



## **Needs Assessment of Provider Needs Related to Chronic Pain and SUD Consultation Service Support**

In September and October 2018, the Massachusetts Behavioral Health Partnership (MBHP) conducted a needs assessment to guide the implementation of a consultation service to support primary care providers (PCPs) and other providers who treat adult patients with chronic pain and/or substance use disorder (SUD). The needs assessment focused on understanding PCPs' needs that the consultation service should address and how to structure the consultation service so it can effectively and efficiently meet providers' needs.

### **Key findings:**

- PCPs have many questions about caring for patients with chronic pain and SUD and are eager for resources to address them.
- Their questions range from specific ones related to prescribing opioids and other medications to more general questions about overall pain management.
- Providers are interested in resource and referral information for programs in the community for people with chronic pain and/or SUD.
- There are some resources already available to support providers in providing Medication-Assisted Treatment (MAT), but providers continue to have questions and can use additional support.
- Providers are interested in non-pharmaceutical treatment of pain, but are unsure about what is covered by insurance.
- They indicate that if a consultation service is available, they will utilize it.
- Lack of case management services for MAT and chronic pain within the PCP setting is a significant problem.

### **I. Methodology**

To gather feedback from PCPs, MBHP developed a provider survey, which asked about: providers' questions related to treating patients with chronic pain and/or SUD; how a consultation service could meet providers' needs; and whether providers would use a consultation service. MBHP distributed it via SurveyMonkey and by hard copy mailing to PCC Plan, Steward Health Choice, Partners HealthCare Choice, and Community Care Cooperative (C3) providers. MBHP also provided the online link to the Partners, Steward, the BeHealthy Partnership and C3 ACOs and asked them to encourage their PCPs to complete the survey. The survey tool is included as Attachment A.

MBHP conducted 17 informational interviews with key stakeholders, to gather input from experts in chronic pain and SUD treatment, as well as others who understand providers' needs in this area. These included experts from academic institutions, professional groups, and patient advocacy groups. Individuals who were interviewed are listed in Attachment B.

MBHP conducted two focus groups. One was with a group of physicians in community health centers who serve as peer mentors related to MAT, and one was with a group of behavioral health leaders to explore how behavioral health providers might use the consultation service. The focus groups are listed in Attachment B.

## II. Survey Findings

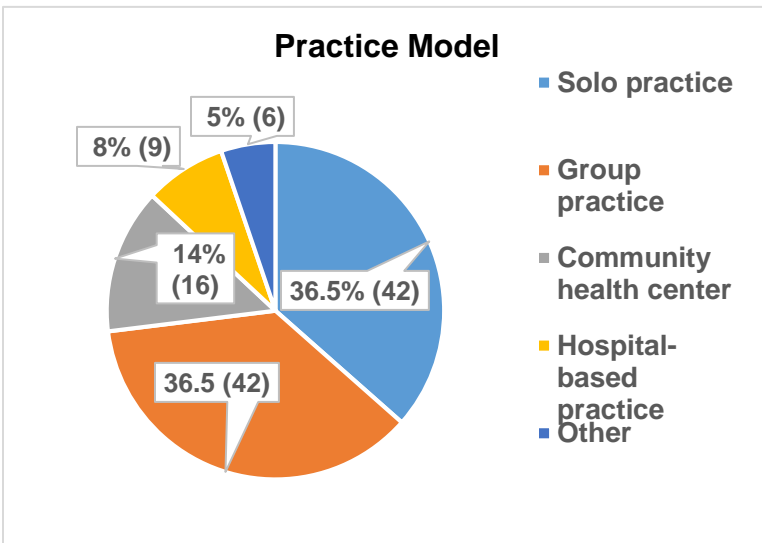
### Demographics

MBHP received 115 completed surveys. A physician, registered nurse, or physician assistant completed the majority (90 percent) of the surveys.

Providers in the Boston and Southeast regions completed the largest number of surveys.

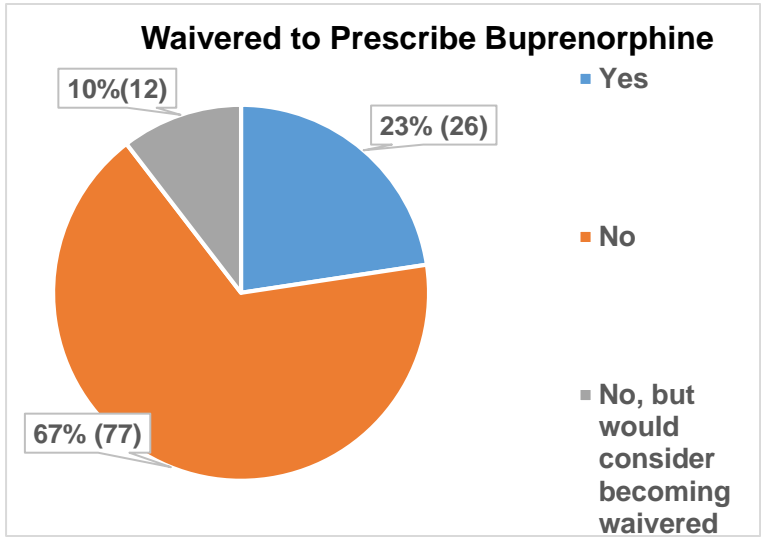
Region	
Boston	30% (34)
Southeast	30% (34)
Central	17% (20)
Northeast	13% (15)
Western	5% (6)
Other	5% (6)
<b>Total</b>	<b>100 % (115)</b>

The majority of respondents work in a solo or group practice.



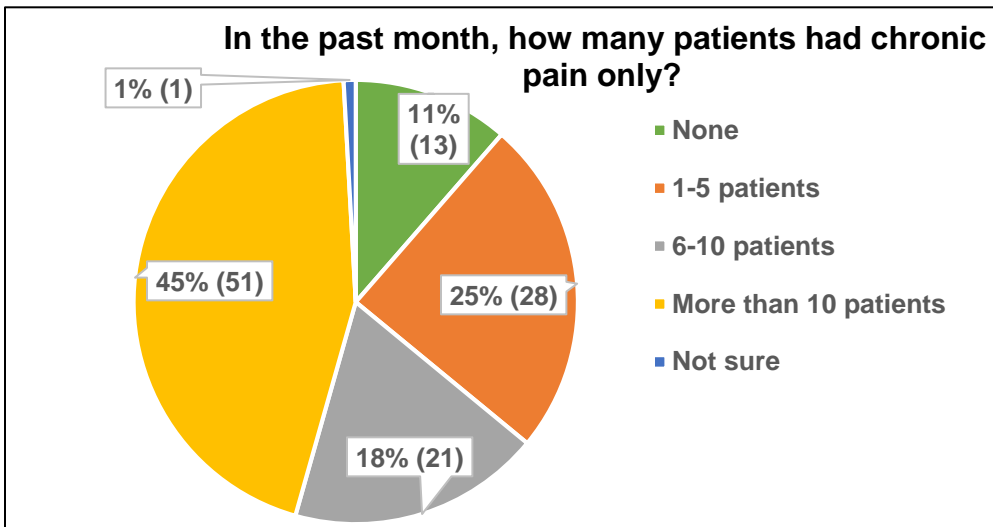
### Providers waived to prescribe buprenorphine

