Safer Opioid Prescribing in Massachusetts
Transcript

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DANIEL ALFORD, MD: Welcome to this special online program created to describe the resources available to generalist and specialist clinicians in Massachusetts who treat patients with pain and/or substance use disorders. I'm Dan Alford, a general internist at Boston Medical Center and Boston University, with expertise in primary care, pain management, and addiction treatment. I'm also the course director of Boston University's SCOPE of Pain Program. In this state-specific online program, you'll hear from several experts who will be introduced more fully in each section. Dr. Alex Walley will discuss current trends in Massachusetts in opioid prescribing and state trends in opioid overdoses and overdose deaths. He'll also guide us through features of the Massachusetts Prescription Drug Monitoring Program or MassPAT, and finally, he'll describe the continuum of services available in the state for people with substance use disorders. Next, Dr. Christopher Shanahan will walk us through an innovative, state-funded consultation program available to clinicians through the Massachusetts Consultation Service of the Treatment of Addiction and Pain, or MCSTAP. And finally, Dr. Erica Bial will help us understand the role of pain specialists in helping you manage patients with acute and chronic pain, and how to find a pain specialist in Massachusetts. After watching this video, you'll be able to navigate to a brief evaluation and receive CME or CNE credit.

I'm delighted that we're going to be talking today about Massachusetts-specific data, addiction resources, and the use of MassPAT. We are fortunate to have Dr. Alex Walley with us to present. He is a professor of medicine at Boston University and a general internist, primary care physician, and addiction medicine specialist at Boston Medical Center. He's also the medical director of the Bureau of Substance Addiction Services at the Massachusetts Department of Public Health. Welcome, Alex. Can you walk us through what you're going to be talking about?

ALEX WALLEY, MD: Thanks so much, Dan; I sure can. Today we're going to cover the following learning objectives. You should be able to know Massachusetts epidemiology of prescribing opioids, opioid use disorder, and overdose. You should understand how to better use the Prescription Drug Monitoring Program. You will learn how to better access substance use care for patients, including the substance use care resources for people in Massachusetts. And you'll be able to communicate and collaborate with substance use care providers, accounting for privacy regulations.

First, Massachusetts epidemiology overdose and opioid prescribing. Here you see the number of deaths from opioid-related overdose each year from 2000 through 2022. Since 2016, there's been more than 2,000 overdose deaths per year in Massachusetts. Illicitly manufactured fentanyl is the main substance that's driving opioid overdoses in Massachusetts. Here again you see the time period, now from 2014 through the first quarter of 2023, and the percentage of opioid overdose deaths that involve various substances. The dark blue line shows fentanyl, which is greater than 90 percent of the opioid overdose deaths, again, since 2016/2017. Other substances that are commonly present in overdose deaths include cocaine, alcohol, and benzodiazepines. You can see some of the substances that are present but less common at 20 percent or less, that include

prescription opioids, amphetamines like methamphetamine, heroin, and first detected in 2022, xylazine.

These opioid overdose deaths are not evenly distributed across the population in Massachusetts. In particular, since 2019, there have been surges in overdose deaths among Black, Hispanic, and American Indian people in Massachusetts. You can see in 2022, 32.6 people per 100,000 died from opioid overdose across all races and ethnicities. For white, non-Hispanic in 2022, it was 33.3; for Black non-Hispanic, 51.7. For Hispanic, 45.5, for Asian/Pacific Islanders who are non-Hispanic, 3.9, and for American Indian non-Hispanic, 143.6. These disparities are important for us to recognize as care providers so that we can really adapt and tailor our treatment and our substance use care efforts to account for these inequities.

Here we see time trends of opioid prescriptions and searches of the MassPAT or prescription monitoring program system in Massachusetts, running from 2015 through 2023. Going from left to right, you see the number of MassPAT or PDMP Massachusetts searches, in green, that occurred in each quarter. And for the most part, you're seeing increases on a quarterly basis with a few exceptions. The number of searches has gone from around 500,000 per quarter to greater than two million, close to 2.5 million searches. Also indicated on the slide are dates of policy changes that required increase in use of the prescription monitoring program by prescribers during that time. With the blue line, you see the number of prescriptions of Schedule 2 opioids, and that's decreasing from 2015 through 2023, going from 850,000 prescriptions per quarter down to less than 450,000. While correlation does not indicate causation, these two sets of data do seem to be related.

DANIEL ALFORD, MD: Thanks, Alex. In your last slide, you discussed MassPAT data. I wonder now whether you could walk us through some of the features of the online MassPAT website?

ALEX WALLEY, MD: Thanks for asking. I'm going to walk you through several features. I do want to mention that this is a test environment. This is actually a fake account that was set up for teaching purposes because if I were to show you my own account, you'd be able to see private and confidential patient information, which is not appropriate for me to share in a teaching environment. So, this is a test environment with a fake account, doctor.walley@dph.com and you'll see a fake patient. This is the regular login screen that you'll see if you go the MassPAT or Massachusetts prescription drug monitoring program website. Now many of you, maybe most of you, have access to this through your electronic medical record. It actually logs into this for you, and you may not have to go to this login page. But if you do, this will look familiar. If you don't, if you use it through your EMR, the rest of it after this page will also look familiar. It's just you don't have to do this page.

After you go this screen, you'll see something like this, which is really the dashboard. It says Home > Dashboard in the upper left-hand corner. And this shows you some nice features: whether you have any alerts, what your recent requests are. A nice feature is you can touch on or click one of your patients there. And you can see the patient for this purpose is Barney Rubble, not a real patient. You can also see who your delegates are. Before we get into specific patient information on Barney Rubble, I want to show you some of the menu features that are a little lesser known and lesser utilized, but I think can be quite helpful. The first one I want to show is one you have to set yourself, and that's your default PMP states. And you can see, under this is the drop-down menu in the upper left-hand corner, where it says user profile, the second one down is Default PMPi States.

If you haven't done this, you should go into that and click all the states represented there. Actually, in the test environment, it's only about 15 states, but in the real environment, it's almost all 50 states, I believe. You check each one of those and then you Click "update defaults." Once you click "update defaults," you don't have to check them again. The PMP will automatically search all of those states, not just Massachusetts. I'll tell you in my experience, it's unusual, it happens, usually it's a bordering state, where we have a patient who's filled prescriptions in other states. But there's no downside to having these all checked. That's the first tip.

