# Improving Chronic Pain Management with Interprofessional Teams: The Maine Chronic Pain Collaborative 2

## ➢ Main Proposal

**Introduction:** Maine has the unfortunate distinction of having the nation's highest rate of prescribing for long-acting and high-dose opiate medications, with a rate that is twice the national average. Over the past two decades, the problem of chronic pain management and rates of opioid for chronic pain have escalated dramatically. Additionally, primary care providers are increasingly challenged to manage chronic pain: review of current practice in Maine has shown a disturbingly high frequency of unsafe prescribing practices including high dosing of opioids, concurrent use of opioids and benzodiazepines, and use chronic opioids in the presence of addiction. At the same time, primary care providers, particularly those in rural areas, express high levels of stress, frustration, and fatigue when facing the challenge of chronic pain management, and report often feeling isolated, alone, and unprepared to manage the complex issues presented by chronic pain. In the course of our frequent interactions with primary care providers throughout the state, we find they are asking for help, and are eager for assistance and support to address this increasingly challenging and complex issue.

We propose to conduct the Maine Chronic Pain Collaborative 2, building on Maine Quality Counts' (QCs) successful track record of supporting primary care practice transformation and implementing provider educational and QI strategies, as well as the University of New England's (UNEs) experience with interprofessional education and pain management. We will leverage QC's experience leading the Maine Chronic Pain Collaborative, an innovative effort working with primary care practices to improve chronic pain management. Additionally, we will engage UNE multidisciplinary clinical faculty with expertise on interprofessional education and chronic pain management to work directly with primary care practices to improve their team-based management of chronic pain. We are confident that this combination of improving interprofessional teamwork and interdisciplinary approaches to the treatment of chronic pain will achieve the stated priorities of "building effective interdisciplinary teams to improve the management of patients with chronic pain through interdisciplinary and interprofessional education" and "integrating and implementing clinical/practice guidelines as a set of practical, relevant, and practice-based activities to drive improvement in both care and cost effectiveness."

**1. Overall goals:** The primary goals of the second round of the Maine Chronic Pain Collaborative (ME CPC2) are to provide much needed support to a set of primary care practice teams across Maine to improve the "Triple Aim" outcomes for patients with chronic pain – i.e. to improve the clinical outcomes and enhance quality of life for patients with chronic pain, and ensure value in health care delivery through team-based care, specifically by building provider knowledge and skills and helping primary care practice teams deliver improved interprofessional team-based, patient-centered, collaborative care.

Our project pulls together three institutions that each bring considerable strengths to meet our goals – i.e. we will leverage Maine Quality Counts' (QCs) substantial experience working with primary practice teams to provide quality improvement (QI) support, including our

current work on the Maine Chronic Pain Collaborative (CPC1) to promote improvements in chronic pain management. Additionally, our partnership with experienced faculty from the University of New England (UNE) brings considerable expertise in interprofessional collaborative practice (IPCP) and interdisciplinary practice. Additionally, we will partner with the Community Health Center (CHC – Middletown CT) which brings extensive experience with chronic pain management through the Project ECHO (Extension for Community Healthcare Outcomes) video case conferencing, promoting interdisciplinary learning by linking primary care providers and teams with multidisciplinary pain management experts from the Integrated Pain Center (AZ).

Our goals, key objectives and strategies are outlined in the attached driver diagram (See Appendix A) and support the following primary objectives of this initiative – i.e. together with our project partners, we will recruit up to 15-20 primary care practice teams from across the state with a focus on rural providers to (1) provide interdisciplinary and interprofessional education for the care of patients with chronic pain that includes both primary care providers and pain management specialists; interprofessional practice-based learning; use of validated tools and quality improvement approaches; and an emphasis on providing team-based services, and (2) provide resources to educate and promote system changes with participating practices that raise the standard of care for patients with chronic pain, and evaluate the outcomes of these efforts that impact the delivery of care for patients with chronic pain.

By pursuing these overarching objectives, we aim to meet the loud and growing need of patients and primary care providers in our communities, and provide education, resources, and support to primary care providers and practice teams who daily face the challenges of managing patients with chronic pain with empathy and compassion. Additionally, the goals and objectives of this project align fully with the mission and strategic priorities of Maine Quality Counts and our partnering organizations, as each strives to achieve the Triple Aim of improvement by providing support to primary care providers and practice teams to build their confidence, competence, and skills to deliver high-quality, team-based care (outlined in more detail in the "Organizational Detail" section, below).