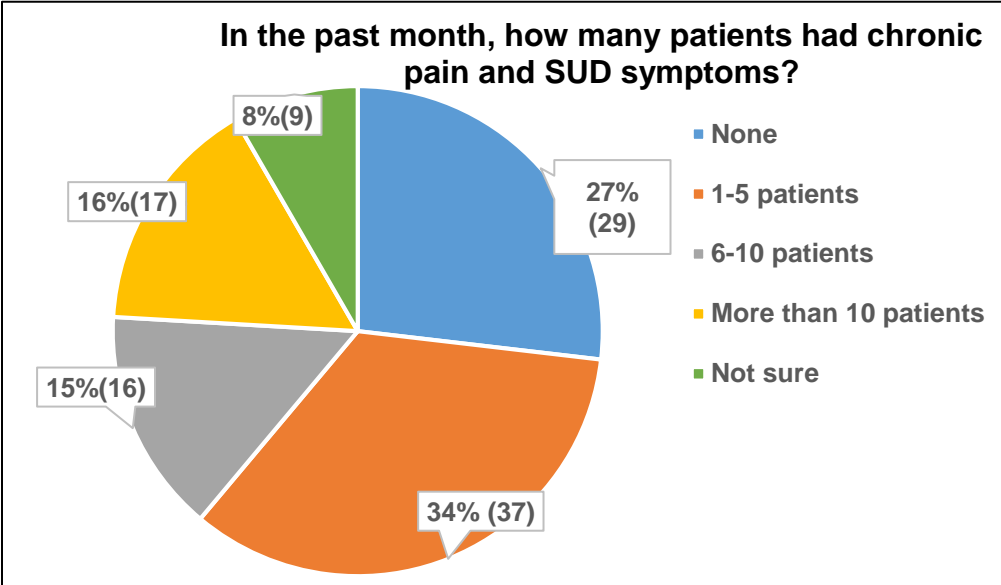
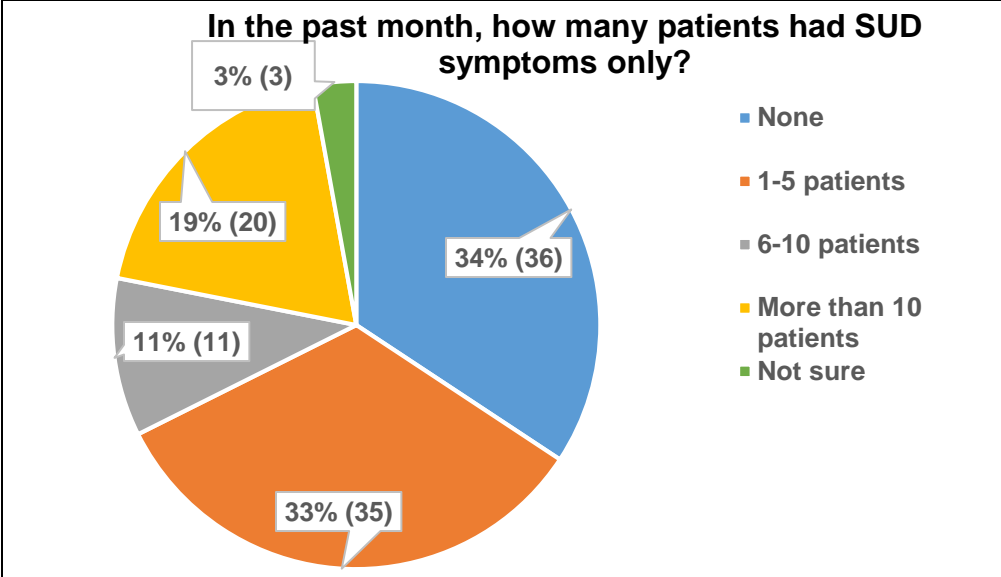
The majority (77 percent, 89 respondents) are not waived to prescribe buprenorphine, although 12 of these providers indicated that they would consider becoming waived.



### Prevalence of patients with chronic pain or SUD

Respondents were asked to estimate how many patients they saw in the past month with chronic pain only, with SUD only, or with both chronic pain and SUD. Respondents saw more patients with chronic pain alone, compared to the other groups. Nearly two thirds saw six or more patients with chronic pain during the past month, and only 11 percent said that they had seen none. Approximately 30 percent had seen six or more patients with SUD or with chronic pain and SUD in the same period.