Next thing to look at in the menu is your Delegate Management. I already mentioned that I had, in this test environment, one delegate. If you click on the Delegate Management page, you'll get to see all of your delegates. In this case, there's only one of them. A delegate is somebody you delegate to be able to access your account. They're a licensed usually nurse, pharmacist, or another prescriber who can look up your account. That really helps if you're having a team approach or if you're having people cover for you. I recommend that you use that delegate feature so the people you want to be able to, that you're willing to delegate to, can see your account.

The next feature from that drop down menu I want to show is the Prescriber Report. The system generates prescriber reports. They'll actually often send you an email with a link to the Prescriber Report so you can see what your prescribing practices are compared to other people in your specialty and prescribers overall. Because this is a test environment, there's no Prescriber Report available for doctor.walley@dph.com and so you can't click on any of the reports. But if you were able to, this is where you'd be able to find them. What I really want to highlight on this page is the fact that there's list of resources. We're actually in the process of getting these updated to be even more useful. For example, one of the things we want to have on here is the SCOPE of Pain training course. What's already on here are the Massachusetts Board of Registration in Medicine Prescribing Practices, Policies, and Guidelines; the Massachusetts Medical Society's online learning module called The Opioid Epidemic; a guide to using this page; the Prescriber Report User's Guide; some information from the CDC and from the Massachusetts BSAS.

The next thing I want to show you is Request History. When you click on Request History, it shows you the list of patients who you've done prior requests on and it also, I believe, shows you who your delegates have done requests on. That's a quick way of being able to access the individual patient-level information without having to go through typing in their name and their birth date, which I'll show you how to do at the very end.

In this case, we're going to click on Barney Rubble. Here you can see the dashboard for Barney Rubble, or the main page. This is a very long page. I'm going to show you a series of slides that show the different features on this page. This is really where we get the information on the specific patient. In this case, it shows you when the report was generated, the report date range – look, it goes back two years – and the number of prescriptions, what the insurance source has been, the total number of prescribers. It uses the term narcotics, which I don't like. We're trying to change that. And then also shows, specifically, buprenorphine.

I'm scrolling down here a little bit more on the page, and here you see the number of prescribers and the number of pharmacies in the last 12 months. For this patient, Barney Rubble, it was four prescribers and three pharmacies. Then you're starting to see the individual prescriber information and some nice features. This is where I, frankly, do most of my looking when I look up a patient, is this Prescriptions window, where it shows me the date the last prescription was filled, when it was

written, when it was sold, what it is, the quantity, the number of days, who the prescriber is, and then the dispenser is actually the pharmacy where the prescription was generated. A lot of these columns have this nice rollover feature where you can get more details if you roll your cursor over. I'm going to give you an example of that. Before I do that, I just want to point out there's the daily dose, which is the number of morphine milliequivalents, and you'll notice for opioids like oxycodone with acetaminophen, it shows you the morphine milli-equivalents. Buprenorphine is does not; it just shows you the total daily dose.

Now I'm going to click; you'll see that rollover feature where you see Injured Workers Pharmacy, 300 Federal Street, Andover, Mass. in the black box. It's a nice feature where I see what actual pharmacy the prescription was dispensed from and get the information. I think that gets to one of the overall messages that we're trying to get at here is with safter opioid prescribing: you really want to communicate amongst the other prescribers. In the prescriber column, I could look up the other prescribers, what their names were, and I can also communicate with the pharmacy so that we can make sure that the patient's getting what they need at the pharmacy. And if there's any concerns among the providers, that facilitates communication, so we can talk to each other.

I'm scrolling down a little bit more and you can see this Rx Graph. This has different categories of medication, and it shows all prescribers, and it really gives you a visual representation of the overlap of controlled substances or substances that are prescribed that are recorded in the PMP, and the density of those. We have red for narcotics, again that word I don't like. Buprenorphine is purple, sedative is a teal color, stimulant is green, and other is gray. You can toggle these so you can highlight one prescription or type and not the others. I'm going to show you that. Here I just unclicked all the other boxes except for buprenorphine and now you can see just the buprenorphine prescriptions. You can see how some of the prescribers overlapped and how they covered for each other. And when the patient had gaps in care, the white spaces, over the last, in this case, one year.

Going down, next you have the prescribers. This is where you get that detail on the prescribers. If you don't want to hover over and you want to scroll down, you can do that. Then we start to see some of these other features. Prescription drugs by fill, so this is just another way of seeing what drugs were filled in the last 30 days. And then buprenorphine prescribed over time in the last 30 days. So, remember, we ran this report June 11th. The last prescription was, I think, in April so nothing's showing up for the last 30 days. This allows you to toggle along the top line there from last 30 days to last 60 days, 90 days, one year, or two years. I'm going to show you what it looks like for the same patient, same categories, but over two years rather than over 30 days.

Here I've extended it out to two years for both of these categories and you can see essentially the number of buprenorphine prescriptions. There were 15 over the last two years, and there were 13 oxycodone/acetaminophen prescriptions and 3 gabapentin prescriptions. Then it looks at, in this case, buprenorphine over the last two years and you can see the milligrams. Actually, if you look at the milligrams prescribed, it's typically two milligrams, but there are spikes where this patient got over 20 milligrams for short periods of time.

Going down here, the same idea: over the last two years, it shows you the morphine milli-equivalents prescribed per day over time. It shows you the average morphine milli-equivalents per day of 6.5, and then morphine milliequivalents per prescription of 363. But then it also shows you

where over the calendar those prescriptions spiked and where there were gaps. Then this patient also received for a little bit some lorazepam, and you can see how that was prescribed.

I'm going to go back here to your menu in your dashboard, and I'm going to show you the last thing, which is just how to look up a patient. Here I'm going to hit Patient Request under Rx Search. It's the last feature I'm going to show you, which I think maybe most of you already know. Here, if I wanted to manually look up Barney Rubble, I'd have to type in Barney and Rubble and then Barney Rubble's birth date. Then I hit the green continue button at the bottom and that will take me the record which I just showed you.

