Game-Changing Use of Data Drives Opioid Practice

A stunning series of reports on the opioid crisis in Massachusetts is positioned to substantially drive evidence-based clinical practice and policy intervention — and is the result of a quietly signed, pioneering state law. “Chapter 55,” which Governor Baker signed into law in 2015, got little attention at the time of its passage. The law authorized the Department of Public Health to link nearly 20 different state departments and agencies, the Department of Health, the Department of Mental Health, and the Department of Public Safety, to share patient data across the state.

The resulting synthesized data are now feeding into the Massachusetts Prescription Monitoring Program, the Department of Public Health’s prescription monitoring system, the most comprehensive in the nation. The program was launched in 2009 and now maintains data for more than 3.2 million people who are prescribed opioids, which the Department of Public Health has used to address overdose threats across the state.

The result of a quietly signed, pioneering state law, the data-sharing initiative is positioned to substantially drive evidence-based clinical practice and policy intervention — and is the result of a quietly signed, pioneering state law. “Chapter 55,” which Governor Baker signed into law in 2015, got little attention at the time of its passage. The law authorized the Department of Public Health to link nearly 20 different state departments and agencies, the Department of Health, the Department of Mental Health, and the Department of Public Safety, to share patient data across the state.

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President’s Message

Opioids: A Case Study in Lifelong Learning

It was only a few short years ago that the opioid crisis emerged across the country, with particular ferocity here in the Commonwealth. In retrospect, we realize that the signs were clearly there. Unfortunately, many of them were missed. Looking back, the role of the physician in this was clear. While our goals were laudable in trying to assuage our patients’ pain, some wrote too many prescriptions, and in those prescriptions, authorized too many pills.

This is not to cast blame. This is to focus on the problem and appreciate just how far we have come since the epidemic was first noted. The medical community quickly recognized that we had a more important role to play moving forward — as part of the solution. The Medical Society, on our behalf, led the charge.

We have improved our prescribing practices. Data from the state show a 23 percent reduction in opioid prescriptions since 2015 and a nearly 50 percent reduction in prescribing to patients who had not previously received an opioid script.

We are working to improve patient access to life-saving care, from naloxone to medication-assisted treatment. Of course, we are looking to ensure that those in need of pain management are able to get the help they require.

Now, while law enforcement tackles the larger issue of non-prescription illicit narcotics, we physicians must continue to address the numerically smaller, yet no less critical, issue of over-prescribing opioids for pain, and the diversion of medications. Progress has been made; more needs to be accomplished.

We all know the value of lifelong learning as physicians. This crisis, and our response to it, shows how quickly we can learn and how much we can change. May we continue to do so until this epidemic is over.

— Henry L. Dorkin, MD, FAAP

Game-Changing Use of Data

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The reports are all archived in the MDPH website. Previously, intelligence on the opioid epidemic in Massachusetts was limited to quarterly data reports on overall opioid-related overdose fatality rates and some rudimentary prescribing metrics.

State Law Two Years In

The Medical Society applauds the state for the signage of Chapter 55 and the resulting reports and analyses. The last few years have seen several high-profile comprehensive bills passed on Beacon Hill that are related to the opioid epidemic — addressing, for example, inpatient treatment capacity, opioid prescribing, and medication-assisted treatment and prior authorization — and dozens more proposed each session.

For an update on federal and state plans to address the opioid crisis, see page 5.

How the New Database is Driving Practice and Policy

Examples of Findings from the August 2017 Chapter 55 Report

Informing Clinical Practice

“Our data show us that after a non-fatal overdose, if an individual is started on buprenorphine or methadone, their risk of subsequent death goes down 50 percent. This has really been a call to action for our clinical partners to work to increase access across Massachusetts for these vital medications.”

— Commissioner Bharel

• Twenty percent more opioid-related deaths occurred per day on weekends and during the first three days of the month
• The risk of fatal opioid-related overdose is six times higher for persons diagnosed with a serious mental illness, and three times higher for those with depression
• Between the third trimester of pregnancy and the first six weeks postpartum, the opioid-related overdose rate increases almost four-fold; it is highest 6 to 12 months postpartum

Informing Policy

“Our data showed us that when someone is released from incarceration they are at an incredibly high risk of overdose: 120 times higher risk. This has opened the door to a whole new dialogue with our colleagues in criminal justice.”

