IMPLEMENTATION OF PROFESSIONAL EDUCATION AND TRAINING

Dr. Scott Fishman, University of California, Davis
Dr. Sharon Hertz, Food and Drug Administration
Dr. David Thomas, National Institutes of Health

Implementation of the National Pain Strategy Professional Education and Training

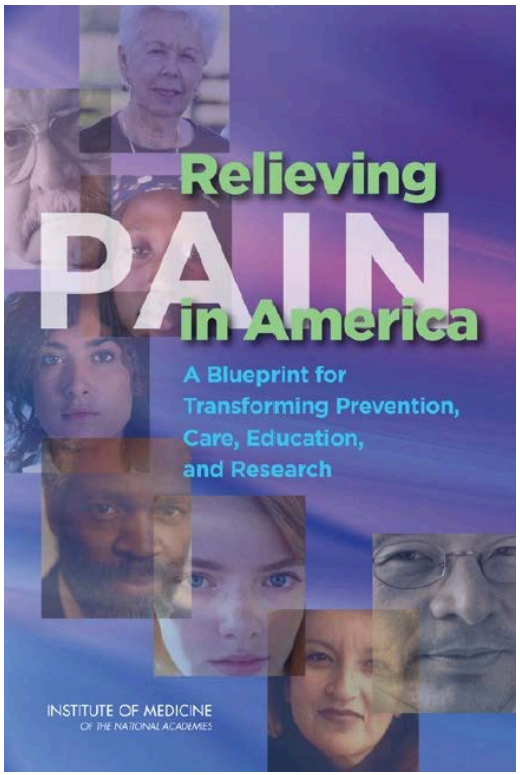
- Scott M. Fishman, MD
- Professor and Chief, Division of Pain Medicine
- Executive Vice Chair, Dept. of Anesthesiology
- Director, Center for Advancing Pain Relief
- University of California, Davis School of Medicine

UC DAVIS HEALTH SYSTEM

Disclosures

- I have No Direct Financial Relationships with drug companies
- I receive NO compensation from industry speakers or consultation programs
- I participate in official CME programs
- I receive royalties from publishers of the books I have authored/edited
- I am…
  - Past President of The American Academy of Pain Medicine
  - Past Chair of The American Pain Foundation Board of Directors
  - Past-Chair/Current Member : Pain Care Coalition
    - American Society of Anesthesiology, American Pain Society, American Academy of Pain medicine

The Problem of Pain in America



- *"There are strong indications that pain receives insufficient attention in virtually all phases of medical education"*

Institute of Medicine (U.S.). Committee on Advancing Pain Research Care and Education. (2011). *Relieving pain in America : a blueprint for transforming prevention, care, education, and research*. Washington, D.C.: National Academies Press.

National Pain Strategy

A Comprehensive Population Health-Level Strategy for Pain

Professional Education and Training

- Demonstration of competency required for:
  - *Licensure, certification, accreditation*
- *Objective: [Overarching Objective]*
  - Develop core competencies
    - Undergraduate and graduate levels
  - The relevant accrediting, certification, and licensing entities should be involved
    - At early planning and subsequent phases

Pain Medicine

Pain Medicine 2013; *: **–**
Wiley Periodicals, Inc.

Core Competencies for Pain Management: Results of an Interprofessional Consensus Summit

Scott M. Fishman, MD,* Heather M. Young, PhD, RN, FAAN,† Ellyn Lucas Arwood, EdD, CCC-SLP,‡ Roger Chou, MD,§ Keela Herr, PhD, RN, AGSF, FAAN,¶ Beth B. Murinson, MS, MD, PhD,†† Judy Watt-Watson, RN, MSc, PhD,¶¶¶ Daniel B. Carr, MD, FABPM, FFPMANZCA (Hon.),‡‡ Debra B. Gordon, RN-BC, MS, DNP, ACNS-BC, FAAN,§§ Bonnie J. Stevens, RN, PhD,¶¶¶ Debra Bakerjian, PhD, RN, FNP,† Jane C. Ballantyne, MD, FRCA,§§ Molly Courtenay, PhD, MSc, BSc, Cert. Ed, RN,**** Maja Djukic, PhD, RN,¶¶ Ian J. Koebner, MSc, MAOM, LAc,* Jennifer M. Mongoven, MPH,† Judith A. Paice, PhD, RN,*** Ravi Prasad, PhD,††† Naileshni Singh, MD,* Kathleen A. Sluka, PT, PhD,** Barbara St. Marie, PhD, RN, ANP, GNP, ACHPN,‡‡‡ and Scott A. Strassels. PharmD, PhD§§§

*Department of Anesthesiology and Pain Medicine, School of Medicine and

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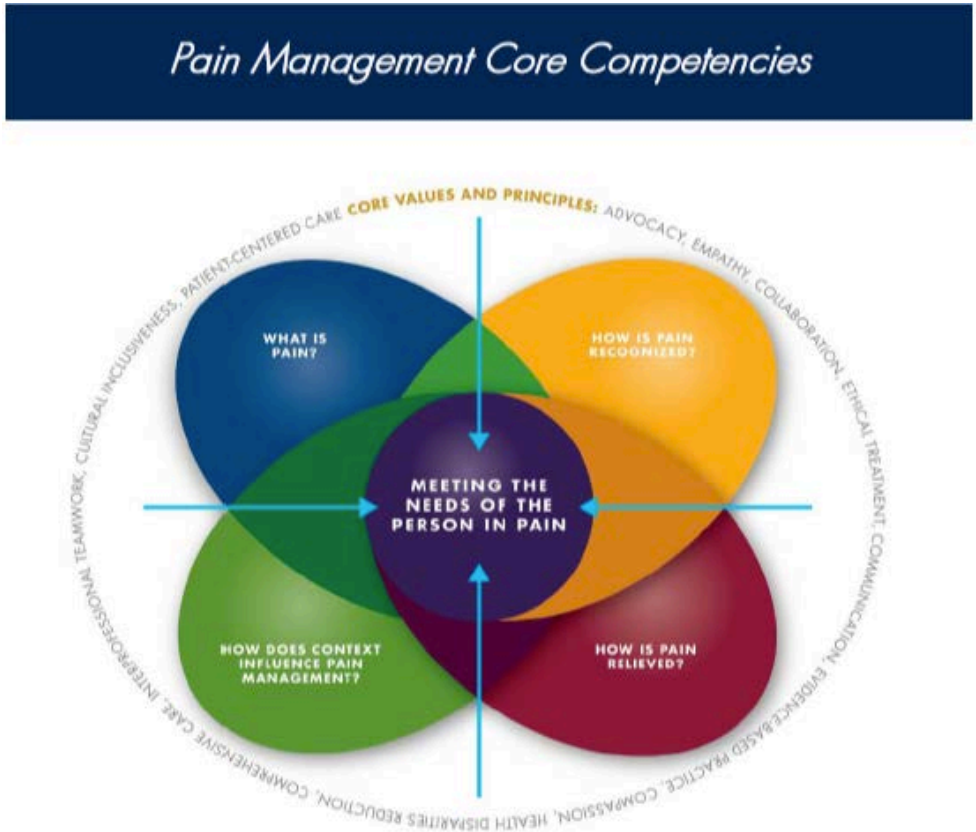
¶¶¶Lawrence S. Bloomberg Faculty of Nursing,



Competencies are the goals of curriculm that serve as the destination for the journey of education

Pain Management Core Competencies

ENDORSEMENTS

American Academy of Pain Medicine, American Pain Society, Commission on Collegiate Nursing Education, Council on Social Work Education, International Association for the Study of Pain, National Association of Social Workers, American Council of Academic Physical Therapy

SUPPORT

American Association of Medical Colleges, American Psychological Association, American Nursing Association, others

USMLE®

UNITED STATES MEDICAL LICENSING EXAMINATION ®

- November 2014
- A blue ribbon panel of 12 internationally recognized experts in pain a review of the USMLE exam for inclusion of pain competencies
- Secure Review at NBME Headquarters in Philadelphia

USMLE Pain Review

- Dan Carr, MD (AAPM President-elect Member, Professor-Tufts)
- Martin Cheatle, PhD (Pain Psychologist, Penn)
- Scott Fishman, MD (AAPM Past President, Professor- UC Davis)
- Rollin Gallagher, MD (AAPM Past President, National Director for Pain Management VAHS, Professor-Penn)
- Joanna Katzman, MD (Director of Pain Medicine and Pain ECHO, Professor, University of New Mexico)
- Beth Murinson, MD, PhD(AAPM BOD – Professor-John Hopkins)
- Sean Mackey, MD, PhD (AAPM President & Chief of Pain Medicine, Professor- Stanford)
- Rosemary Palomano, PhD, RN (University of Pennsylvania School of Nursing)
- Adrian Popescu, MD (Deputy Director for the National Pain Management VA Health System)
- Jim Rathmell, MD (ASA BOD and Pain Committee, Chief of Pain Medicine, Professor-Harvard/MGH)
- Rick Rosenquist, MD (ASA Pain Committee Chair, Past President of ASRA, Professor, Cleveland Clinic)
- David Tauben, MD (Chief, Pain Medicine, Professor, Univ. of Washington)

- Submitted for Publication
  - Under Review/ Embargoed
  - Not for Distribution

Pain Medicine Advance Access published August 24, 2016

Pain Medicine 2016; 0: 1–3
doi: 10.1093/pm/pnw216

OXFORD

Commentary

Driving Needed Change in Pain Education

Despite public health crises of prescription opioid abuse and inadequate treatment of pain, despite calls from blue-ribbon panels for better clinician training in pain and pain treatment, and despite earnest efforts by individual clinicians, professional societies, and educators, we have failed to provide high-quality pain management training for our nation's health professionals [1,2]. The 2013 Institute of Medicine report on Pain in America stated, "Education is a central part of the necessary cultural transformation of the approach to pain," and recommended improving the curriculum and education for health care professionals [1]. The 2016 National Pain Strategy from the US Department of Health and Human services concurred: "Most health care professions' education programs devote little time to education and training about pain and pain care" [2].