Just to review, I showed you several features that I think are very helpful in the prescription monitoring program. We first talked about the default PMP states and how to set the default. I talked to you about delegate management and how to see who your delegates are, and then we talked about the Prescriber Report which we didn't actually look at a Prescriber Report, but you go to see where there are some helpful resources listed under the Prescriber Report. Then we went through Requests History, and we used that to get into a specific patient and then I walked you through each of the features on that long page that you get under a patient's record.

I hope this was helpful for you and I really encourage you to make the PMP your friend and not your enemy. Share what you're doing with your patients, engage them in the discussion. Really the main learning point I want to get across is that you could use the PMP to talk, communicate better with your patients, but also with the other care providers, the pharmacists and the prescribers that are involved in your patients' care.

DANIEL ALFORD, MD: Thanks, Alex, that was incredibly helpful. Now I'd like to turn our attention to resources that are available to Massachusetts residents who are diagnosed with a substance use disorder. Can you show us what's available throughout the state?

ALEX WALLEY, MD: Dan, I'm so glad you asked. We're going to take a few minutes to go through the care continuum available in Massachusetts for people who use substances. Note that all of these resources are accessible through the Massachusetts Substance Use Help Line. I'll show you a link to that resource after I get through going through the continuum.

The first resource I'm going to highlight are Community Behavioral Health Centers. These programs offer immediate, confidential care for mental health and substance use services. This includes assessment, diagnoses, and referral to local providers. Sites are also able to provide bridge prescriptions for medication for substance use disorder, such as buprenorphine.

The next resource I want to highlight are bridge clinics, which are typically, though not always, hospital-based programs that provide diagnosis, assessment, and transitional care for patients with substance use disorders, in order to stabilize them while they are connected to ongoing community-based care for longer-term treatment. This can include providing a bridge prescription for medications like buprenorphine, naltrexone, and in many cases, dosing of methadone in the first three days or over a 72-hour dosing period.

Next, I want to highlight office-based addiction treatment, which is an addiction treatment program that provides assessment and treatment for substance use disorders including alcohol, opioid, and stimulant use disorders with medications available including buprenorphine, injectable

buprenorphine, injectable naltrexone, and oral naltrexone. These programs are often based in Federally Qualified Health Centers, though not always. Patients receive specialized treatment for their substance use disorder integrated with wraparound care in a primary care setting, allowing all of their medical needs to be address by a team of providers in a one-stop shop.

Next, I want to highlight office-based opioid treatment, which is an addiction treatment program that is specifically focused on patients with Opioid Use Disorder. Medications here include buprenorphine, injectable buprenorphine, injectable naltrexone, and oral naltrexone in an outpatient clinic setting.

Next, I want to mention Peer Recovery Support Centers, which are free, warm, and welcoming peer-led spaces that provide individuals in recovery from substance use disorder, as well as families and loved ones affected by addiction, the opportunity to both offer and receive support in their community environment. These spaces are grounded in the values and principles of multiple pathways of recovery.

The Massachusetts Substance Use Helpline is the only statewide, public resource for finding licensed and BSAS-funded harm reduction, substance use treatment, and recovery services. The Helpline can assess and individual's needs, provide referrals to substance use-related services, and assist an individual in accessing treatment, provide information and answer questions about substance use disorders, treatment, and recovery; and even follow up after the first call to check in.

Now that you know where the treatment continuum is, and what it is in Massachusetts, I want to take some time to talk about broadening naloxone distribution, getting the antidote to an opioid overdose into the hands of your patients and their families. There are multiple ways that you can do this. First, I want to mention partnering with harm reduction providers to get naloxone to those at highest risk for overdose. There's a community program standing order through the Massachusetts Department of Public Health that allows community harm reduction providers to distribute naloxone and do overdose education. You're going to see in a subsequent slide where those programs are throughout the state. You can facilitate pharmacy distribution, and this includes by referring your patients to get naloxone at a pharmacy where there is a pharmacy standing order that is in existence at all pharmacies in Massachusetts. You can engage your addiction treatment provider colleagues, Federally Qualified Health Centers, and emergency departments to distribute naloxone to people that they encounter who are high risk. Know that first responders in Massachusetts are, in many cases, equipped with naloxone. They're able to administer it during an overdose and in a case of EMS, they're able to leave it behind at the scene of an overdose with the people and the family or the friends of the person who just overdosed. Naloxone is now, since last year, 2023, available widely over the counter, including online sites like Walmart and Amazon. And some insurance companies may cover the OTC naloxone products if you take it to the pharmacist at the pharmacy. MassHealth will cover most prescription and OTC naloxone with no prior authorization and a zero-dollar co-pay. Note that over the counter naloxone is often kept behind the pharmacy or the checkout counter and that's something that you might want to let your patients know about.

Here you see a map of Massachusetts that locates where the naloxone distribution programs and syringe service programs are. Overdose education and naloxone distribution programs provide overdose training in naloxone to people who are at risk of experiencing or witnessing an overdose.

OEND programs focus on working with people who use drugs and are typically embedded in syringe service programs. Syringe service programs are where people who use drugs can access safer drug use supplies, including sterile needles, syringes, and other harm reduction supplies. People can also dispose of used needles and syringes and get connected to other services, such as testing for Hepatitis C, HIV, and other sexually transmitted infections.

In the purple dots, you see community naloxone programs, or CNP, locations. These are programs that provide counseling on overdose prevention and training on overdose response, and provide naloxone at no cost to the individual, supported by the Massachusetts Department of Public Health.

I also want to mention the Safe Spot Overdose Prevention Helpline. This is a virtual spotting and overdose detection service for people who use drugs. Trained operators ask callers for their location and their phone number before they use drugs. If during the call they stop responding, the line will get them help, either through a predetermined responder or by notifying their local emergency medical services. This number is active and supported by trained operators 24 hours a day, 7 days a week. I recommend that you let your patients and their families know about this line. You can even call the line with your patients and try it out. There will be no questions asked and the line is expecting people to call just for information.

DANIEL ALFORD, MD: Thanks, Alex. That was a wonderful, comprehensive overview of what's happening in Massachusetts in terms of what resources are available to our patients. I guess the next question that comes up is how do we, as primary care providers, interact with that system? It's not like sending a patient to endocrinology and we have systems in place. How would you recommend to our audience how they should interact with these substance use disorder programs and resources that you discussed?