— Commissioner Bharel

• Nonfatal overdoses increased about 200 percent from 2011–2015; the total number of nonfatal overdoses exceeded 65,000 in this period
• The number of initial prescriptions for patients classified as not having received an opioid prescription in the previous six months dropped by 47 percent from 2012–2015
• The opioid-related overdose death rate is 16–30 times higher among homeless individuals than among the non-homeless adult population

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EDITOR: Lucy Berlington

EDITORIAL STAFF: Charles Alagero, Office of General Counsel; Robyn Alle, Public Health; Lori DiChiaro, Government Relations; Yael Miller and Jillian Pedrotty, Managed Care; Stephen Phelan, Membership; Cathy Salas, West Central Regional Office; Deanna Biddy, Physician Health Services

PRODUCTION AND DESIGN: Department of Publishing Operations; Department of Printing Services

PRESIDENT: Henry L. Dorkin, MD

EXECUTIVE VICE PRESIDENT: Lois Dehls Cornell

DIRECTOR OF COMMUNICATIONS AND MEDIA RELATIONS: Kate Connors

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Prescription Monitoring Programs Become Vital Tool in Clinical Decision Making

BY BRENDAN ABEL, JD, MMS LEGISLATIVE AND REGULATORY AFFAIRS COUNSEL

Prescription monitoring programs (PMPs) are undergoing a revamp in their role in clinical care — becoming less a checkbox dictated by law, and more a vital piece of the standard of care in the prescribing of many controlled substances.

PMPs have become ubiquitous across the country. For some time, tracking opioid prescribing was discussed in the context of providers meeting their obligation to administrators at the Massachusetts Department of Public Health (MDPH). But the role of PMPs is expanding as physicians seek to meet patients’ pain treatment needs in the context of the opioid epidemic, and as medical and legal stakeholders — including licensing boards, courts, and legislatures — pay closer attention to the standard of care of prescribing.

Improving Clinical Practice

The PMP has broadened the clinical expectations of prescribers, and has become a tool for informing conversations with patients and clinical decision making. For example, prescribing an opioid to Patient X may seem appropriate given the patient’s clinical presentation. But information from the PMP — such as Patient X’s other opioid or high-dose benzodiazepine prescriptions — could bring the appropriateness of the new prescription into question. The implications go beyond noncompliance to the possibility of substandard care.

The recent death of singer Tom Petty helps demonstrate the clinical value of the PMP, says Dennis Dimitri, MD, chair of the MMS Task Force on Opioid Therapy and Physician Communication. "Medical examiner reports indicated presence of multiple opioids, benzodiazepines, and antidepressants in his blood stream. All may have been legitimately prescribed by different doctors for the several conditions (broken hip, depression) that Petty suffered. If the PMP was not being regularly checked, it is possible that various treating physicians may not have been aware of the dangerous combination of medications."

The Medical Society urges all physicians to become familiar with the PMP laws and regulations in Massachusetts (see massmed.org/masspat for more information), and to find systems and processes to incorporate PMP use into clinical practice. In 2014, the MMS House of Delegates recognized the need to facilitate physician communication about opioid prescribing for the same patient: "Regular utilization of the PMP is one of the solutions to that communication gap," says Dr. Dimitri, a past president of the MMS.

Enforcing PMP Requirements

The Medical Society strongly supported the 2016 transition to the Massachusetts Prescription Awareness Tool — MassPAT — with its improved functionality and ease of access. Prescribers have responded to increasing statutory requirements to use the system. Now, they are required to query the system prior to every Schedule II and III narcotic prescription, and before a patient’s first benzodiazepine prescription.

