▪ Chemical denervation<br>▪ Intrathecal medication delivery<br>▪ Nerve blocks (image guided)<br>○ local anesthetics<br>○ neurolytic solutions<br>▪ Surgical techniques for nerve decompression or destruction<br>▪ Neuroaugmentation techniques<br>○ transcutaneous electrical nerve stimulation (TENS)<br>○ brain and spinal cord stimulation<br>○ peripheral nerve stimulators<br>▪ Radiofrequency, pulsed or conventional thermal | | |

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| | ▪ Vertebral augmentation (kyphoplasty; vertebroplasty) | | |
| ***3.2.6 Complementary and Alternative Approaches (CAM)/Integrative Medicine*** | | | |
| A. Describe the common complementary and alternative medicine modalities available for managing pain.<br>B. Explain the evidence that supports the use of complementary and alternative medicine approaches for managing pain. | ▪ Acupuncture<br>▪ Herbal products<br>▪ Rolfing<br>▪ Yoga<br>▪ Meditation | | |
| **3.3 Assessing and Managing Pain in Special Patient Populations, Contexts, and/or Settings** | | | |
| **POTENTIAL LEARNING OBJECTIVES** | **POTENTIAL AREAS OF STUDY** | ***Content location in curriculum*** | ***Method(s) of Assessment*** |
| ***3.3.1 Assessing and Managing Pain in Special Patient Populations*** | | | |
| A. Identify the signs and symptoms of pain in special patient populations.<br>B. Identify tools for evaluation of pain and patient's experience of pain in special patient populations.<br>C. Identify the basic physiology and pathology associated with each special patient population.<br>D. Distinguish between signs and symptoms associated with acute vs. chronic pain in special patient populations.<br>E. Describe each of the specific pain conditions as follows:<br>i. signs and characteristics<br>ii. pathophysiologic processes<br>iii. methods of diagnosis<br>F. Recognize and manage patients who are at risk for underreporting and undertreating of their pain.<br><br>*(In-depth training in this area may be more appropriate at the graduate level of medical training)* | ▪ Opioid tolerant patient<br>▪ Opioid naïve and non-naïve patients<br>▪ Active or history of substance abuse<br>▪ Chronic pain<br>▪ Pregnancy, childbirth, and breastfeeding<br>▪ Infants, children, and adolescents<br>▪ Developmentally disabled<br>▪ Geriatric/elderly<br>▪ Palliative care/end of life<br>▪ Chronic co-morbidities<br>▪ Cognitive impairment<br>▪ Alzheimers/dementia<br>▪ Traumatic brain injury/stroke<br>▪ Cancer survivors<br>▪ Obesity<br>▪ HIV/AIDS<br>▪ Hepatitis C<br>▪ Perioperative pain<br>▪ Polypharmacy<br>▪ Psychiatric disorders<br>▪ Trauma history/PTSD<br>▪ Specific occupations/occupational hazards (e.g., military, law enforcement, airline pilot) | | |
| ***3.3.2 Assessing and Managing Pain in a Patient with Specific Pain Conditions*** | | | |

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| A. Describe each of the specific pain conditions as follows:<br>i. signs and characteristics<br>ii. pathophysiologic processes<br>iii. treatment (curative and pain management)<br>B. Identify the common medical conditions that are associated with chronic substance use disorder, such as:<br>i. HIV<br>ii. Hepatitis<br>iii. Cancer<br>iv. Cardiovascular disease<br><br>*(In-depth training in this area may be more appropriate at the graduate level of medical training)* | ▪ Pain states:<br>o acute<br>o acute recurring<br>o chronic (persistent)<br>▪ Nocioceptive – somatic pain<br>o acute pain<br>- postoperative pain<br>- pain due to acute injury<br>o cancer pain<br>- primary<br>- metastatic<br>- cancer survivors<br>o intraoral pain<br>o cervical/thoracic/lumbar pain<br>o low back pain<br>o musculoskeletal pain<br>- osteoarthritis<br>- inflammatory arthritis<br>o muscle and myofascial pain<br>- fibromyalgia<br>▪ Nocioceptive – visceral<br>o sickle cell crisis<br>o chronic urogenital pain<br>o pain in pregnancy and labor<br>o postoperative pain<br>▪ Headache and facial pain<br>o headache<br>- migraine<br>- tension headache<br>- cluster headache<br>o orofacial Pain<br>- Temporomandibular joint (TMJ) pain<br>▪ Pain due to nerve damage<br>o neuropathic pain<br>- postherpetic neuralgia<br>- trigeminal neuralgia<br>- phantom limb pain<br>- diabetic neuropathy<br>- chemotherapy-induced<br>o central pain syndrome<br>o complex regional pain syndromes<br>▪ Other:<br>o HIV/AIDS | | |