Why have we not made more progress educating clinicians about pain when, ironically, pain is so prevalent in

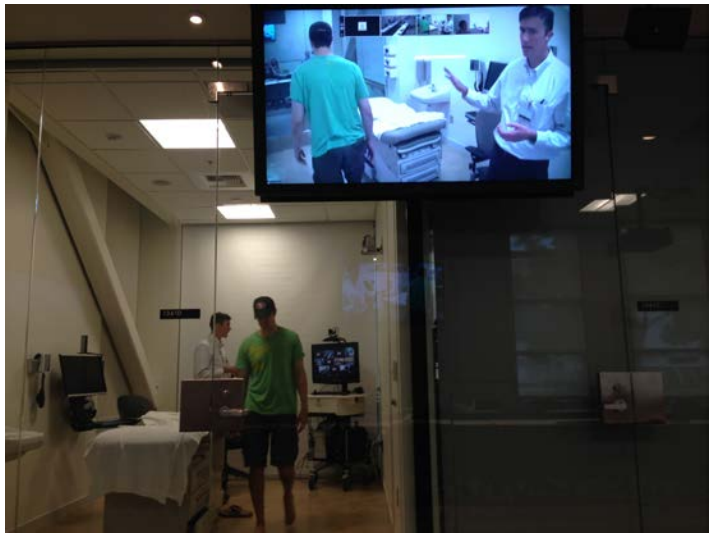
the outcomes of this education with the most compelling drivers and enforcers of change in curricula at medical schools and schools for other health professions—the accreditors and testing organizations. According to The Liaison Committee on Medical Education (LCME), which accredits medical schools, "The accreditation process requires a medical education program to provide assurances that its graduates exhibit general professional competencies that are appropriate for entry to the next stage of their training and that serve as the foundation for lifelong learning and proficient medical care" [3]. Given the ubiquity of pain in clinical settings, it is difficult to understand how medical education programs can be required to demonstrate "general professional competencies" without requiring competency in pain management.

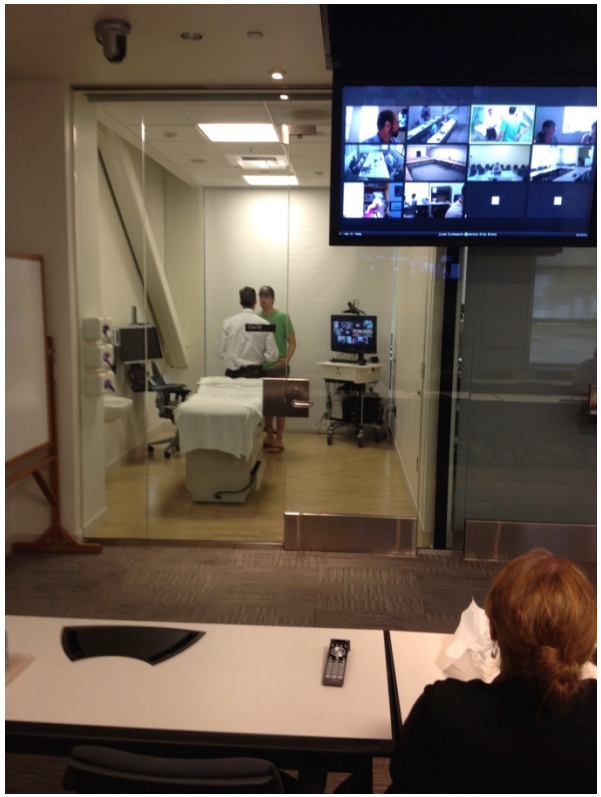
Indeed, because pain is one of the most common reasons for a health care visit, pain management skills and knowledge should be a substantial component of general professional competencies. Yet accreditors of health

Fishman SM and Young HM:
Pain Medicine. 2016 Oct;17(10):1790-1792

Addressing the Education Gap in Practicing Clinicians

- ECHO Tele-Mentoring
  - Improving pain competency in primary care communities





UC Davis ECHO®
Pain Management

- Peer-to- peer Tele-Mentoring program
- Fosters primary care centers of excellence in pain management
- Videoconference sessions held weekly
  - 75 minutes
  - Didactic presentations, demonstrations, and case discussions

Addressing the Education Gap in Practicing Clinicians

- ECHO Tele-Mentoring
  - Improving pain competency in primary care communities

- Primary Care Pain Fellowships- TNT
  - Training New Trainers who will lead and perpetuate pain education for their primary care communities

UC Davis TNT Primary Care Pain Fellowship

Overview of Program

Train New Trainers Primary Care Pain Management Fellowship

A UC DAVIS HEALTH PROGRAM

Expanding and Optimizing the Chronic Pain Management Workforce

Overview

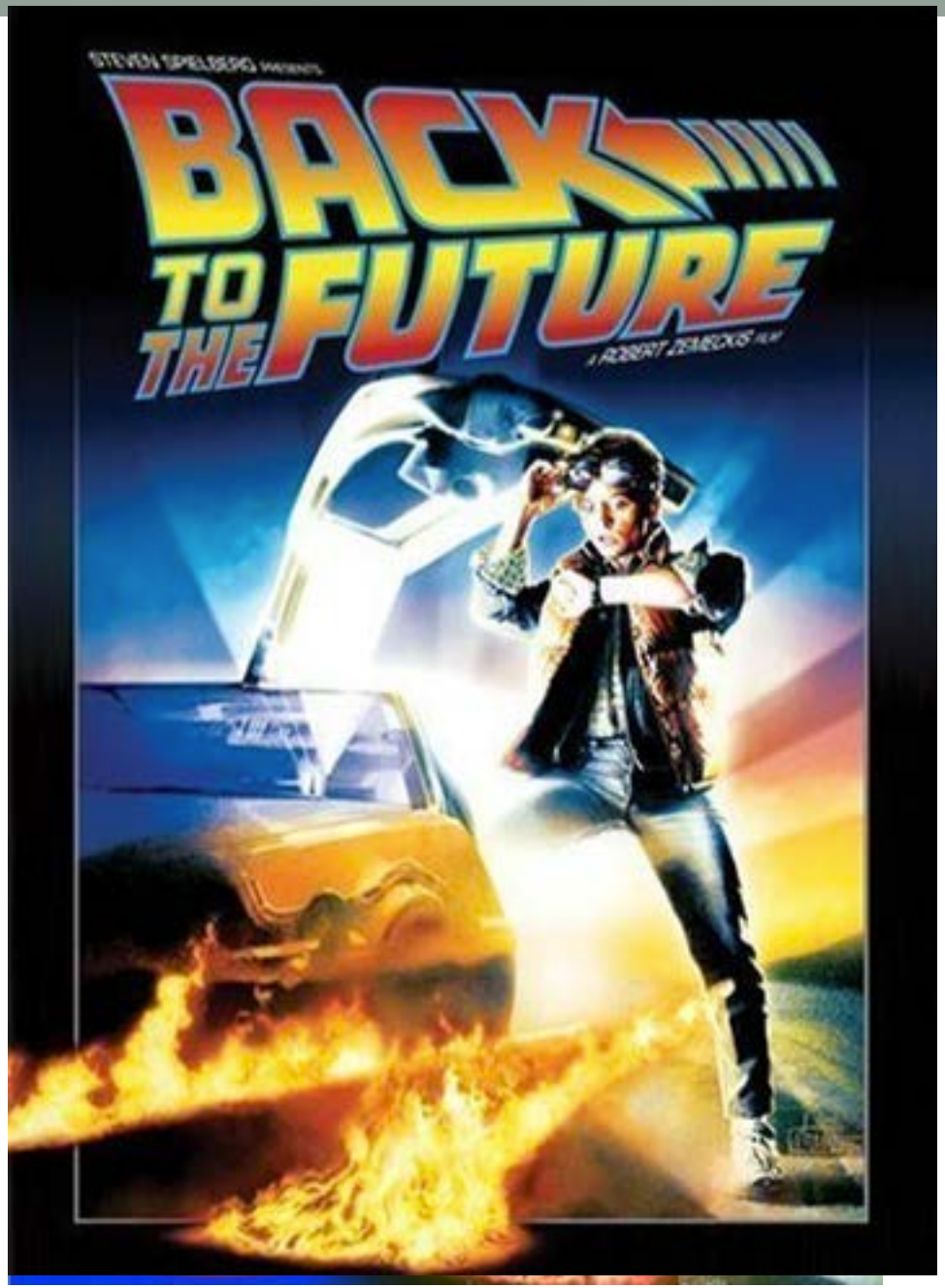
Pain is the most common reason a patient seeks heath care yet it is not widely included in health education or a high research priority. While more than 100 million Americans suffer in chronic pain costing more than $600 billion per year, and prescription drug abuse mounts, there is an increasing expectation that primary care clinicians are competent at diagnosing and treating pain. The problem is that most were never adequately trained.

