# *Past Event: 2023 APRN Roundtable* - Outcomes from the National Academy of Medicine's Action Collaborative on Countering the U.S. Opioid Epidemic: Implications for the Health Care Professions Video Transcript



**Event**
2023 APRN Roundtable

More info: https://www.ncsbn.org/past-event/2023-mym

**Presenters**
Kathy Chappell, PhD, RN, FNAP, FAAN, Senior Vice President, Accreditation, Certification, Measurement, Institute for Credentialing Research and Quality Management, and Advanced Practice Initiatives, American Nurses Credentialing Center;
Steve Singer, PhD, Vice President for Education & Outreach, Accreditation Council for Continuing Medical Education

- [Kathy] Thank you so much for inviting us to share our work from the National Academy of Medicine's Action Collaborative on Countering the U.S. Opioid Epidemic. My name is Kathy Chappel, and on behalf of Steve Singer and myself, we're pleased to provide this overview of implications for the healthcare professions.

Steve and I co-chair the health education and training work group for this Action Collaborative, and we also sit on the steering committee and on the data research metrics group. Here's what we plan to share today. We do want to take a few minutes to ask you to reflect on this opioid crisis from your individual perspectives.

We'll then talk about the different stakeholders and roles that impact the opioid crisis, we'll frame the opioid crisis with some data. We'll talk about gaps that exist in practice and the variation that exist within the requirements of regulators, certifying bodies, and accrediting bodies. We're going to highlight some tools and resources that have been developed by the collaborative work groups.

We're going to talk a little bit about the MAT and MATE Act and the implications for you. And then we're going to close with another reflection that kind of ties back up the conversation that we've had and your thoughts at the beginning with what you think about after the presentation. And then we're going to open up the conversation to your questions.

So, please be writing them down as we go. So here's what we'd like to start out with. We'd like you to reflect for a few minutes on how the opioid crisis has impacted you in your own setting. We know that

your clinicians, your prescribers, your regulators, or your certifying bodies, but we also know your individuals, your parents, your siblings, and you may be a spouse.

You all have a unique and very important and sometimes very personal perspective of the opioid crisis. So right now, please take a few minutes to jot down the biggest challenges you're facing or you have faced, and where are the most opportunities for having a positive impact as a collective?

Okay, so let's talk about the various stakeholders and their roles in the opioid crisis. Certainly, this is an abbreviated list, but we think these are some of the most important stakeholders to discuss today.

We know that many of you are APRNs and you want to deliver safe and effective high-quality care, and you want to comply with reasonable regulatory expectations. For regulators and certifying bodies, your responsibility is to protect the public. We know you need to maintain required documentation and you want to validate those regulatory requirements with a reduced burden.

For accreditors, we maintain standards for independent evidence-based continuing education that's developed to address gaps in practice. And we have requirements to evaluate learners beyond the level of knowledge gain, so actually applying that knowledge in practice. The other professions, they want to understand our shared gaps and needs, and they want to collaborate across the professions for higher impact.

And finally, the larger continuing education community wants to develop continuing education that meets the needs of multiple professionals and addresses the identified gaps in practice. So with that, I'm going to pass over to Steve, who's going to frame the opioid epidemic with some data and share some other information with you.

Steve.

- [Steve] Thank you, Kathy. That was a great introduction. I'm Steve Singer. It's great to be presenting with Kathy and presenting to you today. I thought it would be helpful to frame the problem and provide some context to help you understand the work that we've done with the Opioid Action Collaborative.

And really the theme of this is that this is a complex and evolving crisis. Here we see overdose deaths in the United States over the period of several years, and this is both a reflection of the crisis, the changing nature of the crisis. We have some successes in the reduction of opioid deaths related to prescribed opioids, of course, but an absolute growth year after year of deaths related to synthetic opioids.

We also see the complication of the crisis due to polypharmacy or the overdose deaths in the case where opioids are involved, but other drugs are involved as well, such as methamphetamine, cocaine, etc. And this is really highlighted on this slide when we look at the overdose deaths for 12 months related to all drugs on the right-hand side, and then the involvement of different other substances across this table.

So we know, we are aware that the opioid crisis per se is certainly a convenient name for the crisis for the past several years, but it's no longer an opioid crisis. It's really a substance use crisis. And we have to make sure that the strategies and tactics that we identify are able to address the complexity of that crisis.

