

FULL PROPOSAL FINAL REPORT

TO:

**PFIZER MEDICAL EDUCATION GROUP
AND THE
AMERICAN COLLEGE OF EMERGENCY PHYSICIANS**

**THE EMERGENCY DEPARTMENT PAIN REGISTRY:
IMPACT EVALUATION OF THE 2012 AMERICAN COLLEGE OF
EMERGENCY PHYSICIAN OPIOID PRESCRIBING GUIDELINES**

**REPORT PERIOD: DECEMBER 1, 2012 – NOVEMBER 30, 2015
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Abstract

Purpose: To develop practice-based educational materials to support superior pain management practice in the emergency department (ED) and to enhance clinical competencies of patient care, interpersonal and communication skills, as well as professionalism when treating patients who present to the emergency department with pain.

Scope: Pain is a major symptom presenting to the ED. Efforts to improve pain management have contributed to a large increase in opioid prescribing, with resultant increases in opioid abuse, addiction, and death. While alleviating pain and suffering are primary responsibilities of emergency physicians, we have a concurrent duty to limit personal and societal harm resulting from opioid over-prescribing.

Methods: We conducted formative qualitative evaluations of CME content and assessment tools, incorporating participant feedback and physician focus group results into subsequent revisions. We conducted a national online panel survey of 204 key emergency medicine opinion leaders to generate peer and expert benchmarking data. We produced multiple video segments of national emergency medicine experts and patient advocates highlighting CME content and model best practices.

Results: The EMPainline curriculum (www.empainline.org) is now available for national dissemination. Preliminary results indicate marked increases in prescription drug monitoring program use (pre 6%, post 24%), and the proportion of patient receiving written instructions regarding both opioid storage (pre 1%, post 62%), and opioid disposal (pre 1%, post 55%). EMPainline is the first practice improvement activity approved by the American Board of Emergency Medicine addressing opioid prescribing in the ED.

Key Words: emergency medicine, practice improvement, pain, prescription drug abuse, opioids

Purpose

Objectives of Study

The purpose of our project is to develop practice-based learning and improvement educational materials to support superior pain management practice in the emergency department (ED). Our goal is to enhance clinical competencies of patient care, interpersonal and communication skills, as well as professionalism when treating patients who present to the emergency department with pain, particularly with regard to prescription opioid decision-making.

Scope

Background

With support from the Centers for Disease Control and Prevention, in 2012, the American College of Emergency Physicians developed evidence based guidelines to assist emergency physicians in conducting risk assessments of patients presenting with pain to the ED and in making opioid-related prescribing decisions.¹ Dr. Todd served on the writing panel for these national guidelines. The initial phases of our project targeted the dissemination of these guidelines as originally written, using peer clinician and patient feedback to achieve higher rates of implementation than traditional dissemination strategies. By the project's end, we developed an American Board of Emergency Medicine (ABEM)-approved practice improvement educational activity, the first CME activity recognized by ABEM to meet maintenance of certification (MOC) requirements for emergency physicians renewing their specialty board certification.

Context

Pain is a major presenting symptom to the ED, with up to 42% of visits related to painful conditions.² Efforts to improve pain management, both within the ED and in other treatment settings, have contributed to a large increase in opioid prescribing over the past two decades, with resultant increases in opioid adverse effects, including prescription drug abuse, addiction, and death.

The day-to-day practice of emergency medicine is characterized by the need to make rapid decisions in the face of diagnostic uncertainty. Decisions regarding the treatment of pain and opioid prescribing are particularly problematic in the face of the nation's epidemic of prescription opioid related overdose and death. Emergency physicians' opioid prescribing practices vary widely, even within individual practice groups and small geographic areas. Much of this variation is driven by individual biases regarding the management of pain and lack of feedback from peers and patients on what constitutes superior pain management practice. While alleviating pain and suffering are primary

¹ Cantrill SV, Brown MDk Carlisle RJ, et al. Clinical Policy: Critical issues in the prescribing of opioids for adult patients in the emergency department *Annals of Emergency Medicine* 2012;60:499-511.

² Pletcher MJ, et al. Trends in opioid prescribing by race ethnicity for patients seeking care in US emergency departments. *JAMA* 2008;299:70-78.

responsibilities of all who practice emergency medicine, we have a concurrent duty to limit personal and societal harm that may result from over-prescribing opioids.

Settings

This project targets the daily decisions emergency physicians make regarding pain treatment, particularly when decisions involve prescription opioids.

Participants

For the initial formative stages of this effort, we focused on a group of emergency physicians practicing in the Houston metropolitan area. As our curriculum evolved (www.empainline.org), we expanded our pilot activities to all Texas emergency physicians, and subsequently to a national audience. In addition to ACCME certification, we applied for, and received, recognition from the American Board of Emergency Medicine that our educational activities met their requirements for maintenance of certification (MOC), and we are currently poised to promote the program nationally.

Incidence and Prevalence

National surveys estimate that 24 million adults with chronic pain visit the ED annually and that 12 million visits are due to exacerbations of chronic pain syndromes.³ Approximately 40% of these patients are on chronic opioid therapy. Although the prevalence of prescription opioid misuse and abuse among ED patients presenting with pain is unknown, it is generally recognized that the ED serves a population at increased risk for substance use.