Primary care clinicians from all professions are responsible for the large majority of pain care, and often struggle with how to most effectively prescribe pain medications The UC Davis Train New Trainers (TNT) Primary Care Pain Management Fellowship will provide primary care providers with the training, mentorship and evidence-based clinical resources needed to provide safe and cost-effective pain care.

Fellowship Core Training

Over 50 hours of training during non-work hours and will lead to a certificate of completion from the UC Davis Division of Pain Medicine and the UC Davis Center for Advancing Pain Relief.

1. *Two weekend teaching sessions (20-24 CME hours);*
2. *One hour per month of individualized, in person or teleconferenced mentoring sessions with a pain management fellowship faculty member / mentor (12 non-CME hours);*
3. *Live, case-based discussions and patient interviews with a focus on integrated primary care pain management on a twice per-month basis (20 CME hours).*
4. *Join faculty in once a week office Hours to ask questions and receive both group and individualized mentorship remotely with our faculty.*


BACK
TO THE FUTURE

National Pain Strategy

A Comprehensive Population Health-Level Strategy for Pain

- NPS calls for <u>improving pain education</u>
  - Assuring clinicians are competent
    - *Prelicensure Education*
      - Affirm Core Competencies
      - Engage Accreditors and Licensing Bodies
        - Multi-Professional Issue
          - Example in Medicine
            - – LCME, USMLE, ACGME
          - Parallel examples in Nursing, Pharmacy, Physical Therapy, etc.

National Pain Strategy

A Comprehensive Population Health-Level Strategy for Pain

- NPS calls for <u>improving pain education</u>
  - Assuring clinicians are competent
    - *Postgraduate Clinicians*
      - Novel competency based education programs
        - National networks for tele-mentoring
        - TNT PC Fellowships
          - CMS Incentives
            - for primary care practices that invest in pain education/competency

- THANK YOU
- smfishman@ucdavis.edu

Update on Opioid Analgesic REMS: Professional Education and Blueprint

Sharon Hertz, MD
Division of Anesthesia, Analgesia, and Addiction Products
Office of New Drugs
Center for Drug Evaluation and Research

Implementation of the National Pain Strategy
Listening Session
May 11, 2017

Outline

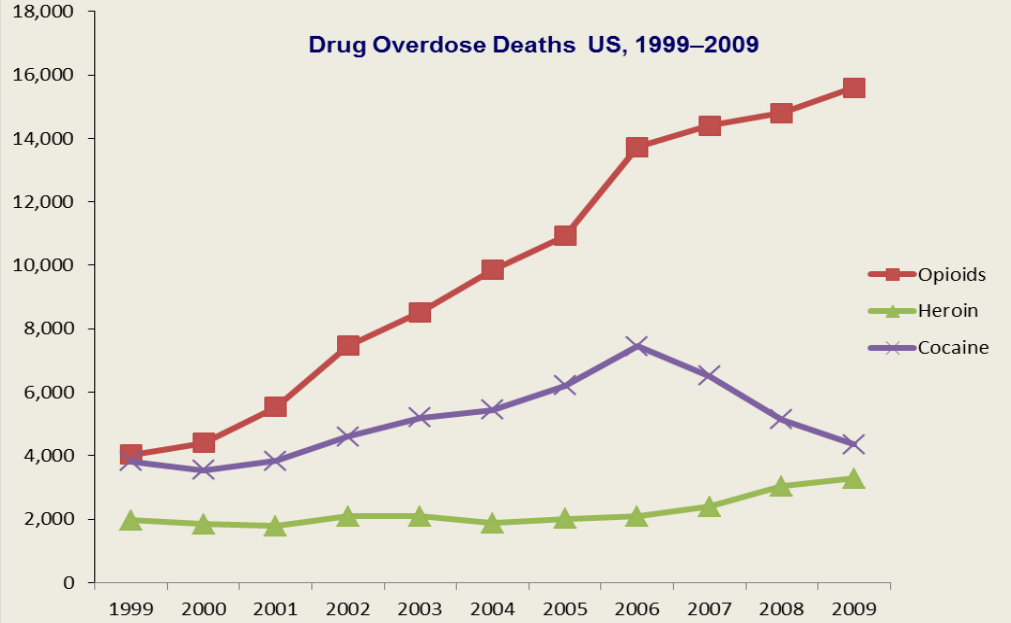
- Background on risk evaluation and mitigation strategies (REMS)
- History of risk management for extended-release and long-acting (ER/LA) opioid analgesics
- Recommendations from the May 3-4, 2016 Joint DSaRM and AADPAC Meeting
- Current status of the ER/LA opioid analgesic REMS
- Draft revisions to the FDA Blueprint for Prescriber Education for ER/LA Opioid Analgesics

REMS 101

- A REMS is a required risk management plan that utilizes risk mitigation strategies beyond FDA-approved professional labeling
- Food and Drug Administration Amendments Act of 2007 provided FDA the legal authority to require a REMS for applicable drugs if FDA determines a REMS is needed to ensure the benefits of the drug outweigh the risks
- REMS are developed and after approval by FDA are implemented by the drug manufacturers
- Elements to Assure Safe Use (ETASU)
  - Of the 6 possible ETASU, certification and/or **specialized training of HCPs** who prescribe the drug(s)

History of Opioid Analgesic Risk Management

- Early 2000s, reports of prescription opioid abuse, especially ER formulations.
- Progression of added warnings to product labeling and Risk Management Plans
- 2009 FDA notification of requirement for a REMS, followed by a number public meetings, advisory committee meeting, and public docket to get stakeholder input.



Source: National Vital Statistics System

ER/LA Opioid Analgesic REMS

- FDA approved the Shared System REMS on July 9, 2012
  - 24 sponsors / ~ 60 applications (NDA and ANDA)
- Goal - To reduce serious adverse outcomes resulting from inappropriate prescribing, misuse, and abuse of ER/LA opioid analgesics while maintaining patient access to pain medications. Adverse outcomes of concern include addiction, unintentional overdose, and death.
- Primary component - Manufacturers required to make training available to prescribers of ER/LA opioid analgesics by providing unrestricted grants to continuing education (CE) providers to develop CE based upon the FDA Blueprint

Prescriber Training

- REMS-compliant training:
  - Offered by an accredited CE provider
  - Includes all elements in the FDA Blueprint, knowledge assessment
  - Subject to independent audit
- Training voluntary
  - FDA supported mandatory training linked to DEA registration as proposed in the Administration's comprehensive plan to address the epidemic of prescription drug abuse in April 2011
- In 2012, FDA estimated total number of ER/LA opioid prescribers at 320,000
- Training target – 25% March 2015, 50% March 2016

Assessment of the ER/LA REMS

- Advisory Committee meeting held on May 3-4, 2016 to obtain input on whether the REMS was meeting its goals
  - key assessment findings were presented
- FDA also sought input from the committees on:
  - Alternative methodologies for evaluating the program
  - Whether the FDA Blueprint should be revised and/or expanded
  - Whether to expand the REMS program to include IR opioid analgesics
  - Need for additional modifications to the REMS

https://www.fda.gov/AdvisoryCommittees/CommitteesMeetingMaterials/Drugs/DrugSafetyandRiskManagementAdvisoryCommittee/ucm486856.htm

HCP Participants in REMS-Compliant Training

- Over 400, 000 HCPs participated in or completed REMS CE training, many of which were not prescribers targeted for the education.
  - These numbers are impressive for a program that is voluntary
  - 67% primary care, 13% pain specialists
- The reason that ER/LA opioid analgesics prescriber targets were not met is not entirely clear, possibilities include:
  - Multiple sources of education on opioids some that are mandated by states or employers
  - Scope of the training was narrowly focused on ER/LAs
  - Not required in order to prescribe

Advisory Committee Recommendations

The majority of the committee members recommended modifications to the REMS:

- Extend REMS requirements to the IR opioid analgesics
- Broaden education to include pain management
- Extend the training to other HCPs involved in the management of patients with pain
- Integrate the REMS education with mandatory education provisions

Updating the ER/LA Opioid REMS

- On January 25, 2017, all affected sponsors were informed of the Agency's intention to require a REMS for IR and ER/LA opioid analgesics.
- Exploring mechanisms to make training material appropriate for all HCPs involved in patient care.
- Considering ways to broaden the FDA Blueprint: additional background on pain management; broad principles of acute and chronic pain management; non-pharmacologic treatments for pain; and pharmacologic treatments for pain (both non-opioid analgesic and opioid analgesic)

Development of Blueprint Revisions

- Searched existing opioid/pain management training for six disciplines (prescriber, pharmacist, nurse, pain educator, dentist, and federal agency)
  - Identified relevant professional associations, state societies, CE vendors; reviewed each organization's website for pain management CE courses.
  - Compiled key information from relevant courses: title, key objectives, content, length, live or online.
- Identified courses that could serve as models or provide useful information for the revised blueprint.
- Based on the material reviewed, developed an outline with key messages.