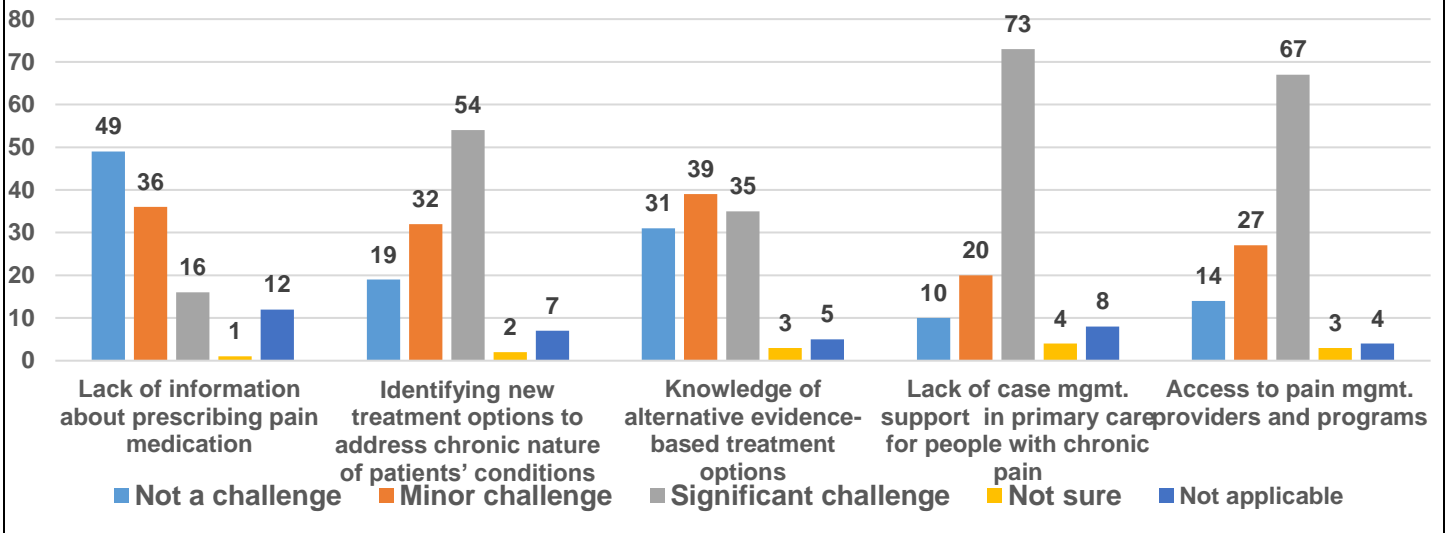




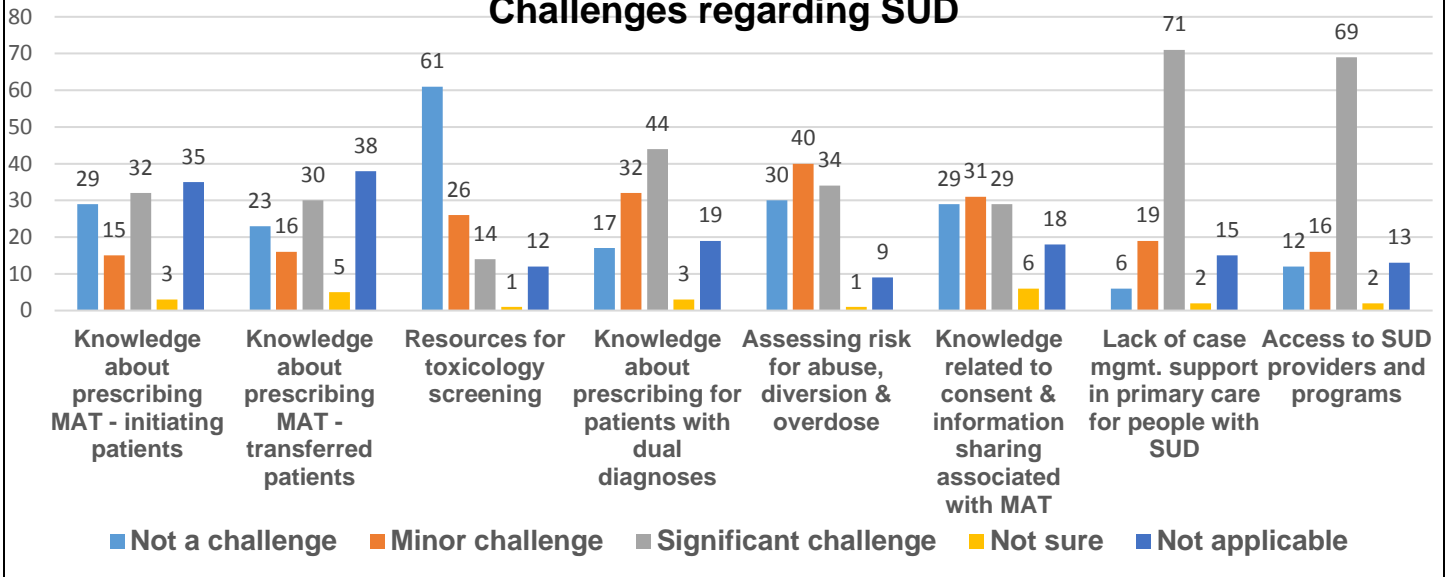
**Challenges in treating patients with chronic pain or SUD**

Respondents were asked about challenges they experience when treating patients with chronic pain and with SUD. Lack of case management and access to chronic pain management and SUD programs and resources were significant challenges for the majority of respondents. Identifying treatment options for people with chronic pain was also a significant challenge. Of providers for whom it was applicable, 46 percent felt that knowledge about prescribing for patients with dual diagnoses was a significant challenge. Of providers for whom it was applicable, 41 percent said that knowledge of initiating MAT was a significant challenge.

### Challenges in treating patients with chronic pain



### Challenges regarding SUD



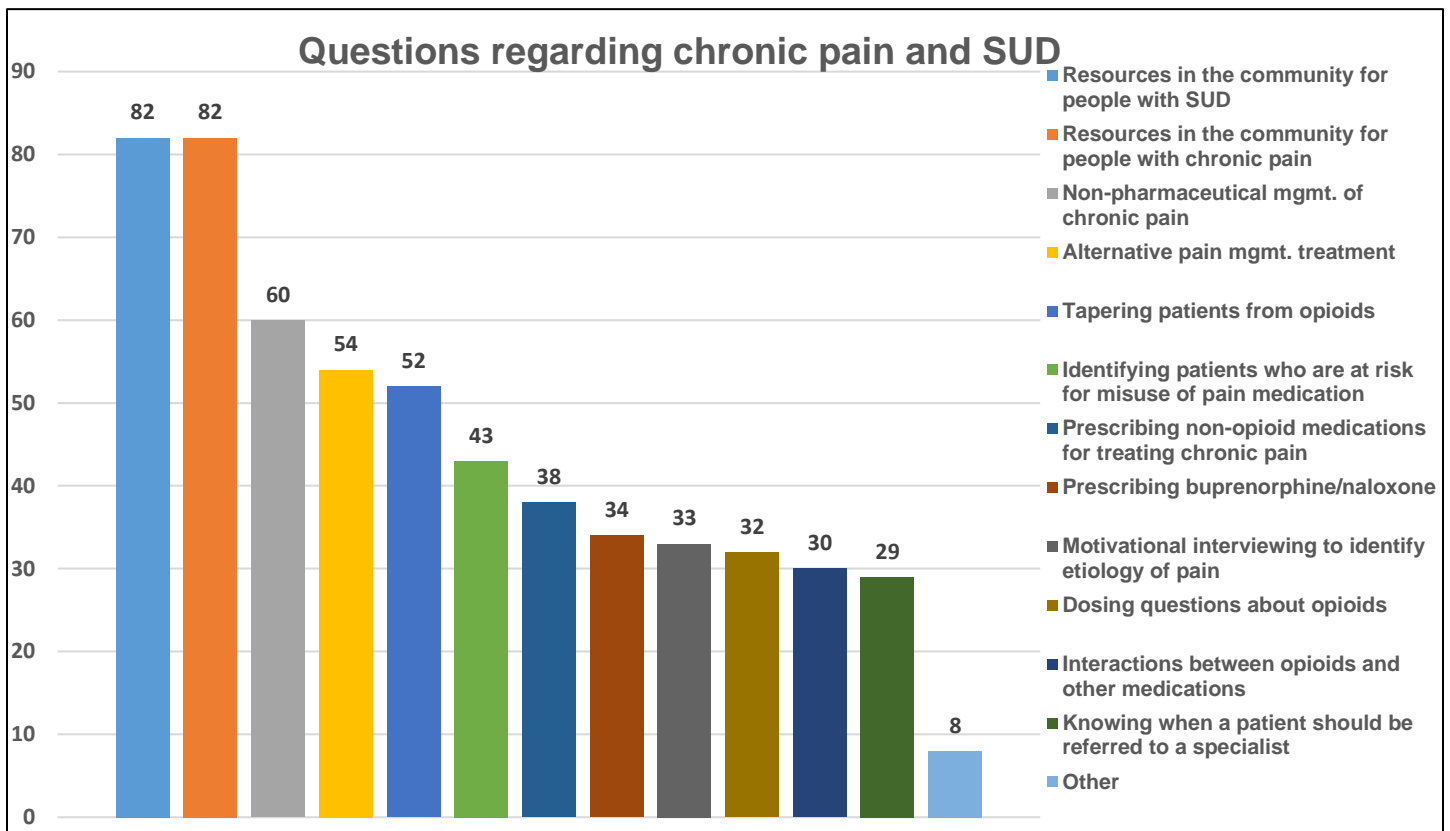
Respondents were asked about other challenges they experience. Many responses focused on access to behavioral health services and lack of workforce to treat people with chronic pain and SUD, indicating that the lack of support and resources make it difficult to assess and treat patients with chronic pain and SUD. Challenges that they identified included:

- *Timely access for patients' mental health services. The wait is often four to six months.*
- *Lack of resources, therapists, psychiatrists, and peer specialists are primary difficulties in caring for patients with chronic pain, who need my help the most.*
- *We recently lost two psychiatrists in our SUD program. We need more workforce.*

Respondents were asked about their comfort level in treating patients with chronic pain and SUD. They indicated that overall they feel comfortable treating patients with these conditions; 73 percent and 70 percent were somewhat/very comfortable treating patients with chronic pain and with SUD respectively. Nine percent indicated they are very uncomfortable with treating patients in both groups. Seventy percent indicated that they were comfortable with requesting patients to complete a toxicology screen and with discussing results with them.

