

AFMC RESPONSE TO OPIOID CRISIS: FACULTY DEVELOPMENT



4,588

OPIOID-RELATED
DEATHS¹



13,320

SUSPECTED
OPIOID-RELATED
OVERDOSES¹



5,349

OPIOID-RELATED
POISONING
HOSPITALIZATIONS¹

BACKGROUND

The opioid crisis continues to be a growing national emergency. In addition to the concerning numbers above, vulnerable populations are disproportionately affected by the opioid crisis. Respecting equity-oriented healthcare, populations that have been adversely affected by the social determinants of health, trauma and oppression are more likely to experience an adverse event.² However, there is a discordance between the evident increase in opioid-related harm and medical education on opioid prescribing and non-cancer chronic pain. According to a survey of incoming PGY-1 residents, approximately 63.5% (n = 273) were not at all comfortable with managing opioid therapy.³ There is a timely opportunity to approach the opioid crisis at the educational level, to further educate stakeholders including faculty, preceptors, residents, and medical students about both opioids, their appropriate use and response to misuse.

IMPACT ON MEDICAL EDUCATION

In 2019, AFMC had performed a high-level environmental scan of the national and international programs that address the opioid crisis. This scan provided guidance for the development of national, standardized educational programs targeting undergraduate undifferentiated medical students to teach effective therapeutic use of opioids and management of opioid use disorder.⁴ There are 10 interactive, bilingual modules (as seen below) created so that teachers and learners can have access to standardized material both for teaching and learning purposes. These are accessible for teachers and learners at <https://opioids.afmc.ca/>. They contain standardized material on chronic pain – its importance, evaluation and management and therapeutic modalities including narcotic analgesics.

KEY MODULES

Best Evidence Training for the New Generation of Canadian Physicians on Pain Management, Opioid Stewardship and Substance Use Disorder.

Topic titles:

1. The Public Health Perspective
2. Core Concepts in Pain
3. Core Concepts in the Management of Chronic Pain
4. Pathophysiology of pain and Pharmacology of Opioids
5. Opioid Prescribing
6. Opioid Stewardship in Palliative Care
7. Safe Storage and Proper Disposal of Opioids
8. Recognizing Opioid Use Disorder
9. Management of Opioid Use Disorder
10. Cultural Considerations, Legalities, and Enhancing Competence

EDUCATORS MAY CHOOSE TO EXPLORE TOPICS FURTHER THROUGH

1. Case discussions
2. Didactic lectures and formative assessment
3. QI projects
4. Standardized program design



PEARLS FOR TEACHERS SUPERVISING MEDICAL STUDENTS AND RESIDENTS: AN APPROACH TO MANAGE PATIENTS WITH NON-CANCER NON-PALLIATIVE PAIN ALREADY ON OPIOID THERAPY

Chronic pain is a commonly managed disease in medicine. It has been recently recognized as such, with integration of Chronic Pain as a Priority Topic within Family Medicine, with nine defined Key Features. In the context of an ongoing opioid crisis, and with limited pharmacologic options for treatment of chronic non-cancer non-palliative pain, developing a solid knowledge base and approach for opioid management, including appropriate opioid deprescribing is crucial.

SUPERVISING MEDICAL LEARNERS: Building upon the 10 modules developed by the AFMC's Response to the Opioid Crisis, the following areas of focus are based on the CanMEDS Roles and the AFMC Response to the Opioid Crisis Learning Objectives. These can be used when reviewing a medical learner's clinical presentation of a patient with non-cancer non-palliative pain, recognizing that expected proficiency will vary dependent on the level of training.

1. Uses patient-centred interview skills to effectively gather relevant biomedical and psychosocial information. (LO 11) (Med Expert, Communicator)
2. Performs a patient-centred clinical assessment to establish treatment goals and a management plan with patients presenting with chronic pain. (LO 12) (Med Expert)
3. Implements a patient-centred care plan that supports ongoing care, follow-up on investigations and further consultation if needed. (LO 18) (Med Expert)
4. Determines the most appropriate procedures, therapies or interventions for managing chronic pain. (Med Expert)
5. Applies knowledge of clinical and biomedical sciences to safely prescribe opioids and other non-opioid therapies when warranted. (LO 41, 39) (Med Expert)
6. Recognizes and reflects on personal and systemic stigma, when the values, biases or perspectives of patients, physicians, or other health care professionals have an impact on the quality of care and modifies the approach to the patient accordingly. (Professional)
7. Recognizes and knows how to integrate the roles of other physicians and healthcare professional colleagues to support a collaborative relationship-centred care plan. (Collaborator) Supervising Post-Graduate Residents: Fieldnotes or written formative assessments are to be offered in a timely manner, based on the observed performance of essential competencies, and ideally focuses

SUPERVISING POST-GRADUATE RESIDENTS: Fieldnotes or written formative assessments are to be offered in a timely manner, based on the observed performance of essential competencies, and ideally focuses on one take home message to continue and/or one to modify. This single message approach does not overload the learner or the preceptor or/supervisor. Feedback is intended to stimulate self-reflection and support learning. Using these foci enables preceptors to identify what residents must *critically do, identify what they often find difficult doing, or areas that they frequently miss which may impact patient safety and quality care*. As preceptors often learn with their residents, these foci can also be used as areas for self-directed learning for preceptors who are honing their own opioid prescribing and deprescribing skills.