Updating the ER/LA Opioid REMS

- On May 9, 2017, FDA made available for public comment draft revisions to the FDA Blueprint*.

  https://www.fda.gov/Drugs/NewsEvents/ucm553931.htm
- Seeking stakeholder input on the FDA Blueprint through a public docket.

*On May 9-10, 2017, FDA held a public workshop to discuss how best to ensure that HCPs receive training in pain management and the safe use of opioids https://www.fda.gov/Drugs/NewsEvents/ucm538047.htm. The Blueprint was made available to provide context for this public workshop and was not a discussion topic at the workshop.

Outline of Draft Revisions to the FDA Blueprint

SECTION 1: THE BASICS OF PAIN MANAGEMENT

- **I. DEFINITIONS AND MECHANISMS OF PAIN**
- **II. ASSESSING PATIENTS IN PAIN**

SECTION 2: CREATING THE PAIN TREATMENT PLAN

- **I. COMPONENTS OF AN EFFECTIVE TREATMENT PLAN**
- **II. NONPHARMACOLOGIC THERAPIES**
- **III. GENERAL PRINCIPLES OF PHARMACOLOGIC ANALGESIC THERAPY**
  - A. Non-opioid analgesics and adjuvant medications
  - B. Opioid analgesics
- **IV. MANAGING PATIENTS ON OPIOID ANALGESICS**
  - A. Initiating treatment with opioids – acute pain
  - B. Initiating treatment with opioids – chronic pain
  - C. Periodic review and monitoring for patients on opioid analgesics
  - D. Long-term management
  - E. When to consult with a pain specialist
  - F. Medically directed opioid tapering
  - G. Importance of patient education
- **V. ADDICTION MEDICINE PRIMER**

Next Steps for the ER/LA Opioid Analgesic REMS

- FDA will consider public comments to the Blueprint docket as it considers possible modifications to the ER/LA Opioid Analgesic REMS.
  - Docket closes July 10, 2017
- FDA will work with the manufacturers to ensure a timely REMS modification.

Thank you

David A. Thomas, Ph.D.
NIDA/NIH Pain Consortium

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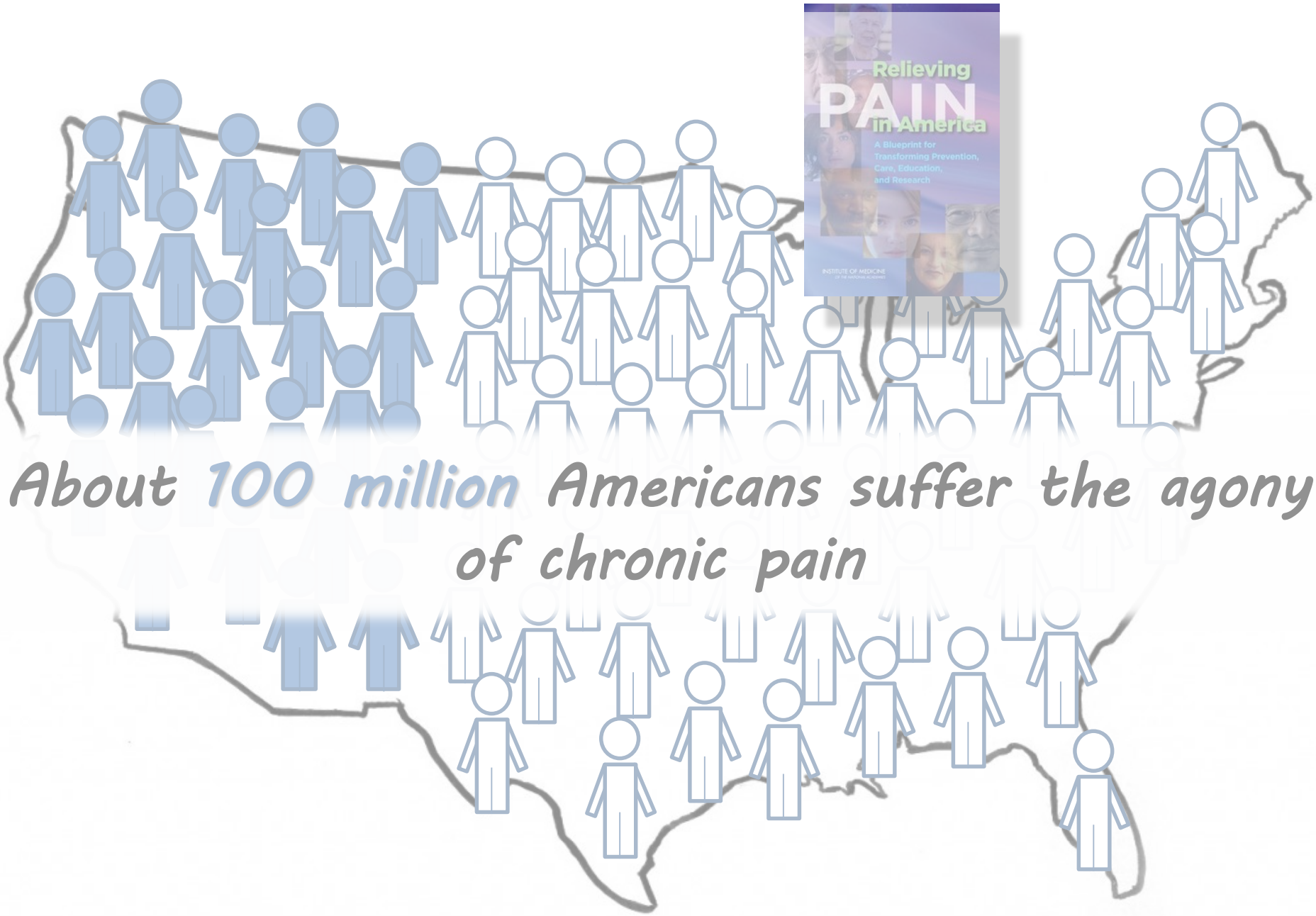
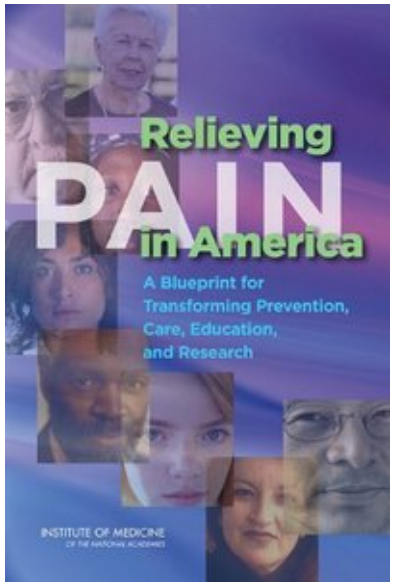
301 435 1313

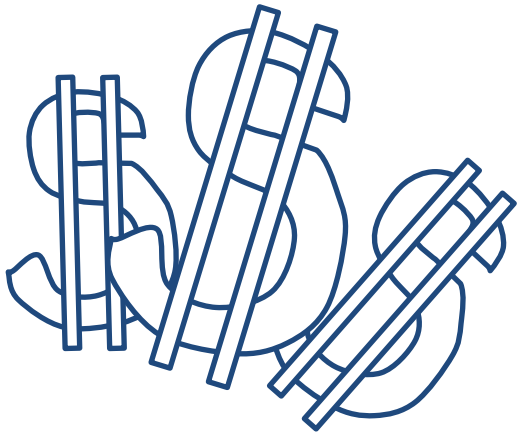
National Institute on Drug Abuse
The Science of Drug Abuse & Addiction