So we thought that it would be helpful in terms of the context, and particularly for you as an audience that includes regulators to think about the facets of our understanding of what would be an ideal. Like, if

we were going to work together to try to address problems in the opioid crisis as regulators, as educators, as professionals, health professionals, what would help us to understand that?

So I have several slides that use a few anecdotal quotes to get at some themes that we're going to talk about. So here we have two quotes. "We were never trained for dealing with drug-seeking patients. We don't have the time in our clinic structures to handle these patients.

I don't really know what I can do differently," or, "It's frustrating when everyone has the right to decline scripts, but no one has to provide a viable alternative solution. I'm the one left to care for the patient alone." So these are opportunities for reflective practice, self-awareness to identify one's own professional practice gaps, and educational needs that would help to address these challenges that we see in these quotes.

Another facet is educational engagement. So here, "I try to take the best care of my patients, but I was never trained on how to identify misuse and early abuse or manage these complex patients in my office." "My state requires opioid use disorder training and then makes me take the same unhelpful course every year."

So these are our challenges around educational engagement, how health professionals interact with educational systems locally, nationally, regionally. "Why can't I test out of mandatory continuing education if I demonstrate my competence?" "Considering the time it takes, what evidence do you have that this education will actually help me to improve my practice?"

These are both questions about learning outcomes, right, and connecting between learning for what really matters to practice and matters to the individual's health professional needs. Lastly, a couple of other quotes. "Show me evidence that investing more in interprofessional continuing education will improve care and reduce cost in our system."

So that's something that you might hear from healthcare leadership, right, or from policymakers. "Everyone wants community health workers with lived experience, but no one helps me find, train, or retain those folks." So these are things related to population outcomes and the connection between the value proposition of demonstrating improvement and the impact on population health.

So if we pull these four areas together, we can envision a system, an ideal system, if we go round in a circle, you know, starting at the top where there's educational engagement so that education supports my practice-based needs as a member of a team or as a healthcare practitioner, we want learning outcomes.

We want to know that the learning that we participate in connects to helping me do well by my patients. Population outcomes that we are improving together, that we're part of a learning health system or a learning healthcare enterprise. And then lastly, as clinicians, as individuals, that I feel safe and supported, that there is a connection to my unique practice-based needs from my healthcare setting, the population of patients that I work with, and my own personal professional development.

So with that as sort of a context, I'm going to hand things back to Kathy to talk about the Action Collaborative and the work that we've done so far.

- Thanks, Steve. I do want to share a little overview of the National Academy of Medicine's Action Collaborative in case you have not heard of the work that we've been doing. I also want to let you know

that you can use the QR code here to download a lot of the tools and resources and publications that we've done over the past four years.

We've been working on this for four years, and I think we're now in the next two-year phase of operationalization of some of the work that we've done. All the resources are free, so please feel free to use that code and download those tools. So the Action Collaborative, the mission of the Action Collaborative is here.

And I want to note it is a very large public-private partnership that is deliberately inclusive and interprofessional. I think that interprofessional theme has been a priority of this work, and I think it leverages all of the professions that we have with greater impact. So, as I said, Steve and I chair the health professional education and training work group.

We do that along with our colleague, Dr. Eric Holmboe from ACGME. One of the first things that we did in our work as the health education and training work group was to look at professional practice gaps and existing regulatory requirements and policy standards across five different professions.

And the professions that we looked at were the profession of medicine, nursing, pharmacy, dentistry, and PAs. And we then identified, after we did the literature review and looking at the regulatory requirements, we identified five actionable priorities to strengthen the coordination and collaboration across the health education system.

And that means from undergraduate education, through graduate education, through residencies and fellowships, and into the continuing education space. I'm going to share with you what we found in the literature in relation to professional practice gaps and what we found in the literature from our scan of the regulatory requirements.

We did a comprehensive review of the peer-reviewed, published, and gray literature, and then we coded those professional gaps into overarching themes. The vast majority of professional practice gaps were associated with prescribing or tapering opioids. The other gaps were much smaller by comparison.

And then when we did a deep dive and we looked at the root causes of why those professional practice gaps existed, they were around, wasn't aware of the best practice. Attitudes and biases were really predominant in this area, and/or the use of or failure to use evidence-informed tools and resources.

So they either weren't aware of an evidence-informed tool or resource, or it wasn't available to them at the point of care. And then other gaps in the literature included communication challenges and constraints in the practice setting. Time always comes up as a constraint in the practice setting. But communication and collaboration, not only within one profession but across with members of the other professions of the healthcare team also were factors that negatively impacted care.

