**Special Commission to Examine the Feasibility of Establishing a Pain Management Access Program**

**September 19, 2016**

**Present**: Secretary Marylou Sudders, Chancellor Michael Collins, Niels Puetthoff, Ray Campbell, Dr. Debra Poskanzer, Dr. Robert Cohen, Dr. Dan Fanselow, Dr. Paul Mendis, Alysa Veidis, Rosa Rodriguez-Monguio, Dr. Scott Sigman, Dr. Julian Robinson, Dr. Thomas Lynch, Dr. Joji Suzuki, Dr. Jim Gessner, George Zachos, Jennifer Barrelle, Kevin Wicker, Lorena Silva

***VOTE 1. Approval of the minutes from August 16, 2016***

**Secretary Sudders** began the meeting asking if the Commission had any comments on the proposed minutes, hearing none. Motion to approve the minutes was made and seconded. Minutes approved unanimously.

***VOTE 2. Approval of remote participation via telephone at the next meeting***

Motion was made and seconded. Remote participation approved unanimously.

***Discussion:***

Secretary Sudders reminded the Commission of the upcoming November 1, 2016 due date for the Commission’s recommendations – a blueprint for the direction of the Commission’s work. The Secretary then introduced Massachusetts Health Quality Partners (MHQP) President Barbra Rapson.

**Barbra Rapson** began her presentation titled, “Engaging Patients to Co-Design a More Effective Approach to Pain Assessment”. She reviewed the background and governance of MHQP. MHQP’s goal is to drive change within healthcare system with a dual approach that engages both stakeholders in the healthcare systems and patients, and this focus on patient-centered care historically has involved systematically integrating the patient voice into care improvements. She described the concept of ‘human-centered design’ and noted that ‘human-centered design’ will give us a fresh and innovative approach that will be different from current approaches.

Ms. Rapson explained that pain assessment plays a pivotal role in pain treatment. MHQP is focusing on improving current pain assessment tools (e.g. the ten-point scale). The ten-point scale has not proven to be effective. She noted, early experiments, such as those conducted at Geisinger, have shown that improving pain assessment tools can reduce the prescribing and use of opioids. Ms. Rapson stressed we have a significant opportunity to better calibrate the prescribing of opioids to actual needs of patients through the co-designing of solutions with patients: a common language for patients and providers, incorporating the needs and values of each of the key groups that hold a stake in the solution, new options for assessing pain based on best practices and current models (e.g. the American Chronic Pain Association Quality of Life Scale and the Geisinger pain scale), and an expanded understanding of the range of pain treatments available to patients.

Ms. Rapson then introduced the Geisinger pain scale to the commission, which is more specific than the ten-point scale currently used. She noted that there has been an 84% drop on pain score by patients identifying their pain on the Geisinger pain scale as well as a 17% drop in opioid prescribing, calling it upstream prevention. Ms. Rapson then introduced her colleague, Dan Coleman, to elaborate on MHQP’s proposal.

**Dan Coleman** introduced himself and showed examples of how engaging patients in the opioid crisis can make treatment more effective – using every tool in the toolbox. He concluded the presentation by noting, the complexity of this opioid crisis requires us to try new approaches for problem solving, and we are likely to gain new and better insights by engaging our patients to co-design solutions.

**Secretary Sudders** noted that MCPAP is a human-centered design.

**Scott Sigman** remarked that the presentation was great and will dovetail his own presentation.

**Robert Cohen** complemented the presentation, especially as it relates to assessment, which is a missing part right now especially for those suffering from chronic pain.

**Secretary Sudders** then introduced Dr. Scott Sigman to present on “The Societal Impact of Opioid Overreliance Use After Surgery & the Importance of Non-Opioid Options”.

**Dr. Scott Sigman** began by remarking that elective surgery has become an inadvertent gateway to the opioid epidemic. Dr. Sigman noted that the new faces of the opioid epidemic are a young grandmother from a middle-class suburb, an accomplished athlete, or an average high school student. Dr. Sigman stressed to the Commission that we need to minimize the exposure to opioids, as one in ten patients become addicted. Dr. Sigman remarked that over 70 million patients per year are prescribed opioids for postsurgical pain. Dr. Sigman said that in patients undergoing various soft tissue or orthopedic procedures, six percent of patients continued on new opioids 150 days after surgery. Furthermore, he noted, one year after elective spine surgery, one-third of all patients were still using opioids and 18 percent of previously opioid-naïve patients were still using.

Dr. Sigman noted he has dramatically changed the way he operates and prescribes post-operation. Dr. Sigman noted that the majority of his patients are off opioids within 24-72 hours of surgery. He noted that populations at higher risk for dependence include veterans, bariatric patients, as well as those with previous substance abuse disorders. Dr. Sigman remarked that multiple organizations have urged a shift toward non-opioid options, with JCAHO recommending “an individualized, multimodal treatment plan should be used to manage pain, upon assessment, the best approach may be to start with a non-narcotic”; CDC recommending “health care providers should only use opioids in carefully screened and monitored patients when non-opioid treatments are insufficient to manage pain”; and ASA recommending “a multimodal approach to pain management – often beginning with a local anesthetic where appropriate”. He also noted prescribers must ask patients if their family history included substance use disorders.