About 100 million Americans suffer the agony of chronic pain



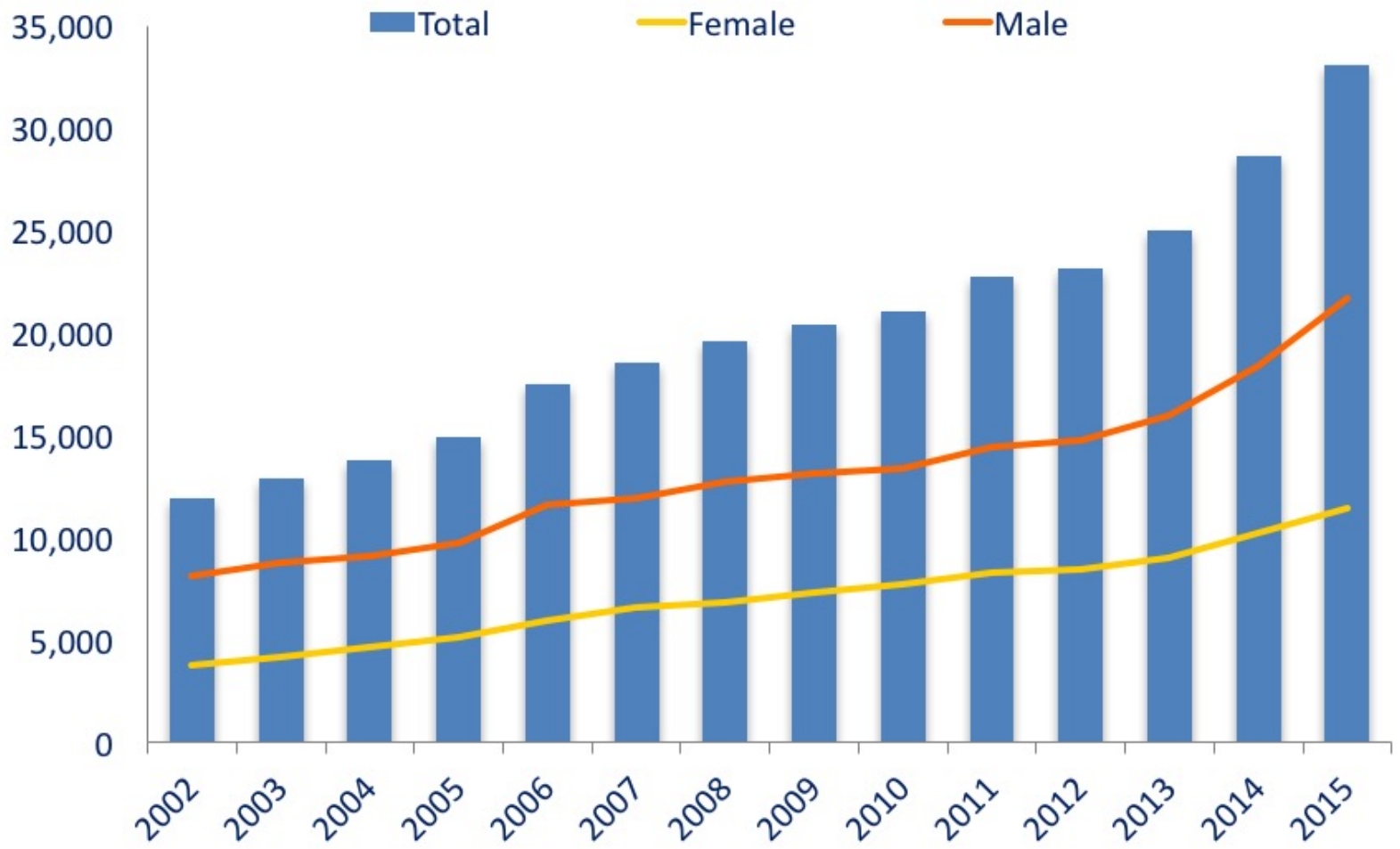
It costs $560-$630 BILLION every year



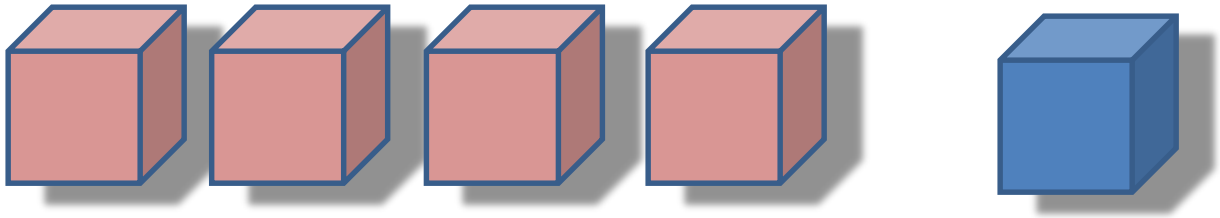
National Institute on Drug Abuse

National Overdose Deaths

Number of Deaths from Opioid Drugs

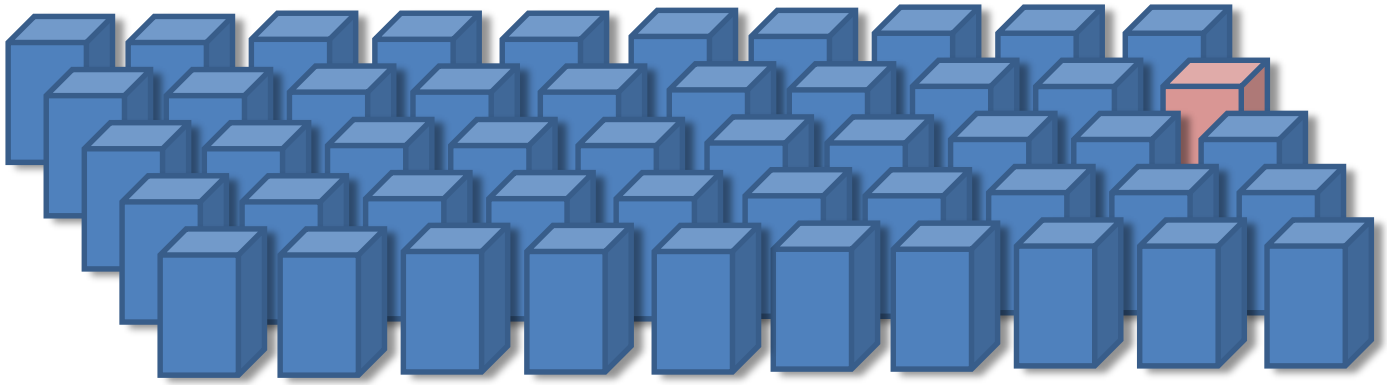


Source: National Center for Health Statistics, CDC Wonder



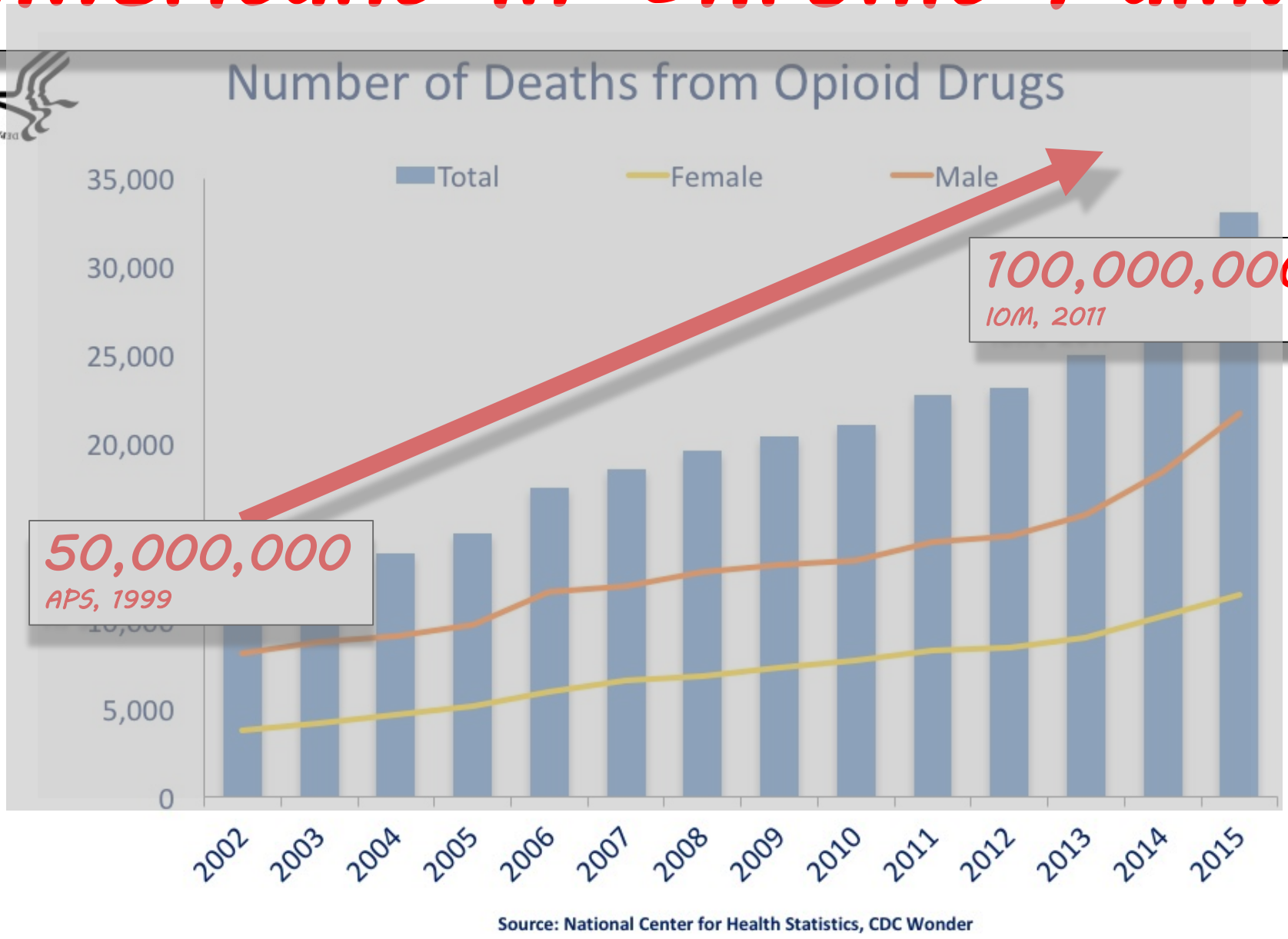
Nearly 80 percent of people who reported initiating heroin use in the past year had previously abused prescription pain medications…