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| | ○ hepatitis C | | |
| ***3.3.3 Assessing and Managing Pain of Patients in Special Contexts and/or Settings*** | | | |
| A. Recognize the distinct aspects of pain in special contexts and/or settings<br>B. Recognize the distinct aspect of the patient's experience of pain in these special contexts and/or settings<br>C. Describe the unique considerations and potential pitfalls in managing the pain of patients in the following special contexts and/or settings. | ▪ Emergency rooms/departments<br>▪ Hospitals<br>▪ Intensive care units<br>▪ Urgent care centers<br>▪ Walk-in clinics<br>▪ Long-term care facilities<br>▪ Outpatient care<br>▪ Hospice | | |
| **3.4 Screening for and Assessment of Co-occurring Problems** | | | |
| **LEARNING OBJECTIVES** | **POTENTIAL AREAS OF STUDY** | ***Content location in curriculum*** | ***Method(s) of Assessment*** |
| ***3.4.1 Screening for and Assessment of Co-Occurring Psychiatric Disorders*** | | | |
| A. Identify common co-occurring mental health disorders (e.g., anxiety disorders; depression; Post-traumatic stress disorder (PTSD); somatoform disorder; bipolar disorder; schizophrenia; cognitive impairments).<br>B. Recognize the bidirectional relationship between psychiatric disorders and substance use disorders.<br>C. Identify and discuss the impact that concurrent mental health disorders and social history can have on successful referral and treatment for substance use disorders.<br>D. Recognize and identify your own and the societal stigmatization and biases against individuals with substance use disorders and associated evidence-based medication-assisted treatment. | ▪ Bio-psycho-social model of disease/illness<br>▪ Adverse childhood experience study and questionnaire<br>▪ Prevalence and statistics of mental illness including economic impact<br>▪ Psychiatric interview including mental status exam<br>▪ Motivational Interviewing<br>▪ Psychological factors affecting medical conditions<br>▪ Understanding healthcare disparities and mental illness<br>▪ Cross cultural communication and influences/Hays Addressing Model (Understanding diversity in patients)<br>▪ Normal vs. abnormal behavior vs. mental illness<br>▪ DSM-5 diagnostic criteria<br>▪ Risk assessment including suicide<br>○ Columbia-Suicide Severity Rating Scale (C-SSRS)<br>○ Suicide Assessment Five-Step Evaluation and Triage (SAFE-T)<br>▪ General screening assessments<br>○ Patient Stress Questionnaire<br>○ Symptom Checklist 90-Revised (SCL-90-R)<br>▪ Disability assessment<br>○ WHODAS-2.0<br>▪ Behavioral health screening and assessment<br>○ Depression in adults<br>- Patient Health Questionnaire-9 (PHQ-9)<br>- Patient Health Questionnaire-2 (PHQ-2<br>- Beck Depression Inventory - 2 | | |

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| | - Hamilton Rating Scale for Depression (HAM-D)<br>○ Anxiety in adults<br>- Generalize Anxiety Disorder -7 (GAD)<br>- Hamilton Anxiety Rating Scale (HAM-A)<br>- Panic Disorder Severity Scale (PDSS) | | |
| ***3.4.2 Screening for and Assessment of Substance Use Disorders*** | | | |
| A. Recognize core aspects of a substance use disorder.<br>B. Identify and describe evidence-based tools, instruments effective in screening patient at risk for developing substance use problems.<br>C. Recognize the role screening tools serve in early intervention, assuring quality care, and patient safety.<br>D. Describe the concept that a substance use disorder may exist along a spectrum from mild to moderate to severe.<br>E. Identify other substances (medications, chemicals, plants, etc.) with the potential for abuse.<br>F. Understand the difference between a substance use disorder, physical dependence, and analgesic tolerance.<br>G. Demonstrate the ability to recognize patients displaying signs of aberrant prescription use behaviors.<br>H. Summarize the precipitants and factors that interfere with successful treatment of substance use disorder.<br>I. Describe the impact that substance use disorder can have on chronic health conditions, including diabetes, oral health, and infection.<br>J. Describe the withdrawal syndromes associated with the most common substances of abuse. | ▪ Nature of substance use disorders<br>▪ Spectrum of substance use disorders - mild to moderate to severe<br>▪ Difference between substance use disorder, physical dependence, and analgesic tolerance<br>▪ Precipitants and factors that interfere with successful treatment of substance use disorders<br>▪ Impact that substance use disorders can have on chronic health conditions, including diabetes, oral health and infection.<br>▪ Potential assessment tools:<br>○ Opioid Risk Tool (ORT)<br>○ Diagnosis, Intractability, Risk, Efficacy (DIRE)<br>○ Screener and Opioid Assessment for Patients with Pain-Revised (SOAPP-R)<br>○ Screening Instrument for Substance Abuse Potential (SISAP)<br>○ Prescription dispensing records (e.g. the Prescription Drug Monitoring Program or "PDMP")<br>○ Motivational Interviewing (MI)<br>○ Screening Tool for Addiction Risk (STAR)<br>○ Pain Assessment and Documentation Tool (PADT)<br>○ Urine drug testing | | |
| **3.5 Treating Pain in Patients with Co-Occurring Problems** | | | |
| **LEARNING OBJECTIVES** | **POTENTIAL AREAS OF STUDY** | ***Content location in curriculum*** | ***Method(s) of Assessment*** |
| ***3.5.1 Treating Pain in Patient with Co-Occurring Psychiatric Disorders*** | | | |
| A. Recognize a holistic view of the patient presenting with distress and the need for a comprehensive biopsychosocial evaluation. | ▪ Principles of diagnostic interviewing with humanistic, non-judgmental approach, building therapeutic alliance with emphasis on patient-doctor partnership and shared decision-making | | |

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| B. Recognize the process of diagnosis and evidence-based psychosocial and pharmacological treatment for common co-occurring psychiatric disorder (such as anxiety, depression, PTSD, somatoform disorder, suicide) with chronic pain.<br>C. Recognize primary vs. secondary (to substance use disorder or adjustment disorder) psychiatric symptoms.<br>D. Identify treatment settings for co-occurring psychiatric disorders (ambulatory, intensive outpatient and inpatient settings)<br>E. Recognize the impact of psychiatric disorder, such as depression, on the perception and experience of pain.<br>F. Recognize the impact of under-recognition and under-treatment of co-occurring psychiatric disorders on treatment outcome of chronic pain and vulnerability for developing a substance use disorder.<br>G. Recognize the need for working within a multidisciplinary team, identify systems issues related to type of practice and the importance of communication at multiple levels. | ▪ Diagnostic criteria for major depression, anxiety disorders, PTSD, somatoform disorder and other major psychiatric conditions according to the Diagnostic and Statistical Manual for Mental Disorders-fifth edition (DSM-5) Recognize symptoms as reaction to pain and functional limitations vs. symptoms indicating primary psychiatric disorder (e.g. feeling of hopelessness, anxiety, excessive fear, catastrophic thinking) vs. symptoms secondary to co-occurring substance use disorder.<br>▪ Use of screening tools for emotional distress (e.g. Beck depression inventory, brief patient health questionnaire, Davidson Trauma scale)<br>▪ Psychosocial interventions including individual and group therapy & types of psychotherapies (cognitive behavioral therapy, motivational therapy, mindfulness-based therapy)<br>▪ Principles of psychopharmacology and optimized treatment response for major drug classes for common psychiatric disorders (antidepressants, antipsychotics, mood stabilizers, anticonvulsants, sedative-hypnotics.<br>▪ Advantages/ disadvantages of specific medication in patients with chronic pain and co-occurring psychiatric condition (antidepressants (TCA, SNRI) & anticonvulsants) may benefit both, while sedative hypnotics may represent increased risk for developing SUD in vulnerable patients.<br>▪ System issues, optimized communications among multidisciplinary team, use of available resources and referral for specialized treatment and coordination of care. | | |
| ***3.5.2 Treating Pain in Patients with Substance Use Disorders*** | | | |
| A. Identify the current substance use status – at risk substance use disorder, active addiction or in stable recovery.<br>B. Identify patient's current level of risk.<br>C. Recognize the bidirectional relationship between chronic pain and substance use disorders.<br>D. Identify evidence-based pharmacological and psychosocial interventions for substance use disorders, with emphasis on opioid use disorder.<br>E. Recognize the need for multidisciplinary team to address patient with chronic pain and SUD's. | ▪ Definition of addiction or substance use disorder (3C's: impaired control or compulsive use of the substance, continued use despite harm, and craving)<br>▪ (or Substance Use Disorder in DSM-5), physical dependence, tolerance, recovery, relapse.<br>▪ Use screening scale for substance use disorders (ASIST, AUDIT, AUDIT-C)<br>▪ Understand the neurobiology underlying the substance use disorders and shared neurophysiological patterns with chronic pain<br>▪ Understand the implications for treatment in patients with co-occurring chronic pain and substance use disorder. | | |

