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[0:00:46]

AARON WILLIAMS: Good afternoon, and welcome to the SAMHSA-HRSA Center for Integrated Health Solutions' Quarterly National Webinar entitled Building Organizational Infrastructure to Treat Chronic Pain and Prevent Abuse of Prescription Medications. My name is Aaron Williams, Director of Training and Technical Assistance for Substance Abuse for the SAMHSA-HRSA Center for Integrated Health Solutions at the National Council for Behavioral Health, and I will be serving as your moderator for today's webinar. [0:01:18]

As you may know, the SAMHSA-HRSA Center for Integrated Health Solutions promotes the development of integrated primary and behavioral health services to better address the needs of individuals with mental health and substance abuse conditions, whether seen in specialty, behavioral health, and primary care provider settings.

In addition to the national webinars designed to help providers integrate care, the Center is continually posting practical tools or resources to the CIHS website providing direct phone consultations to providers and stakeholder groups and directly working with SAMHSA primary and behavioral health care integration grantees and HRSA-funded health centers. [0:02:03]

Before we get started, presentation slides can be downloaded by clicking the dropdown menu labeled Event Resources on the bottom left of your screen. Slides are also available on the CIHS website using the links shown on your screen.

The purpose of today's webinar is to provide valuable information and resources to health centers and primary care safety-net provider organizations to help them in achieving the balance between appropriate pain management and preventing abuse of prescription medications.

During today's webinar we will review the health center's innovative approach to addressing pain management with clients, provide administrative guidelines for treating chronic pain in the health center, outline workforce needs for effective pain management in health centers, and

identify resources for further guidance and information for staff on chronic pain management. [0:03:08]

Among the presenters today includes Laura Makaroff, Senior Clinical Advisor for the Office of Quality and Data, Bureau of Primary Health Care at the Health Resources Services Administration; Dr. Daren Anderson, VP/Chief Quality Officer, Community Health Centers Incorporated and Director of the Weitzman Quality Institute, and also Associate Professor of Medicine at Quinnipiac University; Dr. Kevin Sevarino, Medical Director, SAMHSA's Providers' Clinical Support System for Opioid Therapies; and Chris Fore, Dr. Chris Fore, Indian Health Service Telebehavioral Health Center of Excellence, Great Plains Area Indian Health Service Center Task Force for Prescription Drug Abuse. [0:04:12]

A couple of housekeeping notes to keep in mind. Today's presentation - during today's presentation your slides will automatically synchronize with the audio, so you do not need to get any slides to follow along. You'll listen to the audio through your computer speakers, so please ensure that they are on and the volume is up.

You may submit questions to the speakers at any time during the presentation into the Ask a Question box in the lower left portion of your player. Finally, if you need technical assistance, please click on the Question Mark button in the upper right corner of your player to see a list of frequently asked questions or contact info for tech support if needed.

And now, I'd like to turn things over to our first speaker, Laura Makaroff, for opening remarks. [0:05:04]

LAURA MAKAROFF: Hello, good afternoon, and good morning to the west coast. Thank you so much for joining us today. On behalf of the Bureau of Primary Health Care at HRSA, it's my sincere pleasure to welcome you to today's webinar. We are really excited to partner with SAMHSA and the Center for Integrated Health Solutions to bring you this important and timely webinar on chronic pain treatment and the prevention of abuse of prescription medications. [0:05:30]

The mission of the health center program remains to ensure access to comprehensive high-quality primary care for underserved and vulnerable populations. With more than 1200 health centers providing care to over 21 million patients, the impact and spread of the health center program is indeed impressive.

Comprehensive primary care often involves chronic pain management, and we are really glad to partner with the Center in supporting health center providers and staff in caring for patients with chronic pain in a holistic patient-centered way which includes behavioral health and primary care integration. [0:06:02]

Chronic pain management can be complex, and providers often feel ill-equipped to be able to safely and effectively treat chronic pain, at least this is how I often feel when I have seen patients. And we know that health center patients often have significant comorbidities, including

multiple chronic medical conditions, mental illness, substance abuse disorders, and other socioeconomic challenges which can further complicate treatment of chronic pain.

Today's webinar will provide a lot of helpful ideas and tools to guide you in your work. You will hear from several leading national experts in the field and go away with some really practical ideas of how to build your infrastructure to support safe and effective chronic pain treatment. Thank you again for joining us today, and thank you to SAMHSA and the Center for Integrated Health Solutions for this great opportunity, and I'll turn it back to you, Aaron.

AARON WILLIAMS: Well, thank you, Laura, and now I'll turn it over to our next speaker, Dr. Daren Anderson.

DAREN ANDERSON, MD: Well, good morning and good afternoon to everybody, and thank you, Aaron, and everyone at the Center for Integrated Health Solutions for the opportunity to present to you today. [0:07:08]

I'm a primary care provider, by training I'm a general internist, and when I finished residency and first came to practice at the Community Health Center of New Britain I was feeling pretty confident I knew how to intubate and extubate patients, wean off ventilators. I could manage vancomycin-resistant infections and had a pretty good understanding of diabetes, diabetes treatments, insulin pumps, and all sorts of things. And so it kind of came as a rude shock when I walked into the exam room to see my first patient as a fully credentialed and certified primary care provider, and he came in and his chief complaint was "I need a refill of my Percocet." And as I started to employ my highly skilled HPI techniques and patient interviewing, I elicited a history of substance abuse, cocaine, heroin, and a long history of chronic pain from a back injury that had occurred over a decade ago. [0:08:08]

And as the interview continued and the physical exam and I started reviewing records, I was becoming increasingly less confident and increasingly uncertain of myself and my skills, and I realized that I was in trouble. I realized that as much as I had learned a lot as an internal medicine resident I was not prepared to deal with this particular case and felt extremely vulnerable and extremely worried that I would make the wrong decision and not know what to do.

So what I'd like to do in the time allotted is to talk a little bit about primary care, substance abuse, opioid medications for chronic pain, describe some of the interventions that we have made at the Community Health Center, and kind of set the stage for what will be a brief description of Project ECHO.

So first of all just to orient everybody, I work at a federally-qualified health center called Community Health Center Incorporated. I'm the Chief Quality Officer, and we are a multi-site federally-qualified health center that takes care of about 140,000 patients across Connecticut. We deliver service in a wide range of locations, from homeless shelters and schools to 13 brick-and-mortar primary care hubs. And like most FQHCs, we deliver behavioral health and primary care services as well as dental care and a variety of other ancillary services as well. [0:09:31]

And like most, we have a large population of indigent and underserved patients. We take care of a wide range of ethnic and racial groups, and we do so in a manner consistent with the patient-centered medical home and have achieved level three recognition by the NCQA.

We also have a newly created institute called the Weitzman Institute which is committed to improving primary care by promoting research, training, education, and intervention, and much of the work that I'm going to describe has come out of the Weitzman Institute in a combination of research and quality improvement work that's been focused for several years now on helping primary care providers and delivery systems deliver more effective and appropriate care to patients suffering from chronic pain. [0:10:16]

So by background, most of you are well aware that chronic pain is extremely common, and over a hundred million Americans suffer from chronic pain and it's extremely costly, and many if not most of these patients will seek care, at least initially, in a primary care setting from providers like me.