Methods

Study Design

Our project ultimately consisted of three phases:

- (1) Developing and testing CME modules based on the ACEP guidelines as well as enrollment and feedback strategies for emergency physicians in the Houston area;
- (2) Revision of educational materials based on lessons learned and physician focus group results;
- (3) Launch of EMPainline (www.empainline.org), an American Board of Emergency Medicine (ABEM)-approved, web-based CME/MOC resource targeting emergency physicians' opioid prescribing behaviors.

Project Team

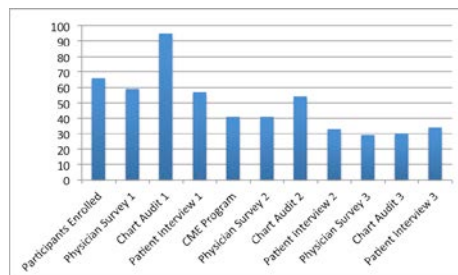
In addition to Dr. Todd and ACEP staff, the project team included Dr. Cielito Reyes-Gibby, PhD, Associate Professor in the Department of Emergency Medicine at MD Anderson Cancer Center, with a background in survey design and epidemiology, and four full or part-time research assistants (Danielle Campbell, Neera Gupta, Zeena Shalal, and Diem Nguyen).

³ Todd KH, Cowan P, Kelly N, Homel P. Chronic or recurrent pain in the emergency department: a national telephone survey of patient experience. *Western Journal of Emergency Medicine* 2010;11(5):409-416.

A number of emergency department medical directors and practicing physicians in the Houston area provided invaluable feedback in the formative stages of our project. The project benefited from participation by a number of emergency physicians at the following hospitals: MD Anderson, Baylor/Ben Taub, San Jacinto Methodist, Memorial Hermann, Methodist TMC, St. Lukes, and a number of free-standing emergency centers. Finally, Robert Batte and his team at CE Symmetry supported the development of our final website and video offerings.

Data Sources/Collection

For the Houston area project, we enrolled 66 emergency physicians from hospital and freestanding emergency departments. Participants completed a variable number of attitudinal and practice surveys (total 129 surveys), performed 178 chart audits, and conducted 124 patient interviews over the course of the pilot.



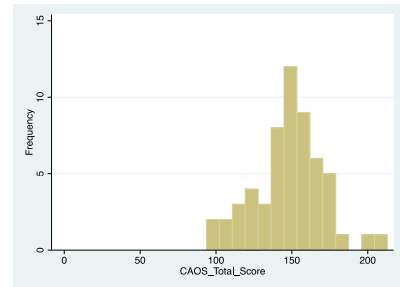
- **Physician Surveys:** A number of vignettes and attitudinal assessments using various physician response categories were examined and piloted over the course of the project.
 - **Patient Vignettes:** Two patient vignettes are currently used in our materials, one intended to represent an emergency department patient at lower risk, and one at higher risk, for prescription opioid misuse and abuse. Ultimately, in our physician response items, we chose to focus on clinicians’ opioid prescribing patterns and utilization of prescription drug monitoring programs as feasible targets for practice change. Patient vignettes and physician response options are reproduced in Appendix A.
 - **Attitudinal Assessments:** Emergency physician attitudes toward opioid prescribing vary within small geographic areas and even within individual practice groups. Opioid-related attitudes are predictive of prescribing habits, and assessments of these beliefs are important to our understanding of educational interventions targeting clinician behaviors. The national increase in opioid prescribing and related adverse effects over the past two decades has only heightened the importance of this understanding.

In exploring attitude and belief instruments applicable to emergency medicine, we reviewed the recently published Clinician’s Attitudes and Belief About Opioid Survey (CAOS), developed by Dennis Turk’s research team at the University of Washington.⁴ The CAOS is a 38-item instrument that includes five subscales (Impediments and Concerns,

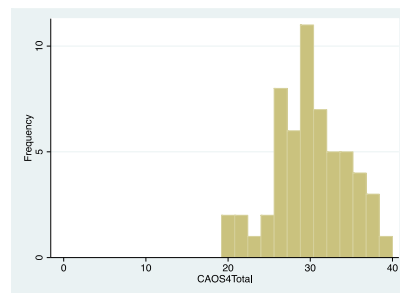
⁴ Wilson HD, Dansie EJ, Kim MS, et al. Clinicians’ Attitudes and Beliefs About Opioids survey (CAOS): instrument development and results of a national physician survey. *Journal of Pain* 2013;14:613-627.

Perceived Effectiveness, Medical Education, Schedule II vs. III Opioids, and Tamper Resistant Formulations and Dosing).

After eliminating a number of items with insufficient applicability to emergency medicine or lacking face validity, we administered 25 items from two CAOS subscales (Impediments and Concerns, Perceived Effectiveness, possible range 0-250) to 57 physicians in the Houston area. The distribution of these responses can be seen in the graph at the right (higher scores indicate more negative opioid-related beliefs).