Muhuri, P. et. al., *Associations of Nonmedical Pain Reliever Use and Initiation of Heroin Use in the United States*, CBHSQ Data Review (August 2013), retrieved from http://www.samhsa.gov/data/sites/default/files/DR006/DR006/nonmedical-pain-reliever-use-2013.htm.

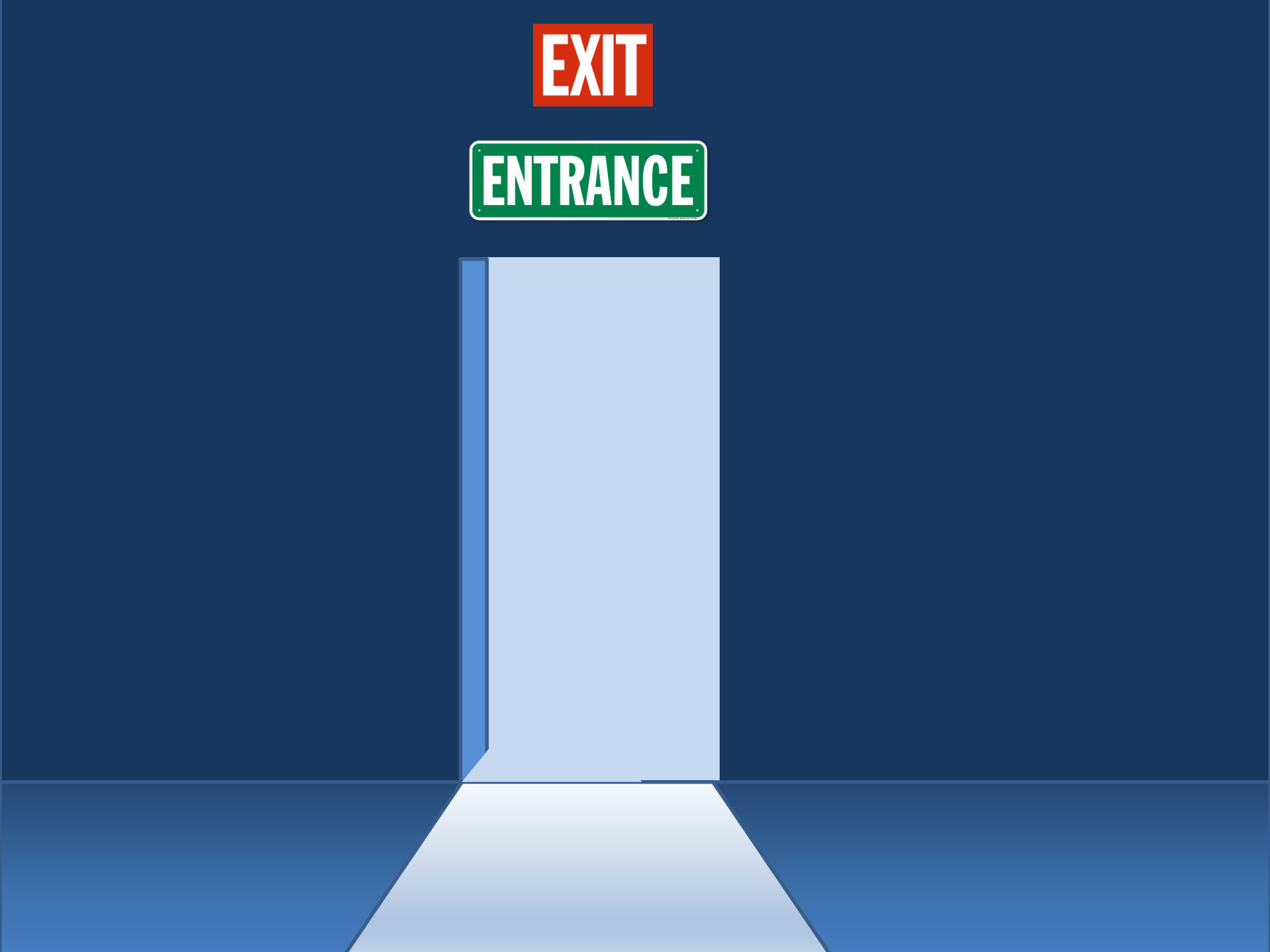



HEROIN
FENTANYL
CARFENTANIL
Milo Police Department

Americans in Chronic Pain!!



Source: National Center for Health Statistics, CDC Wonder


EXIT
ENTRANCE

https://painconsortium.nih.gov

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NIH Pain Consortium

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Recent News

Save the Date: NIH Pain Consortium Symposium 5/31-6/1/2017

Congratulations to 2016 Mitchell Max Awardee, Dr. Ditre

Asst. Sec of Health releases National Pain Strategy

Centers of Excellence in Pain Education Trailer

NIH Pain Consortium
Centers of Excellence in Pain Education

CoEPEs
CENTERS OF EXCELLENCE IN PAIN EDUCATION

First Pain Care Curriculum Improves Clinical Skills

Access clinical training module

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. The consortium supports initiatives, development of research resources and tools, and hosts events to promote collaboration and highlight advances in pain research.

Tweets by @NIHPainResearch

NIH Pain Resear...