ALEX WALLEY, MD: That's a great question, Dan, and I think it's a really important one. I can tell you from my experience as a primary care provider and as an inpatient addiction specialist who's trying to link patients to outpatient services, it's really important that we individually build our networks, our relationship networks, with substance use care providers. That includes the treatment providers that we went over as well as harm reduction programs. How do you do that? Well, it does require work. I think it's best to do be done opportunistically when you have a patient who's looking for a particular type of care, now you know where to direct them through the Massachusetts Substance Use Helpline. You can facilitate their linkage by contacting that program and offering any support in the referral and also encouraging them to follow up with you about the patient's programs. That type of communication, I think, can be really helpful and really fruitful and, frankly, really satisfying because one of the things I think that promotes success in caring for people with substances is taking a team-based approach, and not feeling like all of the care falls on one provider. But that, on the other hand, requires communication. And one of the key communication issues that often comes up are the privacy rules. It turns out historically there have been separate privacy rules for people involved in substance use care. But recently a lot of that has been clarified and actually brought into alignment with other privacy rules like HIPAA that exist when we care for people as medical providers.

I'm going to show you a slide that shows some of these points here. You may hear about 42 CFR Part 2. That was the federal regulation that really required and promoted privacy, special privacy provisions, among people who use substances. But as of February 8, 2024, there have been key

updates to this final rule that, as I said, brings things more into alignment with what we're using to in mainstream medicine regarding privacy. Some background: 42 CFR Part 2 protects patients' substance use treatment records by any program receiving federal funds to address concerns that discrimination and fear of prosecution deter people from treatment. The updates in February 2024 include permitting a single consent for all future uses and disclosures for treatment, payment, and healthcare operations. This aligns with HIPAA. Specifically, the redisclosure rules are now aligned with HIPAA so it's the same procedure that you'd take around redisclosure with 42 CFR Part 2 as you do with HIPAA. There's also an alignment of substance use counseling notes with HIPAA psychotherapy rules. The disclosure of these requires a specific consent, both counseling notes and psychotherapy notes. It does restrict the use of records and testimony in legal proceedings against patients, absent patient or a court order. So, you can reassure your patients that their records cannot be used in legal proceedings unless they have consented or there's a court order. Lastly, segregating or segmenting the Substance Use Part 2 records is not required. And so there can be integration of substance use care records with regular medical records.

DANIEL ALFORD, MD: Thanks, Alex. That was actually a great summary of the rule changes. I think it's an important thing for the folks to understand. However, I can imagine that not all treatment providers are up on these rule changes. I'm wondering what you would recommend our listeners, in terms of how to navigate that, when they still get pushback despite these rule changes.

ALEX WALLEY, MD: That's a great question, Dan. Certainly, it takes time for clarifications or changes in regulation to translate into implementation and I think it's important to be transparent that as I'm encouraging care providers to communicate, coordinate, and partner with their substance use care colleagues, that they may run into problems. There are two things that I want to highlight on this slide that providers can do. First of all, they can refer to the SAMHSA Fact Sheet that specifically focuses on the 42 CFR Part 2 final rule updates. And then, I also want folks to be aware of the DPH Bureau of Substance Addiction Services Complaint Line. Complaint Line is maybe an unfortunate name, but it is the place that you can report problems that you're having in communicating with your substance use care colleagues. They are a responsive line. It's checked regularly. It's an effort that BSAS really takes seriously to improve the care coordination, communication, and partnership between the substance use care system and the public as well as medical providers.

DANIEL ALFORD, MD: Thanks, Alex, for joining us and thanks for the wonderful overview of the statewide trends as well as resources and then in particular the changes that have occurred around confidentiality and basically improving our ability to coordinate care for our patients.

ALEX WALLEY, MD: You're welcome, Dan. Thanks for the opportunity and I'm glad for the interest. Take care.

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DANIEL ALFORD, MD: Among the resources available to Massachusetts clinicians is the Massachusetts Consultation Service for the Treatment of Addiction and Pain, or MCSTAP, which is funded by the Massachusetts Executive Office of Health & Human Services. I'd like to welcome Dr. Christopher Shanahan, who is the MCSTAP's Medical Director. Doctor Shanahan is a clinical associate professor of medicine at Boston University Chobanian & Avedisian School of Medicine,

and a practicing primary care physician with expertise in addiction medicine, chronic pain management, and community-based care. Welcome, Chris.

CHRISTOPHER SHANAHAN, MD: Thank you, Dan.

DANIEL ALFORD, MD: To start off, can you tell us about MCSTAP?

CHRISTOPHER SHANAHAN, MD: MCSTAP, its mission is to support clinicians in increasing their capacity for and comfort in using evidence-based practices to screen for, diagnose, treat, and manage the care of patients with chronic pain, substance use disorder, or both. MCSTAP provides real-time phone "Curbside Consultations" for clinicians on safe prescribing and managing care for Massachusetts adults with chronic pain or substance use disorder. You can call for free consultations for patients at 1-833-PAIN-SUD, Monday to Friday, irrespective of patients' insurance. You can also contact us online by using the link on the slide or just going to mcstap.com and then clicking on Request A Consultation.

Our staff is composed of experienced physician consultants who are expert in treating addiction and pain. We provide live telephone support on clinical issues. We provide overall evidence-based patient-centered approach to care of patients with SUD using medications for Opioid Use Disorder, also known as MOUD. Specifically, that usually is buprenorphine and naltrexone. We also provide support on chronic pain using short- as well as long-acting opioids.

MCSTAP provides expert treatment planning, review and ongoing revision for complex patients including initiation of care, dose adjustments, treatment outcome and risk monitoring, and then clinical decision-making on when and how to terminate prescribing or to refer them or to titrate the dose of their medication. You can get assistance when you need it, that you need, at the point of care, in less than 30 minutes. You can review the care of your patient before, during, or after office visits, or schedule it at some other time when you are available. We can provide you longitudinal support: you can request the same consultant for the same patient in the future. And we can support you around other issues, specifically around pregnant women, special populations, ethical concerns, managing stigma both with patients as well as clinicians and staff.

The types of consultations that MCSTAP received last year, just to give you a sense of the type of service we provide: 66%, or 2/3 of our calls came from physicians, and a full quarter of them came from Nurse Practitioners or PAs. Most of our calls – actually our calls are pretty much spread out across the state: 25% are Metro Boston, 25% are Northeast. Over a third of our calls are around chronic pain. Just under a third are for SUD, and almost a fifth, or actually a fifth, are a combination of both. In addition, chronic pain or SUD often is complicated by mental health disorders and we often speak to clinicians around those issues as well.

