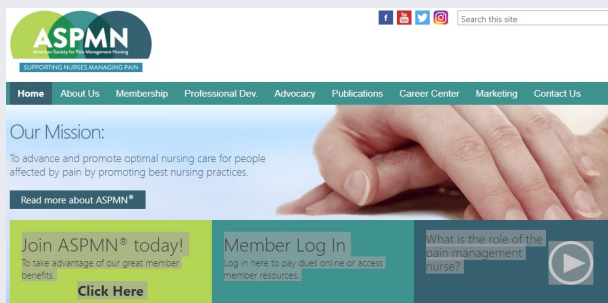




Atul A. Walia, DO  
 Interventional Pain Management/ Anesthesiology  
 Medical Director, INTEGRIS Pain Management  
 Medical Director, Plaza Surgery Center

1

## American Society of Pain Management Nursing



- 1990

Evaluation by American Pain Society,  
 American Society of Anesthesiologists,  
 American Society of Regional Anesthesia

2

### Mission Statement & Goals

The American Society for Pain Management Nursing®'s mission is to advance and promote optimal nursing care for people affected by pain by promoting best nursing practices. This is accomplished through education, standards, advocacy and research.



#### Access to quality care

All people will have access to healthcare services that provide quality pain management care as defined in core values.

#### Public awareness

The public will demonstrate self-advocacy skills essential to their pain care needs.

#### Professional Resources

Members will have instant, easy and affordable access to current, best practices, evidence-based resources.

#### Education

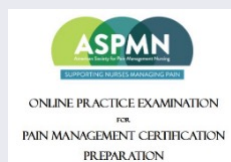
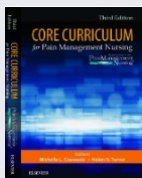
All healthcare professionals and their patients will benefit from pain management education.

#### Professional Recognition

Nurses in pain management will be respected, valued and compensated for their expertise as an integrated and indispensable member of the healthcare team.

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### Pain Management Nursing Certification



- Active RN degree
- At least 2,000 hours in last 3 years
- CME over last 3 years
- Pass ASPMN Pain Management Nursing certification exam

# RN-BC

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## Advanced Practice Program

ASPMN® Advanced Practice Program



- Advanced Practice Registered Nurse
- Pain Management Nursing Certification
- Completion of Portfolio

# AP-PMN

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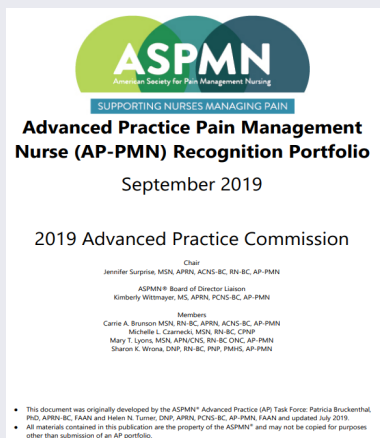


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Category	Activity	Description	Date(s)	Total Points
A	1	CE Total	2017-2019	30
B	3	Establish Team	2018	10
C	4	QI project	2017	10
D	3	Reviews	2017-2018	10
E	2	Conference Presentation	2018-2019	15
G	1	APRN National Certification	2017	25
TOTAL POINTS				100

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## Lumbar Imaging With Reporting Of Epidemiology (LIRE)—Protocol for a pragmatic cluster randomized trial<sup>☆</sup>



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### ARTICLE INFO

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 Cluster randomized trial  
 Back pain  
 Spine imaging  
 Lumbar imaging  
 Stepped wedge design

### ABSTRACT

**Background:** Diagnostic imaging is often the first step in evaluating patients with back pain and likely functions as a “gateway” to a subsequent cascade of interventions. However, lumbar spine imaging frequently reveals incidental findings among normal, pain-free individuals suggesting that treatment of these “abnormalities” may not be warranted. Our prior work suggested that inserting the prevalence of imaging findings in patients without back pain into spine imaging reports may reduce subsequent interventions. We are now conducting a pragmatic cluster randomized clinical trial to test the hypothesis that inserting this prevalence data into lumbar spine imaging reports for studies ordered by primary care providers will reduce subsequent spine-related interventions. **Methods/design:** We are using a stepped wedge design that sequentially randomizes 100 primary care clinics at four health systems to receive either standard lumbar spine imaging reports, or reports containing prevalence data for common imaging findings in patients without back pain. We capture all outcomes passively through the electronic medical record. Our primary outcome is spine-related intervention intensity based on Relative Value Units (RVUs) during the following year. Secondary outcomes include subsequent prescriptions for opioid analgesics and cross-sectional lumbar spine re-imaging. **Discussion:** If our study shows that adding prevalence data to spine imaging reports decreases subsequent back-related RVUs, this intervention could be easily generalized and applied to other kinds of testing, as well as other conditions where incidental findings may be common. Our study also serves as a model for cluster randomized trials that are minimal risk and highly pragmatic.