**2. Technical Approach (Key Objectives and Strategies):** We will meet the primary objectives listed above through the following key objectives and strategies:

***Objective 1: Improve provider confidence, competence, knowledge and skills to manage chronic pain using interdisciplinary and interprofessional educational activities:***

- **Link primary care providers with interdisciplinary chronic pain management specialists through Project ECHO Pain:** We will leverage our experience with Maine CPC1 (i.e. our first round of the Maine Chronic Pain Collaborative that includes eight primary care practice sites) to offer ME CPC2 providers access to Project ECHO Pain video case conferencing. Project ECHO Pain is an evidence-based method for providing video case conferencing for primary care providers[i], linking them with expertise an experienced multi-disciplinary team of chronic pain experts to build provider knowledge, confidence, and skills to manage chronic pain.

  CHC's Project ECHO Pain is a highly successful weekly videoconference that joins up to 20

primary care practices with a highly experienced multidisciplinary team of pain specialists from the Integrative Pain Center of Arizona (http://www.ipcaz.org/project-echo/) and using state-of-the-art web-based videoconferencing technology to mentor primary care providers to improve their care and management of patients with chronic pain. The ECHO Pain interdisciplinary team includes specialists with wide expertise in pain management including anesthesiology, physical medicine and rehabilitation, behavioral health and pharmacy. Participating practices are asked to identify a lead provider ("ECHOist") to participate in case conferencing sessions twice monthly, and are expected to lead a specific case presentation at the ECHO session at least three times over the 14-month period of the project. Additionally, UNE interdisciplinary faculty will be invited to participate Project ECHO sessions to build links with local interdisciplinary experts.

Unlike the traditional pain consult model or traditional telemedicine interventions, Project ECHO uses case-based learning to provide support and education to primary care providers, enabling them to more effectively manage complex pain cases. The interdisciplinary specialist team provides advice and guidance for each case presented by the participating provider, and delivers brief didactic content on a pain-related topic in each session. Cases are discussed in an interactive format led by the ECHO team with input from specialists in pharmacy, behavioral health, internal medicine and pain management as well as participants. Questions are posted by participants on Twitter and answered "live" by the faculty team. Members keep a live blog where they note key points and other reflections on each week's presentation. By building both relationships and knowledge, Project ECHO creates "knowledge networks" that build expertise in primary care providers and primary care practices, and creates a collaborative interdisciplinary learning environment between specialties and the primary care team.

- **Spread provider interdisciplinary and interprofessional education and skills training through enduring web-based resources:** While Project ECHO Pain has proven to be an excellent resource for Maine CPC1 providers participating in the case-conferencing sessions, input from participants in the first round suggests that practice teams can benefit greatly from spreading the ECHO multidisciplinary and interprofessional learnings to other members of their practice team. Given that input, we will work with colleagues from UNE and CHC to construct a web-based platform that will create a set of enduring resources and provide a venue for sharing these resources with other providers and members of the practice teams to learn and share evidence-based knowledge, news, and resources about multidisciplinary approaches for chronic pain management. This platform will feature video recordings of Project ECHO Pain sessions, and will offer a range of supportive, interactive, collaborative, education activities to build a greater collective understanding of the multi-disciplinary chronic pain management strategies that impact on patient health status and resource utilization/cost reduction. This resource will provide a scalable, system-level intervention guided by the needs of primary care providers, and will improve the quality and safety of chronic pain management and opioid prescribing by educating prescribers and care teams.
- **Provide support from Physician Peer Leaders:** Additionally, we will leverage another

strong and successful component of the Maine CPC1 – i.e. support from a set of experienced Physician Peer Leaders. Through our current ME CPC1 effort, we have identified a set of three highly respected Mane physicians who have an interest and expertise in chronic pain management and have served as a resource to participating primary care providers, providing them with direct outreach and support. These Peer Leaders bring knowledge, tools, and resources to participating providers, and importantly, provide support and collegiality while bringing the credibility of another provider who has "been there" through the challenges of chronic pain management.