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| F. Recognize priorities of modalities of pain treatment (non-opioid analgesics) and risk/benefit analyses for using opioid based analgesics.<br>G. Identify non-pharmacological therapies in chronic pain (therapeutic exercise, physical therapy, cognitive-behavioral therapy, complementary and alternative medicine).<br>H. Identify and treat or refer for care of co-occurring psychiatric disorders.<br>I. Identify the risk of opioid therapy for patients in recovery from substance use disorders and cautionary steps when opioid therapy is considered.<br>J. Recognize need for referrals for substance abuse treatment programs for those with active substance use, coordination of care within a multidisciplinary team and communication across providers and systems of care.<br>K. Recognize stigma and own negative response towards patients with chronic pain and co-occurring SUD's. | ▪ Continuum of care setting (office-based outpatient, intensive outpatient, and inpatient residential & therapeutic community settings.<br>▪ Psychotherapies (motivational enhancement therapy, cognitive behavioral therapy, contingency management, relapse prevention, substance use disorder counseling and 12-step facilitation therapy)<br>▪ Pharmacotherapy for opioid use disorders "Medication Assisted Treatment" (methadone maintenance, office-based buprenorphine/naloxone (sublingual) or buprenorphine monthly (subcutaneous) maintenance, injectable, long acting naltrexone therapy.<br>▪ Pharmacotherapy for other substance use disorders (alcohol use disorder: naltrexone hydrochloride, acamprosate, disulfiram, off label topiramate and gabapentin; smoking cessation medications: nicotine-replacement (patches, gum, nasal spray and nasal inhaler), bupropion, and varenicline.<br>▪ Indication, mechanisms of action, risk, benefit and interactions for each medication when used with chronic pain.<br>▪ Patient education, setting treatment goals & expectation, treatment agreement and selection and initiation of treatment, documentation and treatment monitoring including urine drug screens and referral for supportive substance use disorder counseling.<br>▪ Use assessment tools (mentioned in 4.7.2. above) to aid in monitoring aberrant & risk behavior. | | |

## 3.6 Referrals to and Collaboration with Pain Specialists and Services

| POTENTIAL LEARNING OBJECTIVES | POTENTIAL AREAS OF STUDY | *Content location in curriculum* | *Method(s) of Assessment* |
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| A. Describe the core aspects of inter- or multi-disciplinary evaluation and management of pain.<br>B. Identify the role, scope of practice, and contribution of the different professions within a pain management care team.<br>C. Identify the various specialties and allied health professionals involved in pain management and when to involve them to accomplish treatment goals.<br>D. Describe "universal precautions" for opioid-involved pain management.<br>E. Describe initial and ongoing opioid (and other substance) use disorder assessments and when to | ▪ Pain, especially chronic pain, is often complex and may be best understood and addressed using a biopsychosocial model<br>▪ Potential consultants for addressing the above domains include:<br>o interventional pain management<br>o other medical specialties (e.g., addiction medicine; neurology; physical medicine & rehabilitation; psychiatry; rheumatology)<br>o surgical specialties (e.g., neurosurgery; orthopedic surgery)<br>o nursing specialists<br>o psychology<br>o complementary and alternative medicine (e.g., acupuncture; massage; yoga; tai chi) | | |

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| consult with or refer to addiction medicine specialists or substance use disorder treatment centers.<br>F. Summarize the importance of proper referral process for specialty evaluation and treatment of substance use disorders.<br>G. Identify how to appropriately refer patients to addiction medicine specialists and treatment programs for both relapse prevention and co-occurring mental health disorders.<br>H. Describe how to discuss the diagnosis of substance use disorder with a patient including methods for effective referral of a patient for treatment of substance use disorder. | ○ osteopathy<br>○ pharmacy<br>○ social work<br>▪ Implementation of "universal precautions" in pain management including:<br>○ assess pain level and function pre- and post-intervention assessment<br>○ perform psychologic assessment, including personal and family history of addictive disorders<br>○ make working diagnosis and consider appropriate differential diagnosis, tailoring the treatment accordingly<br>○ obtain informed consent and treatment agreement<br>▪ Clear expectations and obligations of patient and the team of clinicians involved | | |