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### 1. Introduction

Diagnostic imaging is often an early step in the work-up of back pain and a likely gateway to subsequent interventions. Unfortunately, these

<sup>☆</sup> Funding sources: NIH 1U42AT007766-01 and 4R01AR06795-02. Trial Registration: ClinicalTrials.gov NCT02015455.  
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### Lumbar Imaging With Reporting Of Epidemiology (LIRE)—Protocol for a pragmatic cluster randomized trial<sup>☆</sup>

**eTable 4. Examples of intervention text**

**Modality: X-ray Age: 40-60**

The following findings are so common in normal, pain-free volunteers that while we report their presence, they must be interpreted with caution and in the context of the clinical situation. Among people between the age of 40 and 60 years who do not have back pain, a plain film, x-ray will find that about:

8 in 10 have disk degeneration  
6 in 10 have disk height loss

Note that even 3 in 10 means that the finding is quite common in people without back pain.

**Modality: MRI Age: 61+**

The following findings are so common in normal, pain-free volunteers that while we report their presence, they must be interpreted with caution and in the context of the clinical situation. Among people over the age of 60 who do not have back pain, an MRI will find that about:

9 in 10 have disk degeneration  
9 in 10 have disk signal loss (desiccation)  
8 in 10 have disk height loss  
8 in 10 have a bulging disk  
4 in 10 have an annular fissure  
4 in 10 have a disk protrusion  
4 in 10 have facet degeneration  
3 in 10 have spondylolisthesis

Note that even 3 in 10 means that the finding is quite common in people without back pain.

**eTable 5. Intervention implementation details**

Feature	System A	System B	System C	System D
Informatics system used to insert intervention text	EMR	RIS	EMR	EMR
Intervention text location	Pop-up alert	End of report	End of report	End of report
Intervention text insertion timing	When report viewed by referring provider	At time of dictation	After report finalization by radiologist	After report finalization by radiologist
Intervention text could be modified/removed by radiologist	No	Yes	No	No

Abbreviations: EMR – electronic medical record; RIS – radiology information system

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### Lumbar Imaging With Reporting Of Epidemiology (LIRE)—Protocol for a pragmatic cluster randomized trial<sup>☆</sup>

#### RCT Effect of Benchmark Prevalence Data in Spine Image Reports on Health Care Utilization Among Adults

**POPULATION**

101 499 Men  
137 373 Women  
14 Patients with unknown gender



Adults in primary care clinics who received lumbar spine imaging  
**Mean (range) age, 56.7 (18 to ≥90) y**

**SETTINGS / LOCATIONS**



98 primary care clinics within 4 large US health systems

**INTERVENTION**



238 886 Patients randomized



117 455 Usual spine imaging reports

Usual spine imaging reports without benchmark prevalence data for common imaging findings

121 431 Benchmarks for spine imaging reports

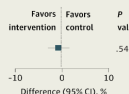
Inclusion of age-appropriate prevalence data for common imaging findings in people without back pain

**PRIMARY OUTCOME**

Spine-related relative value units (RVUs) within 365 days of index imaging, a composite measure that reflects overall intensity of resource utilization for back pain care

**FINDINGS**

No significant difference in spine-related RVUs generated from care of spine imaging patients with usual imaging study reports compared with reports that included benchmark prevalence data (Adjusted difference: -0.7%; 95% CI, -2.9% to 1.5%;  $P = .54$ )



Adjusted median RVUs:  
Control, 3.56 (2.71-5.12)  
Intervention, 3.53 (2.68-5.08)

**eTable 2. Examples of spine-related CPT codes and associated RVUs**

CPT Code	Description	RVU <sup>a</sup>
72100	X-ray exam of lower spine – 2 or 3 views	0.99
97501	Physical Therapy Evaluation	2.18
99214	Detailed office visit	3.03
99284	Emergency department visit – high intensity	3.32
64483	Epidural injection for lumbar spinal stenosis	6.26
72131	CT lumbar spine without contrast	5.09
72148	MRI Lumbar Spine without contrast	6.37
63647	Removal of spinal lamina (laminectomy)	32.13
22804	Fusion of the spine	70.65

a. Relative value units (RVUs) include work and practice components. RVUs may change over time. The median value over the study period was assigned to each CPT code to avoid any potential time-related bias.