In the ME CPC2, the three Physician Peer Leaders will each take responsibility for providing periodic outreach and support to 5-6 participating practices, with the goal of helping practice providers provide leadership and direction to the practice's ongoing improvement efforts with managing chronic pain. They will provide education, peer support, and expert consultation to participating primary care providers to increase knowledge of best practices and evidence-based courses of treatment for managing chronic pain; support provider self-efficacy with the management of chronic pain; encourage provider behavior change experienced in times of delivery system re-design, providing "just in time" support and trouble-shooting. Additionally, they will provide assistance to help practices assess and/or analyze their current processes and approaches to caring for patients with chronic pain; and support the practice team's lead provider identify priorities and develop action plans for improvement. Of note, our Maine Peer Leaders have all completed a multi-day "Pain Collaboratory" training curriculum provided at the outset of CPC1 (Atlanta, Feb 2013), and have formal training in chronic pain management .

***Objective 2*: Improve systems of care and the capacity of primary care practice teams to manage chronic pain** by offering the following set of specific supports and resources:

- **Offer a structured system of collaborative learning (ME CPC2):** QC and UNE will use the Learning Collaborative model, based on the Institute for Healthcare Improvement's (IHI) Breakthrough Series model to offer a structured program of collaborative learning[ii, iii] to support participants in implementing quality improvement methods to improve chronic pain. The CPC2 Learning Collaborative will bring together learners (rural primary care providers and practice teams) and experts (UNE multidisciplinary clinical faculty) in periodic day-long Learning Sessions and monthly web-based educational sessions to learn from and with each other. Project staff will provide direct quality improvement (QI) assistance to practices between Learning Sessions through practice outreach, site visits and QI coaching. QC has a strong track record of successfully implementing the Learning Collaborative model with primary care practices to implement practice change, including running a multi-year Patient Centered Medical Home (PCMH) Learning Collaborative with over 100 primary care practices across the state, and the ME CPC2, working with eight practices in an initial effort to improve chronic pain management in the state.

  The ME CPC2 collaborative faculty specifically will bring multi-disciplinary pain management specialists from UNE's Center of Excellence in Neuroscience together with participating primary care practice teams to provide training on interdisciplinary strategies

for pain management. These will include specialists from physical therapy, occupational therapy, nurse anesthesia, social work, and pharmacy - all disciplines available in rural Maine and accessible to work with UNE clinical faculty. The UNE faculty team will interact with practice teams through three daylong Learning Sessions during the 14-month intervention, in addition to monthly educational webinars for practice teams. The UNE faculty will also help participating practice teams build connections and interprofessional competencies with specialists from a range of disciplines in their local community. Since the UNE clinical faculty also practice in Maine and retain strong connections with their community-based colleagues through their relationships with them as clinical preceptors, they will use these connections to link the Learning Collaborative practice teams with appropriate local clinicians in order to develop interprofessional relationships.

UNE clinical faculty will focus on shared interdisciplinary learning to address chronic pain and connecting participating practices with referral resources in their community; additionally, they will also emphasize building interprofessional competencies through the lens of addressing chronic pain. UNE clinical faculty from the Center of Excellence in Neuroscience are also trained and educated in interprofessional approaches, and will integrate these strategies into the sessions. For instance, the CPC2 sessions will feature UNE interdisciplinary clinical pain faculty who will help improve participant's knowledge about each discipline's roles and responsibilities when working with chronic pain patients; ways to improve interprofessional communication, including how various disciplines use of technical language; the values and ethics of each discipline, with the goal of establishing a set of shared values and ethics; and how each discipline contributes to a team.