DANIEL ALFORD, MD: Chris, if a primary care clinician who is in private practice out in the middle of the state calls you, what can they expect? Can you walk us through a sample consultation?

CHRISTOPHER SHANAHAN, MD: Here's a typical case. The patient maybe is a 62-year-old female who is new to your practice. The patient has several medical problems. They have chronic low back pain and they're on chronic opioids, a total of 131 morphine equivalents per day. This low back pain is also accompanied with fibromyalgia, major depression, anxiety, PTSD, and obstructive

sleep apnea. The patient is seeking your care to manage her pain because her previous doctor required her to commence a taper of her pain medications.

The clinician expects to see the patient later this day. They are concerned about what to do with this new patient who has got chronic low back pain and was started by another clinician, many, many years ago. Then on top of it, this patient is switching to you because they want to continue to take that medicine and the new doctor that they've been assigned to doesn't. In this situation, the physician, at a loss for what to do, is worried because this patient is going to be here in a few hours, calls MCSTAP to request a consultation during lunch, to get a few ideas about how to approach this patient. They don't know even that much about them, but they're looking for some pointers about how to just get started. That's a reason why somebody would call. The physician gets a call from the consultant at 12:30 and speaks for about 12 minutes during that call about the patient. After the clinician quickly presented the case, the consultant and the calling clinician discussed the case and came up with a co-developed clinical plan that had a couple of objectives to address during this first visit. Now the clinician feels confident about their strategy for this patient visit and they're ready to manage some basic issues that might arise. The clinician now has a plan for the next visit and has expert backup by a colleague who already knows the case and can be called again in the future when needed.

Three months later, during the patient's third visit, increasing pain is reported, prompting the clinician to change the treatment plan. After the physician, the clinical calls to schedule another MCSTAP consultation to review the changes she made to the treatment plan and begins planning the next steps. Alternatively, they could have called right then and there and asked any consultant who was on call at that moment during business hours. The point is, you can go back to the original consultant, or you could get a quick consult from somebody who may not know the case, but you can get an instant result.

DANIEL ALFORD, MD: Thanks, Chris, that's super helpful and very clear. You mentioned early on that you have a team of consultants. Can you tell us a little bit about who they are?

CHRISTOPHER SHANAHAN, MD: Our consultants are the best part of MCSTAP. We have 10 physician consultants who represent six help systems across Massachusetts. They're all generalist physicians. Five of them are internal medicine, four of them are family medicine, and we have one ER doc who also practices palliative care. Some key facts about them: most of them have expertise in Chronic Pain or SUD. They all have experience being teachers and mentors for trainees and practicing clinicians. They're all deeply committed to helping other clinicians achieve better outcomes for patients with chronic pain and/or SUD. And they all have broad practice experience. Eight of them have academic teaching practice experience. Five of them have worked or currently work in methadone treatment programs. Three of them work at community health centers. One is in private practice, and one works in hospice. The other thing you should know about my consultants is that whenever they get a call or a request for information that they don't have an answer, they email each other back and forth. There's a very constant, active conversation going on between my consultants behind the scenes. So, you're not just getting one doctor supporting you, you're actually getting more than 10. To be exact, you're getting 12. These are my docs. I won't read all their names off, but you can see that they are represented across the state. I'm very, very, very proud to be working with them. They are a fantastic team.

DANIEL ALFORD, MD: Thanks, Chris. I know there are other services besides the consultation service and I'm wondering if you could tell us a little bit more about what else MCSTAP offers clinicians.

CHRISTOPHER SHANAHAN, MD: Absolutely. The basic MCSTAP services is that you have a problem at this moment, and you can schedule a time to speak to a consultant about that problem, at that moment or at some point in the future. In addition, we have a mentoring program, which is a 12-week personalized professional clinical mentoring program with a designated physician consultant that you're assigned to. The mentoring focuses on monitoring and evaluating the process and quality of care in clinical cases within the clinician's practice in clinical areas where the clinicians need support. Basically, your panel of patients that have SUD or chronic pain or both.

When can mentoring be helpful? Well, it can be very helpful for people that are newly starting to prescribe buprenorphine, clinicians who are unsure about managing complicated patients with chronic pain and/or SUD or OUD, or when a clinician inherits a patient or a panel of patients on high-dose opioids from another practice. Those are things that we can do with the mentoring program.

MCSTAP also has Tip Sheets on our website that can be downloaded for no cost. An example of one is The Nuts and Bolts of Buprenorphine: Basic Buprenorphine Prescribing for Opioid Use Disorder. This tip sheet aids in the development and evaluation of processes and quality of care in clinical practice in areas where clinicians may need additional support. Those are available for free along with other tip sheets on our website.

Finally, we provide training. We have a monthly webinar where we do a case presentation and a very, very interactive audience discussion around the case. We provide free CME for that. Again, this is our contact information.

DANIEL ALFORD, MD: Thanks, Chris. That was incredibly helpful and a really tremendously important resource for Massachusetts clinicians and their teams. Hopefully, we'll drum up some business for you because it's really an important resource for folks. Thanks again.

[Music]

DANIEL ALFORD, MD: One difficulty generalist physicians face when working with patients with pain is how to find and successfully refer to a pain specialist. Dr. Erica Bial joins us to discuss the issues surrounding that barrier. Dr. Bial is an interventional pain specialist practicing in the Greater Boston area for over 15 years. Previously she served as Director of Non-Surgical Spine Care in the Department of Neurosurgery at the Lahey Clinic & Medical Centers, and Director of Pain Medicine at Mount Auburn Hospital. Her areas of special expertise include the non-surgical management of spine disorders, neuropathic pain, neuromodulation, and non-opioid medical strategies in the treatment of pain. Erica, welcome. Can you set the stage? What should we be thinking about as we work to overcome barriers to pain care?