# DOMAIN IV: OTHER CONSIDERATIONS RELATED TO PAIN AND PAIN MANAGEMENT

## 4.1 Disparities in Healthcare

| POTENTIAL LEARNING OBJECTIVES | POTENTIAL AREAS OF STUDY | *Content location in curriculum* | *Method(s) of Assessment* |
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| A. Identify beliefs and values that may influence pain evaluation and treatment of individuals from populations known to have experienced health disparities.<br>B. Discuss the history and current trends of pain evaluation and treatment of marginalized and vulnerable populations.<br>C. Identify data regarding social determinants of health into treatment planning for substance use disorders.<br>D. Incorporate data regarding social determinants of health into treatment planning for substance use disorders. | ▪ Inequities in the use of various pharmacological pain medication classes by race/ethnicity among the US pain population<br>▪ Cultural influences on pain perception<br>▪ Social determinates of the experience of pain<br>▪ Values based practice of medicine<br>▪ Patient population health disparities<br>▪ Pain management in vulnerable populations<br>▪ Palliative care in vulnerable populations<br>▪ Ethical care of underserved and vulnerable populations | | |

## 4.2 Health Policy, Legal and Ethical Considerations Related to Pain Management

| POTENTIAL LEARNING OBJECTIVES | POTENTIAL AREAS OF STUDY | *Content location in curriculum* | *Method(s) of Assessment* |
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| A. Explain why undertreated and/or untreated pain is an ethical health issue.<br>B. Explain challenges special patient populations face in gaining access to pain treatment.<br>C. Explain other ethical issues related to pain, pain management, and patient care of such.<br>D. Identify and recognize various state and national legislation, rules, and laws related to providing ethical care and treatment of patients with pain.<br>E. Recognize the historic development of state and national policy related to providing ethical care and treatment of patients with pain.<br>F. Identify and recognize various factors influencing a patient's ability to access care for pain including:<br>i. adequate economic resources<br>ii. adequate medical insurance<br>iii. travel/transportation<br>iv. availability of a primary care physician | ▪ Patient safety<br>○ education on how to take/use medications appropriately<br>○ education on medication efficacy and sensitivities.<br>○ education of medication toxicities and dangers including acetaminophen<br>▪ Risk management strategies<br>○ controlled substance treatment agreements, required for long-term opioid therapy under Florida Administrative Code (64B8-9.013) and Florida Statute (456.44)<br>○ random urine drug screenings in high-risk patients<br>○ use of drug databases<br>○ use of automated prescription systems<br>▪ Drug diversion and reporting systems<br>▪ Use of appropriate screening tools for prescription misuse/abuse<br>▪ Secure storage of prescription pads<br>▪ Secure storage of medications and medical supplies<br>▪ Safe disposal and/or destruction of medications<br>▪ Prescribing and dispensing laws and rules | | |

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| G. Recognize, without discrimination, that all patients have the ethical right to receive adequate pain treatment.<br>H. Recognize pain and substance use disorders as a public health issue. | ▪ Criteria and evidence for using DEA Schedule II, III, IV, V medications and/or substances<br>▪ Training on FDA required "Risk Evaluation and Mitigation Strategy"<br>▪ Florida legal and regulatory aspects of prescribing controlled substances for the management of chronic non-cancer pain.<br>o acute pain: 2018 Florida Opioid Legislation – HB 21 (Chapter 2018-13 Laws of Florida) (http://laws.flrules.org/2018/13)<br>o chronic pain: 456.44, Florida Statutes – Controlled substance prescribing<br>o chronic pain: Chapter 64B8-9.013, Florida Administrative Code – Standards for the Use of Controlled Substances for the Treatment of Pain | | |

## 4.3 Drug Databases

| POTENTIAL LEARNING OBJECTIVES | POTENTIAL AREAS OF STUDY | *Content location in curriculum* | *Method(s) of Assessment* |
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| A. Identify and recognize appropriate use and reporting of state and national prescription database systems.<br>B. Identify the benefits of a prescription database system as a tool used by states to address prescription drug abuse, substance use disorders, and diversion. | ▪ National Alliance for Model State Drug Laws (link)<br>▪ Florida's prescription drug monitoring program (PDMP): *Electronic–Florida Online Reporting of Controlled Substance Evaluation* (E-FORCSE)<br>▪ Potential benefits of a PDMP<br>o support access to legitimate medical use of controlled substances<br>o identify and deter or prevent drug abuse and diversion<br>o facilitate and encourage the identification, intervention with and treatment of persons addicted to prescription drugs<br>o inform public health initiatives through outlining of use and abuse trends | | |

## 4.4 Economic and Psychosocial Impact of Pain

| POTENTIAL LEARNING OBJECTIVES | POTENTIAL AREAS OF STUDY | *Content location in curriculum* | *Method(s) of Assessment* |
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| A. Recognize the economic impact of pain on society.<br>B. Recognize the economic impact of substance use disorder and addition on society.<br>C. Recognize the psychosocial impact of pain on society.<br>D. Recognize the psychosocial impact of substance use disorder and addiction on society. | ▪ Loss of work productivity-absenteeism<br>▪ Increased cost to healthcare industry<br>▪ Decrease in labor force<br>▪ Loss in US productivity<br>▪ Increased demand on emergency rooms<br>▪ Social stigma of pain leading to isolation | | |

## 4.5 Transition of Care and Discharge Planning: Ensuring Patient Safety

| POTENTIAL LEARNING OBJECTIVES | POTENTIAL AREAS OF STUDY | *Content location in curriculum* | *Method(s) of Assessment* |
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| A. Demonstrate the ability to assess and manage pain across settings and transitions of care.<br>B. Describe the importance of proper discharge and transitions of care planning in ensuring patient safety.<br>C. Describe the value associated with establishing treatment goals and how they are documented and monitored throughout treatment and discharge, and from venue to venue.<br>D. Describe the process of patient education related to discontinuation of therapy.<br>E. Recognize that discharging patients from a practice for evidencing substance use disorders is not acceptable medical practice.<br>F. Identify and recognize the importance of patient communication and education regarding the risks and benefits associated with each available treatment option, including the potential for overdose.<br>G. Recognize the risk factors for, and signs of, opioid overdose.<br>H. Demonstrate the correct use of naloxone rescue.<br>I. Identify and recognize methods for patient education related to proper medication usage, storage and disposal.<br>J. Describe the role that shared decision-making can play when considering opioid therapy, including the possible role that family members can play, especially in younger patients. And patients at high risk (e.g., history of substance use disorders)<br>K. Identify the role for, and describe the components of, a controlled substance treatment agreement. | ▪ Discharge/transfer checklist to:<br>○ ensure coordination of care across various settings<br>○ identify and resolve any logistical, psychological, or socioeconomic barriers to obtaining and adhering to prescribed pain-management therapies<br>▪ Best practices in transitional care across all settings:<br>○ patient-centered focus<br>○ medication management<br>○ communication and care coordination<br>○ timely follow-up by healthcare providers, and<br>○ patient education and coaching<br>▪ Instruction of patients and caregivers in naloxone rescue and provide prescription as needed<br>▪ Instruction regarding non-pharmacologic interventions<br>▪ Early referral to chronic pain specialists may minimize opioid use and potential abuse<br>▪ Treat or refer - You can “fire” the opioid molecule but you may not fire the patient | | |