**Providers questions about treating patients with chronic pain or SUD**

Respondents were asked about the types of questions they have about managing care for people with chronic pain and/or SUD. The most common questions were about resources in the community for people with SUD and chronic pain (71 percent, 82). Other common questions related to non-pharmaceutical pain management (52 percent, 60), alternative methods of pain treatment (47 percent, 54), and tapering patients from opioids (45 percent, 52).



Providers were asked for examples of questions that they would have contacted the consultation service about if it had been available in the past month. Many responses were about titrating patients’ medications or tapering opioids. A few examples are:

- *How to titrate someone off a very large dose of oxycodone*
- *Weaning/management of patient of >500 mg/day morphine sulfate after hospitalization*
- *A patient with chronic pain due to multiple medical issues, such as sciatic post-traumatic pain from years ago, who had surgery and a recent increase in med requirements. Need help titrating down or completely off.*

Many questions related to overall management of patients with pain and/or SUD. For example:

- *71 y.o. man with severe rheumatoid arthritis, currently maintained on Oxycodone 10 mg taking Q6 hours without fail. Any alternatives?*
- *Patients with longstanding narcotic treatment for chronic pain, still poor functional status due to pain, but limited options for pain control/treatment*
- *How to manage patients with complex pain syndromes who have not responded to traditional interventions without access to non-interventional pain specialists*
- *What to do with chronic pain patients who have SUD and violated their contract but still need pain control*

Several questions related to alternative therapies, such as:

- *How to provide effective alternative therapy for narcotics. What therapies are particularly effective for patients who are used to being on chronic narcotics?*
- *Resources for chronic pain patients that insurance will cover that are ancillary, i.e., chiropractors and acupuncture*
- *What services for alternative pain management are covered under MassHealth?*

There were also multiple questions about accessing outpatient services. These included behavioral health services, SUD services, and specialists for on-going pain management.

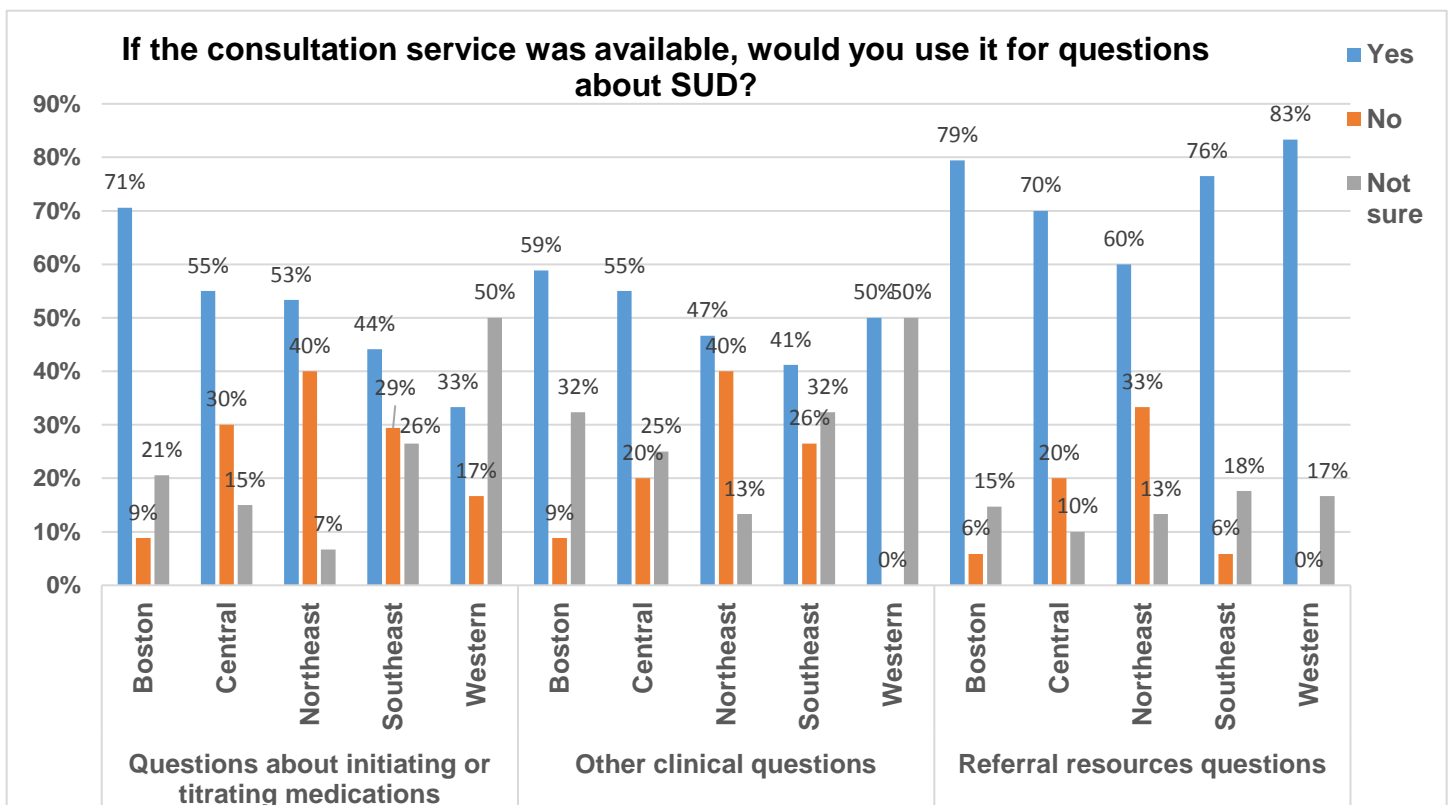
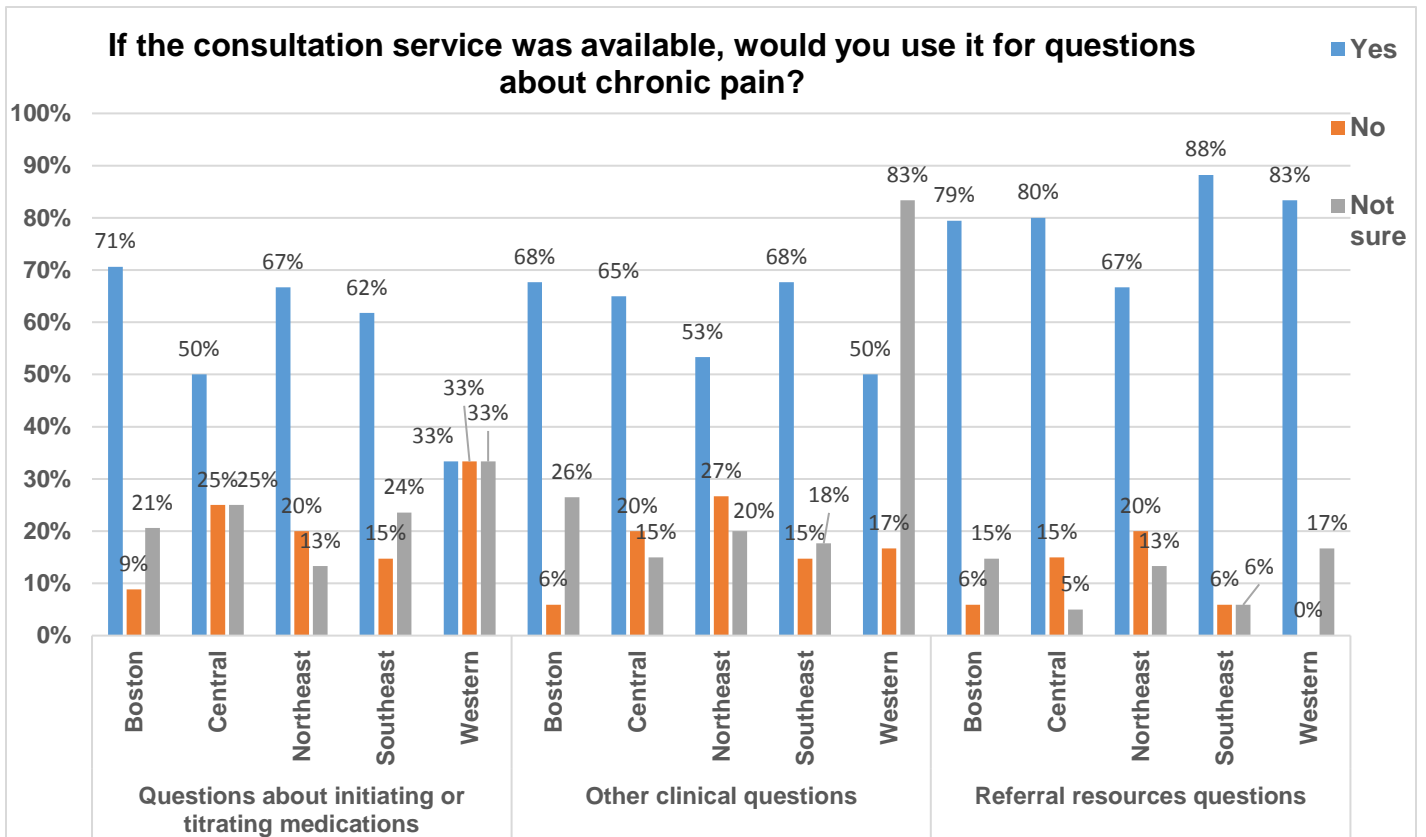
### **Features of consultation service**