Primary care providers, if you ask them though, will tell you just like I did that they don't have a lot of knowledge about how to manage chronic pain and they have limited, if any, confidence in their ability to do it effectively. And we have relied heavily on opioids for the management of chronic pain in the recent past, and as anyone who's picked up a newspaper recently will attest to, prescription opioid overdose and opioid addiction in general is a major and growing public health concern. [0:11:04]

So how did we get here? Well, at the time that I was coming into practice, "Pain is the fifth vital sign" was a popular phrase that you would have heard, and pain scores were increasingly being administered all over the place, including at the intake of every primary care visit. And that "Pain is the fifth vital sign" presented a piece of clinical information to a group of well-intentioned primary care providers who had trained like I had to alleviate suffering and improve quality of life. And we went at this challenge with our very best intentions, and at the same time we ran headlong into an industry that was on the cusp of developing some new medications, some new medications that were expensive and that could generate significant profits, and this was OxyContin, and the OxyContin underground and painkillers in Newsweek became increasingly common topics that would come up in the popular media. [0:12:01]

And you can see this is a graph that shows right around the late nineties, at the time I was going into practice, how our prescription rate for medicines like OxyContin and others started increasing dramatically. And not surprisingly at the same time, the rates of prescription painkiller deaths and overdoses started increasing as well. And this is kind of the perfect storm that really coalesced around the primary care provider that was trying to do their best. We had an increasing demand to manage painful conditions. We have, as I've mentioned, high rates of opioid abuse, limited training, poor access to specialists, particularly for those of you working in under-resourced settings like I am, and limited access, if any, to pain specialty centers to help.

And so we - and this is an indictment on myself as much as anybody - we continued to prescribe opioid medications, even in circumstances when there was limited indication. We often ignore recurring non-reassuring behaviors that patients come in with. We don't consider, as we should,

the household or community environment into which these drugs are being placed. And we treat pain without focusing on addiction, devalue many effective alternatives, and although we don't like what's happening, we don't like what we're doing, we haven't done much to change it. [0:13:22]

So what I'd like to talk about at this point is something called the step care model, and this is a model of care that's predicated on one principal point, and that is that primary care needs to have competence in managing chronic pain. I think many of us have gone through a hopeful period where we thought it would be possible to refer patients away and basically to have the chronic pain problem reside elsewhere in comprehensive multidisciplinary centers. There are a few of them. Many of you have worked with them know that they can provide very, very successful and effective treatment, but they will never have the numbers or the availability and access to treat all of the patients that we are seeing in primary care. [0:14:02]

So basically the step care model as it's applied to pain care, this is an adaptation of it that we did at the community health center. Essentially it posits that primary care medical homes need to have the basics of pain management. They need to routinely screen for the presence and intensity of pain due to perform a comprehensive assessment; to document function status and goals; to manage common painful conditions; and to do that with team-based care using medical assistants, nurses, and others with everybody working at the top of their license and supporting the endeavor of managing chronic pain.

And as patients increase in complexity or fail to respond to the basics, we increasingly need to bring collaborative co-management principals to bear with behavioral health, mindfulness, rehab, and other partners, whether internal or external, and only at the top of the step care model do we refer out to those multidisciplinary pain centers.

So we conducted an evaluation in our own environment, and Aaron and presenters, if someone could advance the slides. I've just lost the ability to present them myself. If I can just say "next slide" for somebody to click next, I can still hear everybody and hopefully you're hearing me. But I've lost Internet connection temporarily.

AARON WILLIAMS: Yes, we can do that, yes.

DAREN ANDERSON, MD: Okay. I'm just going to say "next slide," and I have the slides in front of me, so we'll continue. [0:15:28]

So we conducted - as part of a multiyear quality improvement initiative aimed at implementing the step care model and helping our primary care providers tackle what we perceived as the epidemic of chronic pain, we conducted a baseline assessment to give us more information on exactly what was going on in primary care, and I think the results probably won't surprise any of you who are practicing in a similar environment.

But to summarize, we found that chronic pain was extremely common, and it looked like about one in three of all adult visits were for patients who were suffering from chronic pain and that those who were using opioids for chronic pain were coming in greater than ten times per year. So

when providers said "I feel like all I'm doing all day is managing pain," they were very accurate in that assessment. Pain was extremely common and taking up a large amount of their time. [0:16:14]

And yet when we did a detailed chart review looking at some of the best practice recommendations for how to document and manage pain, we found the documentation was very poor. And in particular, that functional assessments, one of the recommendations for how to assess pain, the assessment of the impact of pain on function was rarely if ever done. And when we surveyed our primary care providers on their knowledge about pain, we found that knowledge was fairly low. Providers expressed low confidence, but they felt the pain was really important.

So if I could have the next slide, this shows a table that we created, which essentially was an action plan for how to address these principal deficiencies that we had identified, or let's say opportunities to improve. And I'm going to walk through briefly some of the key elements that we implemented as a result of this initial assessment and the quality improvement initiative that we started. [0:17:08]

So first of all, we found low pain knowledge and low self-efficacy. Just as when I came out of residency, I felt very limited confidence in what I knew about pain; our other provider said the same thing.

And so if I could have the next slide, we implemented a policy of providing CME, pain-specific CME, to all of our primary care providers and requiring that they do that on a twice-yearly basis. There are many opportunities and many potential places that you can obtain CME, and I have just some examples of a couple of recent ones from Pri-Med to conferences.

But if I could have the next slide, we utilized an online resource called the Virtual Lecture Hall which allowed all of our providers to log on and to take a series of core modules on chronic pain at their leisure. And we set it up so that they did it in a team-based setting with a combination of their nurse and their behavioral health provider, and they would go into the Virtual Lecture Hall and review the cases they actually presented. It was a case-based learning module that presented classic cases and then presented questions, and the team would discuss them and come up with answers together and engage in this as kind of a collective learning opportunity. [0:18:21]

So the second area that we focused on, if I could have the next slide, was documentation of pain and functional status, and in particular, documentation of pain reassessment. It's critical importance for a provider to be able to look through the note and see sort of what's the plan, what is the patient suffering from, how is pain impacting their function, and to be able to look and to follow that up over time.

And as I mentioned, we found fairly poor documentation. So if I could have the next slide, we created a series of templates for chronic pain management embedded within the electronic health record that walked the primary care provider exactly through the appropriate elements of a documented chronic pain visit, and it goes from the documentation and the location to the specific impact on function and what modalities have been tried in the past and what the patient's

functional goals are. And we use eClinicalWorks as our EHR which allowed us to build these templates ourselves. I've seen many good paper templates as well, which I'll show a couple of examples in a second if I could have the next slide. [0:19:25]

We also embedded something called the Opioid Risk Tool, which is a risk assessment tool that measures a patient's potential risk for opioid misuse prior to the initiation of opioids, and that was built into the template and we encouraged all of our providers to utilize this before embarking on a chronic opioid therapy regimen.

If I could have the next slide, this is an example of a follow-up assessment form that can be used in paper format. It also can be used as the content for any template that you create in electronic health record. But the combination of assessment forms and tools such as these was very effective in helping our primary care providers give proper documentation in the chart so that they could follow up effectively and others who would come into contact with the patients would know what was going on. [0:20:15]

If I could have the next slide, the additional thing that we observed in looking at our prescribing data was that there was a fairly substantial variation in how opioids were being used. There were providers who weren't using opioids at all. There were providers who were using them extensively. And as part of - if I could have the next slide - we created a policy that stated that all chronic opioid therapy patients must have an opioid agreement and must be screened periodically with a u-tox and have a follow-up visit at least once every three months, and this brought some structure to the process of opioid prescribing and opioid monitoring, and it gave providers some additional tools which are helpful in appropriately tracking, monitoring, and having conversations with patients for whom they're managing with chronic opioid therapy. [0:21:06]

And one of the core processes that we recommend for pain management is the establishment of standard policies; it makes it easier for providers to say "This is our policy, this is routine," and it puts some important tools in their hands for tracking and monitoring patients.

Next slide is a sample of our opioid agreement. There's increasingly a recommendation from the pain societies and others to actually turn this more into an informed consent type of a process, which I'll mention briefly, where patients are fully informed of the risks and benefits of opioid therapy and made fully aware prior to initiating chronic opioid therapies.