# MEDICAL SCHOOL EXECUTION OF THE COMPETENCIES

As medical schools across the nation strive to improve the training of their students in the areas of pain and pain management, along with the behavioral sciences (including substance use disorders and other psychiatric disorders), it is important for the implementation of any curricula to be effective and meaningful to the practice of medicine. The list of domains and competencies noted in this document are important because they provide schools with a foundation for use in enhancing their curricula regarding the significant clinical and ethical responsibilities of managing pain and substance use disorders.

As curricula are implemented, medical schools should look beyond simply having their students meet the basic competencies laid out in this document; they should strive to ensure that students meet the standards of entrustment. In order to better prepare students in the areas of pain and pain management and related behavioral sciences, medical schools might consider the following processes:

- Implement curricula that allow students to become competent in the areas described in this document.
- Assess the students' competence in a variety of clinical environments.
- Give formative and summative feedback to the students so that they can improve.
- Perform quality improvement to ensure that the curriculum that is being delivered is providing the desired outcomes.
- Periodically review the curriculum to ensure students are learning the most up to date material in these areas.

# STUDENT ASSESSMENT OF LEARNING

At a minimum, students should be assessed on the competencies in these objectives using methodology that are commensurate with standards for assessment the LCME and COCA expect for institutional program objectives and sound educational methodology for assessment. Since pain management is an area of patient care that carries potential for high morbidity and mortality, students should have to demonstrate the competencies in low stakes environments (simulation; standardized patient activities), followed by choice of treatment and entering of orders which require discussion and subsequent co-signature by a licensed physician. The designation of competency at the end of medical school in the area of basic pain management should be based on multiple assessments over their educational time which allow the students to demonstrate their competency. Assessments should focus on the students' knowledge, skills, and attitudes with respect to the objectives described in this document. For example, assessments can be done via written and/or oral examinations, objective structured clinical examinations (OSCEs), direct observations and oral patient presentations. Medical schools should prioritize the pain management curriculum so that the actions an intern might execute the first day of having their DEA license, and the necessary supporting medical knowledge, would be assessed in order to meet the standards of entrustability. Other aspects of the pain management curriculum would be assessed to make sure the students have met the objectives listed in this document that are deemed a priority by the medical school's curriculum committee.

Pain management objectives should be aligned with the proper phase of education as determined by the curriculum committee. For example, the pharmacology of opioids at the level of basic science would be taught in the pre-clinical years. Assessment could be via multiple choice test questions and USMLE Step 1. The choice of opioid for a particular medical condition and dosing, may be assessed in the clinical years, as it is taught in patient care. Assessments should mimic intern year as much as possible in the clinical years.

# PROGRAM EVALUATION

Programmatic evaluation should begin with the creation of an inventory of the sessions in the curriculum which teach pain management. This inventory should be reviewed by experts and the curriculum committee so that gaps and redundancies are identified. Program evaluation should use the assessments of students' knowledge, skills, and attitudes to determine if objectives are being met and competency is being obtained. It is recommended that pain management be a topic of continuous quality improvement (CQI) using the standards for CQI used by the LCME. It is recommended that osteopathic medical schools follow standards consistent with those used by the COCA. In addition, the college should be reviewing the education literature in order to make sure they are aware of new and improved methods of curricular delivery.

# RESOURCES, REFERENCES, AND WEBSITES FOR PAIN MANAGEMENT AND EDUCATION

| STATE OF FLORIDA RESOURCES | | |
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| **Florida Department of Health (DOH)** | The Florida Department of Health provides oversight of many health aspects of pain management in Florida. The State Surgeon General serves as the head of the Florida Department of Health. | http://www.floridahealth.gov/ |
| **Health Practitioner Regulation** | The Board of Medical Quality Assurance, within the Florida Department of Health is responsible for the regulation of 26 types of health practitioners in the state, including, but not limited to the regulation of allopathic and osteopathic physicians. The Board of Medicine and Board of Osteopathic Medicine, both of which consist of individuals appointed by the Governor and confirmed by the Florida Senate, work with the Department of Health on matters relative to licensure and regulation of physicians in the state. | http://www.floridahealth.gov/licensing-and-regulation/index.html |
| **Pain Management Clinic Regulation** | The Department of Health and AHCA is responsible for registration of pain management clinics in the state. Sections 458.3265 and 459.0137, Florida Statutes, provide for regulation of the registration, management, and inspection of pain management clinics.<br>If the Pain Management Clinic will not be entirely physician-owned, registration with the Agency for Health Care Administration (AHCA) is required. | http://www.leg.state.fl.us/Statutes/<br>http://www.floridahealth.gov/licensing-and-regulation/pain-management-clinics/index.html |
| **Prescription Drug Monitoring Program (PDMP): EFORSCE** | The PDMP is a state-run electronic database used to track the prescribing and dispensing of certain controlled prescription drugs to patients. The PDMP is designed to monitor this information for suspected abuse or diversion and provide prescribers and pharmacists with critical information regarding a patient's controlled substance prescription history. | https://florida.pmpaware.net/login |
| **Statewide Drug Policy Advisory Council (DPAC)** | The Statewide Drug Policy Advisory Council was established pursuant to s. 397.333, Florida Statutes. The DPAC is composed of the State Surgeon General, Attorney General, Executive Director of the Department of Law Enforcement, Secretary of Children and Families, Director of the Office of Planning and Budgeting in the Governor's Office, Secretary of Corrections, Secretary of Juvenile Justice, Commissioner of Education, Executive Director of the Department of Highway Safety and Motor Vehicles, Adjutant General of the Department of Military Affairs; or their respective designees. In addition, there are members appointed by the Governor, president of the Senate, Speaker of the House of Representatives; and Chief Justice of the Supreme Court. The DPAC is charged to conduct a comprehensive analysis of the problem of substance abuse in Florida, make recommendations for developing and implementing a state drug control strategy, review funding on substance abuse programs and services and carry out a number of related duties. | http://www.floridahealth.gov/provider-and-partner-resources/dpac/index.html |
| **Florida Agency for Health Care Administration (AHCA)** | The Florida Agency for Health Care Administration regulates health care facilities in Florida, manages Florida's Medicaid Program, and administers the sharing of health care data through the Florida Center for Health Information and Policy Analysis. Health facility regulation (such as hospitals, nursing homes, and other facilities) addresses matters relative to pain management and prescription, administration, and dispensing of medications. The Medicaid Program includes requirements relative to Medicaid managed care organization and Medicaid provider prescription, administration, and prescription of controlled substances. | http://ahca.myflorida.com/ |
| **Florida Department of Children and Family Services (DCF)** | The Florida Department of Children and Family Services is responsible for regulation, administration and management of behavioral and substance abuse health systems of care in Florida. The Department of Children and Family Services contracts with Managing Entities (MEs), which are private non-profit organizations responsible for overseeing contracts with local service providers for the provision of prevention, treatment and recovery support services. Chapters 394 and 397 are the components of the Florida Statutes that address mental health and substance abuse treatment. | http://www.myflorida.com/accessflorida/ |