Respondents were asked for input on several features of the consultation service. Most important to them was the service's awareness of resources in their region (82 percent, 94), availability of a follow-up consultation (81 percent, 93), multidisciplinary expertise of the consultation team (81 percent, 93), and waiting time for speaking with a specialist (78 percent, 90). They were asked how they would like to access a specialist to answer clinical questions. Most people (71 percent, 82) favored real-time telephonic consultations. In addition, 47 percent (55) respondents would like to be able to email questions to a help desk and to schedule calls as needed.

### **Projected level of use**

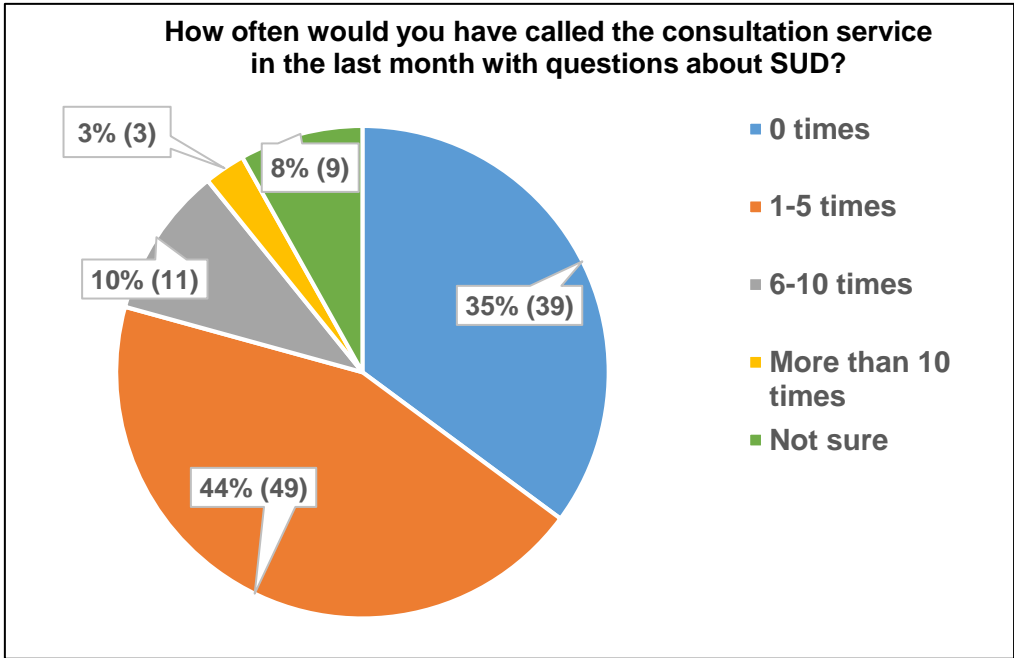
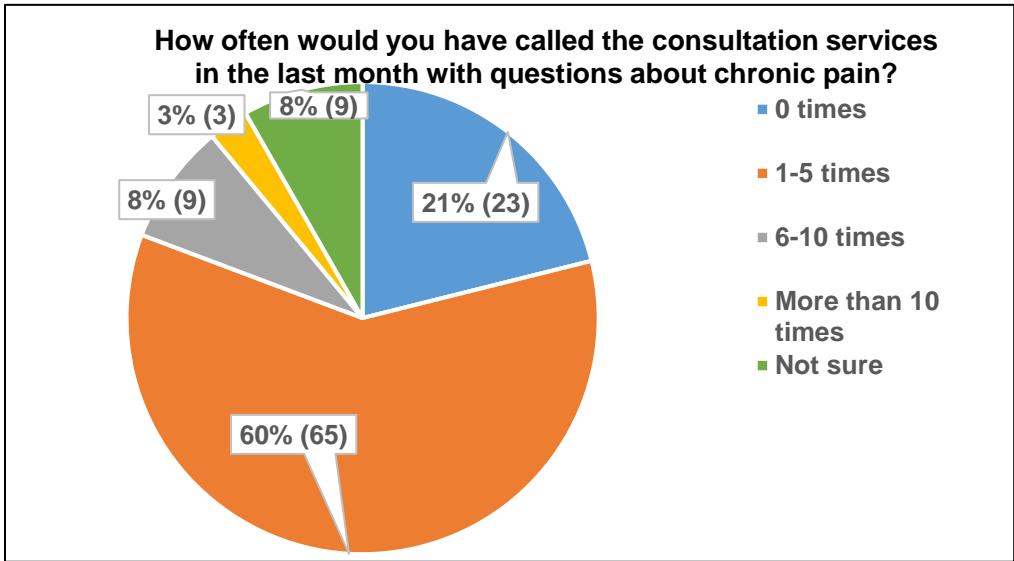
The survey asked if respondents would use the consultation service for questions about medications, other clinical questions, and/or resource information. The highest use would be for questions about chronic pain and SUD resources (78 and 71 percent respectively). There would be slightly lower use for questions about medication and for other clinical questions – approximately 60 percent of providers for chronic pain and 50 percent for SUD.