If I can have the next slide, this is a screenshot showing an opioid dashboard. This is a type of a registry that allows every primary care provider to see which patients they have who are being managed with chronic opioids, and it shows them which of them have or are due for things like opioid agreements and urine tox screens. And it's a critical piece of information for the provider to have because it helps you sort of keep a population management perspective on the population of the patients that you have with chronic opioids. And we made this information fully visible and available to all primary care providers so that they could see sort of how they were doing in regard to their peers and utilize the information proactively as part of a morning huddle process to see who was coming in, who was due for things like urine tox screens. [0:22:30]

Next slide, we found limited behavioral health co-management despite the fact that the vast majority of patients with chronic pain had coexisting either addiction and/or behavioral health problems. And if I can have the next slide, we spent quite a bit of time really working closely with our behavioral health colleagues, not only collocating them in the primary care space, but also creating a mechanism for warm handoffs and for group therapy that was focused on pain so that patients with pain could have fully integrated treatment with a behavioral health provider who was conversant and able to work with them on issues of framing and cognitive behavioral therapy and a wide range of tools that are employed to help support the management of chronic pain from a behavioral perspective. [0:23:14]

Next slide we found fairly low use of complementary and alternative strategies which many patients find effective. And so on the next slide you'll see an image of a chiropractor who now works side by side with our primary care providers in many of our sites, providing onsite chiropractic care, also with high degrees of satisfaction from the patients and the providers as an additional modality of treatment to offer patients who find that to be useful and aren't doing well at step one of the step care model.

And the next slide shows acupuncture. We are in conversations with some certified acupuncture providers, hoping to be able to provide that onsite as well. I think the point of both of these, and of behavioral health as well, is to provide more of a toolkit, more opportunities for multidisciplinary collaborative practice for patients with pain, so that the primary care provider has more in their toolkit than just an opioid prescription. The more we approach chronic pain management as a team sport and where everybody is involved and where multiple different disciplines are contributing to the management, the better it is for us and for our patients. [0:24:21]

And if I could have the next slide, we still, even with all of these tools in place, struggled with limited access to specialty consultation, and even with all these things there are complex patients who we need input from the specialist. And so that brings us to Project ECHO, and in the remaining minutes that I have I want to talk a little bit about Project ECHO, and I know the next speaker is also going to talk a little bit about it.

So Project ECHO, many of you are likely aware, was developed by a gentleman named Sanjeev Arora in New Mexico at the University of New Mexico, and he created Project ECHO to provide access to primary care practices in rural locations who were having difficulty getting patients in for hepatitis C treatment, and unfortunately in New Mexico he was the only provider in the state who was treating Medicaid patients or uninsured patients for hepatitis C. And his idea was that if he could link the primary care providers across the state by video, they could present their cases to him in a multidisciplinary team and he and the team could coach them on the proper way to manage hepatitis C. [0:25:30]

And many of you who have seen the results of this initial Project ECHO study; it was published in the New England Journal. Those results showed that the primary care providers who engaged in Project ECHO and treated hep C got results that were as good or better as the patients who were being managed by the specialists. And from that work and those results, the Project ECHO initiative really grew and took off and has now turned into a multinational Project ECHO being

replicated in states and countries around the world for multiple different conditions. And one of the most common and popular is chronic pain, for the same reasons that I've been alluding to, in that pain specialty knowledge is critical, we need it, we have limited access to it, and so Project ECHO pain management really grew out of this initial Project ECHO.

If I could have the next slide, we at CHC learned about Project ECHO and realized that although we aren't a rural state, we had similar issues in Connecticut with access. And so we sought to replicate the same concept or Project ECHO in our setting, an urban underserved geographically widespread federally qualified health center, and to provide a model that was flexible to allow our primary care providers to access Project ECHO, and to utilize that as a tool to expand their ability to manage complex illnesses for underserved patients.

So if I could have the next slide, the technological infrastructure was relatively simple. We use a technology called video which allowed providers to join onto Project ECHO from almost any device. They can join it from an iPad or from a laptop computer. You can join from a video conferencing system or even from an iPhone. We even had a provider who joined from an airplane at 35,000 feet to tune in and listen to the sessions and even to speak and to ask questions. [0:27:19]

So if I could have the next slide, this is a screenshot of our CHC version of Project ECHO for pain management. And what's unique about it, it follows the exact same model as Dr. Arora originally developed with a multidisciplinary team in the center that's listening to the cases and providing advice with primary care providers around, as you can see in the margins, listening and presenting their cases.

What's different about it is we're in Connecticut and our providers are in Connecticut, but the pain center happens to be in Arizona. Many people have asked me, why is your pain center in Arizona, and I think the answer is why not? The pain center is in Arizona because there was an interesting willing participant that was extremely high quality that thought this was a neat idea. And given the beauty of video conferencing and Project ECHO, the infrastructure we had created, the specialists and the primary care providers can be anywhere. And that's the real power of the ECHO model is it really takes away geographic boundaries and lets the right people be present around the table regardless of whether they happen to be in close proximity. [0:28:17]

So if I could have the next slide, the Integrative Pain Center of Arizona is a multidisciplinary team that takes care of patients with chronic pain on a daily basis. They work together as a team, and on our Project ECHO sessions they present and listen to cases as a team as well. And on a weekly basis, on Thursdays at eleven o'clock Eastern time, they present a brief didactic, 10 to 15, sometimes 20 minutes, and then they listen to cases from the participating primary care providers. If I could have the next slide, they're a truly experienced team that's been working together for 15 years in South Arizona and they've been really excited participants in our Project ECHO.

So if I could have the next slide, what's also somewhat unique as we realized pretty early on, that the ECHO sessions were highly valuable, that lots of people wanted to join on. And so kind of in

the same way that we were able to go to an ECHO provider out in Arizona, we started providing access to primary care FQHCs in other practices in other states as well. [0:29:20]

So when you tune into our Project ECHO for pain management now, you have our community health center practices in Connecticut along with colleagues from Arizona, from Delaware, from California, from Maine, and next month also from New Jersey. And we have continued to add practices interested in joining on, and it really creates a multistate, multidisciplinary consultation that's really kind of fun and exciting. And you realize that a provider in Northern California may have a slightly different environment in which they work, but their cases have every bit as much to teach us as do the cases that we have right here in our backyard. And so really, many people who join kind of describe it as being part of a family, and you get to know each other even though you may be separated across the country. [0:30:04]

So if I could have the next slide, we've created a Project ECHO website where we have a variety of things that allow participants to access the content in different ways. In addition to taking part in the live sessions, there is what we call a clinical pearls blog where each week one of our providers actually captures in a blog what he thinks were some of the key points from that most recent session. And we also have video cataloged all of the sessions, the didactics, and the individual cases. So you can log on and search for a case about neuropathy or a case about fibromyalgia and just watch that specific case.

If I could have the next slide, in addition we've been in the midst of a rigorous evaluation, trying to get more data to support the outcomes that Project ECHO leads to. We're studying primary care providers' knowledge and self-efficacy as well as their prescribing behaviors and the degree to which they adhere to best practices and really looking to build a case in the evidence that Project ECHO has the impact that we all feel that it does. [0:31:04]

So to conclude, I want to just give you a snapshot; I'm on the slide that says Preliminary Results. I'd like to go through just really quickly some of the types of data that we're capturing and some of the things that we're seeing as we look in our own practice and other practices to see how these quality improvement strategies I've talked about - how they impact our practice.

So if I could have the next slide, these are graphs showing an improvement over the period of one year during which we first implemented the opioid dashboard, showing increases in the use of urine tox screens, opioid agreements, and a formalized functional status assessment tool.

If I could have the next slide, this shows that we've noticed actually a decrease, a fairly significant decrease, in patients presenting with a severe pain score of greater than or equal to eight.

If I could have the next slide, we have, for the first time ever, seen not an increase in chronic opioids, which is what we've been seeing really over the last decade, but actually a slight decrease. And although this is a small change, it's the first change in the inflection point of that prescribing needle that we've seen, suggesting that perhaps some of these interventions are having an impact on prescribing patterns, and particularly the use of chronic opioids in circumstances that may not be appropriate. [0:32:19]

And the next slide shows an increase in behavioral health co-management followed by the next slide showing increases in referrals to chiropractic and decreases in referrals to surgical specialties and a decrease in referrals to pain management as well.