The importance of providers’ compliance with the PMP is emphasized by the Medical Society, health care administrators, and lawyers. Warnings to prescribers have often referenced potential enforcement actions by the MDPH. This advice holds true. The MDPH and its Medical Review Group have the authority to refer concerning cases to appropriate licensing boards, and the MDPH could revoke prescribers’ Massachusetts Controlled Substances Registration, which is necessary for prescribing.

The Board of Registration in Medicine has referenced PMP usage when considering whether to suspend physicians’ licenses. Malpractice cases are increasingly citing PMP use as an element of compliance with the standard of care. With all of these changes, proper usage of the PMP continues to be a vital component of clinical practice.

Bringing Addiction Care into the Community

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yet up to half of the clinicians who get waivered do not go on to treat patients with this medication. "The training is very detailed and covers every imaginable situation — withdrawal, pregnancy, relapse prevention, and so on. It has a tendency to scare people off," says Dr. Sanchez. Part of the present challenge, then, is connecting physicians with mentoring and further support.

Team-Based Care

Making specialist support available to primary care providers improves clinical practice, Dr. Wakeman says. In October 2014, MGH launched a system-wide redesign of addiction care, encouraged by the positive outcomes of research completed by colleagues at Boston Medical Center. The program incorporated addiction treatment into hospital care and connected addiction consultants with primary care practitioners. "We are not necessarily asking physicians to open their practices to this new patient population," says Dr. Wakeman. "We just want to equip them to care for the patients they already have. Providing effective primary care to someone with untreated OUD is very challenging." Surveys of general internists at MGH suggest that simply having a patient receive care via the redesigned model has generated positive changes in the physicians’ attitudes, preparedness, and clinical practice related to SUD, including greater willingness to prescribe medications for addiction (Journal of Addiction Medicine, 2017).

Any physicians can access national and state resources for building their addiction treatment capacity (see box).

Destigmatizing Treatment

A bitter reality for people with OUD is that while their condition is stigmatized, so is its most effective treatment. The notion that treatment with methadone or buprenorphine is not a “legitimate” form of recovery still lingers in communities, legislative chambers, and even some medical practices. “Patients are quick to pick up on physicians’ judgment,” says Dr. Sanchez. “A patient told me a PCP said to him, ‘Methadone’s a bad medication; why are you on it?’ It’s about providers’ naiveté, not wanting to stand how methadone works.”

“The term medication-assisted treatment is itself stigmatizing and is falling out of favor. We don’t call insulin medication-assisted treatment,” says Dr. Alford. Medication treatments for OUD are not “less than,” he says — if anything, they are “more than.” “This is medication plus.” Medication brings to an end the highs, withdrawals, and neurological changes associated with street drugs of unknown provenance and composition. On medication, physiology stabilizes; brain-imaging studies show the normalization of patients’ neurochemistry, says Dr. Alford. And when patients are no longer living in fear of withdrawal, they return to school, become employed, or access other forms of treatment, such as counseling.

“We’re talking about people who are seeking treatment,” says Dr. Alford. “They’re coming to you saying, ‘I want help, I need help.’ You have the ability to become qualified to offer a medication to save this person’s life, and often it’s a young person.”

Resources for Providers

Providers Clinical Support System (PCSS-MAT): National training and clinical mentoring program

Boston Medical Center’s Office Based Addiction Treatment Program (OBAT)

• Project ECHO: Free, case-based telementoring program
• Free training and clinical tools

Luis Sanchez, MD

Dennis Dimitri, MD

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Talking to Patients about Reversing Opioid Overdose

BY THERESE FITZGERALD, PHD, MSW
MMS DIRECTOR OF HEALTH CARE RESEARCH, ANALYTICS, AND INSIGHTS

A pharmacist demonstrates how to use Narcan (naloxone) nasal spray in the current episode of Physician Focus at massmed.org/physicianfocus.

It’s a message as jarring as it is factual: A patient cannot receive proper clinical treatment for substance use disorder if that patient is not alive to receive it. This is why access to naloxone, and effective and efficient deployment of the drug, are growing more critical by the day.

“Unfortunately, overdose is no longer a rare event,” said Alexander Y. Walley, MD, MSc, director of the Addiction Medicine Fellowship at the Clinical Addiction Research and Education Unit, Boston University School of Medicine. “Access is also critical in other areas of society; for example, to someone who owns a restaurant, where the bathroom could potentially be a place where drugs are ingested.”