ERICA BIAL, MD: I came up with an acronym for this that I think makes it easy, and these are mostly intuitive points, but my acronym for those first steps, that initial approach to treatment, is "BEAM ME UP." So, what does it stand for? The B is for Believe. The E is for Equity. The A is for Ask, M for

Medicalize, second M for Multimodal, E for Educate, U for Urgency, and P for Pattern. In thinking about BEAM ME UP, of course we want to believe the patient. We have discussed previously how validation itself improves trust and patient outcomes and that there's no risk to believing the patient's pain. Equity, of course, really matters. And so we always want to consider the role of our own implicit biases as well as cultural influences that the patient may have on expression of pain and acceptability of medical care, and these may impact the need for individualized treatment. Ask questions about the patient's beliefs about pain care. Ask questions that help us to understand the patient's potential fears and their potential barriers to pain care internally. Medicalize the person's pain as a complex disease. This helps to legitimize the reasonableness and the universality of the patient's compliant. This may inform, then, offering a Multimodal, simultaneous approach; for example, suggesting heat, ice, meditation, anti-inflammatory, and referral for physical therapy. Educate the patient about the broad range of options available. This provides reassure that the patient isn't stuck and that a logical and step wise approach will be taken. Also, I think it's important to educate the patient that if you're referring to another provider that you're not abandoning or dumping that patient somewhere else. Finally, we want to consider the urgency of the referral. That urgency should really match the level of acuity, risk, and functional impact, as well as the severity of the patient's pain, and consider the pattern of pain as it might inform your choice of specialist.

Very often the first steps are not to refer the patient to a physician specialist, but to a potential non-physician specialist, and there's a pretty broad range of options to consider. Physical therapies are usually the cornerstone of a first step, especially for a musculoskeletal complaint. Sometimes patients are very interested or already participating in, I hate this term, but complimentary and alternative medicine modalities or CAM. Of course, that brings up the alternative to what, but other non-allopathic approaches to care, chiropractic care, as well as psychological and behavioral health approaches, all are modalities that might be readily available to your patient.

Thinking first about physical therapy, some ideas, and tips. This is almost always a first step in the presence of a functional impairment. We want to get the patient functioning physically. Early mobilization is well-demonstrated, particularly when we're talking about back pain, to help improve outcomes and avoidance of disability. One thing I really like about physical therapy is that usually these require active participation from the patient. Obviously, that can improve function, autonomy, as well as aid in diagnosis. Physical therapist calls you and says, "I'm really concerned about this joint or this particular process for the patient." It can be very helpful, getting a different perspective on the exam of a patient.

Thinking about some of the available CAM modalities, things like acupuncture, massage, Reiki, others: most of these approaches are generally safe. It's important that we recognize that patients are very often availing themselves of CAM modalities and we need to be asking questions particularly about supplements and herbal medications or traditional medications that they might be using, because there is a risk of interactions. I think core to the decision about the use of CAM modalities is really the patient's belief in the modality. Personal cultural experience and comfort can influence outcome. That's probably always true, including patients' response to most allopathic modalities. These are typically safe but again, always ask. There's no harm in asking open-ended questions. Sometimes patients conceal their non-Western or non-allopathic beliefs or values from their allopathic providers. So, we should be asking about that in a non-judgmental way.

Chiropractic care is an extremely common modality that many patients will self-refer or request referral, especially as a first line treatment, especially in the care of back pain. The care that's administered is highly variable. There is evidence of benefit, but that's conflicting. But a challenge is that chiropractic is often a passive modality, and it requires ongoing and often expensive and frequent care that is, I suspect, non-superior to physical therapy modalities.

One modality that I think is probably under-utilized but when it's accessible, psychological and behavioral care approaches can be very impactful, particularly with chronic pain. We imagine that likely all chronic pain has a feedback loop with behavioral health. So, learning skills like pacing, coping, shifting of our attention, as well as things like meditation, all have strongly demonstrated benefits. Most of the time when we're thinking about psychological or behavioral health approaches to pain care, these are CBT modalities. Additionally, we know that there's a very significant overlap in comorbidities of depression and anxiety, and that these can amplify the pain experience, or they can be a cause of the pain itself, so addressing those is generally speaking beneficial.

It's a fun fact that there are tools like functional MRI-assisted brain-body skills that actually have a demonstrated potential for durable benefit, so things like specifically guided biofeedback, no medication, no intervention, have demonstrated durable pain-relieving effects in and of themselves.

Sometimes we need our specialist physician friends, too. There's a broad range of specialties that might be able to help in different situations of pain for our patients. Firstly, the pain specialist, what I do for a living. We also think about our close colleagues, the substance use disorder specialists, neurologists, rheumatologists, physical medicine and rehab docs or physiatrists, surgeons, and our palliative care colleagues are all folks that in some way or another – in an overlapping fashion very often in terms of the skills that we provide – can help to contribute to the care of your patients. Let's think about who we should ideally refer to, given that we might have many options, as a first contact.

I'll talk first about what I do. For pain specialists, ideally the patients referred to us should have a problem that is likely to have an interventional solution because that is, for most pain doctors, the top of our license, the things that other specialists can't necessarily provide. Or if the patient requires complex medication management or complex coordination with other providers, or a patient who has more than one pain process. Most of us will offer a broad range of interventions, so injections, or neuromodulation, as well as decision support for complicated medication management and for opioid management. Our training, by definition, is interdisciplinary. This is the reason that we often have overlapping skills with many of our other colleagues.

The next specialist that I want to talk about is the substance use disorder specialist. I think that patients ideally should be referred first to an addiction specialist when the highest priority illness is an opioid use disorder or the patient has an active substance use disorder that is impacting their pain care, particularly when there may be polysubstance use. Patients with a history of overdose event or any kind of complex dual diagnosis, I think if it's available to you, getting help from an SUD specialist is a great idea.

The neurologists also see quite a few pain complaints. They are particularly fantastic when it comes to help with treating patients with headaches, neuropathies, or if there's an underlying

systemic or neurologic disease that's the likely pain generator, then it's logical to refer to neurology first. Some nice other perks are that many neurologists can offer EMGs. Some offer limited interventional care: the interventions are usually more focused on headaches, so things like neurotoxins, like Botox treatment, that kind of thing. But they're very, very skilled with specialized medications for primary diseases of the nervous system and sometimes critically helpful in the treatment of post-stroke pain syndromes, although fortunately those are not common.