So it looks like early data showing - we're seeing some differences in the pain scores as well as prescribing patterns, and our referral patterns are shifting as our providers adopt some of these best practices and as they gain expertise and confidence through Project ECHO.

The next slide confirms that and shows that providers, after taking part in the year of ECHO, express much, much higher self-efficacy and confidence in their ability to manage chronic pain.

And the next slide, number 53, shows an increase in our pain knowledge assessment score, which has gone from 157 to 169, which, given the scale of this tool, is actually a very high score. [0:33:19]

And my last slide, just some comments from providers: The sessions are fascinating, great didactics, collegial feel, provides the opportunity to inspect my own clinical reflexes. They're informative and helpful, and they present the type of cases that I see in my everyday practice.

So if I could conclude, first of all, I want to thank everybody for your attention. I apologize for losing access in the middle, but hopefully we were able to keep up with the slides. And I think to improve the management of pain and primary care it requires a variety of things. No one of the things that I talked about is enough to help us. Treating patients with pain is difficult, and it requires organization and structure, it requires policies, increase in knowledge, access.

And the more we can approach this as a team sport, medical assistants helping with u-toxes, nurses doing panel management with providers, chiropractors, behavioral health providers, everybody engaged to manage patients and to bring the appropriate level of resources to the patient, it's the only way to get us out of the mess that we've created with opioids and the only way to really help patients who are truly suffering and need our help. We've devalued many of these other solutions, but they are every bit as efficacious, if not more so, than the treatments we've been employing. [0:34:39]

So with that, I'd like to end, and I know there will be time for questions afterwards, so I'll turn it over to our next provider. Thank you.

AARON WILLIAMS: Thanks, Daren. Thanks for that presentation. Before we go to actually our next presenter, we do have some time here to get in a couple questions here, a number of questions, you know, that have been asked about by two or three students, see if you may have some thoughts about it. One is what do you think the - can you tell about the role of the biofeedback in addressing pain management issues? Is that a viable alternative? You know, if you could talk more about the role of biofeedback as related to pain management… [0:35:18]

DAREN ANDERSON, MD: Well, I think the only thing that I'll say, and with the disclaimer I'm a primary care provider, I don't claim to be an expert in pain management, and my focus has

been on systems redesigned to support pain. And I will say I've seen, you know, a lot of evidence for a lot of things, and I've seen a lack of evidence for a lot of things. And I think the more alternative modalities that we can bring to bear and offer to patients, the better. Because the principal modality we've been using, namely opioids, has limited to no evidence for its efficacy in the management of chronic pain. [0:35:51]

So I would argue there's more evidence in favor for things like chiropractic, biofeedback, massage, behavioral cognitive strategies, than there is for opioids. So kind of in the vernacular I'd say whatever works, and I think that tools like that, if they're available, are great things to offer for our patients. And I hope that we, with more focus on chronic pain and on the research behind it, will be able to build more of an evidence space (ph) to demonstrate the impact of some of these important modalities.

AARON WILLIAMS: Okay, thank you. There is another question here which talks about where - do you happen to do (ph) a website and someplace where we can access some - people on the webinar can access some of the tools that you cited, some of the pain management tools, the worksheets, the SAMHSA tools? Is there a place where you've gone or some resource that we can provide for people on the webinar? [0:36:51]

DAREN ANDERSON, MD: Yeah, absolutely. In fact, if you go to our website, CHC1.com, www.CHC1.com, you'll find a link to our Weitzman Institute where you can find out a lot more about Project ECHO and some of the tools and research projects that we have going on. There's also a link to contact us, and, you know, I'd be happy to provide any of the specific tools that anybody was interested in as well. [0:37:16]

And I will mention that we are openly looking for additional providers and practices that want to join onto Project ECHO, and so please feel free to contact us if there's any interest in any of the material that we've presented, or if you'd like to watch and join on and see what a Project ECHO session is all about.

AARON WILLIAMS: Okay, all right, very good. Thank you. And then the last question again would be before we get to our next presenter. It is: When thinking about the adverse childhood experience scales, or the ACE scale, there are a lot of correlations between scores in the ACE scale and chronic pain. Do you know of any research or any work that's being done limiting chronic pain management and the study of ACE scores? [0:38:04]

DAREN ANDERSON, MD: Yeah, I think it's a fabulous question, and it's actually something that we've talked about here quite a bit. I don't know of a lot of research that has looked into it other than to say that there is increasing understanding that the child, that adverse child circumstances and history of trauma, are directly correlated with poor chronic disease outcomes and with chronic pain, and we're very interested actually in studying that ourselves and it's one of the - in our research brainstorming sessions, it's one of the topics that we have been actually talking about investigating further. I think embedding some form of trauma screening into routine primary care is important and it's something that we should all be doing. We're not doing it here yet, but I would very much like to. I think the question is, when you identify that history, what sort of interventions can be effectively employed to help patients, and specifically to help

with their chronic pain treatment? I think it speaks even more to the importance of integrated behavioral health and the need for a behavioral health provider to be an active participant, really a co-manager of that patient who is suffering from chronic pain. But it's a great opportunity to do some research and we're very interested in looking into that further; and particularly if anybody has interest in talking with us further about that, we would love to. [0:39:21]

AARON WILLIAMS: Okay, thank you. There are a number of questions that are still coming in, but at this point we're going to turn it over to our guest speaker, and we are hoping to have enough time at the end to address a few more of these questions. But thank you, Daren, for that presentation. I'm hoping you'll be back and answer a few more of these questions, but now I'm going to turn it over to Kevin, Kevin Sevarino, the Medical Director at SAMHSA's Providers' Clinical Support System for Opioid Therapies. Kevin, I'm turning it over to you.

KEVIN SEVARINO, MD: Okay, well, thank you very much. I hope you can all hear me, and that was just an excellent presentation. I, too, am from that little sports backwater between New York and Boston, Connecticut, so I think it's interesting there are two presentations from people from Connecticut. And my main home is at the Newington branch of the Connecticut V.A., which is right next door to New Britain where Dr. Anderson sounds like he got his start. [0:40:16]

What I'd like to do today in just a few slides is present to you a resource funded by CSAT and SAMHSA known as the Providers' Clinical Support System for Opioid Therapies and Pain Management called PCSS-O. This is actually a free resource, and to address one of the questions, would actually direct you to resources and be able to get things like the opioid risk tool and sample contracts for patients, et cetera, so it would be to complement the information from community health centers and others like such as Dr. Anderson has.

So let me explain to you what the PCSS-O is. Let me see if I have - I do. PCSS-O, as I said, is funded by CSAT/SAMHSA, which is one of their I think creative ways of trying to get the word out on how to responsibly prescribe opioids for the treatment of chronic pain as well as to treat opioid use disorders. It supports innovative multiple different kinds of approaches to educating clinicians who prescribe opioids, and so of course the main focus would be on primary care providers who do much of that prescribing. [0:41:34]

The focus is on, A, as I said, the safe use of opioids in the treatment of pain, including training on how to recognize misuse, abuse, addiction, and also how to effectively use opioids as well as non-opioid modalities in terms of treating pain. Because as Dr. Anderson said, so many people feel like, "Well, if opioids aren't my option, then I have nothing to offer," and there actually is a tremendous amount to offer. And then, of course, the use of opioid therapies for the treatment of opioid dependence, so that would be the use of methadone, the use of buprenorphine in the formulation suboxone, and finally the use of naltrexone. [0:42:14]

So the strength of PCSS-O is that it's a marvelous collaboration though (ph) it's led by the American Academy of Addiction Psychiatry. It's got a number of large groups affiliated with it: The American Psychiatric Association, American Medical Association, and American Dental Association. Importantly, it has the branch of the osteopaths, the American Osteopathic

Academy of Addiction Medicine, and then American Society for Pain Management Nursing, and the International Nurses Society on Addictions. So that's important because the training tools that are developed within this grant can be disseminated by, for example, dentist-to-dentist, so in their annual meeting and through the CME sites that they normally use, and similarly for AMA, et cetera. [0:43:06]

So we use a number of training modalities that have been developed. So the two most traditional are just like we have here today: A webinar, where you have a live online speaker along with slides, after which there is question-and-answer services such as at the bottom of the screen. And so far we've got 78 webinars archived, and if you go to www.pcss-o.org, you can find all of those, and those are freely available. Now, in this iteration of PCSS-O, there was not funding to make those CME accredited to various specialties, but in the next application, both ASAM and AAAP are competing for PCSS-O grants, where I believe these will become CME-accredited.