- **Support practice teams in implementing team-based, multidisciplinary systems change using a QI approach and a set of standardized key changes for chronic pain management*:***

  The ME CPC2 will promote a systematic, patient-centered comprehensive approach to chronic pain management that includes team-based care, use of best practice guidelines, and implementation of workflows that use standard processes and procedures. In our experience with conducting the ME CPC1, we convened a multi-stakeholder steering group to identify a set of "key changes" for chronic pain management that participating practices were asked to implement. These "Chronic Pain Key Change" concepts are summarized below, and are outlined in more detail in Appendix B:

  1. Leadership and culture of safety
  2. Team-based approach to care
  3. Risk stratification & population management
  4. Comprehensive assessment & evaluation of chronic pain
  5. Comprehensive approach to co-management of chronic pain
  6. Mindful approach to initiating opioids for pain management
  7. Safety first with patients receiving opioid therapy
  8. Inclusion of patients & families
  9. Integration of community & clinical resources

10. Optimal use of health information technology to support effective chronic pain management & safe prescribing, including use of Maine Prescription Monitoring Program (PMP)

Through our support to ME CPC2 practice teams, we will provide assistance to implement this set of Chronic Pain Key Changes using a range of proven QI tools and educational strategies, including rapid cycle change cycles ("Plan-Do-Study-Act"). These methods will build the skills, competence, and self-efficacy of primary care providers and practice teams to effectively partner with patients, families, and other community providers to manage chronic pain using patient-centered, evidence-based, and team-based models of care.

- **Provide practice teams with evidence-based interprofessional trainings**: QC and UNE project leaders will provide structured inter-professional training to participating ME CPC2 practice teams using two evidence-based models to promote team-based care:
  - **Interprofessional Collaborative Practice**: UNE's Center of Excellence in Interprofessional Education will provide participating primary care teams with **interprofessional collaborative practice (IPCP) training** with the objective of building nationally-recognized IPCP competencies that have been shown to improve the ability of multi-disciplinary providers to work together effectively. UNE has been training and educating health professionals and health professions students for several years with a curriculum based on these competencies, which are focused on: values and ethics for interprofessional practice; roles and responsibilities; interprofessional communication; and teams and teamwork. UNE clinical faculty will provide this training as part of the CPC2 Learning Collaborative, incorporating content into Learning Sessions and monthly educational sessions. The specific IPCP training will be delivered by the leadership of UNE's Center of Excellence in Interprofessional Education, with the goals of building some basic IPCP competencies. The CPC2 Learning Collaborative sessions with UNE clinical pain faculty will follow, and provide participating practices opportunities to use the basic IPCP competencies in the context of caring for patients with chronic pain and working with clinicians from a variety of professions to address chronic pain.
  - **TeamSTEPPS for Primary Care:** After basic IPCP training, QC and UNE will use the federal Agency for Healthcare Research and Quality (AHRQ) validated interprofessional training tool, Team Strategies and Tools to Enhance Performance and Patient Safety (**TeamSTEPPS**) as part of the IPCP training, using UNE clinical faculty and QC staff who are certified master trainers in TeamSTEPPS. While basic IPCP training provides context and background as well as some primary IPCP competencies, TeamSTEPPS provides specific IPCP tools providers can use right away to improve teamwork and patient care. The main focus will be the Primary Care module of TeamSTEPPS, recently developed for use with ambulatory providers. We will use the Learning Collaborative structure to weave together these models to ensure that pain management in these primary care clinical settings is addressed using the local expertise from different professions and using validated IPCP team strategies.

***Objective 3:*** **Build compassion and empathy for treating chronic pain by strengthen patient-**

**provider partnerships:** We recognize that a significant challenge in providing effective chronic pain management includes the need for providers and practice teams to understand the perspectives of patients living with chronic pain, and the need to maintain empathetic and supportive care. We also recognize the need to more fully engage patients in their care, including engaging in shared decision making and informed choice when using high-risk medications. We will aim to meet this objective by offering the following:

- **Incorporate the patient voice using narratives and video portraits:** We will bring the patient perspective to this initiative through the innovative use of patient narratives and video portraits of patients living with chronic pain. This technique has been used successfully to educate UNE students and faculty through such projects as Portraits of Pain, a web-based collection of patient stories that eloquently and compassionately describe the challenges of living with chronic pain. These innovative tools can offer new insights to providers, as well as teach skills for listening and communicating effectively. This effort will be led by UNE faculty Shelley Cohen Konrad, PhD, LCSW, who has successfully trained health professionals and students on patient centeredness with these techniques for years using a shared learning approach. By using video portraits, patient voices are brought into the learning experience, and providers are able to share their struggles, such as with patient fatigue, burnout, and lack of empathy. By addressing these critical issues, providers are able to improve their interpersonal presence with patients and their care.
- **Offer Choosing Wisely decision aids that promote more productive patient-provider interactions:** QC has excellent experience with implementing the American Board of Internal Medicine's (ABIM) Choosing Wisely® decision aids designed to improve conversations between patients and providers. Choosing Wisely offers evidence-based recommendations for both providers and patients, including recommendations from a several physician specialty societies regarding the use of opioid analgesics in chronic pain that are intended to promote conversations between patients and providers about the use of test and treatments. The ABIM has also partnered with Consumer Reports to create patient versions of many of these recommendations, made available to patients through Choosing Wisely plain language informational sheets as well as web-based short video clips. Given the need to more fully engage patients in their care, participating practices will be encouraged through the Maine CPC2 and interactions with project staff and Physician Peer Leaders to use Choosing Wisely decision aids with patients to help them become more engaged and make informed decisions about their treatment options.
- **Provide enduring resources for interprofessional training that promote patient and family-centered care and raise the standard of care for patients with chronic pain care:** While we anticipate engaging up 15-20 primary care practices across the state in the ME CPC2 Learning Collaborative, we recognize that there is an enormous need to capture and spread the learnings from this effort to other providers, patients, and community members. We will use UNE's extensive video and online technology infrastructure and experience developing web-based learning tools to develop online educational modules on the interprofessional approach to chronic pain management. These tools will use the voices of the patients, practice providers, pain management experts, UNE clinical faculty, and UNE interprofessional education experts. We will integrate existing materials such as UNE's

"Portraits in Pain" , online video portraits featuring patients living with chronic pain. We will also promote use of UNE's IPCP COMPTime training videos (Competencies for Collaborative Health Care), an online training for interprofessional education currently under development by UNEs Center for Excellence in Interprofessional Education. This resource ultimately will include a series of up to five interactive online modules, including several modules developed to date including an introduction to interprofessional education, and a module highlighting the importance of teamwork to decrease medical errors. We will also videotape the CPC2 Learning Session presentations and webinars and interview UNE clinical faculty and participating providers to add the IPCP and clinical pain expertise to this set of enduring resources. These modules will be available as a sustainable resource tool for other providers and practice teams, providing tools that can be readily accessed by busy providers and team members.

***Objective 4:*** **Evaluate the impact of the above interventions:** Per Section 5. Evaluation Design

**Anticipated challenges and solutions:** We anticipate (and know from experience) that providers identify many challenges related to management of chronic pain, including limited time for patient visits; low self-efficacy and a sense of isolation and fatalism in managing chronic pain; lack of confidence in alternative chronic pain treatments; limited awareness of standards and evidence for chronic pain management; and bias about motives of patients seeking treatment for chronic pain. We are confident that we can address these challenges by bringing a systematic approach to chronic pain that builds interprofessional competencies and links primary care providers and teams with other professions who have pain management expertise. We will leverage the expertise of UNE clinical faculty from different professions who have chronic pain management expertise, and will teach providers skills for listening and communicating effectively.

**3. Current assessment of need in target area**

Like many states, Maine faces enormous challenges with supporting the effective chronic pain management and safe prescribing of prescription opioids. Our experience supporting primary care practices through the Maine PCMH Pilot, the Maine CPC1, and other quality improvement initiatives indicates that many providers express a significant lack of confidence, as well as high levels of frustration in managing chronic pain and the safe use of opiates, and are eager for assistance to bring a quality improvement approach to this complex issue. In a recent PCMH Learning Session, providers responded overwhelmingly positively to a plenary session focused on chronic pain management and asked for additional assistance to implement QI workflows to support best practices. Additionally, providers and practice teams participating in the ME CPC1 have similarly expressed a strong need for such support, and have been very grateful for the resources made available to them through that effort.