Subscribe to the:
NIH Pain Consortium Listserv

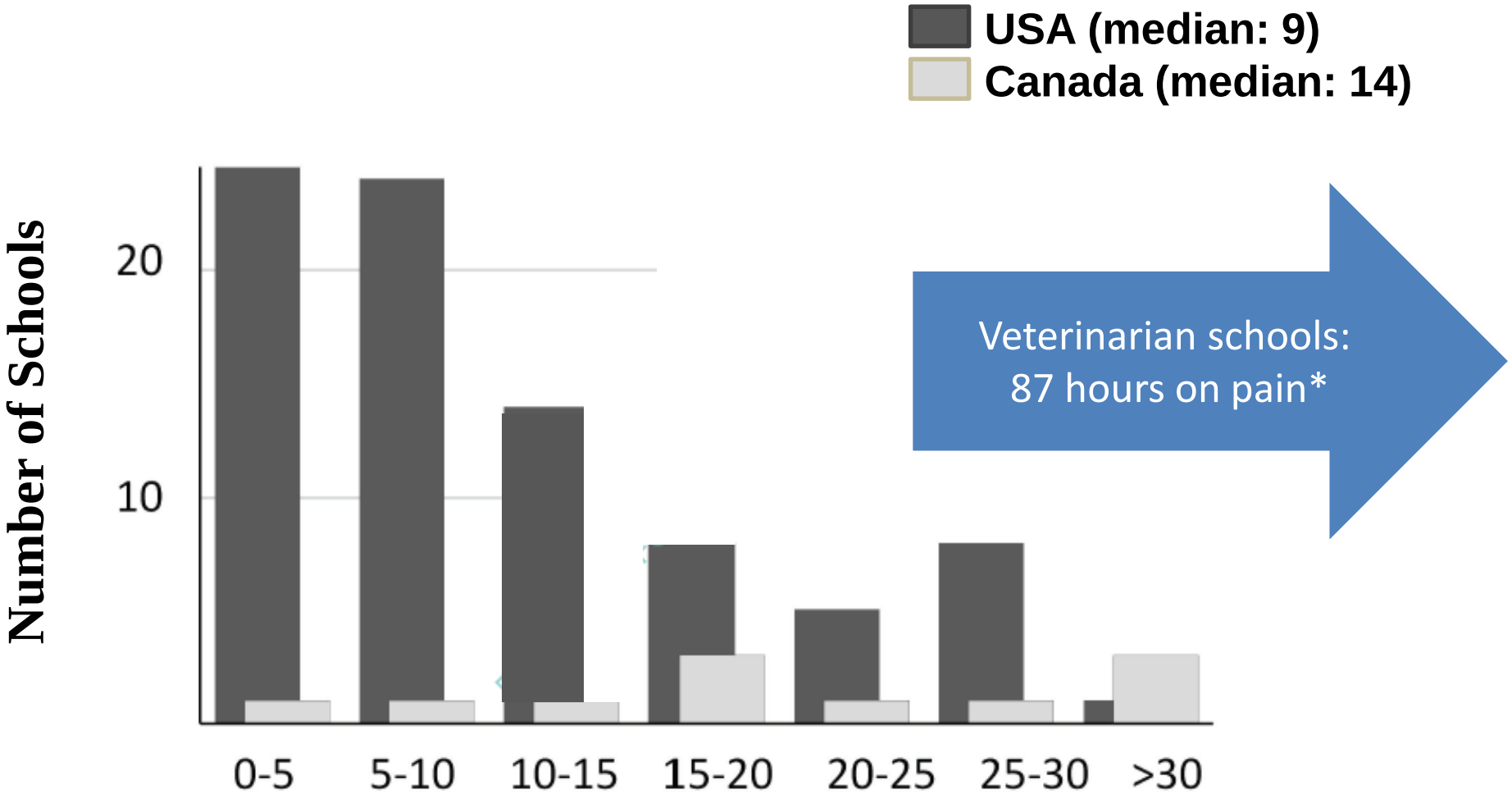
Prevalence

- 100+ million Pain Sufferers (cost over ½ Billion)
- 73.36 million High Blood Pressure
- 17.0 million Diabetes
- 16.8 million Coronary Heart Disease
- 11.7 million Cases of Cancer

But….

Cardiovascular:	45 courses (156 hrs) = 7020 hrs
Oncology:	16 courses (50 hrs) = 800 hrs
Pain:	1 course (36 hrs) = 36 hrs

Education on Pain in Medical Schools

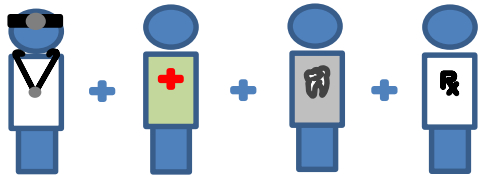


Lina Mezei, B.S., and Beth Brianna Murinson, M.S., M.D., Ph.D. 2011

**Watt-Watson J. et al., Pain Res Manag. 2009*

Overall Goal:
Improve pain treatment though education

1) Develop and include pain education in the CoEPEs curriculum
2) Develop online pain education resource on the Pain Consortium website (and others)
3) Dissemination/Evaluation

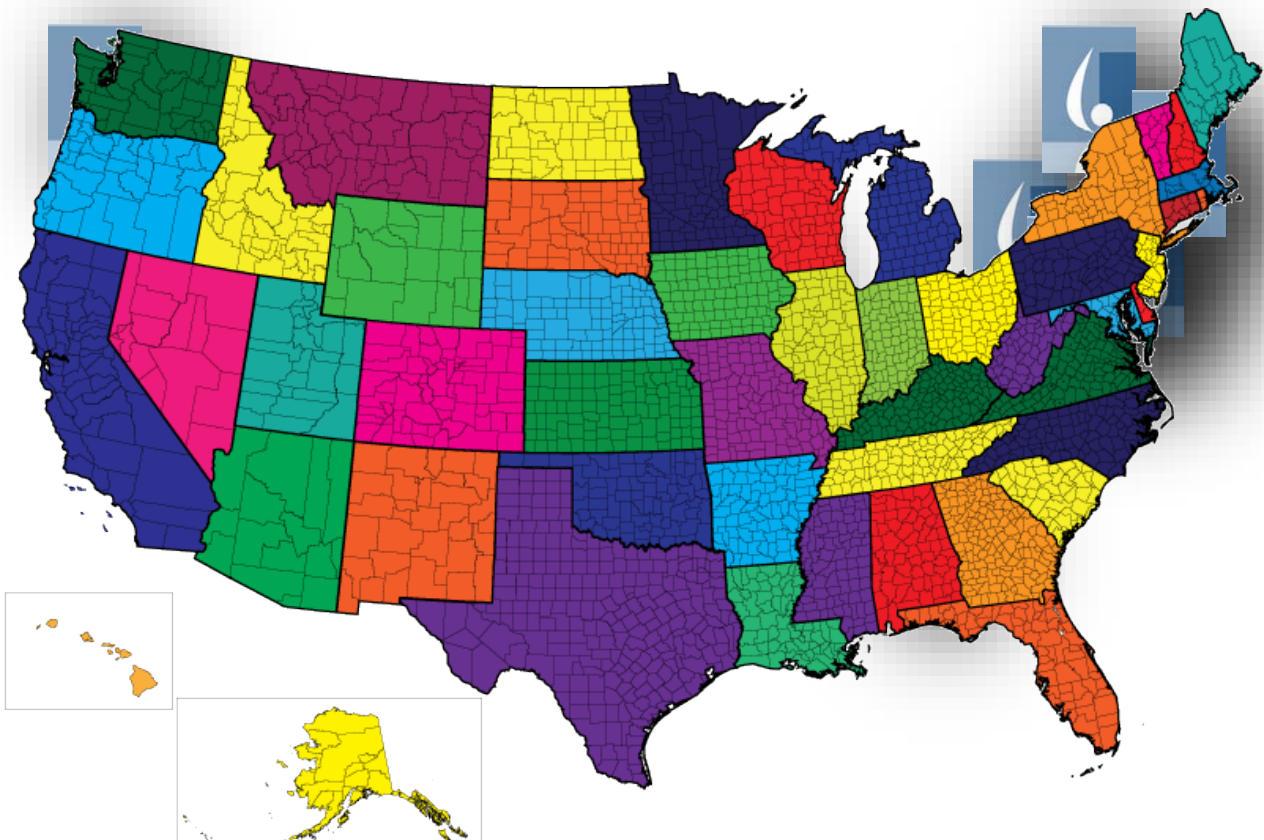



EXIT

NIH Pain Consortium Centers of Excellence in Pain Education

John D. Loeser Center of Excellence in Pain Education at the University of Washington
The University of Pennsylvania Center of Excellence in Pain Education
Southern Illinois University Edwardsville/St. Louis University Center of Excellence in Pain Education
Rochester Area Collaborative Center of Excellence in Pain Education
Harvard School of Dental Medicine Center of Excellence in Pain Education
University of Alabama at Birmingham Center of Excellence in Pain Education
University of Pittsburgh Center of Excellence in Pain Education: Pain Challenges in Primary Care
Johns Hopkins University Center of Excellence in Pain Education
University of Iowa Center of Excellence in Pain Education

CoEPEs
CENTERS OF EXCELLENCE IN PAIN EDUCATION



NIH ICs Involved:

ORWH	NIA
OBSSR	NINR
NIDA	NICHD
NIDCR	NIAMS
NINDS	NCCIH

View the CoEPEs Trailer to see some of the work in progress.

Check out our pain education modules! We will be revising and adding more education modules on a continuing basis. Please check back as our learning resource library grows.

Through the case study, you follow **Edna**, a seventy-year-old woman with chronic low back pain. You'll learn questions for health history, and physical exams to perform. You'll discover setbacks commonly found with chronic pain patients. View interactive module and here for 508 compliant text version (*pdf, 406 KB*) .

Through the case study, you follow **Beverly**, a forty-six year-old woman with chronic burning pain in her mouth. You'll learn about her health history, and physical exams to perform. You'll also learn about the condition of Burning Mouth Syndrome (BMS), and how it is related to other common orofacial pain conditions. And you will discover potential treatments for patients like Beverly. View interactive module and here for 508 compliant text version (*pdf, 340 KB*) .

Through the case study, you will follow **Peter James**, a former stone mason, who was called up from the reserves to serve in Afghanistan. His convoy hit an IED and caused extensive damage to his left leg, which required amputation. He is now dealing with PTSD, insomnia and phantom limb pain. Follow his interdisciplinary treatment as he moves away from the overuse of opioids and toward comprehensive treatment and recovery. View interactive module and here for 508 compliant text version *(pdf, 367 KB)*

COMING SOON: **Mr. Frank** is a 73 year old nursing home resident. Recent years have been marked by progressive cognitive decline attributed to Alzheimer's disease. Over the past 12 months he has become non-ambulatory and now uses few words most often out of context. He does still feed himself and swallows without difficulty. He is typically "pleasantly confused" and compliant with staff guidance and care.