After conducting the analysis, we then categorized the findings into groups that could be addressed with different interventions. Some interventions were amenable to education and could be directed at broader issues that impact care beyond the opioid crisis.

So thinking about negative attitudes or biases or communication challenges, those all are beyond the opioid crisis and really are important professional practice gaps to address. But then there were also some that were specific to pain management, so struggles in treating chronic pain as compared to acute pain. If you have a broken bone, that's a pretty easy thing to address.

If it's a chronic and lingering pain, that was harder for clinicians to care for. There were variations in prescribing practices by provider and type of pain, and there was a lack of trust related to the subjectivity of pain that clinicians had to manage. And then there were also interventions that were not amenable to education but really had to be addressed at the system level, so things like insufficient members of interprofessional teams couldn't access tools or the tools weren't user-friendly.

Challenges with reimbursement. So maybe wanting to refer a patient to another practitioner, but that coverage wasn't there for that individual. And then certainly inadequate numbers of certain types of critical providers. That was what was in the literature.

So we then looked at licensing certifying and accrediting body requirements, and we found that there was substantial variation in requirements and standards. Yes, organizations had standards for pain management, for example, and substance use disorder. However, there were a fair amount of bodies, whether it was a licensing certifying or accrediting body that did not have those standards or the individuals were unsure if those standards existed.

Again, we looked at the education continuum from academia through the continuing education space. So it didn't hit on one area. However, if you were in an academic program, there was less variation, so more consistency in academic program expectations.

They had the least amount of variation. But those that focused on individuals, so certifying individuals, licensing individuals, or regulating individuals had the most variation. We also found variation among those who practice under the direct supervision of others.

There were fewer requirements for those individuals, and it maybe reflects how they practice. We also found that expectations for individuals in relation to pain management, to opioid use, and substance use disorder are most often expressed as mandatory participation in continuing education. So finally, the summary from that publication, again, which is available for you to download, we established five key priorities that we are currently moving forward.

The first that we're working on, and actually Steve will be sharing, is to establish minimum core competencies for all healthcare professionals. The second and the third are to align accreditors' expectations for interprofessional collaboration in education and to optimize regulatory approaches. The fourth is really to use the current continuing education system to meet the educational needs of our learners.

And the fifth is to create partnerships among stakeholders that can collaborate to harmonize requirements. And these are the areas that we really see as shared targets for change. Simplifying documentation and processes for licensing boards and for licensees. Looking at reducing that unwanted variation where it doesn't make sense.

Supporting our educators and educational engagement for licensees. And then enabling the system to address the complexity of highly variable local needs. So we know that the needs are different for those in general practice as compared to pain management specialists, for example.

There may be differences in pediatric patient populations as compared to geriatric patient populations. And so we're looking at how the educational system can work collaboratively to address those specific needs and still meet the expectations of safety and evidence-based practice. So with that, Steve, moving back to you.

- Thanks, Kathy. So to take a dive into the competency framework, again, with the framing that Kathy provided, we have to reflect on these bullets. You can read as I'm talking. The opportunity for what a competency framework can do. It can help educators, it can help to reveal critical professional practice gaps, and is really focused on developing a core framework across professions as a minimum level of competence and really as a way to sort of lift all boats.

The framework identified a foundational set of knowledge, skills, and attitudes that all health professionals, regardless of profession or level, should have with regard to their care of patients with pain and/or substance use disorder. And we wanted to use a public health approach in an implementable framework that really would be...you know.

We have to sort of balance complexity and the ability for the framework to address kind of diverse areas while at the same time being simple enough in its organization, very implementable. And I think that we've succeeded in balancing those two. But as I'm going to talk about in a minute, we're really sort of now into the point at which we want to share this framework, have educators and others take up the framework for implementation, and hopefully, from that engagement and that utilization provide us feedback about the opportunities or any challenges that the framework provides.

So again, you have a QR code here that will take you directly to the page that hosts the framework publication and other supporting materials. We identified six core competency domains under...

Well, I'm going to show you the graphic in just a moment, but those core competency domains include baseline knowledge, applied knowledge, patient-centered practices, team-based care, health systems and environment, and professionalism, and two important factors that help to create the facilitating conditions for success, which are interprofessional collaboration and learning, and continuous learning and improvement.

So here we have a graphic summary of what is called the 3Cs Framework. So we see that there are three central areas, core knowledge, clinical practice, collaboration. We found it helpful and very important to make sure that a patient and family focus was at the center. The competence related to pain and SUD is not something that is exhibited on patients or families but through partnership with patients and families and communities.