We also have clinical online modules, which is a set of - it's a slide deck that's provided, and those have focused on all sorts of basic information about opioid-dependent treatment as well as chronic pain treatment, treatment in special populations, safe and effective use of opioids for chronic pain treatment. And so far we've got 25 online modules conducted to date, but there's four just about ready to be released. So it's actually a fairly rich source of information. [0:44:30]

We also have what used to be called a mentoring system, it's now a colleague support system, where mentees, usually people early in their training but it can be any practitioner, can ask to be paired with a clinical expert in a certain area. And they can either have - they can be paired for a longer-term relationship, or if they want just one or two questions answered they can do that as well. And then another way to get questions answered is David Fiellin at Yale moderates a

PCSS-O listserv where one can get - you can see the info at pcss-o.org. One can get on the listserv and ask questions, and it really does spawn some lively debate when somewhat controversial questions are asked. [0:45:17]

And then we also have a phone app, to be a little up to date, although as a more elderly provider I'm a little technologically challenged. Our phone app is called Safe Opioid Prescribing; it's available free of charge. And, well, it used to be just for iPhones; it now can be on multiple platforms, iPhones, androids, and including on the Web, so on your iPads, whatnot. And there at your fingertips you could get something like an opioid risk tool that - I mean the opioid withdrawal scales, et cetera, so it's actually nice to have on your phone. And then maybe people can ask me some questions about those…

So far we have - through the online modules and webinars mainly but also through presentations at annual meetings, we've interacted with more than 15,000 individuals in trainings, and they represent a number of diverse disciplines and specialties; not just prescribers but also pain management nurses and the many other myriad of people that interact with our patients who are in pain. There's been a high satisfaction rate so far, and more than 70 percent of the participants indicate they have changed, or changed their practice based on the training. [0:46:38]

And we've added this last year what are called mini grants, so people that - organizations that are not currently funded can apply to mini grants. So we have Allan Tasman who is seeking to disseminate this information internationally through the addictions training and technology transfer center network. And we have a mini grant where they're using their network to make some of these presentations CME-certified, and they have a wonderful network of dissemination to providers especially that are dealing with underserved populations and there are other mini grants now we have. [0:47:16]

And what was nice about today's invitation to speak is just to let people know that PCSS-O exists. It's one of SAMHSA's ways of trying to get information out to people, and hopefully you'll find that AAAP has done a good job of getting these organizations together and disseminating useful information. So with that, I can answer questions.

AARON WILLIAMS: Okay. Thank you, Kevin. One of the things I wanted to ask just very quickly is can you tell the audience - can you tell us what the website is for the PCSS-O since (ph) there are folks who know that? [0:48:01]

KEVIN SEVARINO, MD: So it's www.pcss-o.org, but if you just Google PCSS-O you'll get it. The website has both an area for providers that gives them some fairly detailed information about opioid prescribing, the risks of opioid prescribing, the recognition of opioid misuse, et cetera. We're developing a community webpage so that we also will have information regarding - that you can print out to help with patients' families and other providers as far as both the risks of opioids and the benefits of opioids in pain management, but also in terms of treatment of opioid use disorders. And the website links you to the listserv, it links you to the archived webinars, the archived online modules. [0:49:03]

And we also have - as new information comes up, for example, you know, if FDA has a new warning or a new interesting article comes out in JAMA, we'll post a link to that, saying hey, take a look at this, this will be of interest to you guys. So it's a kind of an all-purpose site. There's also the PCSS MAT, which is for medication-assisted therapies, which also has some similar information. So did that answer what you were asking? [0:49:35]

AARON WILLIAMS: Yes, it does. And the other question that came in here, are there any costs to pay in trainings?

KEVIN SEVARINO, MD: No, It's all entirely free. And where other organizations, for example, say APA or ADA, have provided CME, if they provided CME to it that's also free.

AARON WILLIAMS: Okay. Okay, thank you.

KEVIN SEVARINO, MD: But SAMHSA has been really generous in supporting this, because then it gives a lot of free information out.

AARON WILLIAMS: Um-hmm, thank you. I think it's a wonderful resource from SAMHSA, and I'm glad that you all could participate so that we could let folks particularly in health centers know that this resource is available to them or around this critically important issue. [0:50:21]

With that being said, you know, we may have some more time at the end here to ask you a few more questions. But I want to make sure that we turn over to our next presenter, Chris Fore, in order to have him present, and then we can go back with some of the questions as time allows us.

So with that being said, Chris, I'm turning it over to you.

CHRIS FORE, PhD: Great, thank you very much. Good morning and afternoon, everyone. So I'm here to talk a little bit about the Indian Health Service and some of the things we've done, and we've heard some great programs that are out there. I will admit that, you know, I think as an agency we're a little bit behind; there are multiple reasons for that that we will discuss. But there are certainly some - you know, you've heard some great things. But I'll talk about some things we're doing to try to meet the needs that we have in Indian country. [0:51:13]

So let's see. So one of the things I need to share with you, for those of you who aren't aware of the difficulties that we face in treating our population, is these health disparities here. If you look at them, they're astounding, and I realize that these aren't specific to pain. But it does give you some sense of the level of need within the population that we do serve; it is extraordinary.

The other thing I would point out here, with the exception of tuberculosis as you can see, and you could even maybe make a case for tuberculosis, all of these have a very strong behavioral health component: You know, diabetes, suicide, homicide. Even in potential (ph) injuries have a strong behavioral health component.

So for us, that's one of the focus that we've tried to have is more of the integrated model that you've heard about throughout the presentations today, just to tell you a little bit about Indian Health Service again in case you don't know about us. So we're actually part of Health and Human Services; we sit under that umbrella with many of our sister agencies here on the presentation as well. Dr. Yvette Roubideaux is our current Acting Director for the agency. We were established in 1953 to meet the treaty requirements of the federal government. So throughout history of this country, the government entered into treaties with many tribes, and most of those treaties had some component saying that the government would provide health care for natives, and so we were established to try to meet that need. [0:52:53]

We currently have over 350 facilities scattered around the country. As you can see on this slide here, we divide up the country into 12 areas as specific IHS areas. And I want to make a quick correction. The slide set I was actually in the Great Plains area, which is the purple area; I'm actually in the Albuquerque area, which is more of the teal area in New Mexico and Colorado. [0:53:23]

So we have a large part of the country to cover. We cover the entire country. If you think about where natives are, well, unfortunately there aren't a lot of natives left on the East Coast; that's where the first encountered happened with Europeans. And so we serve a lot of the areas west of Mississippi. We serve 567 tribes across the country which accounts for about 5.5 million Native Americans in the country, so ten percent, nine percent, something like that, of the total population. Of course the other part of this that you should know about is we serve Alaska,

which, as you may imagine, is extraordinarily challenging. Alaska is a huge state, extremely rural in frontier, so we face incredible challenges in providing care up in Alaska. [0:54:15]

Just to give you an example, one of the things you should know about the agency is that we have a very small budget relative to other federal agencies that provide direct health care. We're funded at about 56 percent of need, so every dollar that we need to provide adequate health care, we get about 56 percent of that. Unfortunately also, if you look at the spending patterns, more is spent per capita on federal prisoners than it is on Native Americans, so per capita, federal prisoners get more spent on their health care than natives, which, you know, provides us with a significant challenge, especially given the areas that we try to serve. [0:55:00]

If you look at the slide here, where natives live is extremely diverse. There is a large number of Native Americans that live in urban areas. This is downtown Oklahoma City. Certainly here in Albuquerque, in Denver, L.A., there are lots of natives living in urban areas. But then there are also more of the traditional settings that people think about as far as where natives live. The lower right-hand corner there, that House Pueblo has been inhabited for over 1500 years and the native families still live there.