Increased access to naloxone is a priority in MMS advocacy. At the 2017 Interim Meeting, the House of Delegates adopted a resolution that the Society will encourage efforts to ensure all health care professional students in Massachusetts receive training in the administration of naloxone.

Which Patients Need to Hear This
Messaging about how to get and use naloxone should be just as broadly disseminated. Key venues include physicians’ practices. Prescribing an opioid pain medication requires screening the patient for substance use disorder — and regardless of the patient’s risk, providers should always discuss overdoses.

“It’s important for all patients to be educated about the potential risk, and to ask them if they have a plan in place in the event of an overdose,” says Dr. Walley, who practices at the Grayken Center for Addiction at Boston Medical Center. “Any time we’re prescribing an opioid, the patient should hear that it’s a good idea to think about having a naloxone rescue kit.” Their families also need that information.

The public’s heightened awareness of the opioid crisis may facilitate provider-patient discussions. “These conversations have become more normalized as part of the broader conversation on public health. It’s about safety; it’s not accusatory,” says Dr. Walley. “When we talk to patients about wearing seat belts, we’re not accusing them of being a bad driver or of driving drunk.”

Key Messages for Patients

- **Go to the pharmacy:** Since 2014, all Massachusetts retail pharmacies licensed by the Board of Pharmacy must obtain a standing order and maintain a continuous supply of naloxone.
- **Talk to the pharmacist:** Pharmacists at locations that recognize standing orders are required to complete naloxone training approved by the Massachusetts Department of Public Health (MDPH), including how to advise customers on when and how to deploy naloxone.
- **Insurance covers it:** MassHealth, and most insurers in the state, cover naloxone with affordable copays, according to the MDPH.
- **Other options:** The state has a variety of resources that can provide “safety-net” access to naloxone; for example, the Overdose Education and Naloxone Distribution (OEND) pilot program, administered by the MDPH, is aimed at those at most risk of experiencing an opioid overdose, and has 21 locations statewide. mass.gov/ehohs/docs/dph/substance-abuse/naloxone-info.pdf
- **Educational tools:** The MDPH has online and print resources for patients, families, communities, providers, and state municipalities and agencies. mass.gov/overdose-prevention-and-naloxone-access.

Supervised Injection Facilities Gain Momentum

BY TOM FLANAGAN, MMS MEDIA RELATIONS MANAGER

Supervised injection facilities for people who use drugs may shortly be coming to the US, potentially establishing a new frontier in the fight against opioid overdose deaths.

In April 2017, when the MMS passed policy to advocate for a “pilot supervised injection facility (SIF) program in Massachusetts,” it became the first medical society in the US to endorse such sites. The AMA followed suit, voting in June 2017 to support the development of pilot SIF programs.

Organized medicine’s endorsement of SIFs has changed the debate on Beacon Hill. In the months since the MMS SIF policy passed, Massachusetts legislators have debated a bill that would allow for SIF programs — also known as “safer drug consumption programs” — to operate in Massachusetts and proposed a budget amendment to study the feasibility of SIFs.

Secretary Marylou Sudders, the Baker administration’s chief of health and human services (HHS), said on WGBH in January 2018 that she is “open to understanding more” about supervised injection sites, while anticipating that “federal law would pose a challenge to launching any in Massachusetts.” Meanwhile, states such as California, and cities including Philadelphia, New York, and San Francisco, are pressing ahead.

SIFs are rapidly gaining momentum in other states and cities — but advocates may face federal resistance. Read the full story at massmed.org/vitalsigns.
BY SARAH RUTH BATES, MBE, MMS ADVOCACY, GOVERNMENT, AND COMMUNITY RELATIONS

How is Congress aiming to build providers’ treatment capacity for opioid use disorder within communities? Several approaches may make it into a comprehensive legislative package aimed at addressing the opioid epidemic that is expected to be introduced in Congress in the spring. The Medical Society is working with our Massachusetts delegation in the House and Senate, and with regulatory agencies, on measures to help prevent and treat addiction and save lives.