And you'll see how this interprofessional collaboration and learning and continuous learning and improvement are sort of, like, the fuel that helps to support this. The framework's usability and impact, as we've discussed, really depends on support from stakeholders across the different aspects of the system that we've been talking about.

So if you reflect back to that first slide that Kathy had in her introduction about the different roles of stakeholders and of you, members of our audience, it would be helpful if you thought about how could this framework be supportive of the work that you do?

How could it help you to leverage the kind of change and learning engagement that you wish to support? And we, of course, are working now on implementation tools to help stakeholders implement this competency framework into curricula and other approaches. We have been advocating, and I think Kathy is going to talk about, with the recent example of the MATE Act of 2021, which is a recent development about how we have been advocating with the federal government and other organizations and stakeholders the utility of perhaps using this framework as a way to standardize approaches around educational engagement.

And we really think that it can be a helpful tool in the hands of educators to both assess around educational engagement and also articulate practice gaps for both individuals and interprofessional teams.

I want to bring some attention to other workgroup products. So we've been talking a lot about our education and training work group, but among the other work groups, there are a few products that I wanted to sort of point to. One is the Chronic Pain Journey Map. I'm going to show you an example of the map in a second.

These headings on this slide are actually links that will take you to these tools on the website. The Chronic Pain Journey Map is really a terrific tool, and we're currently looking within our education and training group to see how we can connect crosswalk between the journey map and the competencies as a tool, again, for helping practitioners improve practices, address stigma, and other issues.

The journey map really presents a way of outlining the patient journey related to prevention, diagnosis, treatment, long-term recovery. We have also spent a great deal of effort in the action collaborative. Addressing telehealth.

I think that this has really been sort of a feature and outcome of our experience with the pandemic, has been to really in a disruptive way change regulatory policies and expectations around telehealth. And I don't think that we're going back, right? So that opportunity requires a fair amount of attention around the opportunities, competencies, resources, and just attention to improvement to help telehealth be an effective tool for healthcare.

So there are some publications and other things talking about kind of what should be the priorities for all of these different stakeholders with regard to advancing telehealth. The last thing is Kathy mentioned that we both sit on the data and research committee or working group. We have previously developed a research agenda, and right now, or sort of in the interest of implementing all these tools are looking again at how we can set some bold expectations nationally around research, particularly around new data insights related to equity, stigma, and the other key priorities that we've identified.

Here, just as an example of the chronic pain journey, which is just really a terrifically useful tool. This is a static document that you can download from the site, but the actual Chronic Pain Journey Map is a dynamic website that you actually click through. So it can be really sort of a neat education and practice tool.

So just to kind of circle back now before passing it back to Kathy. If we look at the key priorities that Kathy mentioned in the context of these different opportunities, here we see a number of tactics that can be applied as sort of next implementation steps. So I'll just sort of start over on reflective practice.

Integrating interprofessional continuing education in connection with core competencies. Harmonizing those CE requirements that Kathy talked about. If we look at educational engagement, utilizing data systems of healthcare education accreditors to track engagement and to be able to connect education on specific practice-based needs with the health professionals that need that education.

And also to support the work of educators by promoting investment, particularly in innovation and outcomes research relative to effective education. For learning outcomes, these data frameworks could enable national tracking of competencies for individuals and/or interprofessional teams, connecting competencies with quality, and enable accredited CE to fulfill federal practice improvement initiatives.

We know that there's a rich environment, a complicated environment of both statutory, state-based federal improvement initiatives related to substance use and opioids. But we see some opportunities for harmonization, and perhaps around competencies could be a way to do some of that harmonization.

And then lastly, with regard to outcomes, that we support research to study and disseminate those priority practice gaps for individuals and teams that are most critical to helping us sort of move the needle on difficult areas of practice, such as stigma, to establish minimum interprofessional core competencies, which we are well on our way to do, so we talked about that, promote data interop PDMPs.

This is something that is very much underway with leadership from regulatory stakeholders. And then lastly, develop a system of mutual recognition for regulatory requirements across agencies. A great outcome of action collaborative's work has been sort of under the leadership of Dr.

Chaudhry at the Federation of State Medical Boards and interprofessional group of leaders from state licensing authorities, the creation of what is called the Opioid Regulatory Collaborative. So Kathy and I are both engaged with that group, which is really taking a terrific approach to try to address harmonization opportunities sort of in the context of all of this great work that the Action Collaborative has done.