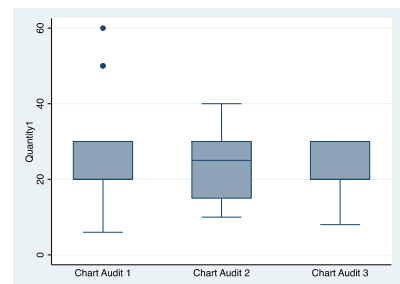


Feedback from our physicians indicated that survey materials were too labor intensive and that wording of many items seemed redundant and often irrelevant to emergency medicine practice. We subsequently modified four items from the Impediments and Concerns subscale to include in our final assessment materials. These responses have a similar distribution to the longer version with most subject responses in the more opioid-negative belief areas of the total score range (possible range 0-40).



- **Chart Audits:** The team developed successive iterations of chart audits to be performed by pilot participants. We initially included multiple variables related to patient presentation, co-morbidities, and physician behaviors, but ultimately focused on key prescribing behaviors, including the number of unit doses of opioids prescribed at discharge, whether PDMP queries were performed, and whether opioid storage and disposal institutions were provided to patients.

As shown in the graph to the right, although unit doses prescribed at discharge declined over the course of three rounds of chart audits, these changes were clinically and statistically insignificant (Audit 1: 25.9 doses, Audit 2: 22.9 doses, Audit 3: 22.7 doses). If pre-education (Audit 1) and post-education (Audit 2 and 3) dose amounts are combined, dose amounts fell by an average of only 3 doses (Pre: 25.9 doses vs. Post: 22.8 doses, $P=0.2$). Whether feedback was given appeared to have little impact on dosing decisions; however, difference in ED characteristics and inability to control for multiple patient variables limit our ability to conclude this with certainty. Notably, chart documentation very rarely indicated that clinicians



had either queried the Texas PDMP or provided opioid storage and disposal instructions to patients.

After pilot testing, with feedback from individual participants and focus group results, we limited chart audit assessments to ten items, four of which are the specific focus of our ongoing practice change efforts. These include the quantity of opioid doses prescribed at discharge, whether the PDMP was queried, and whether oral and written opioid storage and disposal instructions were given. See Practice [Improvement Chart Audit Tools \(pre and post\)](#) on the EMPainline website (Additional Practitioner Resources page).

- **Patient Interviews:** With input from our pilot participants, a patient interview tool and script were developed. We used 15 questions for our pilot, including items about the patients' type and intensity of pain, satisfaction with care, whether discharge prescriptions met patient expectations, opioid storage practices, and plans for opioid disposal.

One-hundred and twenty-three patient interviews contained analyzable data. Approximately 60% of patients presented to the ED with acute pain, while 40% presented with chronic or recurrent pain. By the time of telephone interview, 18% of patients had experienced complete pain relief after their ED visit, while 52% experienced "moderate" or "a lot" of relief. Thirty percent of patients reported "only slight" relief, or that their pain was the "same" or "worse." Most (74%) of patients were "satisfied" or "very satisfied" with their ED pain care, while 14% were "dissatisfied" or "very dissatisfied" while 12% were "neutral." Two-thirds of patients received a prescription opioid at discharge and almost all filled these prescriptions.

Regarding opioid storage and disposal, only 4% kept them "under lock and key." Another 66% kept their opioids "hidden from view," while 30% stored in them "on a counter or somewhere out in the open." Only 19% of patients recalled receiving opioid storage instructions.

Interestingly, only 8% of those receiving opioid prescriptions felt they received more than they needed, while two-thirds of patient had prescription opioids remaining at the time of interview. Thirty-one percent of patients felt they received less than they needed. Remaining pill amounts were small (mean 10 doses, range 1-25 doses). Only 6% planned to dispose of their prescription opioid (flush down the toilet or throw in trash). The majority (80%) planned to save them for use if the pain returned. Only 4 of 123 patients recalled receiving opioid disposal instructions in the ED.

Although asking emergency physicians to interview patients after ED discharge may well be a powerful exercise to alter physician behavior, it proved impractical within the current effort. Privacy concerns, as well as the labor-intensive nature of conducting telephone interviews, argued against the feasibility of including this step in our final ABEM-approved curriculum. Ultimately, chart audits conducted

by the treating physician were judged to be the most feasible method of assessing physician practice.

Physician Focus Group

Our staff conducted a 90-minute focus group with ten project participants on February 26, 2015. The purpose of the focus group was threefold: a) to gather information and generate feedback about their experiences while participating in the pilot project; b) to gauge their attitudes about prescribing opioids and related practices; and, c) to gather suggestions for the next iteration of the project, including content ideas and specific user navigation tips for the EMPainline website.

In general, most participants reported a positive overall experience with the project. When asked about project deliverables (surveys, questionnaires, and chart audits) participants made multiple suggestions regarding the usefulness and accuracy of specific vignettes, question wording and response items, and they highlighted specific areas of the site that needed improving with regard to the user interface. In addition, participants commented favorably on the education portion of the project and generated many useful ideas for improvement, including expanded video and interactive functionality.