Responses by region were also analyzed. Responses were consistent across regions, with the highest use of the consultation service for resource and referral questions.





Respondents were asked how often over the past month they would have called the consultation service if it were available. For chronic pain questions, 60 percent would have called it between one and five times, eight percent would have called it six to 10 times, and 21 percent would not have called it at all. Fewer providers would have called with questions about SUD. Forty-four percent indicating that they would have called it between one and five times, 10 percent between six and 10, and 35 percent not at all.



Survey results suggest that:

- Providers have a variety of questions the consultation service could address.
- An important need is resource and referral information.
- Providers indicate that they would use a consultation service.

### III. Findings from Interviews and Focus Groups

In stakeholder interviews and focus groups, discussion focused on understanding the needs that stakeholders felt that the consultation service should address. The following section summarizes themes and key points that stakeholders emphasized in the interviews.

#### **Skills and competencies for treating people with chronic pain**

Stakeholders highlighted specific competencies and skills that they believe are important for providers when treating patients with chronic pain and SUD. One such focus was completing a thorough risk-benefit analysis before prescribing opioids and discussing the risks, benefits, and alternative options for managing chronic pain with patients. One stakeholder heard from patients that they feel that their providers did not have adequate discussion with them about the risks/benefits of opioids when they were first prescribed. Another felt that many providers would benefit from training on how to screen for risk of addiction before prescribing opioids, how to implement screening into practice, and what to do when they identify patients at risk.

Several stakeholders emphasized the importance of having an alternative plan in place when treating patients with opioids, especially before tapering them. They stressed that PCPs need to understand that they should not take people off opioids abruptly without treatment alternatives to replace them. They also highlighted specific aspects of opioid prescribing that the consultation service should provide support on:

- Information on how to taper opioids safely
- The message that opioids should be the third line of treatment after the patient has tried other ways of managing pain
- Support around implementing pain guidelines

Several stakeholders emphasized aspects of the provider-patient relationship and of the importance of team-based care. For example:

- It is critical that providers work collaboratively with patients with chronic pain and focus on connecting them with resources.
- The provider's role should involve coaching, in addition to prescribing. Providers may need to strengthen their coaching skills and learn how to integrate it into practice.
- Providers should provide options on how patients can manage pain and develop realistic treatment plans that patients understand and will follow.
- Many providers could benefit from enhancing their ability to teach patients self-management skills.
- Trust between patients and providers is key. Patients with pain often do not feel heard and the initial provider-patient conversation is important. Providers should focus on the etiology of pain to identify potential treatments and on the impact of pain on patients' functioning.
- PCPs should implement strategies to treat patients outside of the 15-minute visit framework and consider different models for treating patients with pain, such as medical group visits.
- It is important to reinforce the benefit of working as a multi-disciplinary team for treating patients with pain.

Stakeholders talked about the importance of addressing behavioral health issues associated with pain. One person noted that while patients with chronic pain often have concomitant anxiety and

depression, some providers are unsure how to help them deal with those issues or do not feel it is their role. Another commented that the consultation service could help providers address the complexity around psychosocial issues. He believes that providers who are motivated to call the consultation service will do so because they are dealing with uncomfortable and complex issues, often unrelated to medications, and that the consultation program should include someone who can help the provider deal with those issues.

### **Provider questions about pain and SUD**

During interviews and focus groups, MBHP asked about the types of questions that providers might contact the consultation service about. A major theme was that providers struggle with knowing when it is appropriate to prescribe opioids, and they may want input on the appropriateness of opioids for specific patients they treat.

Stakeholders described scenarios where providers might call the consultation service when they inherit “opioid orphans” from other providers. Some examples include:

- One PCP took on a large number of patients on opioids for chronic pain from a retiring PCP; a consultation could be helpful to assess their needs, whether they should be tapered and other treatment options that could be effective.
- A PCP took over another practice and found a number of patients on benzodiazepines and opioids; this provider could use guidance on how to manage these patients’ medications and their overall pain management.
- Another inherited a patient on a high dose of opioids, which he was uncomfortable with but was concerned about balancing the patient’s chronic pain with physiologic dependence.

Another stakeholder noted that providers are under pressure to lower the dosage of opioids. He sees the consultation service as a resource for providers who want to review their most worrisome patients, consult on whether it is appropriate to taper them off opioids and how to do so, and discuss challenges related to patients with SUD, including how to communicate with them about these issues. Specifically, he thought that providers could identify patients on their panel who are on high doses of opioids to review during a consultation to determine whether to lower doses.

Providers might also like input related to communication strategies. Examples include when a PCP is discussing opioid use with a complex patient or when a patient has unexpected toxicology results and he/she disagrees with the physician’s treatment recommendations.

### **Identifying cases where consultation may be useful**

In addition to setting up the consultation service so that providers can actively reach out to it, some interviewees thought that program could push information outward to providers who might benefit from consultations. There were a number of triggers that interviewees suggested could be used to identify when consultation is needed.

One person pointed out that many opioid-naïve patients are prescribed opioids while inpatient and that there is an opportunity to support PCPs in managing them during the month after discharge. He believes PCPs should have a tapering plan when a patient discharged, though this does not always occur, and that discharge of patients who were prescribed opioids while hospitalized could be an important trigger. In his view, people start “getting in trouble” around three to six weeks after

beginning on opioids and that assessing their opioid needs and their treatment plan one month post-discharge is an important opportunity.

Interviewees identified other potential triggers, based on pharmacy data analysis:

- Patients who are opioid-naïve and who are on opioids for 90 days
- Refills after 30 days
- Patients on more than 120 Morphine Milligram Equivalents (MME) of opioids
- Patients on opioids and benzodiazepines

### **Medication-Assisted Treatment (MAT)**

Many interviewees had views about the role that the consultation service could have in supporting physicians around MAT. The consultation could support providers by:

- Focusing on newly waived prescribers to address their questions and provide support as needed
- Focusing on waived providers who are not doing a large volume of prescribing
- Identifying providers who are waived and outreach:
  - Those who are actively prescribing to see if they need support, such as consults on specific patients or additional education (e.g., Project ECHO®)
  - Those who are not prescribing to understand why and to see if there is any support that they would like

Other interviewees were more ambivalent about how the consultation service could have an impact on providers' challenges with MAT. They think that barriers to prescribing are often at the system level and that on-going mentoring is the most effective approach to helping providers overcome these barriers. One person commented that some providers get waived but do not prescribe because they want someone at their elbow to support them when they start to prescribe. While that is not a role that the consultation service can easily fill, it could triage those providers to a Project ECHO®-type program. Because of this, the consultation service should be aware of available educational resources.