Vital Signs spoke with four members of Congress about their priorities for opioid-related legislation in the coming year.

Loan Forgiveness, e-Prescribing, Expert Consults, Medication-Assisted Treatment

— Congresswoman Katherine Clark, 5th District

“I am pushing four bipartisan bills that address specific problems. One provides student loan forgiveness for people who work in substance use disorder treatment, one encourages doctors to electronically prescribe opioids, one creates a program for doctors to get real-time advice on responsible opioids prescribing, and one expands the availability of medication-assisted treatment for adolescents. Each of these proposals come from feedback that I’ve heard from my constituents, each has broad, bipartisan support, and I am hopeful all four will pass this year. The families battling the opioid epidemic across the country need our help and they need it now.”

Behavioral Health Parity and Reimbursement

— Congressman Joseph Kennedy, 4th District

“By strengthening behavioral health parity enforcement and increasing reimbursement rates, we can ensure treatment is within reach for all Americans suffering from addiction. For families watching a loved one battle a substance use disorder, nothing is more disheartening and disorienting than care denied without reason. Congress must increase funding across the full continuum of care and enact meaningful reforms that will open the door to effective, compassionate treatment.”

Prevention and Treatment, Reducing Fentanyl Supply

— Senator Edward Markey

“The first step is getting our communities the resources they need to enhance prevention, surveillance, treatment, and recovery efforts. That’s why I’ve introduced the Combating the Opioid Epidemic Act, which calls for a $45 billion investment in these activities. I will continue to work with my colleagues in the Senate to get new funding dedicated to this crisis.

“Over the last two years, Congress has taken some important steps. With the passage of the Comprehensive Addiction and Recovery Act (CARA) in 2016, we are expanding access to treatment through language I authored to enable mid-level practitioners to prescribe buprenorphine for patients with substance use disorder. With the recently signed INTERDICT Act, which I introduced in the Senate, we will be providing our border agents with the tools necessary to identify and stop illicit fentanyl and other opioids from entering our country and landing in our communities. In October last year, the President declared the opioid crisis a national public health emergency, but unfortunately nothing of consequence has been done.”

Community Resources, Reducing Rx Misuse, Government Accountability

— Senator Elizabeth Warren

“I’ll continue to fight for more funds, work to reduce prescription opioid misuse, and hold the Trump administration accountable for the promises they have made to deal with this emergency. Last year, I was able to secure additional funding to help states and local communities address this crisis, but our communities need all the support they can get, particularly given the frightening rise of fentanyl and other synthetic opioids.

I hear from health care providers, law enforcement officials, and individuals and families dealing with addiction from across Massachusetts about the devastating toll the opioid epidemic continues to have on our communities.”

Opioids 2.0: MMS Testifies on Governor’s New Opioid Bill

Governor Charlie Baker’s second comprehensive opioid bill — the “CARE Act” — drew an unusually large hearing at the State House in January. The Governor pledged in his testimony to include funding for new treatment beds in the 2018 budget, which his office has since released.

Henry L. Dorkin, MD, FAAP, president of the Medical Society, testified in support of the bill, and was quoted in eight media outlets including the Boston Globe. Dr. Dorkin described the provisions of the bill that the Medical Society supports, including improvements to two existing policies for which the MMS has long advocated: the statewide standing order for naloxone access and the “partial fill” policy on opioid medications.

Dr. Dorkin voiced concern about several provisions, including involuntary 72-hour holds on patients with substance use disorder. Even with the promised new beds, the state would likely lack sufficient locked facilities to care for such patients, potentially exacerbating the problem of “boarding” patients in emergency departments. The Medical Society will continue to follow this bill as it moves through the State House. This month (March 2018) marks the two-year anniversary of Governor Baker signing his first landmark opioid bill into law.
Treating Pain in the Age of Opioid Addiction

BY LUCY BERRINGTON, MS

Fair warning: This article will not tell you how to treat pain in the age of opioid addiction. It may, however, validate your frustrations, offer some clues to what works and what doesn’t, and reassure you that efforts are underway to improve the options for and outcomes of pain treatment. Patients’ pain matters. And so does physicians’, whose pain about pain showed up starkly in a recent collaborative research process in Massachusetts.