Dr. Sigman stressed his conversion to multimodal therapy approaches, which for a total knee replacement, has led to a reduction of length of stay from three to two days, reduced readmission rates, reduced complication rates, improved patient reported outcomes, and reduced the cost of the episode of care by $1,500. Dr. Sigman cited in a recent national study of postsurgical patients, 79 percent of patients say they would prefer a non-opioid and nearly one in four patients indicated they delayed having surgery because they were afraid of taking opioids.

Dr. Sigman noted we need to give our patients a voice – multiple professional organizations have advocated for change among health care providers, but begged the question who is advocating among our patients who need education about their options as well as the empowerment to advocate for themselves. He noted that the prescriber / doctor’s job is to engage their patients in a discussion about what individualized postsurgical course is right for them. Dr. Sigman noted he was proud to be a part of the Choices Matter Campaign, a national patient education campaign aimed at empowering patients to seek out non-opioid options for their postsurgical recovery, enhancing patient / surgeon communications around available options for postsurgical pain management, and driving patient involvement in the decision making process as it relates to their postsurgical recovery.

Dr. Sigman concluded his presentation by explaining we need to incentivize all aspects of the system and noting the ability to reduce, delay, or eliminate the need for opioids in the postsurgical setting is critical to curbing the rapid proliferation of new opioids – and new opioid users – across the United States.

**Julian Robinson** asked what liposomal is. **Scott Sigman** replied that it is a slow release numbing medication.

**Lorena Silva** asked if Dr. Sigman has seen any resistance to Toradol. **Scott Sigman** noted that initial studies have shown that, but from his office anecdotally, he has not seen any issues.

**Robert Cohen** asked Dr. Sigman how he manages his patients with chronic pain.

**Scott Sigman** answered that in the last two or three years, he has chronic pain patients’ pain management specialist manage the pain throughout his procedures.

**Rosa Rodriguez-Monguio** asked if Dr. Sigman had any documentation on his calculations. **Scott Sigman** answered that he can forward the Crimson data on patients at Lowell General Hospital to the Commission.

**Alysa Veidis** noted from the PCP perspective, it is difficult to manage patients with chronic pain, as PCPs are struggling with inheriting patients on long-term opioid treatment and having limited resources to deal with these patients.

**Secretary Sudders** then introduced Dr. Dan Carr to present.

**Dan Carr** thanked the Commission for inviting him to present, explaining that his talk today will update the commission on pain pharmacotherapy and the optimal sequence for nondrug and drug treatments (including opioids); cite tools and instruments to increase patient comfort level and efficiency, raise satisfaction scores, and decrease risk; present evidence for chronic pain as a highly prevalent disease entity per se; and when to refer to a pain specialist.

Dr. Carr noted the goals of chronic pain therapy: decrease pain intensity (resting and with activity), improve other dimensions of health-related quality of life, rehabilitate and restore (through physical therapy, occupational therapy, psychology, etc.), vocational counseling and retraining – re-entry, and moving “big pain, small life” to “small life, big pain”. He noted part of PCPs’ responsibility is when to include a referral to a pain specialist. Dr. Carr stressed that the PCP should know not to promise a pain score of zero.

Dr. Carr noted that non-drug methods of treatment should be used along drug methods of treatment. Dr. Carr then reviewed different types of medications with the Commission including NSAIDS and Coxibs, and touched upon adjuvant medication, such as antidepressants and anticonvulsants. Dr. Carr emphasized individual variability – including genetic (both preclinical and clinical), gender, prior sanitation (often present on history), psychosocial (litigation / compensation, job / family satisfaction, spousal solicitousness, premorbid depression, abuse), and clinician-patient interaction (enabling or medicalizing a somatoform disorder).

Dr. Carr then reviewed the opioid prescribing guidelines – sharing elements from the CDC, which recommended looking at past pain experience, pain history, past medical history, and past family / social history; urine drug testing when appropriate; considering all treatment options, weighing benefits and risks of opioid therapy, and using opioids when alternative treatments are ineffective; start patients on lowest effective dose; pain treatment agreements; documenting and monitoring ongoing pain, prescription progress as well as the Prescription Drug Monitoring Program (PMP); using greater vigilance at high doses; and using safe and effective methods for discontinuing opioids (e.g. tapering, specialist referrals).

Dr. Carr then reviewed “Quality Opioid Prescribing” by Blue Cross Blue Shield of Mass. in 2012, which recommended having a treatment plan including a clear diagnosis, explicit goals, and exploration of other treatment options; informed consent and formal assessment of addiction risk (excluding cancer, end-of-life); written agreement between prescriber and patient addressing issues of prescription management, diversion, and use of other substances; accountable prescription group as well as use of one pharmacy or chain; urine drug testing and specifics (e.g. 2 x 15 day prescription).