Rheumatologists also, of course, see a lot of pain syndromes and they're the great first point of contact when the primary problem is a connective tissue or autoimmune disease. They may offer interventional care, so things like trigger injections and joint injections but those are usually bedside techniques. Very, very skilled with specialized medications for primarily rheumatologic disease and disease modifying therapies. Those, at least for me as a pain specialist, are not categories of medications that I would be using personally.

Our colleagues the Physical Medical and Rehabilitation folks, the physiatrists, are very, very expert when the primary patient concern is a functional impairment, especially after injury and particularly for spinal cord injury. Any kind of therapy that really you expect is a non-surgical, musculoskeletal dysfunction. Many PM&R docs offer EMGs. They are unusually skilled with spasticity care, more than anything else, as well as spinal cord injury. Most of the other overlapping specialists are less skilled with those two big categories. They can be very directive and helpful with physical modalities, and many offer some interventional care like trigger injections, joint injections.

Sometimes we need to refer our patients to a surgeon and this seems obvious, but I know it is not the typical case, is that the ideal person to be referred to a surgeon first is if the problem seems to have a likely surgical solution. Or, understanding the surgical options can sometimes be important for patients for understanding that they don't need surgery. But it may be surprising to learn that only roughly 15 percent of patients referred to a spine surgeon, for example, whether that's orthopedic spine surgery or neurosurgery, for pain concern typically need surgery at all. It's very low yield, in fact, to send them to a surgeon first unless you think this is a patient who needs surgery.

Finally, I don't think that this conversation would be complete without discussing the role of palliative care specialists, who are extraordinarily skilled in the complex needs of cancer pain and end of life care. These physicians often offer a very broad spectrum of symptom management as well as psychological, spiritual and family services that unfortunately most of the rest of us would struggle to offer in a cohesive manner.

DANIEL ALFORD, MD: Thanks so much for that comprehensive overview. That was great. As you know, I'm a primary care physician and now I'm asking myself, how do I find a pain specialist?

ERICA BIAL, MD: It can be challenging. I think step one, of course, is to know what to look for. Ideally you want the specialist to be accessible to your patient and to have an ease of communication back to you as the referring provider. So somebody within the patient's network, both for insurance and access, as well cost concerns but also because that may help to enhance information sharing, chart access, and inter-provider communication. All of those things would be advantageous and important goals. I think the pain provider that you choose should offer the services that you anticipate the patient is likely to require. If you're imagining that the patient

needs surgery, send them to a surgeon. If you imagine that the patient might benefit from spinal cord stimulation, for example, send them to a pain specialist.

When making the decision to send your patient to a pain specialist, we should recognize that pain is, indeed, a specialty, and we're fellowship trained and board certified. ABMS officially-accredited Board Certification in Pain is typically through one of two places, either the American Board of Anesthesiology or the American Board of Physical Medicine and Rehabilitation. It's actually the same exam, and in fact, physicians who have base training in a wide range of specialties will ultimately be board certified through one or the other. It's the same test and it has the same qualifications ultimately. A number of other member boards now co-sponsor that exam, including Emergency Medicine, Family Medicine, Physical Medicine & Rehabilitation, Psychiatry, Neurology, and Radiology. The ACGME only accredits multidisciplinary pain fellowships, and these will almost always through ACGME accredited residencies in Anesthesiology, PM&R, Child Neurology or Neurology, even though the base board certification of the doctors participating in those boards can be varied.

Where should you look? If you want to try, in Massachusetts, to find a pain specialist, I discovered this recently. The Massachusetts Board of Registration in Medicine's website is actually searchable by specialty and location. If you want to choose, for example, the town where you practice, the town where the patient lives, and other places nearby, you can click everything that suits your patient's situation that says pain in the search bar at www.findmydoctor.mass.gov and you can pretty accurately locate pain specialists that are in your community.

You can also find board certified pain doctors through their member boards. It is a little bit easier to search for diplomates in the sub-specialty of Pain Medicine through the American Board of Physical Medicine & Rehabilitation, and I've provided the link here. Additionally, you can find diplomates through the American Board of Anesthesiology at www.theaba.org. Unfortunately, the ABA search requires that you have providers name, and it will only list those providers who are base trained in Anesthesiology. The ABPMR site – and this is just about what's on the back end of their data – allows for a little bit more general search but they are providing you equivalently trained providers, which is important to recognize.

There's also a research tool that would be available both to clinicians and to patients, and I was impressed to see how easy this was to use. You can check a certification at www.certificationmatters.org; that's all one word, "certificationmatters." You can, if you know there's a pain provider in your community but you want to see if this person is board certified in pain, pop their name in and their board certifications will pop right up.

There are a number of training programs in Massachusetts for pain fellowships and I think looking to academic medical centers that offer a fellowship is a great way if you have a complicated patient, somebody with a rare pain disorder. Sometimes an academic medical center, just like for many other diagnoses, for pain can offer a broader evaluation and available tools. But unfortunately, even in Massachusetts, options can be somewhat geographically restricted. There are a number of ACGME-accredited Pain Fellowship programs, and these are currently at Baystate, Mass General, the Beth Israel Deaconess Medical Center, Brigham and Women's, St. Elizabeth's, and there is a Pediatric Pain Medicine Fellowship at Boston Children's Hospital as well.

DANIEL ALFORD, MD: That's helpful. If I identify a specialist, what's the best way to communicate with that specialist and also to set realistic expectations for both my patient and for the colleague I'm referring to?

ERICA BIAL, MD: That's such a great question because of course at the end of the day, communication is the key. It can be really challenging, both for the patient's expectations as well as back and forth for the provider and the referring physician. I think it's really important that we tee up our patients for success. Whenever it's possible, send your records in advance. That should include relevant imaging results and include your notes with your formulation because one of the toughest things on the receiving end as a specialist is to not know why the patient is there. Additionally, and I think this is probably customary in most fields but is particularly important when referring to a pain provider, is send a medication list. You should be as clear as possible with the clinical question or concern or how you're hoping that we can help because sometimes the questions posed by patients make it very difficult to know which aspect of a pain specialist's available skills are the ones that should be applied most quickly.