Physicians joined patients and other stakeholders for a “human-centered” research investigation into how pain is currently assessed and managed, undertaken last year by Massachusetts Health Quality Partners (MHQP). “Clinicians in our workshops said, ‘I never get to talk about taking care of people with chronic pain, how much distrust and frustration there is, how inadequate I feel,’” says Barbra Rabson, president and CEO of MHQP, an independent nonprofit that measures and reports on health care information. “This is a key driver to burnout; we hear it time and again.”

The research, funded by Cigna, yielded five key findings:

Pain Is Poorly Understood

“We heard from clinicians saying, ‘I’m a diagnostic machine. When I can’t explain what’s going on, I’m much less sure of how to proceed. I don’t feel I have all the tools in the toolbox,’” says Rabson.

Even the available tools can be inadequate. The 10-point numerical scale for patients’ pain self-reports, for example, cannot adequately factor in the complex psychological and behavioral components of pain, such as fear and isolation — contributing to pain scores that may seem unconvincingly high to clinicians. In a small, hospital-based study reported at a conference, improved communication about pain assessment resulted in lower patient scores, contributing to earlier hospital discharge and reduced opioid prescribing, says Rabson — revealing a target for prevention-based improvement.

The multidimensional understanding of pain is a key insight of the past decade, and comes from functional brain imaging studies, says Daniel B. Carr, MD, MPH, professor of public health and community medicine at Tufts University School of Medicine and director of Tufts’ graduate program in pain research, education, and policy. “To look at pain as the detection of tissue injury is only half of the picture. The other half is that pain as an experience is very similar to when you’re abandoned or isolated.” A small, persuasive amount of literature has explored the stigmatization of chronic pain, says Dr. Carr, and patients’ depression and social withdrawal are barriers to self-advocating for treatment.

Pain Comes with Distrust

The context of the opioid epidemic is derailing patients’ and providers’ conversations about pain. “A big surprise for me was how painful this is for many of the PCPs,” says Rabson. One physician said, “Taking care of chronic pain patients is the most miserable part of my week.” Another said, “It doesn’t take more than about two patients trying to get drugs off you that they don’t need before you’re distraught of everybody.”

Patients report that their pain has been repeatedly dismissed. The risks of under-treating pain may be overlooked. “I get lots of unsolicited and frequently heartrending emails from patients cut off from their medications very brutally because of the amount of fear around opioid prescribing,” says Dr. Carr. Untreated pain can raise the risk of suicide.

Systemic Barriers Impede Care

“The saying, ‘Every system is designed to get exactly the results that it gets’ couldn’t be truer than in this case,” says Rabson. Physicians and researchers report systemic challenges to clinicians’ ability to support patients in pain — challenges that include a lack of training, insufficient time with patients, and significant gaps in the medical literature. For example, patients respond to information about non-opioid treatments, says Dr. Antranig Kalaydjian, MD, a resident in pain management at St. Elizabeth’s Medical Center, “but it’s hard to find time in 15-minute consults to talk to patients about the evidence behind physical therapy.”

The CDC recommendations include commonsense protocols — taking a thorough history and screening for psychiatric risk — that are largely helpful, says Dr. Carr. But these, too, are undermined by structural barriers to best practice. Pharmacists report that patients filling their opioid prescriptions are sometimes under-informed; they may not know if their medication is an opioid, be naïve to drug interactions, or have unrealistic expectations of pain medications.