Dr. Carr explained the five steps of opioid prescribing: assess pain and abuse risk (prescription agreement), believe but verify (urine drug test), choose per context, deliver prescription deliberately and carefully (PMP), and enable and empower focusing on function. Dr. Carr said the PCP needs to know about mental health history and pain patients – and that he cannot emphasize that enough.

Dr. Carr said he knew the number of bodies who do pain management certification and will get the information to the Commission. Regarding Specialist Referrals, Dr. Carr emphasized building a network of clinical experts to whom you can turn, knowing your limits and refer early, being specific in your requests and in turn expect communication back. Dr. Carr emphasized using a nondrug or non-opioid prescription whenever possible and to validate and titrate chronic opioid prescriptions. Dr. Carr concluded by mentioning the recently developed core competencies being taught to medical students.

**Secretary Sudders** thanked Dr. Carr for his informative presentation, and noted that medical, nursing, physician assistant, etc. schools have all agreed upon core competencies, and now 8,200 students annually will come out of the schools with a different perspective on prescribing, and the Secretary noted we are now talking to other clinician schools.

**Dan Carr** noted that the National Association of Pain Strategy is a good resource.

**Dr. Jim Gessner** noted when chronic pain patients show up at a PCP, a model such as MCPAP can be used as a consulting program. He continued, he was thinking of a CME for this, adding suboxone / MAT training as a 6-12 hour CME, a graded education process for PCPs. Dr. Gessner also stressed including patients in decision, and multimodal education therapy and treatment therapy is essential.

**Secretary Sudders** noted when MCPAP was first established, it was with the PCP because they felt so isolated. Secretary Sudders then introduced Niels Puetthoff to present on the Division of Insurance (DOI)’s work on the Commission.

**Niels Puetthoff** began by talking about DOI’s survey they sent out to carriers regarding DOI’s responsibility in completing a number of the Commission’s charges. He noted that DOI took the words in the Commission’s charges directly from the statute, and that he kept wording broad to get a broad response – using “other services” to be open-ended and eliciting a variety of responses.

**Secretary Sudders** asked Mr. Puetthoff for a timeline. **Niels Puetthoff** responded September 30th is the deadline for response from carriers.

**Rosa Rodriguez-Monguio** asked if the survey touches on the type of insurance patients have or reimbursement rates for that patient. **Niels Puetthoff** responded that DOI is not touching on any of that information with this survey, but they can follow up.

**Rosa Rodriguez-Monguio** asked if only commercial insurers were included in this carrier survey. **Niels Puetthoff** replied yes, but it can be expanded to include Medicaid.

**Dan Fanselow** asked if there is any specific request for information regarding chiropractic services. **Niels Puetthoff** responded that chiropractic services are expected to be a part of “other services”. **Dan Fanselow** noted that there is a new study showing an increase in chiropractic services leads to a decrease in opioid abuse.

**Robert Cohen** asked if other service should be carved out, as meditation has robust scientific evidence as well. **Niels Puetthoff** noted DOI drafted the survey in accordance with the specific charge in the law, but if the Commission wants to carve out any other services in their recommendations, DOI will accommodate.

**Secretary Sudders** informed the Commission we have one more meeting before the initial report is due in November, and asked the group if there are any other issues they want to address or individuals they want to hear from.

**Robert Cohen** noted the Commission should consider including the first presentation’s recommendations, and also recommended hearing from individuals who live with chronic pain.

**Secretary Sudders** noted she has a letter on her desk from numerous individuals in the chronic pain community, and has heard about the difficulty of appropriately obtaining medications.

**Dr. Joji Suzuki** noted that primary care physicians feel so isolated, and added that the addictive patient population comes with a slew of categories, how to include and account for it, emphasizing a spectrum of pain and addiction. Dr. Suzuki indicated that we should hear from PCPs

**Paul Mendis** noted the Commission needs to be open to modifying the MCPAP proposal put forth by MMS because that proposal did not sufficiently address patients with an addiction.

**Dr. Jim Gessner** noted that there was a great overlap between patients with chronic pain and addiction – calling it a cloudy area.

**Secretary Sudders** asked the Commission if next meeting they want to do a panel with patients experiencing chronic pain and a panel of primary care providers.

**Alysa Veidis** noted it would be helpful to include PCPs.

**Ray Campbell** said CHIA can provide information and look into what resources they can get their arms around regarding the pain issues in a quantitative way.

**Rosa Rodriguez-Monguio** said she would like to work together to find the demographics of patients and providers.

**Dr. Jim Gessner** noted it might be useful for the Commission to have a list of programs for pain management certification in Massachusetts, including the different societies.

**Debra Poskanzer** said she wanted to ask the Mass. Medical Society what the number of physicians treating pain is.

**Dr. Jim Gessner** noted that chronic pain in PCP setting is different for specialties, with lots of local resources to aggregate, and adding that a catalogue of those availabilities should be shared.

**Secretary Sudders** asked BORIM’s designee, George Zachos, if BORIM provides a list of specialties. **George Zachos** responded yes. **Secretary Sudders** asked Mr. Zachos if BORIM can share this information at the next meeting. **George Zachos** replied yes.

**Secretary Sudders** adjourned the meeting.

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