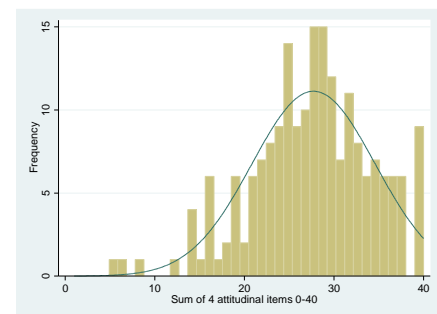
Participant attitudes varied widely with regard to prescribing opioids, providing disposal instructions to patients, using prescription drug monitoring programs and ABEM's Maintenance of Certification process. However, a productive discussion resulted in several excellent suggestions, including providing physicians with examples and modeling of patient conversations.

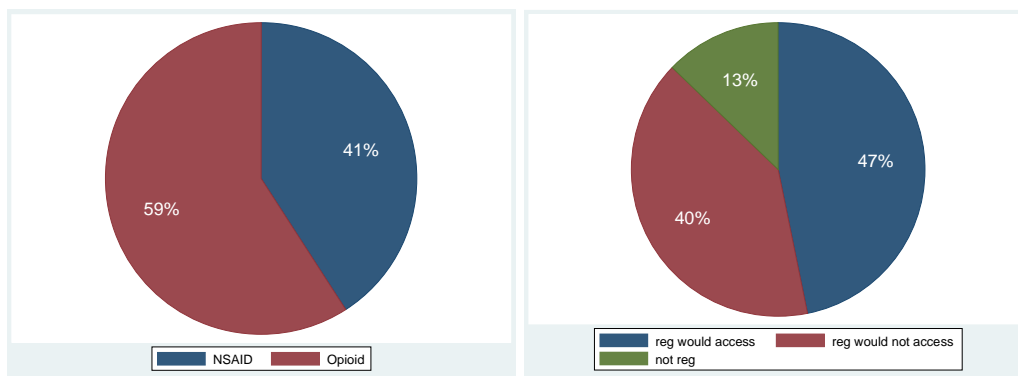
National Emergency Physician Survey

In September 2015, we obtained benchmark data on expert emergency physician opioid-related decision-making, taking advantage of American College of Emergency Physician's Emergency Medicine Practice Research Network (EMPRN). EMPRN is a nationally representative online panel of over 1,000 emergency physician members. ACEP staff disseminated EMPainline physician survey materials (including patient vignettes and attitudinal instruments) to EMPRN members, receiving 204 responses. These results were used to provide peer (and perhaps, best practice) feedback to individual participants enrolled in EMPainline CME/MOC training.

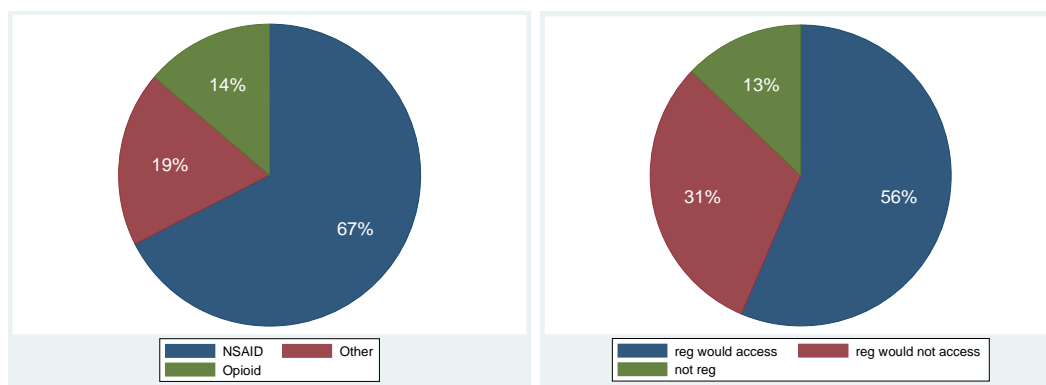
Respondents practiced in 44 states within the U.S. and, similar to the national gender distribution of emergency physicians, 21% were female. The distribution of attitudinal scores is shown at right, and the median score was 28 (range 5-40).

For the low risk vignette, almost 60% of respondents would prescribe opioids, generally between 10-20 unit doses. 87% of respondents were registered for a PDMP and 47% would query one in this case.





For the high-risk vignette, only 14% of respondents would prescribe small amounts of an opioid, and the majority (56%) would query the PDMP.



EMPainline MOC/CME Curriculum Revision

Our pilot curriculum was tied closely to the published ACEP Opioid Prescribing Guidelines, developed with support from the Centers for Disease Control and Prevention and with input from the Food and Drug Administration. Segments of our original online presentations are included on the [“CME Resources”](#) page of the EMPainline site, including two presentations entitled, ACEP Opioid Guidelines, and PAT Registration and Report Generation.