### **Resource and referral information**

Several interviewees emphasized that providers would be interested in accessing evidence-based information on treatment options. They think there is a need for information on non-pharmaceutical treatments for pain, and many providers would prefer alternatives to opioids but are unsure where to send them for alternative treatments. Specifically, providers would be interested in information on chiropractors, acupuncturists, and osteopaths, including the insurance these providers accept.

Three people pointed out that it is challenging for providers to know whether alternative treatments for chronic pain are covered by MassHealth and commercial insurance. For instance, they think that many providers are unaware that Medicaid covers acupuncture and chiropractic care. In their view, the consultation service could play a role in making providers aware of coverage for alternative treatments under MassHealth and other insurance plans.

Some interviewees raised other challenges when providing information about alternative treatments:

- Many alternative treatments are not covered by insurance and are only accessible to people who can self-pay.

- Some health centers offer pilot programs to provide alternative treatments that are not covered by insurance. However, availability is limited.
- Some alternative treatment modalities (e.g., massage, acupuncture) may not be geographically available in all regions.

Several people said that it is helpful to have information about local detoxes, methadone clinics, residential programs, and other SUD resources. The Substance Abuse and Mental Health Services Administration (SAMHSA) treatment locator is helpful, but some providers are unaware of it. Some stakeholders felt that while it would be useful to develop a local list of SUD services, it could be hard to maintain statewide, and it is important to ensure that the information is up-to-date and accurate. Other suggested resource information that would be useful related to:

- Multi-modal pain management programs, including an assessment of the quality of the programs
- Self-care and support groups for people living with pain

### **Consultation service staffing**

Stakeholders had suggestions about how the consultation services should be staffed. They agreed that consultants should have expertise in treating chronic pain and SUD and need knowledge of primary care in order for providers to feel that consultations are relevant to them. Some people also felt that should be a pain specialist as part of the team.

Several people who were interviewed highlighted the importance of a multidisciplinary team in addressing chronic pain. One person whose organization has a multi-disciplinary team to support people with pain commented that it would be rare to find all of the knowledge needed to address complex cases in one person. Some of the roles that ideally would be included on the team include: a pain specialist, an internist, a psychiatrist, a physical therapist, a social worker, an acupuncturist, a nurse practitioner, and a patient navigator.

There were mixed responses about the importance of the capacity to have face-to-face consultations. One specialist described that he has been able to address PCPs' questions related to pain management electronically and by phone. Another person thought that it would be helpful to have the capacity to do face-to-face consults, to assist physicians with high-risk patients who they have challenges in treating.

One person interviewed felt that a consultation service should be regional because it is important to know what resources/programs are in the community. This person stressed that it is important for the PCP to have linkages to the programs/providers that their patients go to so they can know if services are working.

### **Working with accountable care organizations (ACOs)**

Several people feel that ACOs can be an important partner related to the work of the consultation service. For example:

- The consultation service could have a contact at each ACO who would be aware of the full range of specialty services that could be provided to people with chronic pain. Clinicians in the ACOs may not know the non-opioid treatment options that are available to ACO patients, and the consultation service could create a pathway to these services.

- The ACO model may provide the opportunity to support alternative treatments for pain management that are not covered fee-for-service.
- The consultation service could be an important resource for Behavioral Health Community Partners (BH CPs). For example, BH CP Care Managers could use the consultation service to answer questions about medication dosages and interactions.

### **PCPs and pain specialists working together**

In several conversations, there were challenges raised about the way PCPs and pain specialists work together and that there are opportunities to improve partnerships between them. One concern is that when PCPs refer patients to pain specialists, the focus of the pain specialists is to resolve the patient's pain through injections. They feel that patients need so much more to manage their pain. However, it was noted that there are pain specialists in Massachusetts who incorporate a multi-disciplinary approach and offer patients a range of treatment options.

One person noted that pain specialists can have an important role in coaching PCPs. He spoke of his experience in offering PCPs follow-up consult directions and pain protocols after seeing their patients, and the PCPs were pleased to have on-going support. However, he noted that if PCPs interact with multiple pain specialists, they might not get the same answer for the same problem due to variance in treatment approaches.

### **Challenges for providers and patients**

In conducting the interviews, there were a number of challenges and barriers that stakeholders identified that they think are important for the consultation service to keep in mind.

Several people raised the issue that there is considerable focus presently on decreasing use of opioids, and while this is very important, the MME limits are too extreme in some cases. Stakeholders noted that doses above the limit may be appropriate if the prescriber knows the patient well and has assessed him/her for risks/potential for diversion. They feel that the goal should be to manage patients' pain safely and effectively, not only to get their dosages below a certain threshold.

It was also noted that a key issue is that people with pain who are looking for help are feel that they dismissed or not believed. Some have to see four or five doctors in order to find someone who will help them. Some patients feel that these problems have gotten worse because of the opioid crisis. From a patient's perspective, they feel that prescribers are frightened because of the opioid crisis and feel forced to taper patients off opioids even if they are stable.

### **Other suggestions**

When talking with stakeholders, there were other suggestions that could help support providers treating patients with chronic pain and SUD.

- Project ECHO® is seen as a high quality, useful model for educating providers. Several stakeholders note that the program is valuable, including the case consultations. People who would like to participate need to be able to make a time commitment and that because of limited capacity, it is not realistic for all PCPs to participate. One way to extend the reach of the program is to have a champion in a practice participate and share information with others in the practice.
- State guidelines related to opioid prescribing would be helpful, as providers are more comfortable if there is validation locally of guidelines.

- Some community health centers have implemented nurse case management to support patients who are taking buprenorphine, funded by the Massachusetts Bureau of Substance Abuse Services (BSAS). Nurse case management involvement can increase concordance with guideline therapy (e.g., urine monitoring, monitoring of early refills) and can help patients access non-opioid treatment. In a large practice with many patients on chronic opioids, the practice could improve care by incorporating a nurse case manager. One stakeholder referred to this as “Cadillac care.” To have a complete program to address opiate issues due to chronic pain, these nurses should also be available to manage patients with chronic pain.
- Several stakeholders emphasized the need for improved information about insurance coverage related to treatment options and the need for assessment of pre-authorization requirements to eliminate barriers to prescribers.
- The consultation service could be a helpful resource to emergency departments related to initiating MAT, although this service would only be available during business hours.
- Information about non-pharmaceutical treatment for pain may be of interest to behavioral health providers, and it would be helpful to find a way to make this information available.

**Attachment A**  
**Survey on Provider Consultation Service for**  
**Chronic Pain and/or Substance Use Disorder**

Please provide input on how a statewide consultation program could support your practice in caring for your adult patients (over the age of 17) with **chronic pain** and/or symptoms of a **substance use disorder** (SUD). Your input is very important to ensure that the consultation service will be beneficial to you and other providers.

This survey should be completed by someone in your practice who is knowledgeable about the clinical and resource needs of your patients. **Please complete this survey by October 15, 2018.** You may return this survey in the enclosed envelope, fax it to (855) 809 - 8614, or scan and email it to [purvi.patel@beaconhealthoptions.com](mailto:purvi.patel@beaconhealthoptions.com).