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Lumbar Imaging With Reporting Of Epidemiology (LIRE)—Protocol for a pragmatic cluster randomized trial<sup>☆</sup>

**eTable 9. Outcomes by index imaging modality**

Outcome	XR (N = 192,435)	CT (N = 943)	MR (N = 45,508)
<i>RVU at 1 year, mean (SD)</i>			
Manual (e.g. PT)	2.0 (5.6)	3.1 (7.4)	2.5 (6.3)
Evaluation & management	3.6 (7.2)	7.8 (9.4)	6.4 (8.5)
Injections	0.9 (3.6)	3.0 (7.3)	2.9 (6.2)
Imaging	2.2 (5.0)	3.3 (6.6)	2.3 (5.6)
Surgery	1.8 (17.8)	5.3 (25.8)	5.8 (28.9)
Total	10.6 (26.3)	22.5 (39.3)	20.0 (39.0)
Opioid prescription within 90 days, No. (%)			
LIRE provider <sup>a</sup>	55,466 (29)	412 (44)	14,317 (31)
Any provider <sup>b</sup>	64,478 (34)	484 (51)	17,613 (39)

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### Try-It-On: Preparing family nurse practitioners to use holistic integrative interventions to reduce opioid prescriptions in chronic pain management

Gregg, S. Renee DNP, FNP-C (Clinical Assistant Professor)<sup>1</sup>; Brown, Angela DNP, MSN, RN, ANP-BC, FNP-BC, CDE (Clinical Assistant Professor)<sup>1</sup>; Pasvogel, Alice PhD, RN (Assistant Research Scientist)<sup>1</sup>

Author Information

Journal of the American Association of Nurse Practitioners: January 2020 - Volume 32 - Issue 1 - p 37-44

doi: 10.1097/JXX.0000000000000245

 Metrics

#### Abstract

In the United States, more than 130 people die each day from an opioid overdose. Nonopioid chronic pain management options are necessary in primary care. This educational innovation describes a new curriculum to teach future family nurse practitioner (FNP) prescribers holistic integrative interventions to decrease overprescribing of opioids for chronic pain

- “Have you heard of it?”
- “Have you tried it?”
- “Would you use/ prescribe for your patients?”

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### Try-It-On: Preparing family nurse practitioners to use holistic integrative interventions to reduce opioid prescriptions in chronic pain management

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- Recorded lectures for each intervention
  - Background for use
  - How to implement in your practice
  - Do it yourself tutorial
- Pre and post survey
- Results from students
  - More comfortable
  - Believe can work and valuable
  - Increased prescribing of these therapies
  - Increased communication skills

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### Preparing nurse practitioners to combat the opioid epidemic: A survey of nurse practitioner academic programs in the United States

Kameg, Brayden N. DNP, PMHNP-BC, CARN, CNE (Assistant Professor of Nursing)<sup>1</sup>; Fradkin, Dina BSN, RN (Doctoral student)<sup>1</sup>; Mitchell, Ann M. PhD, RN, FAAN, FIAAN (Professor of Nursing)<sup>1</sup>

Author Information 

Journal of the American Association of Nurse Practitioners: October 2021 - Volume 33 - Issue 10 - p 818-823

doi: 10.1097/JXX.0000000000000502

 Metrics

#### Abstract

Between 1999 and 2017, nearly 400,000 individuals died from opioid-related overdoses in the United States. Nurse practitioners (NPs) can be instrumental in providing care for those with opioid use disorders (OUDs) but must be adequately prepared to do so. Currently, there is limited evidence regarding how NP programs are preparing their graduates to address opioid use. The purpose of this study was to evaluate how NP programs have addressed the opioid epidemic within their curricula, and to evaluate barriers to and facilitators of curricular modifications. Electronic surveys were distributed to all 444 NP program directors in the United States. The survey consisted of 10 questions and inquired about curricular modifications made in regard to OUDs, barriers and facilitators of such modifications, and perceived importance of addressing the opioid

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### Preparing nurse practitioners to combat the opioid epidemic: A survey of nurse practitioner academic programs in the United States

Kameg, Brayden N. DNP, PMHNP-BC, CARN, CNE (Assistant Professor of Nursing)<sup>1</sup>; Fradkin, Dina BSN, RN (Doctoral student)<sup>1</sup>; Mitchell, Ann M. PhD, RN, FAAN, FIAAN (Professor of Nursing)<sup>1</sup>