The ACEP clinical policy addressed four “critical questions” related to opioid prescribing in the ED:

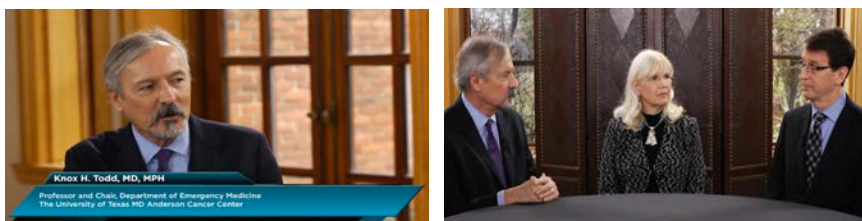
1. In the adult ED patient with non-cancer pain for whom opioid prescriptions are considered, what is the utility of state prescription drug monitoring programs in identifying patients who are at high risk for opioid abuse?
2. In the adult ED patient with acute low back pain, are prescriptions for opioids more effective during the acute phase than other medications?
3. In the adult ED patient for whom opioid prescription is considered appropriate for treatment of new-onset acute pain, are short-acting schedule II opioids more effective than short-acting schedule III opioids?

4. In the adult ED patient with an acute exacerbation of non-cancer chronic pain, do the benefits of prescribing opioids on discharge from the ED outweigh the potential harms?

Although the ACEP guidelines were an appropriate response to the problem of prescription opioid abuse and misuse, they are based on limited evidence and one question (#3) became irrelevant as opioid scheduling changed soon after the guidelines were published.

In response to lessons learned from our pilot projects, individual participant feedback, and focus group, our staff revised our original curriculum, choosing to emphasize key messages regarding risk assessment, prescribing practice, and opioid storage and disposal. With nationally recognized emergency physicians and patient advocates, we produced online lectures and expert commentary to deliver our revised curriculum and to model best practices. In addition to Dr. Todd, who served as facilitator and moderator, our video products included Dr. Eric Legome, Chief of Emergency Medicine at Kings County Hospital in New York, Dr. Lewis Nelson, Fellowship Director of the New York City Poison Center, and as well nationally recognized patient advocate, Penney Cowan, Founder of the American Chronic Pain Association.

Video segments served to highlight specific points related to the CME/MOC curriculum and to model best practices in risk assessment and pain management related to prescription opioid decision-making.



In addition to one hour of ACCME accredited CME, the EMPainline team applied for and received approval from the American Board of Emergency Medicine to certify that completion of EMPainline practice improvement activity met board requirements for maintenance of certification (MOC). (See Appendix C)

Current EMPainline Online Curriculum and Early Results

The EMPainline website, including the Prescription Opioid CME/MOC curriculum, is now online and in its beta testing phase. In the first month it has received approximately 1,700 hits and 200 unique visits. Thus far, 19 physicians have enrolled in the MOC process, with 7 having the completed the program and receiving ABEM MOC practice improvement certification.

Opioid-related attitudinal scores before and after education were similar (pre 28, post 26, on the 0-40 scale). This is an expected result, as clinicians opioid-related attitudes are somewhat fixed, and the primary target of our effort is to influence physicians' behaviors.

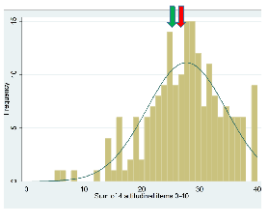
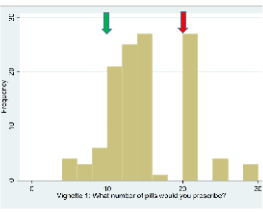
For the low-risk vignette, approximately 70% of physicians in both pre and post surveys would chose to prescribe an opioid, and there was a small decrease in the number of

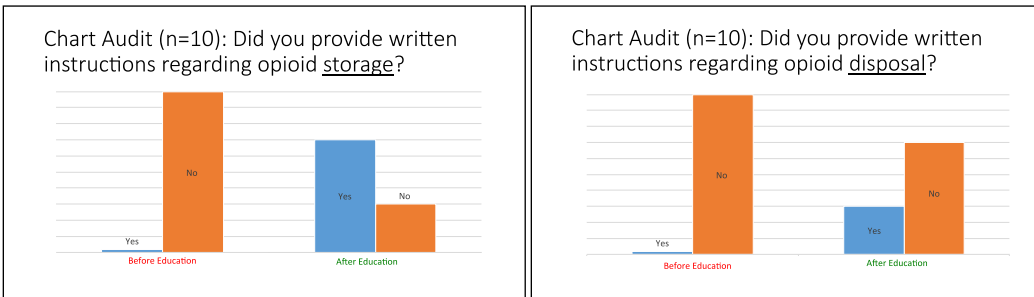
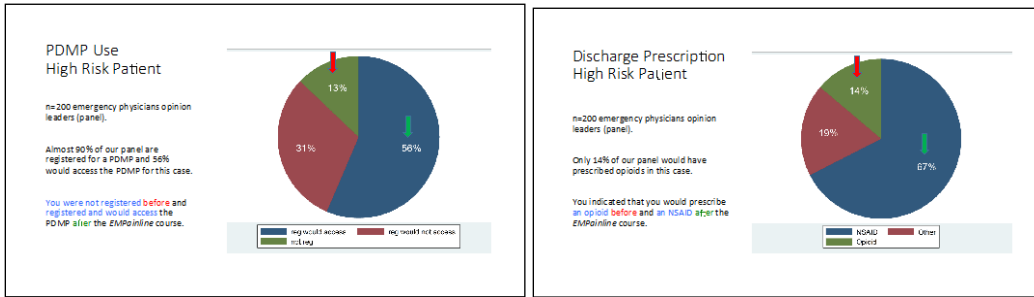
doses prescribed (pre 14, post 12). Approximately one-half of physicians would access an online PDMP in this case (pre 50%, post 57%).