Consider providing a written formative assessment or fieldnote for a 1st year resident in the first four months of their training based on the learner's approach to a patient with chronic pain on opioid therapy. Use the following foci to include in the assessment and discuss it with the resident.

1. ESTABLISHES AN ACCURATE AND SPECIFIC DIAGNOSIS WHENEVER POSSIBLE

- a. Identifies and periodically reviews the etiology of the pain (i.e. what is the pain generator, and what is the type of pain?) **(clinical reasoning, selectivity)**
- b. Provides patient education on the basis for chronic pain to enhance capacity for self-management of the disease **(communication, patient centered approach)**
- c. Periodically screens for potential comorbidities or complications, such as mental illness and substance use disorders, including non-opioid **(clinical reasoning)**
- d. Considers alternate explanations (e.g. malignancy, hyperalgesia, addiction, diversion) for significantly increased pain, rather than assuming the original cause for the pain is the reason for the exacerbation **(clinical reasoning)**
- e. Does not attribute escalating medication requests to substance use disorder without first considering an appropriately broad differential diagnosis **(clinical reasoning, selectivity)**

2. EMPLOYS A BIOPSYCHOSOCIAL APPROACH TO ESTABLISH A PATIENT-CENTERED TREATMENT PLAN

- a. Establishes an effective relationship **(clinical reasoning, patient centered approach)**
- b. Uses shared decision-making to establish or clarify goals of treatment **(clinical reasoning, patient centered approach)**
- c. Engages and communicates with other professionals in the treatment plan, as appropriate and accessible **(clinical reasoning, professionalism)**
- d. Maintains a therapeutic relationship (e.g., is empathic, minimizes stigmatizing language, manages frustration) **(professionalism, patient-centred approach)**

3. INTEGRATES SAFETY CONSIDERATIONS INTO TREATMENT PLAN

- a. Comprehensively documents the assessment, plan, goals and prescriptions details, and ensures the plan is appropriately accessible **(communication, professionalism)**
- b. Uses a written treatment agreement with realistic consequences when prescribing opioids **(communication, professionalism)**
- c. Employs prudent prescribing practices (e.g. limited doses/dispensing interval, check for double doctoring, frequent follow-up) when prescribing opioids, particularly in the context of a limited relationship or insufficient records, and adjusts management plan in response to ongoing developments (e.g. sedating polypharmacy, breach in treatment agreement) **(professionalism, selectivity, clinical reasoning)**

4. PLANS AND EXECUTES AN OPIOID TAPER IF APPROPRIATE

- a. In a patient without signs of opioid use disorder, explores risks and benefits to opioid tapering and establishes a plan based on the patient's stage of change **(clinical reasoning, communication, patient centered approach)**
 - i. If the stage is pre-contemplative establishes appropriate boundaries for safe prescribing (i.e. Treatment agreement, urine drug screening, short dispensing intervals, frequent reassessment, agreement to maintain but not increase dose)
 - ii. If the stage of change is contemplative employs motivational interviewing strategies to encourage the patient to consider a taper and help them to feel confident tapering
 - iii. If the stage of change is preparation, in partnership with the patient, establishes a plan for taper considering factors such as rapidity of taper, opioid rotation, treatment of withdrawal or rebound symptoms and frequency of follow-up
- b. Regularly reassesses a patient during an opioid taper to consider whether tapering has unmasked signs of opioid use disorder **(clinical reasoning)**
- c. When opioid use disorder is diagnosed or suspected, offers a transition to opioid agonist therapy (versus controlled taper if OAT declined), as well as harm reduction approaches including take-home-naloxone training **(clinical reasoning, communication, selectivity, patient-centered approach)**

REFERENCES

1. Government of Canada. Opioid-related harms in Canada, March 2020. <https://health-infobase.canada.ca/substance-related-harms/opioids/>
2. First Nations Health Authority. Overdose data and First Nations in BC: Preliminary Findings, August 2017.
3. Lim M, Klaiman M, Dowhos K, Dussault M, Lainé-Panet G, Rajasingham S. *Guide to Chronic (Non-Cancer/Non-Palliative) Pain Management With Patients Already on Opioid Therapy*. Mississauga, ON: College of Family Physicians of Canada; 2020.
4. AFMC 2019 Environmental Scan. April 2019. https://afmc.ca/sites/default/files/pdf/2019_Environmental_Scan_EN.pdf