Insurance Coverage Is Limited

When pain specialists talk about the best practice in pain treatment, they describe multimodal pain treatment facilities that address pain as a complex biopsychosocial condition. Such centers offer a range of approaches in addition to medication, and individualized treatment plans that include behavioral, psychological, and functional assessments and interventions. Strategies include goal-setting and psychological trauma treatments, as well as physical therapy, acupuncture, or mindfulness, which may reduce or eliminate the need for pain medications. But such facilities and specialists are scarce. Our health care system is oriented toward medical solutions. Insurance plans commonly do not reimburse adequately or at all for alternative pain management approaches, which are inherently difficult to evaluate and sometimes indirectly relevant. “If patients are more resilient, they do better managing their pain,” says Rabson. “If some of these therapies increase resilience, even if they don’t decrease pain, shouldn’t we be looking at that?”

Hope Gets Lost

Those crucial psychological pieces — setting goals, promoting empowerment and hope — are often missing from pain care. “Sometimes it feels like what I am doing most is bearing witness, honoring a patient’s difficult situation, and providing support and clinical empathy. This requires emotional energy and time,” says Stephen A. Martin, MD, associate professor of family medicine and community health at UMass Medical School, who participated in the MHQP research.

Next Steps in Pain

The next stage of the MHQP project will focus on developing tools for improving pain education, providers’ pain assessment, and patients’ resilience, and integrating relevant evidence into health plan coverage decisions. Health care organizations are keen to help test the new resources, says Rabson. “The opioid crisis is serving as a wake-up call to providers and the wider culture about how we can treat pain better,” says Dr. Kalaydjian. “Even the most difficult pain patients are fellow creatures in suffering. Any difference you can make — and sometimes we can dramatically affect their quality of life and functioning — is immensely satisfying.”

Help Your Patients Ask the Right Questions

In the current episode of Physician Focus, the public access television show by the Massachusetts Medical Society and HCAM-TV, a pain physician and a pharmacist answer patients’ common questions about opioid pain medications. The episode is available at massmed.org/physicianfocus. It features Daniel B. Carr, MD, MPH, professor of public health and community medicine, and director of the graduate program in pain research, education, and policy, at Tufts University School of Medicine, and Karen M. Horbowicz, PharmD, RPh, BCP, past president of the Massachusetts Pharmacists Association.
Susan M. Chabot, MD (Tufts University School of Medicine, 1985; residency: Tufts Medical Center), was named to Boston Magazine’s “Top Doctors 2017” list. Dr. Chabot is an orthopedic surgeon at Norwood Hospital.

Douglas B. Jacobs, MD, MPH (UC San Francisco School of Medicine, 2016; residency: BWH), made Forbes magazine’s 2018 “30 Under 30” list for his accomplishments in health care and insurance reform. Dr. Jacobs illuminated “adverse tiering” in which some insurers placed drugs for chronic conditions, such as HIV, in the highest cost tier; the US Department of Health and Human Services subsequently labelled adverse tiering a form of discrimination. Dr. Jacobs is a resident in internal medicine (primary care track) at BWH.

Bisola O. Ojikutu, MD, MPH (Johns Hopkins University School of Medicine, 1999; residency: New York Presbyterian Hospital), has been named a community hero by Action Toward Housing, Inc. and a community hero by Action Toward Housing, Inc. She is an infectious disease specialist at BWH and MGH. The award recognized her role in improving outcomes for people living with or at risk for HIV.

Jeffrey H. Samet, MD, MA, MPH, FACP (Baylor College of Medicine, 1983; residency: Boston City Hospital; fellowship: MGH), received the American College of Physicians Richard and Hinda Rosenthal Award from the Rosenthal Family Foundation for his contribution to addiction medicine care and research. Dr. Samet is the John Noble Professor in General Internal Medicine and chief of general internal medicine at the BU School of Medicine and BMC, and founding director of the BMC/BU Clinical Addiction Research and Education Unit.

Eric P. Winer, MD (Yale University, 1983; residency: Yale-New Haven Hospital; fellowship: Duke University Medical Center), made Medscape’s international list of the 2017 Physicians of the Year. Dr. Winer is chief of the Division of Women’s Cancers and director of the Breast Oncology Center at Dana-Farber Cancer Institute, and professor of medicine at Harvard Medical School. Dr. Winer had revealed that he was infected with HIV during hemophilia treatment. He talked of the devastating stigma of certain diagnoses, and the extent to which health inequities contribute to breast cancer mortality.
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