For the high-risk vignette, 80% of physicians indicated they would prescribe an opioid prior to education, while only 14% would do so after completing the course. The average number of opioid doses prescribed per patient dropped markedly (pre 14, post 1.5). Interestingly, fewer physicians would query the PDMP after completing the training (pre 60%, post 43%). Physicians who decide against prescribing opioids may feel that PDMP databases will not affect their decision-making.

Patient chart audit results indicate the more striking changes that may result from exposure to the curriculum. 164 chart audits have been submitted online thus far (pre 90, post 74). Although the average number of opioid doses prescribed per patient were similar in both periods (pre 15, post 18), the number of patients for whom the PDMP was queried increased markedly (pre 6%, post 24%), as did the proportion of patient receiving written instructions regarding both opioid storage (pre 1%, post 62%), and opioid disposal (pre 1%, post 55%).

Participants actively monitor their prescription-opioid practice patterns, auditing cases before and after receiving the EMPainline curriculum. Data from the EMPRN panel survey allows participants to compare their attitudes and practice patterns to those of a national emergency physician panel, and EMPainline video resources allow them to observe expert responses to patient vignettes. A partial sampling of feedback slides sent to individual participants is included below to illustrate our approach:

<p style="text-align: center;"><i>EMPainline</i> Feedback for First/Last</p>	<p>Feedback Overview</p> <p>The <i>EMPainline</i> project included measures of your attitudes toward opioids and questions regarding prescription drug monitoring program (PDMP) registration and use.</p> <p>Two patient vignettes were used, one at lower risk for prescription opioid misuse, and one at higher risk, to assess your prescribing decisions.</p> <p>We compare your responses to results from a national survey of 200 emergency physicians opinion leaders, and show your scores before (red arrows) and after (green arrows) the EMPainline activity.</p>
<p>Opioid Attitudes n=200 emergency physicians opinion leaders (panel).</p> <p>Scores range from 0 (most positive toward opioids) to 40 (most negative toward opioids).</p> <p>The mean and median score for our panel was 28.</p> <p>Your pre-score was near the median of our panel, and your post-score did not change after completing the activity (pre 27, post 28).</p> <p><small>Note: Attitudes toward opioids are often fixed and unchanging. Practice behaviors are more amenable to change interventions.</small></p> 	<p>Opioid Pills Prescribed Low Risk Patient n=200 emergency physicians opinion leaders (panel).</p> <p>Our national panel would have prescribed approximately 35 opioid doses in this case.</p> <p>You indicated that you would prescribe 20 opioid doses before and 10 doses after the EMPainline course.</p> 



- ### Suggested Practices Based on Your Performance

 1. Register for a PDMP and use it in your practice.
 - ✓ For Texas physicians, open this hyperlink and follow the instructions: [Prescription Access in Texas](#)
 - ✓ For non-Texas physicians, open this link to find the PDMP site for your state: [PDMP Training and Technical Assistance Center](#)

Suggested Practices Based on Your Performance

 2. Provide oral and written opioid storage and disposal instructions to your patients.
 - ✓ Open this hyperlink and print out copies of the brochure for your patients: [Patient Opioid Safety Brochure 2015](#)
 - ✓ The following slide provides a script you can use as you give the patient written instructions.

Example Script

"Ms. Jones, when you take your prescription home, keep it where only you have access to it. Don't keep it with your other medications. A locked cabinet or high shelf is best. That way, you can be sure it won't be taken by someone else. Never leave loose pills out on the kitchen counter, or a night stand, or a coffee table. If your pain goes away and you have pills left over, don't keep them around the house. Get rid of them. One way is to take the pills out of the bottle, mix them in a bag with coffee grounds or kitty litter, and throw them in the trash. Here's a brochure that tells you more."

Results

Conclusions

The major areas of success for the EMPainline effort were to increase awareness of opioid prescribing issues in our pilot population, develop user-tested curricula to engage the emergency physician audience as well as assessment and feedback tools to change their practice, and importantly, obtain institutional recognition and accreditation by the American Board of Emergency Medicine for our practice improvement activity (thus tying our project to board certification renewal for all emergency physicians). This is the

first practice improvement activity approved by ABEM that addresses opioid prescribing in the ED.

Significance

In its present form, the EMPainline website will be available for dissemination through ACEP's multiple channels of communication, including the ACEP website, ACEP News (our monthly news magazine), and EM Today, our online news brief.