On the left-hand side, this is a very interesting native community on Little Diomede Island in Alaska; they are 12 miles from the Russian border. As you can see, it's an extraordinarily isolated community, they have 300 members that live there year-round, and so it is a challenge to get these services to them.

One of the other things, sort of the flipside of getting services to them, is also just the providers who are in those communities often feel extraordinarily isolated. If you can imagine working on that island and living there, especially if you're not a community member, how isolating that must feel, and we feel that here that's across the board. Behavioral health providers, medical providers, mid-levels, just that sense of isolation, is very, very difficult. And it also I think makes you, at times, question your clinical judgment, or at least not being able to consult with other people can be a big challenge, so that really is a problem for our providers. Obviously along with that is a lack of specialty care and specialty services, so that's a huge issue for us as well. [0:56:49]

So with the Center of Excellence here, we've been trying to figure out what can we do to support our providers and to get better access to care for our patients out there, and there are two ways that we do this. One is direct service, and we do run a tele-health program from here, and we go in and provide direct care for those patients, those clients on the other end. So, you know, the provider sits in one end of the unit, the patient is at the other end, and they are the provider. That is one way of doing that. [0:57:22]

The issue with that is it's not cheap; it requires a high bandwidth as far as technology goes, and a lot - a good Internet connection, and it doesn't scale very well. You're still, you know, one provider, one patient. And so, you know, you can in an hour maybe see three or four clients if you're lucky, sometimes only one. So it's not a bad way to deal with the problem, but it's not an efficient, scalable way.

The other idea that we've come across is, well, we need to educate the providers. We need to give them the knowledge and skills that they need and the consultation so that they can actually provide the care there since they're already onsite. And so that's really what I want to talk more about today is that aspect of it. [0:58:08]

So you've already heard about Project ECHO. And as you're hearing it, it is a very well-known way of addressing this problem, and the first presenter reviewed this excellently and I'm not going to go into all the nuts and bolts of ECHO.

What I am going to talk about is some of the ways that we've modified ECHO, because our traditional ECHO that we tried really didn't take off. And so I'm going to talk about some of the modifications we've made to make it work for our agency, given our infrastructure, given our scale, and just given our experience with the more traditional ECHO model.

So as previously said, ECHO is really a way of helping providers in the field provide care that is at the best practice level. They really - with consultation and regular attendance, they can really provide care as good or better as what the patient could get traveling to that specialty provider. [0:59:19]

One of the things that we found, and I saw this addressed in the questions here, was what about time, you know, its providers' time, and so how do you deal with that? And one of the things we found, because we cut across five time zones, that's a big challenge for us. And our schedule wasn't matching up with their schedule and their hosting here at the UNM ECHO, so we decided to host our own, and that really gave us a lot more flexibility on the time frame, but that can be an issue certainly.

The other thing that we decided to change was a move away from the Polycom and direct video connection, and that was quite controversial. You saw on the earlier slides basically almost like a Brady Bunch layout, where, you know, one group of people is in the center; then you have little windows all around with the rest of the presenters, or the rest of the participants rather. [1:00:15]

And what we found were a couple of issues; one is that not everyone had the equipment that would allow that. Certainly as was pointed out, there are some things that you can just put on a laptop or a mobile device, things like that, that can be very helpful. Unfortunately again within our system, we have very few sites that have Wi-Fi even, and so we're still - unfortunately had the hardwired states for many of our sites.

So what we decided to do was to move to a webinar-based format, and we use Adobe Connect, that's the product that our agency has contracted with, and this has done a couple of things for us. One is we still stream video of the consultation team who is here in Albuquerque; two, it has allowed us to really scale up. So whenever we were running the more traditional ECHO, we would have between six and eight, and you can go a little bit more than that. But really, if you start getting 20 or 30 folks signing in, the windows get really small and hard to see; our infrastructure really sort of struggled under that weight. [1:01:23]

But with the Web-based format, we can now - we've had up to a hundred folks on there with us, and so it really has allowed us to scale. Again, because we are covering the entire country in five time zones, that's a big benefit for us, because at one point we were looking at running maybe a couple of ECHOs to make sure we caught everyone. This format allows us to get around that barrier and really scale up with just the one session.

So some of the things that we do with ECHO that you might be interested in are just… To give you an example, so we run modules for the - I should take a step back here. Ours is a pain and addiction ECHO. We wanted to put those two together because they go together so frequently, the pain management and chronic addiction, or/and addiction. [1:02:14]

So one module you can see here we did a course just on addictions. And talking about that, again, a lot of our providers, especially our primary care providers, don't either know a lot about addictions, and/or what they've learned is not current. There's been a lot of change in the literature I would say in the past five years, certainly in the past ten years, about how we understand addiction and the way we treat addiction, and so we run a module just on pain and addictions. As it was previously mentioned as well, they [complementary and a bunch] (ph) of medicines. We have a series of - mini block or series on that as well.

I have to say it's been very interesting that we run blocks on prescribing and blocks on assessments, and those have been great, but really the complementary and alternative medicine block has gotten a lot of attention and just tons of positive feedback, and mostly from primary care providers, just informing them what's out there and how these kinds of folks can help you move forward with the patient, so that's been a surprise for us that's been great. [1:03:21]

We offer free CMEs for all of our sessions that we have; this is through a partnership with the University of Mexico, the class one AMA credits. We also have them for psychologists. We're working on pharmacists. We're working on nursing - no, we have nursing. We're working on social work. We really want to make it as easy as possible for folks to get their CMEs.

One of the things, if you think back to that map I showed you of where we serve our patients, where our patients are located, it's very hard to get CMEs for many of our providers; they're in the middle of nowhere. Yes, online it's helpful, but that can be expensive. So what we've demonstrated last year, last FY I should say, is by doing education - and this goes beyond the ECHO that I'm talking about. But by providing education online for free to our providers in Indian country, they're able to be much more productive. We saved over a half million dollars for the agency and avoided costs for CMEs. And we were able to see - again, this goes beyond the ECHO, but for all the training that we did last year, we saw an additional 70,000 patients because providers weren't on the road driving to and from their CMEs; they were at their desk. They would finish up their CME session, like this ECHO, walk into the clinic, and see their patients. So I could encourage anyone who is looking at this and looking at infrastructure on how to educate, this can be a great thing for you. [1:04:51]

One of the things I also want to point out is that we are also going to do some things outside of the ECHO here. We're going to do a couple of one-off trainings, one on UDS. I saw a question here on UDS; it's very complicated. The more I've gotten into this, in just sort of what's best

practice, I know for our agency we don't have a best practice document for UDS or talk screens, and so we're trying to develop that and then disseminate that information. [1:05:21]

Also because we focus on the addictions piece, we're going to host an online suboxone training. We do not have a lot of providers with waivers in our facilities, and we would like to increase that number of folks to get those waivers and help out and be a part of their pain management team but have that ability to treat those folks who are struggling with overuse and addiction with suboxone, obviously with support of substance abuse specialists as well. But that's another tool that we would like to give our providers, if they're interested, is being able to have those waivers. [1:06:00]

So who's on our team? Now, I think your team can be made up differently. This seems to be what works best for us. We have a pain specialist who's a neurologist who is wonderful; she has a lot of experience in pain.

We have an addiction psychiatrist. Fortunately for us, the University of Mexico has an addiction psychiatry fellowship, so getting that service is not too challenging for us. But that has really been very, very valuable for us, again especially when we're interacting with our medical providers and trying to help them deal with the addictions that they may be seeing in the primary care setting.