At the same time, Maine also has the unfortunate distinction of being the worst state in the nation for rates of diversion and misuse of prescription opioids. Despite this information, primary care providers inadvertently put patient safety at risk on a daily basis through unsafe prescribing practices that commonly include use of high dose opioids (i.e. greater than 100 morphine equivalents daily); concurrent use of opioids and benzodiazepines; and provision of chronic opioid prescriptions to people with history of addiction and other known high risk

factors (e.g. sleep apnea, COPD). According to the Centers for Disease Control and Prevention *Morbidity and Mortality Weekly Report* (MMWR), opioid pain relievers (OPRs) were sold in 2010 at a higher rate in Maine than nationally. The Maine rate was 9.8 kilograms (kg) of OPR sold (in morphine equivalents) per 10,000 people, with the national rate at 7.1 kg per 10,000. Maine's rate was three time higher than nine of the best states.[iv] Maine Dept. of Health & Human Services reports that 2.1 million prescriptions were filled for narcotics, tranquilizers and stimulants in 2013, and that 60% of the 176 drug overdose deaths in Maine in 2013 cited prescription opioids as the cause of death.

These statistics are perhaps even more concerning when recognizing that they occur in a state that has many assets that are intended to support safe and appropriate opioid prescribing. The State of Maine implemented a Prescription Monitoring Program (PMP) in 2003 that requires prescriptions for all controlled substances dispensed in the state to be submitted by pharmacies and other dispensers to a central database. Health care providers and other authorized users are able to register for access and once approved can view information through a secure web portal. Additionally, the Maine Board of Licensure in Medicine Rules, Chapter 21, requires that providers monitor patients for potential abuse/misuse of opioid prescriptions using multiple measures (e.g., use of urine drug screens, pill counts, provider/patient agreements, use of PMP), though the degree to which providers adhere to these requirements varies widely. Information available through Maine's PMP can help providers avoid duplicative prescribing and dangerous drug interactions and can help identify pain management issues and improve communications between PCPs and specialists. However, as of late 2013, only 60.8% of prescribers in Maine were registered to use the PMP; additionally a 2013 survey of PMP registrants showed that 45% of providers reported never using the PMP, or using it on average less than 3 times per month.

Additionally, data on Maine prescribing patterns demonstrates a continued and unsafe increase in the prescribing of opioids for chronic pain, including in primary care settings. According to the Maine State PMP 2013 report[v]:

- Between 2008 and 2012, total number of opioid prescriptions rose by 6%. Additionally, the percent of primary hospital admissions related to heroin/morphine use rose 6%, and primary admissions for complications of opioid use rose 28%.
- In 2012, the national and Maine average number of opioid scripts per person was 1.91 prescriptions per person; in several rural Maine counties, this number was well above that, including Washington County at 2.28; Knox 2.08; Kennebec, Penobscot 2.04; Waldo 2.02.
- The number of hospital admissions related to inappropriate use of prescription opioids has increased much more quickly than admissions for heroin/morphine use: in 2008, 8% of admissions were related to heroin/morphine use and 27% for conditions associated with use of prescription opioids; by 2012, that number had increased to 10% for heroin/morphine use, and to 34% for conditions related to use of prescription opioids.

The primary audience for our proposed intervention to improve chronic pain management and the safe prescribing of opioids in primary care practices, with the goal of recruiting up to 15-20 practices to participate, with a focus on practices from rural parts of the state. While the selected practices and their patients will receive the most immediate benefit from this effort,

we also plan to share the learnings from this project with all 150 PCMH practices in the Maine PCMH Pilot and Medicaid Health Homes initiative, and ultimately, with all providers statewide.

**4. Project Design and Methods**

Our intervention design and methods will support our key objectives and will be focused on improving interdisciplinary and interprofessional education; implementing systems change for practice-based improvement; and building compassion and empathy for treating patients with chronic pain. We will offer participation in this educational and quality improvement initiative (i.e. the Maine CPC2) through a competitive application process open to all primary care practices in Maine, with particular efforts to recruit practices from rural communities. Using predefined selection criteria and guidance from our multi-stakeholder Chronic Pain Leadership Group, we will select up to 15-20 practices to participate in the 14-month intervention. Given the high importance and frequent requests for assistance that primary care practices have voiced regarding the issue of chronic pain management, we anticipate a high level of interest and do not anticipate difficulty recruiting at least 15 practices to participate.

Practices will be selected based on their commitment to improve chronic pain management using evidence-based models to improve care, and their demonstrated capacity and willingness to use performance data to improve clinical quality, efficiency, and patient experience related to chronic pain management. Selected practices will be asked to sign a Memorandum of Agreement (MOA) outlining the specific expectations of their participation, including identification of a leadership team to serve as practice "clinical champions" to lead and spread practice improvement efforts related to chronic pain management at their practice site and to participate in the evaluation and collaborative learning activities.