CoEPEs
CENTERS OF EXCELLENCE IN PAIN EDUCATION

Naloxone

A BRIEF OVERVIEW

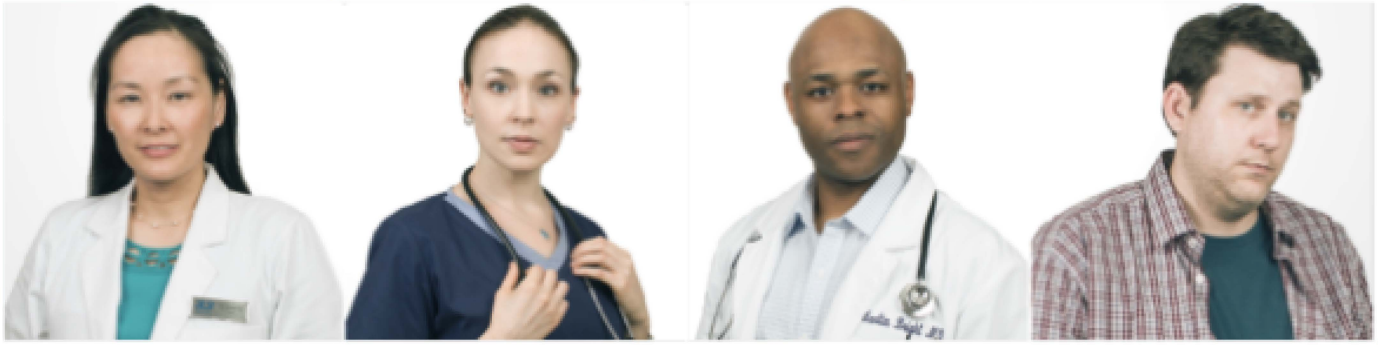
Brought to you by the NIH Center of Excellence in Pain Education at Southern Illinois University Edwardsville and Saint Louis University

Learn more about pain and opioid prescribing risks from these modules created by NIDA/ONDCP:

Joelle is a 25-year-old woman who sustained a third-degree ankle sprain in a motor vehicle accident. She was transported to a local hospital emergency department (ED) where she was treated, her ankle was placed in a boot, and she was given crutches. View the module on Safe Prescribing for Pain.

Edward, a 52-year-old warehouse employee, injured his back at home getting ready for a move out of state. It is now 2 months later and he is in your office as a new patient. View the module on Managing Pain Patients.

The **Department of Health and Human Services - Office of Disease Prevention and Health Promotion** released an interactive training tool, *Pathways to Safer Opioid Use*, which teaches health care providers how to communicate the safe use of opioids to manage chronic pain, and implementation strategies for meeting the opioid-related recommendations from the National Action Plan for Adverse Drug Event Prevention (ADE Action Plan).

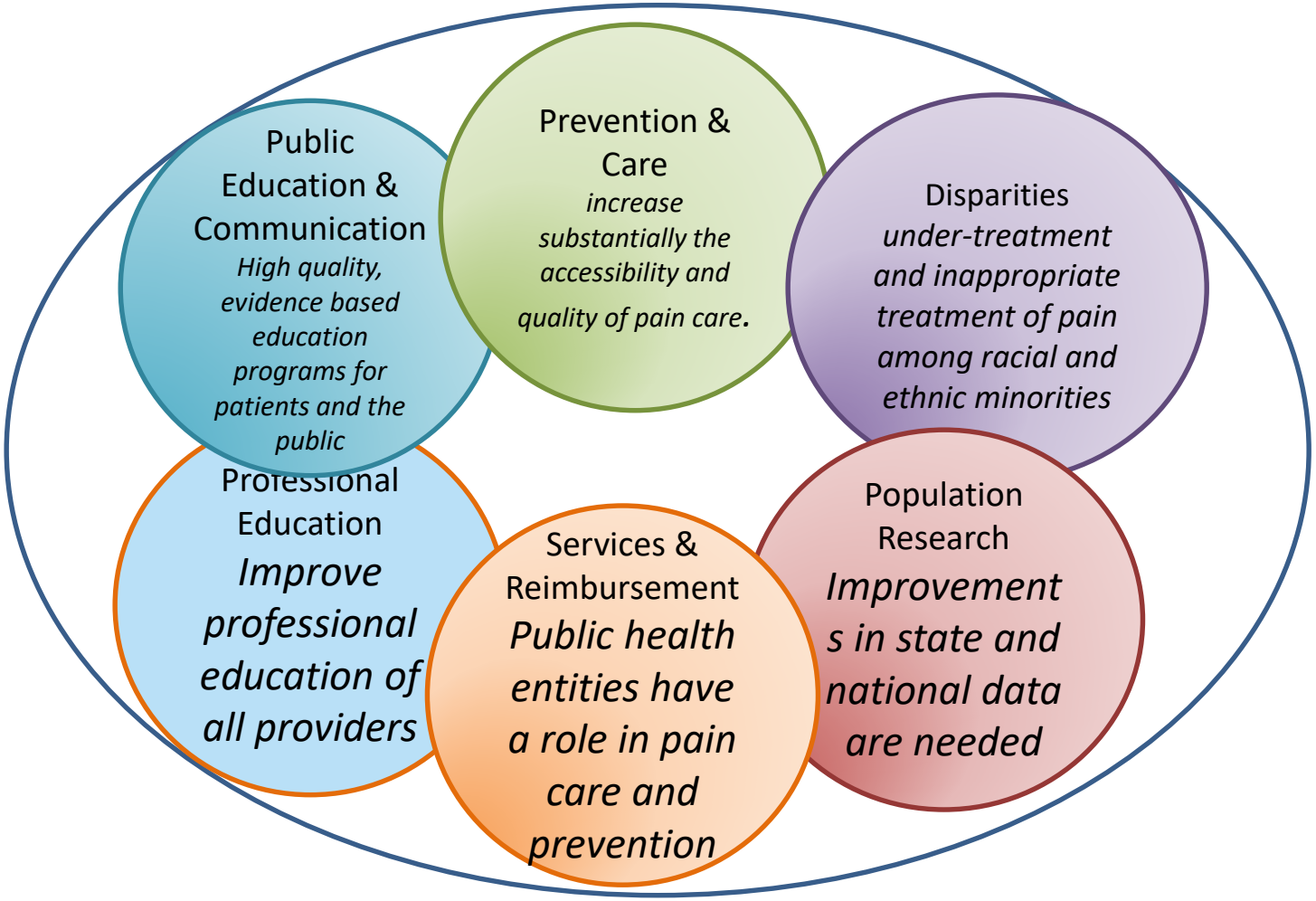


The goal of this simulation is to demonstrate best practices in safe opioid use and prevent adverse drug events. You will play as four individuals (Pharmacist, Nurse, Primary Care Physician, and Patient), make decisions for them, and see how those decisions play out. https://health.gov/hcq/training-pathways.asp

And check out the PBS News Hour report on the need for more pain education, featuring Dr. Dave Thomas (NIDA; CoEPE project lead), Dr. Antje Barreveld (Brigham & Women's Hospital/Harvard Medical School CoEPE), and a paper on pain education publish by Beth Hogans and colleagues from the Johns Hopkins University Medical School CoEPE. Click here to view.

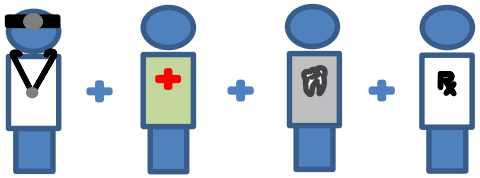
The National Pain Strategy

Oversight Panel



National Pain Strategy

A Comprehensive Population Health Level Strategy for Pain



Objective 2: **Develop a pain education portal that contains a comprehensive array of standardized materials to enhance available curricular and competency tools.** The portal will serve as a central, comprehensive source for pain education materials and will be monitored regularly and updated as new evidence-based guidelines and resources are available. The need for knowledge and skills that address how clinician empathy influences the effectiveness of care should be included in the available educational materials.

Short-term strategies and deliverables: Convene expert stakeholders to determine the content for a pain education portal. The portal would contain evidence-based and/or peer reviewed best practices material about pain care and pain for use by educators and learners. Develop and evaluate a pilot portal that leverages the NIH Pain Consortium Centers of Excellence in Pain Education Coordination Center contract.

Medium-term strategies and deliverables:

Launch the portal.

Reconvene stakeholders to develop an annual survey to measure individual school's progress in teaching about pain. Systematic reviews of studies about pain education would be a starting point in developing the content of the survey.

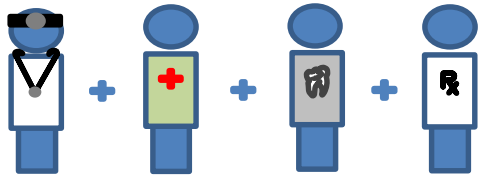
Conduct the initial survey of schools.

Longer-term strategies and deliverables:

Monitor and keep updating the portal, which would be fully developed over a five-year horizon.

Repeat the survey of schools and otherwise monitor pain education to assure that core competencies are taught.

What we need?



- Coordination Center! *RFP draft written, ready for edits.*
- Options for CoEPEs. *Waiting, on purpose…*
- “Boots on the Ground.” *So much to do…*

What We Get:

Editorial

Journal of INTERNAL MEDICINE

doi: 10.1111/joim.12345

Reflections on the role of opioids in the treatment of chronic pain: a shared solution for prescription opioid abuse and pain

D. Thomas, J. Frascella, T. Hall, W. Smith, W. Compton, W. Koroshetz, J. Briggs, P. Grady, M. Somerman, & N. Volkow

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