We have a clinical pharmacist. Our system I think is very heavy with PharmDs and I think we underutilize them, so having a clinical pharmacist has been very, very helpful for us as well; clinical psychology; again, to bring in that behavioral health integration; nursing as well, because they come at things from a different point of view. They also often get to spend more time with the patient than the primary care specialist or provider does, and so they can really maybe do some motivational interviewing techniques, some brief interventions with the patients to help them move along if they are struggling as well. They can also do some of the more in-depth pain assessments, you know, moving beyond just the lacquered skill, which as we've heard in the previous talks today is not really the standard anymore. We're looking at functional analysis and trying to see what impact the pain is having on the person and so a nursing staff can often help support the team in filling that role as well. [1:07:42]

I would say if I had my druthers I would also add a massage therapist, an acupuncturist, and an OT/PT provider on this team. I think those are professions and specialties that can really add something to your pain team and/or your addictions team as well. We just don't have regular access to those folks and so we don't have them on the team currently. [1:08:09]

So our goals here - and we've talked about this before, so it's been mentioned. We really want to educate our providers to increase their confidence and competence. You've seen the data. Our data, again because we're so short-funded, we don't have a lot of outcome data at this time. But our preliminary data is suggestive of what the previous presenter talked about as far as confidence and competence of the providers. They feel much more confident after attending the sessions. They feel like that knowledge that they gain will positively impact their practice, so that's been a wonderful outcome for us.

One of the things that we're trying to do now, we're putting together a proposal. Because we have data from an electronic health record and we could look at prescribing data pre-participation in the ECHO and post, and really see if does the participation in ECHO change prescribing practices, and for us I think that would be an awesome thing to look at. I mean how often do you get objective measures of whether your training is helping or not? And so we're really trying to see if we can pull that together. [1:09:25]

It would also be interesting if there's a dose effect; you know, there is a certain number of sessions that's optimal, or, you know, the more you participate, the better you get. I don't know what that would look like, but I would be really curious to find that out. You know, we really try to promote best practices, obviously shared through the ECHO team, and also we provide that provider to provide a consultation.

So one of the ways we do this - and ECHO is really two parts: It is a didactic session, and then a case-based learning session. So ours is, again, running a little bit differently in that we have half an hour of learning, and then we take cases from any of our participants out there. They send us in the form, and then we go through that case-based learning. And it's been really wonderful to get the feedback from our participants about that, that case-based learning, because even if it's not your case, you will typically learn a lot. Yeah, we'll say a lot more than you do in just the didactic sessions, just because it's a real-world example and you're facing real-world issues with these patients, and this I think makes it a very common - gives a lot of common ground to everyone participating. So we really try to make sure we engage in that and elicit those from our attendees in the session. [1:10:49]

I would also say that we do struggle with this sometimes. I think our attendees feel like they need to have the perfect case or a very complicated case, and that is not what we need. We just need something so we can talk about and again move the learning forward with that. [1:11:04]

I will say there are a couple of issues also that we do struggle with, and again I saw some of these in the questions. Time away from clinic is an issue, you know, and I think that is something along with that administrative support for time away from the clinic is an issue for almost all of our providers. Some of our facilities are solo providers or there's two or three. So that means if you're in an ECHO session with us, learning some great things and getting case consultation, no patients are being seen, or only half the number of patients are being seen as would normally be seen.

And so I think, you know, getting the buy-in is going to be important, talking to your admin staff if you're on that receiving end about, you know, the free CMEs that you're going to be required to get anyway, and this is much more efficient. But also about the best practices, the better care, and then if we can get those outcome data you can also use that. But it is a big challenge. We've struggled to get buy-in sometimes from our hospital leaders and even our clinical directors at times, so it is a huge challenge. [1:12:13]

So what about culture? When we talk about - Indian health service people often want to know about the cultural components to this. I'm glad someone brought up the ACEs earlier. We don't specifically assess for that, but as a population, we know that ACEs within Native Americans are

very, very high. Our population, again, you could think back to my - one of my earlier slides about the health disparities - we also, native populations, have much more trauma. Physical, sexual, emotional traumas are much higher rates. I would also - and if you're not familiar with the term, I encourage you to look it up - there's been some more recent research around historical trauma, the idea that traumas are cumulative across generations, and we've had a couple of great series on that in our presentations and in our ECHO as well. But historical trauma is another issue that many of our - in our population struggle with. [1:13:16]

And then there's just the fact that many of our patients lead very hard lives. We're the lowest SES group in the country, and many of our patients live in very impoverished areas with little or no job prospects, very sort of subsistence (ph) living, so it is a very challenging life. As you saw in the earlier slide again, injuries are much higher than the general population.

So you put all that together, and I think that I don't have research on this, but I feel safe saying that our population probably has disproportionately high numbers of pain disorders just because of the challenges that are faced, including the ACEs, the traumas, and those other issues. [1:14:00]

One of the things when we talk about culture I want to make sure that you are aware of is that we - as I mentioned earlier, we serve 567 different tribes, and I would tell you that there's more differences between any of those tribes than there is between any single of those tribes and the dominant culture; they're extremely diverse. So what we struggle with sometimes is trying to learn, again because we're doing this nationwide, what are your tribal beliefs in the community that this provider is in, and how can we work with that provider and within their cultural context to provide them information, recommendations, that are culturally competent and culturally relevant and culturally sensitive, and that is a challenge for us.

Many of our team members - not all, but many of our team members - also work in troubled communities, so I think that's a big advantage for us; that even if they don't know that specific tribal community and that culture, they do know about some native communities and some sort of pan-native (ph) traditions. But they also know how to learn about culture and how to be culturally sensitive, which I think is probably more important than that specific knowledge. And so we really try to pick our team members to be folks who have not only that good clinical skill and that good skill in teaching, but also that cultural sensitivity piece is really key for those that participate in our team. We really try to make sure we listen to the community members and the providers and engage them. [1:15:36]

One of the things I would also point out, and I think this is across the ECHO, but I think we've seen it being maybe more important for the providers we work with. I think because many of them are in small practices and they feel really uncertain, we take very - we go to great pains to not be critical when a provider presents a case or asks a question. We really want to make this a positive learning experience. And even if we know we may have a significant concern about the way the treatment is progressing, or the patient that the provider is presenting and the care plan, we really try to present the information back to the provider, back to all the attendees, in a very positive way. [1:16:21]

What we have found is many of our providers are sort of hypersensitive. And if they detect any sort of criticism or some sense that they may be way off the mark, it really sort of shuts down the whole discussion, and we've seen that happen a few times. So that's another thing I would throw out is really making sure your team members, if you're building your own team, are good at putting a positive spin on things. That doesn't mean that you don't ever confront or don't ever give direct feedback. But you really want to - at least within our provider population that we are working with, we really have found that we have to be extra careful around the way we give feedback to the provider. [1:17:02]

And that's really what I wanted to talk about is really how do you get this in a high-need, high-risk community with low connectivity? How can you do this? This is the way that we've done this and have adapted ECHO to fit our needs.

If you're ever interested in joining us, here's your information here; it's open to everyone. We don't require any preregistration. You click the link here, and here's your passcode, and here's your time. We'd be happy to have you join us, and just to either see what we do as a model or to be an active participant. We are open to everyone. We are seeing a slight uptick in some of our other federal partners. We've seen a few V.A. folks on. So, you know, certainly if you just want to see what we do, that's great, but if you really want to be an active participant, that is fine, too. And I think that's everything I have. Any questions? [1:18:00]

AARON WILLIAMS: Okay, thank you, Chris. That is a lot of - a wonderful presentation and there's a lot there. You know, just for clarification, that website that you just cited, that is where you can go to get onto your Project ECHO, either for webinars and to asking questions. Is there any other point of contact for information about the project?

CHRIS FORE, PhD: You know, I should have included my e-mail actually. I would be the main point of contact, although you can find it on the webinar and all of our information is there as well.

AARON WILLIAMS: Okay. I can give them your e-mail address. It would be chris.fore,

F-O-R-E, at ihs.gov, so that's for everybody on the webinar page. If you need further information about the project, you can contact them. But we'll be showing the slide in a second that had them on its contact information, but thanks for that clarification. [1:19:01]

We have a number of questions, and we're trying to get through some of these in the time allotted here. One of the questions is for Kevin Sevarino. Has there been any discussion about explaining the PCSS-O to training for large physician groups, so building (ph) much larger or broad physician group trainings around opioids and then prescribing.