**5. Evaluation Design:**

Evaluation for this project will be conducted in partnership with an experienced research team from the CHCs Weitzman Quality Institute (WQI) and participating practice sites. We will utilize an evaluation model that focuses on known gaps in care and incorporates both process measures and provider and patient outcomes – i.e. changes in key processes for chronic pain management, along with measures of provider participation, satisfaction, and knowledge, and patient functional status and quality of life.

We will use a controlled, quasi-experimental design that employs both quantitative and qualitative data collection and analysis, and a composite set of metrics that provide greater validity and enhanced understanding of the results of this multifaceted intervention.
For control purposes, we will identify a comparison group of non-participating primary care practices in Maine to gather pre/post information on provider knowledge and attitude using provider surveys. Data will be collected in a cross-sectional manner at baseline and at the end of the intervention. The time interval between the pre- and post- data collection will be the length of the intervention with participating practices (i.e. 14 months).

The evaluation will be guided by a set of key questions about the current practice gaps in care, and a set of hypotheses to test those key questions:

- **Question 1:** Will a multi-faceted intervention (Maine CPC2) that includes interdisciplinary and interprofessional education; systems change for practice-based improvement; and methods to strengthen the patient voice improve the quality of care for chronic pain?

  **Hypothesis 1**: Implementing the Maine CPC2 will result in improved quality of pain management by participating practice teams through:

  - Increased knowledge about standards of care for chronic pain management
  - Increased adherence to evidence-based protocols and guidelines for chronic pain management and safe prescribing/monitoring of opioids
  - Increased utilization of multidisciplinary treatment options and improved communication with other disciplines on the care team
  - Improved assessment of chronic pain and safe opiate prescribing
  - Improved documentation of pain management
  - Increased use of Maine Prescription Monitoring Program (PMP)
  - Decreased inappropriate use of chronic opioid medications for chronic pain

  **Hypothesis 2**: Implementing the QI intervention will result in improved patient outcomes for patients with chronic pain receiving care from the intervention providers as measured by patient functional status and quality of life.

- **Question 2.** How effective are the Maine CPC2 Learning Collaborative offerings and Project ECHO Pain in helping primary care providers and practice teams improve their systems of care and improve their satisfaction with managing patients with chronic pain?

  **Hypothesis 3:** Providers taking part in the Maine CPC2 will express greater knowledge, confidence and satisfaction with their ability to manage pain by the end of the intervention, as compared to providers in the comparison group.

  We will first measure the extent to which the intervention has been adopted using a series of surveys and phone interviews that will be administered both pre- and post-intervention. We will use provider surveys to measure knowledge, self-efficacy, adherence to pain management standards of care, and attendance and satisfaction with the interventional activities, while patient measures will include the impact of pain on patient function and quality of life. Data on intervention activities will be collected on a regular basis throughout the intervention period (i.e. bi-monthly for all ECHO sessions and monthly/quarterly for the Collaborative activities).

**Participants and Data Sources**

***Providers and Practice Teams*:** Each participating practice will also be asked to identify a provider leader, an administrative leader, and one additional member of the practice to comprise their ME CPC2 improvement team and participate in the Learning Collaborative and evaluation activities. All members of the team will be asked to commit to attending ME CPC2 Learning Sessions, as well as weekly performance improvement team meetings during the action phases. In addition, the identified primary care leader, as well as at least one other member of the practice team will be expected to attend bi-monthly Project ECHO sessions.

***Provider Control Group:*** Since randomization is not practical or feasible within the primary care practice community, we will utilize the next suitable evaluation approach for estimating intervention effect on provider's pain knowledge and self-efficacy in this quasi-experimental,

pre-post design by using a comparison group and adjusting for known differences. QC will identify a comparison group of non-participating primary care practices in Maine to complete the provider knowledge and self-efficacy surveys. QC will assist with identifying a suitable cohort of clinicians to comprise this comparison group, matching control and intervention group on the basis of size, technical capacity, and populations served.