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| **Florida Department of Business and Professional Regulation (DBPR)** | The Department of Business and Professional Regulation is responsible for regulation of the Florida Drug and Cosmetic Act. The role of the Department of Business and Professional Regulation is to protect the public from injury by product use and by merchandising deceit involving drugs, devices and cosmetics. | http://www.myfloridalicense.com/dbpr/ |
| **Controlled Substance Regulation** | ***Florida***<br>Chapter 893, F.S., the Florida Comprehensive Drug Abuse Prevention and Control Act creates criminal offenses related to the manufacture, distribution, preparation, and dispensing of controlled substances. The Act classifies such substances into five schedules, based on the substance's "potential for abuse" and whether the substance has a currently accepted medical use. Under the Act, the unauthorized sale, manufacture, possession, delivery, or purchase of a controlled substance is subject to criminal penalties. The severity of the criminal penalty is dependent on several factors, including the schedule in which the controlled substance is categorized, the amount of controlled substance present and the location at which the illegal activity occurs. | http://www.flsenate.gov/Laws/Statutes/2011/Chapter893 |
| | ***Federal***<br>The Federal Controlled Substances Act, 21 U.S.C. s. 812, also classifies certain substances into schedules based on potential for abuse and whether there is a currently accepted medical use. | https://www.deadiversion.usdoj.gov/21cfr/21usc/812.htm |
| **NATIONAL RESOURCES** | | |
| **Advancing Excellence in America's Nursing Homes Campaign** | Helps nursing homes achieve excellence in the quality of care and quality of life for the more than 1.5 million residents of America's nursing homes. Improving pain management is a top goal nationally. | http://www.nhqualitycampaign.org/ |
| **Agency for Healthcare Research and Quality (AHRQ)** | Provides information on clinical effectiveness and guidelines including pain assessment and management standards for hospitals. | http://www.ahrq.gov/<br>https://psnet.ahrq.gov/resources/resource/31267/pain-assessment-and-management-standards-for-hospitals |
| **American Academy of Pain Management (AAPM)** | AAPM is the medical specialty society representing physicians practicing in the field of pain medicine. As a medical specialty society, the Academy is involved in education, training, advocacy, and research in the specialty of pain medicine. | www.painmed.org/ |
| **American Chronic Pain Association (ACPA)** | Support and education in pain management skills for people with pain, family and friends, and health care professionals. | https://www.theacpa.org/ |
| **American College of Emergency Physicians (ACEP)** | ACEP represents more than 38,000 emergency physicians, emergency medicine residents and medical students. Includes pain management section and clinical policies on opioids and pain related topics. | https://www.acep.org/ |
| **American College of Surgeons (ACS)** | Cancer Programs Standards: Ensuring Patient-Centered Care. These standards address key elements of quality cancer care including cancer pain care, palliative care, and hospice care. An updated version was released in 2016. | https://www.facs.org/quality-programs/cancer/coc/standards |
| **American Pain Society (APS)** | A community of professionals working to transform public policy and clinical practice to reduce pain-related issues. | http://americanpainsociety.org/ |
| **American Society of Clinical Oncology's Quality Oncology Practice Initiative (ASCO QOPI)** | A national oncologist-led practice improvement initiative that addresses pain care, palliative care, and hospice care. | http://qopi.asco.org/index |