Early feedback from our participants has been particularly gratifying. Sample participant comments are included below:

- ❖ *"...you put out a really professional, user friendly, clinically relevant and timely product."*
- ❖ *"Peer profiling has been promised since I was a resident, and you so rarely get it."*
- ❖ *"I think this format of data driven feedback and the addition of concrete suggestions for future improvement that is linked to the feedback data will be really helpful for anyone going through the process."*
- ❖ *"Thanks for putting so much time and effort into really getting this right!!"*

Implications

The EMPainline project provide our staff a wealth of experience to better understand the complicated nature of professional education and the multiple tradeoffs between methodological rigor and user acceptance that are necessary to provide a product that can change real-world physician practice. EMPainline staff are committed to working with physician and patient groups to improve on these efforts. We anticipate that we will identify new targets for practice improvements related to treatment of pain in the ED as well as effort to mitigate opioid adverse effects, including the recognition and management of those with demonstrated prescription opioid abuse and misuse disorders.

Appendix A: Vignettes

Vignette 1 (lower risk):

A 45-year-old female presents with one day of low back pain extending into the buttocks bilaterally. She rates her pain as 10/10. The pain occurred on lifting a toddler while babysitting yesterday. She is visiting from another city in Texas and has taken two 200 mg ibuprofen tablets every four hours for the past day without relief. She plans to return home in 14 days and has a primary care physician. Other than childbirth, her past history is unremarkable. She neither smokes nor drinks and has no contraindications to analgesics. On examination, she is lying on her side and resists movement secondary to pain. You find tenderness bilaterally in the lower back and there is no evidence of muscle spasm or spinal tenderness. Her neurologic exam otherwise appears to be normal. After receiving a total of six milligrams of intravenous morphine she states her pain has improved to 5/10 and she is able to ambulate. You prepare to discharge the patient.

Vignette 2 (higher risk):

A 35-year-old male with a known history of diabetic neuropathy presents on a Friday afternoon with worsening of his chronic bilateral foot pain. He rates his pain as 10/10. The pain is burning and aching in nature and has become worse over the last few days, progressing to the point that he cannot tie his shoes tightly. His physician prescribes pregabalin (Lyrica) and hydrocodone with acetaminophen (Vicodin) for pain and the patient has run out of his Vicodin. His physician is on vacation (with no one covering) but the patient states that he has an office appointment in two weeks. The patient smokes one pack per day and drinks socially. On examination, he has bilateral decreased sensitivity to pin prick below the knees; however, stroking the soles of his feet elicits severe pain. His symptoms improve with six milligrams of intravenous morphine. The patient requests a prescription for Vicodin tablets to manage his pain until his next physician appointment.

Vignette Questions

For both vignettes, the following questions were posed:

- 1. What is your plan for a discharge analgesic prescription?*
- 2. What number of pills/tablets/capsules would you prescribe?*
- 3. On average, how many pills/tablets/capsules would you expect such a patient to consume within the next 14 days? (Indicate number)*
- 4. Would you query an online Prescription Drug Monitoring Program (PDMP), such as Prescription Access in Texas (PAT), prior to writing a prescription in this case?*

Appendix B: Web-Based Resources Resulting from Study

The following resources are all currently available on EMPainline.org. To see an overview of the CME and MOC Educational Pathways, click [HERE](#).

Video Resources

Earlier this year, Dr. Knox Todd was joined on set by several experts in the field of pain management to discuss the topics covered in the CME component of the EMPainline program. Participants include:

- Knox H. Todd, MD, MPH - Program Moderator and Project Director
- Penney Cowan, Founder and CEO, American Chronic Pain Association
- Eric Legome, MD, Chief, Emergency Medicine, Kings County Hospital
- Lewis S. Nelson, MD, Director, Fellowship in Medical Toxicology, New York City Poison Control Center

[Risky Pills or Risky Patients](#)

The discussants provide insight on their views of the role of the medication compared to the role of the patients in the problems associated with opioid prescribing in the ED.

[The Top Three Things to Change in Opioid Prescribing](#)

Our panel discuss the three most important changes needed in prescribing opioids and in interacting with patients in pain.

[Geographic Variability of Opioid Related Issues](#)

Dr. Nelson provides his input on the influence of patient demographics on abuse, misuse and overdose associated with opioid therapy

[Demographic and Resource Issues in Opioid Abuse](#)

Penney Cowan adds her thoughts on the impact of patient factors including education and resources as well as access to care

[Prescription Drug Monitoring Programs - Benefits and Issues](#)

The panel discusses the current status of PDMPs on a state level. There are clearly issues that need to be addressed in order to improve the use of PDMPs, and integration into EMRs will be critical.

[Implementing Prescription Drug Monitoring Programs in the ED](#)

Dr. Legome offers practical insights into the utility of PDMPs and how to increase practitioner use of these instruments.

[PDMP Impact on Opioid Prescribing](#)

Dr. Nelson adds his thoughts on the data that has been generated on the impact of PDMPs on opioid prescribing. He also discusses optional vs. mandatory use of the database when prescribing opioids.

[PDMPs - Mandatory vs Voluntary vs EMR Integrated](#)

The discussion of PDMPs continues and the panel provide their thoughts on the value of

mandatory vs voluntary as well as the tremendous impact of integrating PDMPs into electronic medical records. Also discussed are the biases that impact the use of PDMPs.