If you have questions about this survey, please email [amy.rosenstein@beaconhealthoptions.com](mailto:amy.rosenstein@beaconhealthoptions.com) or call (617) 790- 4186.

1. **In the past month**, approximately how many patients have you seen with the following symptoms?

	None	1-5 patients	6-10 patients	More than 10 patients	Not sure
Chronic pain only					
SUD only					
Chronic pain and SUD symptoms					

2. a. What challenges do you experience in treating patients with chronic pain and/or SUD?

	Not a challenge	Minor challenge	Significant challenge	Not sure	Not applicable
<b><i>Regarding patients with chronic pain</i></b>					
General lack of information about prescribing pain medication					
Identifying new treatment options to address the chronic nature of patients' conditions					
Knowledge of alternative, evidenced-based treatment options					
Lack of case management support in the primary care setting for people with chronic pain					



	Not a challenge	Minor challenge	Significant challenge	Not sure	Not applicable
<b>Regarding patients with SUD</b>					
Access to pain management providers and programs					
Knowledge about prescribing Medication-Assisted Treatment (MAT) for patients who are initiating					
Knowledge about prescribing MAT for patients on MAT who transfer from another prescriber					
Resources for toxicology screening					
Knowledge about prescribing for patients with dual diagnoses (any combination of medical, mental health, and SUD diagnoses)					
Assessing risk for abuse, diversion, and overdose					
Knowledge related to consent and information sharing associated with MAT (42 CFR part 2)					
Lack of case management support in the primary care setting for people with SUD					
Access to SUD providers and programs					
Managing patients' expectations					

2. b. Please briefly describe other major challenges:

3. How comfortable are you with the following?

	Uncomfortable	Somewhat uncomfortable	Neutral	Somewhat comfortable	Very comfortable	Not sure
Addressing chronic pain with patients in your practice						
Recognizing and addressing SUD with patients in your practice						

	Uncomfortable	Somewhat uncomfortable	Neutral	Somewhat comfortable	Very comfortable	Not sure
Requesting a patient to complete a toxicology screen and discussing results with him/her						

- 4.
4. What types of questions do you have about managing care for people with chronic pain and/or SUD? Check all that apply.
- Prescribing non-opioid medications for treating chronic pain
  - Non-pharmaceutical management of chronic pain
  - Dosing questions about opioids
  - Tapering patients from opioids
  - Interactions between opioids and other medications
  - Identifying patients who are at risk for misuse of pain medication
  - Alternative pain management treatment, such as acupuncture and chiropractic care
  - Prescribing **buprenorphine/naloxone (suboxone)**
  - Motivational interviewing to identify etiology of pain
  - Knowing when a patient should be referred to a specialist
  - Resources in the community to help people with SUD
  - Resources in the community to help people with chronic pain
  - Other; please describe:

5. If a consultation service were available to you, how important would the following factors be?

	Not important	Somewhat important	Very important	Not sure
The consultation service's awareness of resources in your region				
Availability of a follow-up consultation after the initial consultation				
Ability to follow-up with same clinician that you spoke with initially				
Multi-disciplinary expertise of consultation service staff				
Wait time for speaking with a specialist				
Ability to schedule a time in advance to consult with a specialist				

6. If a consultation service provided you with access to a specialist to answer clinical/prescribing questions, which modalities would you use? Check all that apply.
- Real-time telephonic consultation
  - Scheduled calls, as needed
  - Calls with the specialist at a scheduled weekly time
  - A learning collaborative (Project ECHO® is a well-known example)
  - On-site education/training

- Email/text to a “Help Desk”
- Other; please describe:

7. If a chronic pain and SUD consultation service were available, would you use it for the following?

		Yes	No	Not sure
<b>Chronic pain</b>	Questions about initiating or titrating medications			
	Other clinical questions			
	Referral resources questions			
<b>Substance use disorder</b>	Questions about initiating or titrating medications			
	Other clinical questions			
	Referral resources questions			

8. If a consultation service were available to you, please provide an example of a question that you would have presented to the service, based on a recent patient you treated.

9. Thinking back on the last month, how often would you have called the consultation service if it were available?

	0 times	1-5 times	6-10 times	More than 10 times	Not sure
With questions about chronic pain					
With questions about SUD treatment					

10. Other comments:

11. Demographics:

a. Your role:

- MD/DO
- Nurse practitioner
- Physician assistant
- BH clinician
- Practice manager
- Other:

b. Are you or someone in your practice waived to prescribe buprenorphine?

- Yes
- No
- No, but would consider becoming waived

c. Approximate number of patients in your panel

- Less than 500 patients
- 500-1,500 patients
- 1,501-2,500 patients
- More than 2,500 patients

d. City/town your practice is located in:

e. Practice model:

Solo practice

Group practice

Community health center

Hospital-based practice

Other:

**Thank you!**

## **Attachment B Individual Interviews and Focus Groups**

### ***Individual Interviews***

Daniel Alford, MD, MPH, Director of Clinical Addiction Research and Education (CARE) Unit at Boston Medical Center

Paul Arnstein, RN, PhD, Director of MGH Cares about Pain Relief

Robert Cohen, MD, pain specialist in Newton; member of Massachusetts Pain Initiative; participated in Special Commission to Examine the Feasibility of Establishing a Pain Management Access Program

Paula Gardiner, MD, MPH, Associate Director of Research, Department of Family Medicine and Community Health; Assistant Director for the Program for Integrative Medicine and Health Care Disparities at Boston Medical Center; Associate Professor Department of Family Medicine at Boston University School of Medicine

Brenda Goldhammer, Program Manager at University of California San Francisco Clinical Consultation Service

Barbara Herbert, MD, MMS, Opioid Task Force pain sub-committee

Jim Hiatt, Director, Substance Use Initiatives, Massachusetts League of Community Health Centers

Laura Kehoe, Medical Director, Bridge Clinic, Substance Use Disorder Initiative at Massachusetts General Hospital

Stephen Martin, MD, Associate Professor of Family Medicine and Community Health at the University of Massachusetts Medical School; co-director of UMass Project ECHO® for OUD

Kaitlin McColgan, Vice President, Government Affairs & Public Policy, Massachusetts League of Community Health Centers

Darshon Mehta, MD, MPH, Benson-Henry Institute for Mind Body Medicine Physician Consultant, MGH

Dan Mullen, PsyD, MPH, Director of the Center for Integrated Primary Care; Associate Professor in the Department of Family Medicine and Community Health at the University of Massachusetts Medical School

Barbra Rabson, Executive Director, Massachusetts Health Quality Partners

Keith Rafal, MD, MMS, Opioid Task Force pain sub-committee

Cindy Steinberg, National Director of Policy & Advocacy at U.S. Pain Foundation; Chair, Policy Council at Massachusetts Pain Initiative

Alex Walley, MD, CARE Unit Faculty at Boston Medical Center; Medical Director of Opioid Overdose Prevention Pilot Program, Massachusetts Department of Public Health

Susan Webb, Director of Department of Health Policy and Public Health at Massachusetts Medical Society

***Focus Groups***

Massachusetts League of Community Health Centers/SUSTAIN Monthly Peer Mentor Program

MBHP Behavioral Health Clinical Advisory Council