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| **American Society of Interventional Pain Physicians (ASIPP)** | Has numerous evidence-based practice guidelines posted on their website. | http://www.asipp.org/index.html |
| **Association of American Medical Colleges (AAMC)** | A not-for-profit association dedicated to transforming health care through innovative medical education, cutting-edge patient care, and groundbreaking medical research. | https://www.aamc.org/<br>https://news.aamc.org/for-the-media/key-issues/academic-medicines-response-opioid-epidemic/<br>https://news.aamc.org/medical-education/article/responding-opioid-epidemic-through-medical-educati/ |
| **Centers for Disease Control (CDC)** | Guidelines, strategies and checklist for prescribing opioids for chronic pain and training for providers | https://www.cdc.gov/drugoverdose/<br>https://www.cdc.gov/drugoverdose/training/ |
| **Center for Healthcare Research & Transformation (CHRT)** | Illuminates best practices and opportunities for improving health policy and practice. Based at the University of Michigan, CHRT is a non-profit partnership between U-M and Blue Cross Blue Shield of Michigan designed to promote evidence-based care delivery, improve population health, and expand access to care. | http://www.chrt.org/ |
| **Centers for Medicare & Medicaid Services (CMS)** | Provides tools and resources for opioid prescribing. | www.cms.gov |
| **Cochrane Reviews** | Search site intended to help providers, practitioners and patients research topics to help make informed decisions about evidence-based health care, including pain care. | http://www.cochrane.org/search/site |
| **Consortium of Academic Health Centers for Integrative Medicine** | Exists to advance the principles and practices of integrative healthcare within academic institutions. Membership is comprised of over 51 highly esteemed academic medical centers and affiliate institutions. | https://imconsortium.org/ |
| **Doc.Com (Academy of Communication in Healthcare)** | A website dedicated to providing curriculum resources on teaching/learning healthcare communication skills. | http://webcampus.drexelmed.edu/doccom/user/ |
| **The Education in Palliative and End-of-Life Care Project (EPEC)** | Offers adaptations for many types of settings, patients, and health care professionals. A significant portion of the curriculum focuses on communication skills. | http://epec.net |
| **Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)** | A survey that is the first national, standardized, publicly reported survey of patients' perspectives of hospital care. Pain management is a core category. | http://www.hcahpsonline.org/home.aspx |
| **Institute for Healthcare Improvement (IHI)** | An independent not-for profit-organization, focuses on system change that leads to safe and effective healthcare. | http://www.ihi.org/ |
| **National Academies of Sciences, Engineering and Medicine** | The Health and Medicine Division (HMD) is a division of the National Academies of Sciences, Engineering, and Medicine (National Academies), formerly the Institute of Medicine. Published Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education, and Research in 2011. | http://www.nationalacademies.org/hmd |

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| **International Association for the Study of Pain (IASP)** | The International Association for the Study of Pain brings together scientists, clinicians, health-care providers, and policymakers to stimulate and support the study of pain and translate that knowledge into improved pain relief worldwide. | http://www.iasp-pain.org/ |
| **The Joint Commission** | Added pain to its accreditation standards; in 2011 they offered advanced accreditation in palliative care; in 2018 added new pain management standards. | http://www.jointcommission.org |
| **National Guideline Clearinghouse (NGC)** | Lists evidence-based clinical practice guidelines for treating pain. | http://www.guideline.gov/ |
| **National Institutes of Health Pain Consortium** | The NIH Pain Consortium was established to enhance pain research and promote collaboration among researchers across the many NIH Institutes and Centers that have programs and activities addressing pain. | http://painconsortium.nih.gov/ |
| **National Institutes of Health National Center for Complementary and Alternative Medicine** | Conducts scientific research on the diverse medical and health care systems, practices, and products that are not generally considered part of conventional medicine. | http://nccam.nih.gov/about |
| **National Quality Measures Clearinghouse (NQMC)** | An initiative of the Agency for Healthcare Research and Quality (AHRQ) of the U.S. Department of Health and Human Services (US DHHS), provides a database and website for information on specific evidence-based health care quality measures and measure sets | http://www.qualitymeasures.ahrq.gov/index.aspx |
| **National Quality Forum (NQF)** | A nonprofit organization, seeks to improve healthcare by building consensus on national priorities and goals for performance improvement and working in partnership to achieve them; endorsing national consensus standards for measuring and publicly reporting on performance; and promoting the attainment of national goals through education and outreach programs. NQF developed the NQP Playbook™: Opioid Stewardship in March 2018 with input from the NQP Opioid Stewardship Action Team. | http://www.qualityforum.org/Home.aspx<br>https://www.qualityforum.org/National_Quality_Partners_Opioid_Stewardship_Action_Team.aspx |
| **Pain Assessment and Management Initiative (PAMI)** | The overall goal of PAMI is to improve the safety of adult and pediatric patients by developing tools for health care providers to recognize, assess, and manage acute and chronic pain in a variety of settings (ED, EMS, hospital, etc.). Funding is provided by a private patient safety grant and University of Florida COM-Jacksonville. PAMI free access tools and resources are designed to be used, adapted and implemented by any health care facility or agency based on their specific needs. The PAMI website also provides pain related resources and news updates. PAMI resources include learning modules, a pain management and dosing guide, a pain discharge planning toolkit, a nonpharmacologic toolkit and distraction toolbox, educational videos and more. Materials are multidisciplinary. | http://pami.emergency.med.jax.ufl.edu/<br>Dosing Guide:<br>http://pami.emergency.med.jax.ufl.edu/resources/dosing-guide/<br>Discharge Planning Toolkit for Pain:<br>http://pami.emergency.med.jax.ufl.edu/resources/discharge-planning/<br>Nonpharmacologic & Distraction Toolkit:<br>http://pami.emergency.med.jax.ufl.edu/resources/new-approaches-to-pain-course/<br>Educational Patient Videos:<br>http://pami.emergency.med.jax.ufl.edu/resources/pami-educational-pain-videos/ |
| **PainEDU** | Improving pain treatment through education. Includes opioid risk management and clinician pain tools and a site for patients (PainAction) | https://www.painedu.org/<br>https://www.painaction.com/ |
| **U.S. Food and Drug Administration (FDA)** | Provides information on the risk evaluation and mitigation strategies (REMS) for numerous drugs and provides information on how to safely store and dispose of prescription drugs. | http://www.fda.gov/ |