Author Information 

Journal of the American Association of Nurse Practitioners: October 2021 - Volume 33 - Issue 10 - p 818-823

- Drug Addiction and Treatment Act (DATA) 2000
  - Physician waiver to treat OUD with naloxone/buprenorphine or buprenorphine
- Comprehensive Addiction and Recovery Act (CARA) 2016
  - NPs and PAs expanded waiver

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### Preparing nurse practitioners to combat the opioid epidemic: A survey of nurse practitioner academic programs in the United States

Kameg, Brayden N. DNP, PMHNP-BC, CARN, CNE (Assistant Professor of Nursing)<sup>1</sup>; Fradkin, Dina BSN, RN (Doctoral student)<sup>1</sup>; Mitchell, Ann M. PhD, RN, FAAN, FIAAN (Professor of Nursing)<sup>1</sup>

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Journal of the American Association of Nurse Practitioners: October 2021 - Volume 33 - Issue 10 - p 818-823

- Since CARA only 15% increase in waivers
- Call to action
  - AACN
  - AANP

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## 2016 CDC Guideline 12 Recommendations

### Determining when to initiate or continue opioids for chronic pain

1. Opioids not first-line or routine therapy for chronic pain
2. Set goals for pain and function when starting
3. Discuss expected benefits and risks with patients

### Opioid selection, dosage, duration, follow-up and discontinuation

4. Start with short-acting opioids
5. Prescribe lowest effective dose; reassess benefits and risks when increasing dose, especially to  $\geq 50$  MME; avoid or justify escalating dosages to  $\geq 90$  MME
6. Prescribe no more than needed for acute pain; 3 days often sufficient;  $>7$  days rarely needed
7. If benefits of continuing opioids do not outweigh harms, optimize other therapies and work with patients to taper

### Assessing risk and addressing harms of opioid use

8. Assess risks; consider offering naloxone
9. Check PDMP for other prescriptions, high total dosages
10. Check urine for other controlled substances
11. Avoid concurrent benzodiazepines and opioids whenever possible
12. Arrange medication-assisted treatment for opioid use disorder



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## Updating the CDC Guideline for Prescribing Opioids?

- In 2016 the CDC guideline indicated the intent to re-evaluate the guideline as new evidence became available and to determine when sufficient new evidence would prompt an update

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## Updating the CDC Guideline for Prescribing Opioids?

- New evidence
  - Benefits and harms of opioids for acute and chronic pain
  - Comparisons with nonopioid pain treatments
  - Opioid tapering and discontinuation

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## Updated Guideline Development

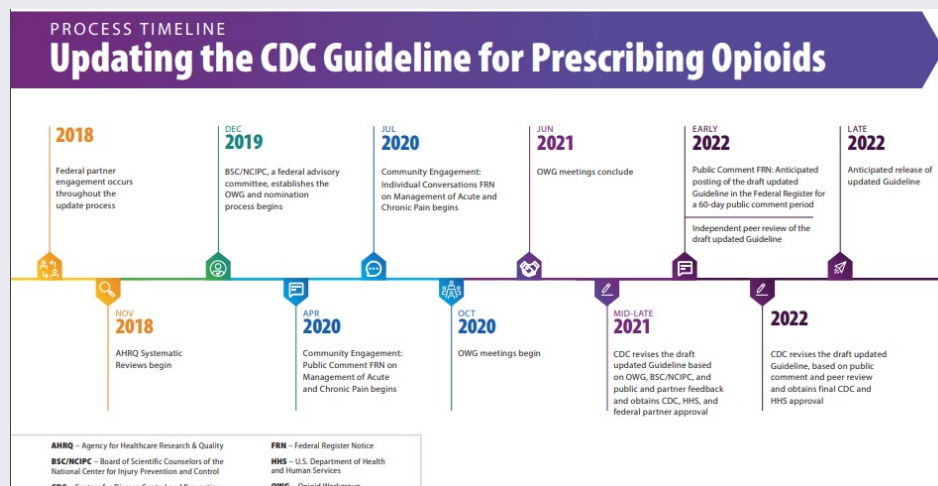
- Key themes expressed included:
  - Need for patients and clinicians to make sure decisions
  - The impact of misapplication of the 2016 CDC guideline
  - Inconsistent access to effective pain management solutions
  - Achieving reduced opioid use through diverse approaches

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## Updated Guideline Development

- Systematic reviews
- Community engagement
- Federal advisory committee engagement
- Federal partner engagement
- Public comment
- Peer review

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