KEVIN SEVARINO, MD: Well, the AAAP application for the new PCSS-O actually includes the American College of Physicians so that they'll have a much more prominent representation of primary care docs. And PCSS-MAT I think also includes American College of Physicians and may include the American Academy of Family Practitioners.

So we still tried - whether or not somebody's actually on one of the kind of the founding members of the grant, we try to, in as many ways as possible, advertise all around that the webinar is going to be given at, you know, a certain time without the online modules available. So we're trying as much as possible to get the word out. [1:20:18]

AARON WILLIAMS: Okay, okay, thank you. So this question is really going out to any one of you. Have any advice to dentists treating opioid abuse or patients with chronic opioid - engaged in chronic opioid therapy?

KEVIN SEVARINO, MD: Repeat the question, please?

AARON WILLIAMS: Any advice to dentists, so dentists, you know, who have, you know, clients who are coming in who are either abusing opioids or are on chronic - well, opioid therapy, so medications for the treatment of opioid abuse. Is there any, you know, thoughts or advice for dentists who are treating clients who are having those issues? [1:21:01]

KEVIN SEVARINO, MD: Well, maybe I'll chime in first, and I think everybody probably has thoughts on that. The first is, in general, to first of all understand their acute needs. Are they asking to come off the opiate? Do they have a detox issue?

But say more generally they come in, and the most important thing is to figure out why they're on the opiate, is there a chronic pain issue, is there not, and then to determine whether they have an opioid use disorder, and then whether or not they recognize that to at least advise them that you think there's an issue, and then to refer them or offer them the various treatment options.

So I'm an addiction psychiatrist, so I can directly say, you know, these are kind of the treatment options. But if I were a primary care doc, hopefully I would have, you know, referral sources, or, in an integrated health system, resources right onsite where I could begin to help them with the process of - it might be detox, it might be transition to another opioid. Not everybody that comes in on an opiate has to come off it. [1:22:08]

AARON WILLIAMS: Yeah, (crosstalk) patient. Thank you. Okay, we have another question that has come in. Can you talk about the realities of how you all see the role of addiction counselors or peer support specialists as they relate to supporting pain management?

DAREN ANDERSON, MD: This is Daren. I will be glad to jump in on that. I think, you know, that one of the most important aspects of our pain management program in primary care and what I try to present is the need for a multidisciplinary team, and in that team can be large and varied, depending on the resources that you have. And we've seen, although we haven't used peer support specifically for pain, I think there's definitely a potential role for them. Because many of the strategies that are most effective for pain management are really adaptive strategies that are helping people to reframe the way they think about their chronic pain, helping them to adapt their life to living with the chronic condition. And the experience of a peer who has been

successful can be highly valuable, and that's been shown in many other conditions from diabetes and on up. [1:23:19]

And I also think that having an addiction specialist, if you're lucky enough to have one on your team actually working in your clinic, is an enormously important person, because many of the patients with chronic pain that we treat have coexistent substance abuse issues as well. And unfortunately these patients with substance abuse do get painful conditions and need to be treated and having an addiction specialist to help with that is extremely valuable as well. So if you have the option of working closely with them in an integrated way, that's a great opportunity.

CHRIS FORE, PhD: This is Chris, and I would certainly echo everything that was just said. I think if you have access to the substance abuse specialists and peer support specialists, you are lucky and should definitely use them. [1:24:01]

I would also throw out that in many of our native communities we have families who often live together with many generations. And if possible, if it's a healthy family system, to maybe have some of those folks as well, either clan members, extended family… They can often help support the patient as far as their pain management goes, and even if they're struggling with addictions they may be able to help. You obviously want to make sure it's a healthy family environment and get the permission of the patient, but what we find is that often we will have the patient and two or three additional family members in there to really help support the patient as well.

AARON WILLIAMS: Okay, thank you. We have another question that came in here with, you know, regards to the uninsured. So any tips for dealing with uninsured populations, particularly if, you know, making referrals to alternative medicine providers? Had that come up as an issue for you all? Any thoughts or suggestions? [1:25:08]

DAREN ANDERSON, MD: Nobody's jumping in, so I will. This is Daren. I think being creative in getting access, just need-to services for the uninsured, is what we specialize in at FQHC and places like the Indian Health; it's what we do. And there's no one simple solution, but I know I've traveled a lot and seen other FQHCs and seen how creative and flexible sites can be in obtaining access to local resources.

In our case, we've been able to bring chiropractic providers onboard and actually were able to bill for chiropractic services for those who are insured which allows them to be available to take care also of patients who are uninsured. There are flexible ways you can do that as well, and others have established partnerships in the community where, you know, providers agree to take care of a certain number of uninsured patients. We have a community collaboration where specialists agree to take our sliding fee scale. [1:26:13]

And then I think, you know, the other point to make is patients, you know, even uninsured patients, are sometimes - you know, will access alternative therapies on their own. If you ask your patients, you may be surprised how many of them are using money to purchase herbs and other things to treat products. So I don't think it's outside the realm of possibility to encourage them to go and to seek alternative therapies outside, you know, even in a fee-for-service kind of environment; local community resources, YMCAs, lots of other places where one can learn yoga

stress reduction, mindfulness, all sorts of different types of interventions that can be helpful. So there's no easy answer, but it is kind of what we do best and what we focus on in the FQHC world.

KEVIN SEVARINO, MD: And I would also echo that. I would also point out we actually had a patient point this out to us I think two weeks ago on our ECHO. We were talking about some exercise and stretching, and they said, "Well, why don't you just send them to YouTube? I go to YouTube and that's where I learned how to do it," so that's another resource. Obviously there's a bunch of not-so-good stuff out there, but if you can screen through, that's another resource. [1:27:22]

I would also just add that there's not a one, easy answer, but if you can be advocates and advocate on behalf of your patients, or if you have patient advocates... And even at the state level I know with the Affordable Care Act that the landscape is really changing and no one is quite sure where it's going to end up. I know our agency overall we feel positive about the potential impacts, but you know, advocating for your state to maybe reimburse things that they don't normally reimburse that would allow you to treat some more uninsured folks or bring more money into your system like was just mentioned with a, you know, massage or acupuncture, things like that can be helpful as well. [1:28:02]

AARON WILLIAMS: Okay, all right, thank you. Now, I know we have a number of questions here, and we're really pleased at the level of interest in this webinar. Definitely we've provided a number of resources. The presenters have been, you know, very good in terms of the information they provided about the topic. I want to be respecting of everyone's time here, so I'm going to provide you with the contact information for everyone who's been a part of the webinar. Just in case you have other questions or concerns, feel free to e-mail up here at the Center; my e-mail address is there. Also we have e-mail addresses of all the presenters who are on the call today, so if you had questions about Project ECHO or the PCSS-O project and you want to correspond with them directly, you can do that there.

Then if you have any additional questions around this topic of integration, you can contact us at the SAMHSA-HRSA Center for Integrated Health Solutions, and our e-mail address is there. Also, I'd invite you to go to our website. There are a number of different tools and resources around integration and pain management. The webinar and the slide and the recording will be posted there on the site, so if you want to go to the recording or direct others to the recording, you can go to our website and type www.integration.samhsa.gov. And if you go under the "about us" section under "webinars," that's where this webinar will be posted. [1:29:35]

Again, I would like to thank our presenters for the excellent job they did with presenting this information on this issue. And just take a moment, you know, at the end of this, to fill out our feedback survey, you know, so we can have more information and really look at other ways in which we could provide you with valuable information related to this topic and other integration topics. [1:30:02]

So again, thank you all for participating, thanks to our presenters, and with that I will say good afternoon. Talk to you all soon. Bye-bye.

KEVIN SEVARINO, MD: Thank you very much.

DAREN ANDERSON, MD: Thank you, everyone. [1:30:17]

END TRANSCRIPT