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| **VA/DoD** | VA provides numerous pain related resources including clinical practice guidelines for opioid therapy in chronic pain, lower back pain (LBP), and post-operative pain (POP). Also has a patient library and Defense and veterans pain rating scale (DVPRS). | https://www.va.gov/painmanagement/resources.asp<br>https://www.healthquality.va.gov/guidelines/<br>http://www.veteranshealthlibrary.org/TestsTreatments/Treatments/142,84775_VA<br>https://www.healthquality.va.gov/guidelines/Pain/cot/VADoDOTCPG022717.pdf |
| **World Health Organization (WHO)** | Pain ladder | http://www.who.int/cancer/palliative/painladder/en/ |
| **OTHER STATE AND UNIVERSITY RESOURCES** | | |
| **Duke University's Integrative Medicine Program** | Health coaching program that works with patients in order to improve the patient's ability to management his/her condition while reducing the negative impact of health conditions | http://www.dukeintegrativemedicine.org/ |
| **Self-Management Resource Center** | Developed an evidence-based model for chronic disease self-management | http://patienteducation.stanford.edu/programs/<br>https://www.selfmanagementresource.com/programs/small-group/chronic-pain-self-management/ |
| **Michigan Advisory Committee on Pain and Symptom Management (ACPSM)** | Model Core Curriculum on Pain Management for Michigan Medical Schools: Recommendations from the multidisciplinary ACPSM are based upon the core curriculum developed by the International Association for the Study of Pain (IASP). The purpose behind providing Michigan medical schools with this model curriculum on pain is to reduce the fragmentation that now exists in pain education, and to ensure comprehensive, essential content on pain education that is consistent across all of Michigan's medical schools. | https://www.michigan.gov/documents/lara/Curriculum_MODEL_CORE_FINAL_APRIL_2013_MAILING_424376_7.pdf |
| **Michigan Quality Improvement Consortium (MQIC)** | Lists evidence-based/consensus guidelines for treating pain. | http://www.mqic.org/ |
| **Pennsylvania Medical Society** | PA opioid prescribing resources | https://www.pamedsoc.org/detail/article/PA-Opioid-Guidelines |
| **Florida Alcohol and Drug Abuse Association (FADAA)** | FADAA's mission is to serve its members by advancing addiction and co-occurring treatment, prevention, and research through communications, professional development, and public policy leadership. | https://www.fadaa.org/ |

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# APPENDIX A

## International Association for the Study of Pain (IASP)

## 2018 Curriculum Outline on Pain for Medicine*

The 2018 Curriculum Outline on Pain for Medicine by the International Association for the Study of Pain (https://www.iasp-pain.org/) has been a resource utilized by the working group. According to the IASP, the prevalence of pain demands comprehensive pain education for all health-care professionals. Yet not all require the same type of pain-related knowledge and skills. IASP developed specific curriculum outlines for medical schools to utilize in their pain education and training to ensure that graduates are adequately prepared to provide safe and effective care to all patients experiencing pain.

As with all health professions, an objective of the curriculum is to instill the knowledge and skills necessary to advance the science and management of pain as part of an interprofessional team. The desired outcomes of education emphasize critical competencies that support the humanistic aspects of health care and the learner's capacity to successfully carry out tasks in the real world. The fundamental concepts and complexity of pain include how pain is observed and assessed, collaborative approaches to treatment options, and application of pain competencies across the lifespan in the context of various settings, populations, and care-team models.

* Published with the permission of the International Association for the Study of Pain

# APPENDIX B

## Patient Information and Public Education on Pain Management and Opioids

**CDC**

CDC – Preventing an Opioid Overdose – Know the Signs
https://www.cdc.gov/drugoverdose/pdf/patients/Preventing-an-Opioid-Overdose-Tip-Card-a.pdf

CDC Promoting Safer and More Effective Pain Management
https://www.cdc.gov/drugoverdose/pdf/Guidelines_Factsheet-Patients-a.pdf

CDC Prescription Opioids: What You Need to Know
https://www.cdc.gov/drugoverdose/pdf/AHA-Patient-Opioid-Factsheet-a.pdf

CDC Guideline for Prescribing Opioids for Chronic Pain (Guidelines at a Glance)
https://www.cdc.gov/drugoverdose/pdf/Guidelines_At-A-Glance-508.pdf

Pregnancy and Opioid Pain Medications (English and Spanish)
https://www.cdc.gov/drugoverdose/pdf/pregnancy_opioid_pain_factsheet-a.pdf
https://www.cdc.gov/drugoverdose/pdf/pregnancy_opioid_pain_factsheet-esp-a.pdf

CDC Guideline for Prescribing Opioids for Chronic Pain: Effective and Responsible Chronic Pain Management
https://www.cdc.gov/drugoverdose/pdf/Infographic-CDC_Guideline_for_Prescribing_Opioids_for_Chronic_Pain-a.pdf

CDC – Know the Risks (Guidelines Patients Poster)
https://www.cdc.gov/drugoverdose/pdf/Guidelines_Patients_Poster-a.pdf

**JAMA**

JAMA Patient Page (English and Spanish)
https://jamanetwork.com/journals/jama/fullarticle/2503507
https://sites.jamanetwork.com/spanish-patient-pages/2016/hoja-para-el-paciente-de-jama-160419.pdf

**Florida DOH**

Florida Department of Health: When the Prescription Becomes the Problem
http://www.floridahealth.gov/provider-and-partner-resources/dpac/_documents/prescription-brochure-fact.pdf

**American Chronic Pain Association**
American Chronic Pain Association's Educational Video for Chronic Pain – "A Car with Four Flat Tires".

Watch a helpful pain analogy from the ACPA. Web link

**Pain Assessment and Management Initiative**
Pain Discharge Patient Instructions: http://pami.emergency.med.jax.ufl.edu/resources/patient-resources/
Educational Patient Videos: http://pami.emergency.med.jax.ufl.edu/resources/pami-educational-pain-videos/

- Additional Therapies to Help Manage Pain: Non-pharmacological and alternative therapies for pain management
- Pain Medication Safety: Useful information and tips on taking pain medication safely
- Preventing and Relieving Back Pain: Tips and exercises to manage back pain
- Ways to Manage Chronic Pain: Helpful tips on managing chronic pain

**PainAction**
https://www.painaction.com/
The goal of painACTION is to help people improve their self-management of their pain condition. Written with the help of health educators, pain experts, and people dealing with pain, this site is a resource to come back to repeatedly.

**US Pain Foundation**
https://uspainfoundation.org/programs/
The mission of U.S. Pain Foundation is to empower, educate, connect, and advocate for people living with chronic conditions that cause pain. As a 501(c)(3) organization dedicated to serving those who live with pain conditions and their care providers, U.S. Pain Foundation helps individuals find resources and inspiration.