So with that, I'll hand things back to Kathy.

- Great. Thank you, Steve. So, as Steve said, I do think these are the major areas that the health education and training work group are moving forward to Opioid Regulatory Collaborative and then piloting the 3Cs Framework. The MATE Act, I will touch on and share with you some feedback we had to SAMHSA and the DEA related to those expectations.

The Opioid Regulatory Collaborative, as Steve said, the FSMB is hosting. They have a hosted site with resources. The professions participating in the Opioid Regulatory Collaborative right now are medicine, nursing, pharmacy, and dentistry. And there's a task force within that group that is looking at where across either state lines or across professions within state there can be harmonization of the regulatory requirements related to pain or substance use education and/or mutual recognition.

So if somebody is licensed in Michigan and somebody is licensed in Illinois, there's really no reason why they should have to do the same types of continuing education in both states. If there was an opportunity to have mutual recognition on that, it would decrease the documentation and oversight burden of the boards, as well as decrease the burden on the individual licensees.

With piloting the 3Cs Framework, what we're looking at, as Steve said, the accreditors having CE providers potentially map their education along the competencies are against the competencies of the 3Cs Framework so that we can evaluate and track education that is in alignment with the 3Cs Framework. The other thing that we're looking at in collaboration with the National Academies is trying to fund some pilot sites to actually design and measure outcomes at the practice setting that is in alignment with the 3Cs Framework.

So we might want to look at how people are implementing that framework in the ambulatory care setting, in the inpatient setting, etc., and looking at outcomes of learners engaging with that continuing education and what they're seeing. And you can see now kind of the inner relationship between the

education and training work group, the research and data metrics group, and how we're cross-collaborating in order to really, hopefully, have a positive impact on the opioid crisis.

So the MAT and MATE Acts passed in December as part of the Consolidated Appropriations Act. It eliminates the need for clinicians to apply for an X-Waiver to prescribe buprenorphine, and it eliminates the patient caps on restricting the number of patients that a prescriber can treat. It does, in law, require individuals when they come up for renewing their DEA license to complete a one-time eight-hour training on treating and managing patients with SUD.

And I'll share on the next slide kind of some of the feedback that we gave to SAMHSA and the DEA related to that, because there's not a lot of clarity right now on what that eight-hour training requirement looks like. And so there needs to be further work here in that area. And I am happy to say that SAMHSA and the DEA have reached out to multiple stakeholders to get input because they want this to be successful as much as we want it to be successful.

So our accreditor feedback during an open call with SAMHSA and the DEA really focused on several different areas. Using the accredited CE system, our continuing education providers know how to assess gaps.

They know how to develop outcomes. They know how to measure longitudinally. They know how to design education that's specific to a target population of learners. And so our conversation with them is really to let the system function in the way it's designed to function. We already have standards that are based on valid content, independent of industry to control for bias. We know that we have a set of these shared competencies that education can be designed around.

We already utilize multiple types of formats and track changes beyond knowledge gain, really looking at competence or performance in practice or patient outcomes. And they need funding. CE providers need to have funding in order to design education that meets the needs of our learners in practice, of the patients and families we serve at the least burden.

So we are hopeful that SAMHSA and the DEA will operationalize this. We will absolutely share what we find with you all. I know it's just as important to you as it is to us. So work in progress, but we are at the table, and I think that that's critically important to success.

So as I said at the beginning, we wanted to circle back, and you had written down some reflections on your experience with the opioid crisis, some of the barriers that you identified, and some opportunities that we hoped that you might be able to think about in terms of what would be most helpful to you in your practice setting.

So pull out that list if you have it, if you have it on a piece of paper, if you have it on your phone. Hopefully, we've identified and addressed some of the barriers that you also identified, that we were able to share some potential tools or resources that you may be able to implement in your own practice setting wherever you are, whether you're a clinician who's prescribing, whether you're a regulator who's tracking, whether you're a certifying body who's setting expectations also.

And we'd like you to reflect on what out of this presentation you might be able to bring back to your organization and what change you personally would like to make. I want to say thank you so much for inviting us to this conference. We've shared our email addresses. If there's anything that you need or you'd like to reach out to us, please feel free to do so via email.

We are invested in this work. Steve and I have been invested in this work, like I said, for the past four years. We have another two years ahead of us. And we work with an amazing group of people who all have the same passion that we do. So with that, we would like to wind up this presentation and open it up for your questions. Thank you so much.

- Thank you.