If you don't know your network of pain providers, and I know this is going to sound very old timey of me, but I think picking up the phone, calling and establishing a relationship and asking questions about the services that they provide can't be replaced any other way. It may also help to lay out how you can best function as a team and to learn what services your local pain doctor does, and maybe more importantly, does not provide. Because this is disappointing, I know, to many referring providers, we do not just take over opioid prescribing for others, and many can only provide consultation and advice, sometimes short-term management, or stabilization when it comes to medication management. It's extremely difficult for everyone: for the referring provider, for the accepting provider, as well as for the patient, when patients expect us to provide opioids especially at the time of the first visit, if at all. We want to make sure that we set patient expectations, so let them know what we might be able to help with. Never send your patient with the expectation of a specific treatment. When patients come to my office and they say, "I'm here for my medication" or "I'm here for you to order my MRI" or "I'm here for my injection," this sets patients up for confusion and disappointment and also it may take away an element of physician autonomy which can be very difficult to overcome.

DANIEL ALFORD, MD: I wonder if you could give me a little bit of insight into how pain specialists conceptualize pain. That would be very helpful when I'm talking to my patients about what to expect.

ERICA BIAL, MD: We have an old adage in terms of how pain physicians think, and we also assert there's no pain till there's pain in the brain. So, whether the pain is acute or chronic, it always requires perception ultimately. We imagine the pain, maybe it's emanating from somewhere in the periphery and is traveling north to the brain, also that the brain may be providing dissenting inhibition to a pain signal. We imagine every influence that is affecting the patient's pain perception or it's functional impact. Each one of those thoughts, every synapse is an opportunity for intervention. Every major synaptic point that you can envision in the particular patient's presentation is, therefore, a potential treatment opportunity. We want to consider cognitive influences that might magnify or change the patient's pain experience, so we do think about things like sleep, depression, anxiety, and stress, as well as the patient's beliefs about what they can or can't or should or shouldn't do. Then we measure pain, both by its physical attributes and the truth is, I pay more attention to this one, its functional impact. Then ideally, we try to start to think about

what's available in our toolbox to address the physical, the psychological or behavioral as well as the functional attributes of the patient's presentation.

DANIEL ALFORD, MD: This leads me to my next question which is I have a patient sitting across from me and I want to send not to just one pain specialist but to multimodal, multidisciplinary care. How do I do that?

ERICA BIAL, MD: It's hard is the short version. You and I have talked a lot in the past about the importance and really the strong evidence base for multimodal pain care, particularly in complex chronic pain. The truth of the matter is that true multimodal care, where the paint gets a team-based approach with a team-based prescription, where multiple people are going to be contributing all at once in concert together for the patient's care, can be very difficult, in fact, to access. When you send a patient to a, for example, pain specialist, we look broadly to what's available in our personal toolboxes and then can also coordinate with others.

I often explain to my patients that there's a range of options that I might draw from. When it's appropriate to do so, I provide them with reassurance that at one of the spectrum we could do nothing and that that's okay. At the opposite end of the spectrum, and most patients thinking is the idea, that they require surgery. The work that I do is everything in between, so medications, injections, physical therapies, other stuff, are sort of the broad categories of what the pain provider can either personally provide or help to coordinate, depending upon the needs of the patient.

DANIEL ALFORD, MD: It seems like what you're doing is beyond your skill set coordinating care with other specialists, and I'm wondering how does that differ from what a primary care doctor does?

ERICA BIAL, MD: It's a great question, Dan, because it is and yet it isn't different. Much in the same way that as a primary care provider you probably do a lot of things that have strong overlap with specialists. The patient comes to you, they have a cardiac complaint. You probably manage a wide range of cardiopulmonary disease in your practice. But when the patient requires specialist care, you refer to the specialist. And the specialist-specific treatments that they can offer, and coordinate would be a little bit more specialized, for lack of a better word, and with more depth and content. Similarly, as a pain specialist, I am board-certified in providing especially interventional care, which would not generally speaking be the scope of any other field of specialization. We can be very, very specific in terms of mixing together from that toolbox of medications, injections, physical therapies, complementary and alternative care, neuromodulation, other stuff.

Realistically, while a multimodal approach is often ideal, for a more focal or a brief episode of pain, a targeted initial approach is often all that's needed and sometimes might be all that is available to the patient. Similarly, if I see a patient, I'm bringing to the table the benefit of clinical judgement. Two general thoughts will often guide me. The first one is that just because you can do a thing doesn't mean you should. It's really the consideration in an individualized way for the patient that allows us to determine which intervention, which first step, needs to be undertaken. We need to show restraint, particularly for things that can't be reversed, like a surgery, or might be invasive, like an injection, or might carry higher risk, like complex medication management or complex opioid management.

The second thing, getting back to your question about how is this similar to or different from primary care, is what I like to call Slay One Dragon at a Time. What I mean by that is that just like in

primary care where you might recognize that the patient has multiple, not necessarily competing but occurring in tandem medical needs, that it is often too much, either that it's unnecessary, that it increases risk, that it adds stress, time consumption, financial constraints to the patient to try to fix everything all at once. Instead, we want to slay one dragon at a time. What I mean by that is I might be aware that the patient has a very acute need for one initial set of therapies, but knowing in the back of my mind what would be my next priority and then my next priority, and that this is not a one-time opportunity to intervene with the patient but that it instead is a program of care over a period of time, to try to optimize their function and minimize their pain.

DANIEL ALFORD, MD: Erica, thank you so much for giving us so much information in terms of what are pain specialists, how do I find a pain specialist, how do I find multimodal care, and how do I communicate with my patients and pain specialists. I want to thank you again for coming and presenting such clear and important practical information.

Thank you for watching this Massachusetts-specific module. Please proceed to the evaluation by using the navigation bar on the right side of your screen. Once you've completed the evaluation, you'll be able to print your CME or CNE certificate.

While you're here, please be sure to take a look at our other resources and educational programs at www.scopeofpain.org. This includes our core program on safer opioid prescribing for acute and chronic pain, in a variety of formats including online, podcast, and live, as well as a range of additional topics, such as treating adolescents and young adults, post-operative pain management, strategies for safer opioid tapers, and ways to incorporate safer opioid prescribing into your practice. We also have podcasts on the role of nurses and pharmacists on the care team when supporting patients who are prescribed opioids for chronic pain. We have programs on managing patients who have opioid use disorders and alcohol use disorders. We also have a collection of brief – less than five minute – micro-cases addressing key issues when managing patients with pain and/or addiction. All of these programs are free.

Thanks again for participating in our program.

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