[Value of Risk Assessment Tools](#)

It is very common to have agencies recommend a variety of Risk Assessment Tools. The utility of the tools are looked at and surprising recommendations about their use in the ED are presented.

[Strategies for Managing Patient Expectations in Chronic Pain Management](#)

Penney Cowan discusses how she advises chronic pain patients on how they can manage their pain and how to incorporate a complete approach not just pharmaceutical management.

[Strategies for Managing Patient Expectations in Chronic Pain Management - The ED Physician Perspective](#)

Lewis Nelson, MD provides his perspective on the interaction with patients with pain in the ED.

[Results of a Chronic Pain Patient Survey Regarding Visits to the ED for Pain Related Episodes](#)

A review of the Chronic Pain Association survey and their satisfaction with ED visits and physicians. The discussion includes surprising insights into chronic pain patient interactions, imaging studies and the appropriateness of care.

[Press-Ganey Scores Impact on the ED Practitioner Behavior](#)

Lewis Nelson offers insight on the insight on prescriber behavior due to Press-Ganey scores. Do they really change behavior?

[Press-Ganey Scores: Do They Drive Prescriptions?](#)

An interesting discussion on how to increase the patient-practitioner interaction time. Additional resources are called for.

[Opioid Storage and Disposal](#)

The discussants offer thoughts into the critical issues of safe opioid storage and disposal. They also offer insights into the role of communication and other members of the healthcare team.

[Safe Storage of Opioids](#)

Lewis Nelson offers valuable insights into the impact of improper med safety. The discussion addresses written instructions, lock boxes, and general advice on safe storage.

[Safe Storage of Opioids: A Physician-Patient Interaction](#)

An example of a physician/patient interaction regarding the risks associated with improper storage

[The American Chronic Pain Association Advice on Safe Storage of Medication](#)

Penney Cowan reviews the unique methods of communicating to their patients and others about how to utilize safe storage practices of all their pain medications.

[The Dilemma of Prescribing for a Patient Suspected of Drug Seeking Behavior - Part 1](#)
Dr. Legome discusses how he would manage a patient suspected of drug seeking behavior.

[The Dilemma of Prescribing for a Patient Suspected of Drug Seeking Behavior - Part 2](#)
Dr. Nelson adds his insight on this important and difficult clinical interaction

Additional Practitioner Resources

Opioid Prescribing Guideline Materials

- [ACEP Opioid Prescribing Guidelines \(pdf\)](#)
- [Opioid Risk Tool \(editable pdf form\)](#)
- [Patient Pain Contract \(editable pdf form\)](#)
- [Patient Opioid Safety Brochure](#)
- [EMPainline User Guide](#)

Practice Improvement Surveys and Audits: The following tools are replicas of the tools used on the online course material and can be downloaded.

- [Pre-Activity Physician Survey](#)
- [Pre-Activity Practice Improvement Chart Audit](#)
- [Post-Activity Physician Survey](#)
- [Post-Activity Practice Improvement Chart Audit](#)

Additional CME Resources: We have provided a series of additional brief presentations for your convenience. Some expand upon topics covered in the CME component and others will help offer insight that may be helpful while completing the Physician Surveys on the site.

- [ACEP Opioid Guidelines](#)
- [PAT Registration and Report Generation](#)
- [Patient Vignette 1: Expert Review and Discussion](#)
- [Patient Vignette 2: Expert Review and Discussion](#)

Appendix C: American Board of Emergency Medicine Certification Letter



American Board of Emergency Medicine

3000 Coolidge Road
East Lansing, Michigan 48823-6319

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www.abem.org

June 11, 2015

Knox H. Todd, MD, MPH
Robert Batte
EM Painline
1515 Banks Street
Houston, TX 77006

Dear Dr. Todd and Mr. Batte:

The American Board of Emergency Medicine (ABEM) has determined that the EM Painline Prescribing Opioids in the Emergency Department module can be used by ABEM certified physicians toward fulfillment of a current ABEM Maintenance of Certification Assessment of Practice Performance (APP) – Practice Improvement (PI) activity.

EM Painline may advertise that the Prescribing Opioids activity can be used to fulfill an ABEM MOC APP PI requirement. The following statement should be used: "Physicians certified by the American Board of Emergency Medicine may satisfy one current Assessment of Practice Performance requirement by completing this activity." The ABEM logo may not be used. Physicians who have questions about how the activity can fulfill their ABEM MOC requirements should be directed to the ABEM office.

This ABEM affirmation is effective July 1, 2015, and extends through June 30, 2018. At that time, you may apply to renew ABEM affirmation. If the design of the module changes significantly, please notify ABEM and provide documentation describing the new design.

Thank you for submitting an application for ABEM to review an activity that will meet MOC APP requirements. This helps ABEM meet its objective of providing a broader array of options for its certified physicians to participate in practice improvement.

If you have any questions or concerns, please contact the ABEM office at 517.332.4800 ext. 308 or MOC@abem.org.

Sincerely,

Earl J. Reisdorff, M.D.
Executive Director

EJR/LJF/emd

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