***Patients*:** All adult patients (age >= 18) with chronic pain of any cause, cared for at sites participating in the study will be eligible to be reviewed as part of the evaluation. We will use a validated algorithm that uses a combination of visit codes, medication data, and pain scores to identify patients with chronic pain; from previous studies, this algorithm has been shown to be 95% accurate in correctly identifying patients with chronic pain using large data sets.

**Data Sources and Collection Methods:** Pre- and post-intervention data will originate from multiple sources: EHR systems, using queries and chart reviews; online survey instruments; phone interviews; and progress reports. Study data will be collected at baseline and post-intervention and will include operational measures, knowledge and attitudes surveys, provider treatment choices and patient outcomes. All data on patient outcomes and provider practice decisions will be retrieved from the **EHR** systems, de-identified, and analyzed by the study team. All data retrieval queries will be validated by random chart reviews of at least 25 records per practice. Data elements will include the provider name and specialty, their demographics, patient pain scores, medication prescribing records, laboratory results, opioid agreement use, and behavioral health and medical referrals. Random manual chart reviews will be conducted to validate electronic queries and to capture data not available through electronic queries. **Operational data** on Maine CPC2 Learning Sessions, monthly webinars, and ECHO Pain sessions will be collected prospectively to assess engagement of the target audience (providers and practices) and reviewed regularly with the Principal Investigators, with ongoing evaluation and process improvement during the intervention period. **Interview** data will be obtained from individual members of all improvement teams participating in the improvement collaborative. Measures will focus on primary care team satisfaction and team effectiveness. The actual number and depth of changes made to improve chronic pain care will be assessed using monthly reports from teams to project staff. Other measures will include spread of changes, reported barriers and facilitators to change, and practice and healthcare center characteristics.

**Metrics:** Primary outcomes will be assessed using the following metrics:

I. Primary care provider outcomes
   - *Pain care knowledge survey:* The KnowPain-50 (KP50) Survey is a 50-item, validated tool for assessing physician pain management knowledge. To assess primary care providers' knowledge about pain and pain management, we will administer the KP50 Survey to all providers in the intervention and control group at baseline and 9 months after the start of the intervention.
   - *Pain management attitudes and beliefs:* The Pain Care Beliefs Survey is an 11- item measure assessing PCP's attitudes and beliefs regarding pain care survey.
   - *Pain management self-efficacy survey:* The Project ECHO self-efficacy survey is a 21-item measure (*University of New Mexico Project ECHO)*

II. Opioid prescribing safety and monitoring

- % of PCP adult panel receiving opioid prescriptions
- % of high-dose opioid prescriptions (> 100 mg morphine equivalent)
- % of patients receiving chronic opioids with a documented opioid agreement
- % of patients receiving chronic opioids with a urine toxicology screen within past 6 mos

III. Multimodal care

- % patients with chronic pain co-managed by one or more other medical disciplines
- % patients with chronic pain referred for complementary and alternative medical (CAM) modality

IV. Patient outcomes

- *Pain functional status scores (SF-8):* Providers often focus on diagnosing and treating conditions, while patients are more concerned about quality of life (QOL); thus we include QOL as an important outcome in the evaluation. We will evaluate the QOL in patients with chronic pain by means of the SF-8 Health Survey. This is an 8-item version of the SF-36 that yields a comparable 8-dimension health profile and comparable estimates of summary scores for the physical and mental components of health and can be answered in a shorter time compared with other questionnaires including SF-36.
- % patients with documentation of a pain assessment through discussion with the patient, including the use of a standardized tool(s) on each visit
- % patients with documentation of a follow-up plan when pain is present
- % patients with documentation of a pain assessment
- % patients with documentation of a pain care plan
- % of patients with documentation that the patient received pain education

**Analysis:** Clinical, operational and demographic data will be analyzed using descriptive statistics. Appropriate statistical analyses will be undertaken to test for statistically significant differences pre- and post-intervention as well as between the two groups of providers in the study (intervention and control). Primary study hypotheses regarding between-group differences on provider measures (e.g. pain management knowledge, attitudes and beliefs about pain care scores, and self-efficacy scores) will be examined. The impact of the intervention on different providers' measures will be tested statistically using a 2x2 mixed factorial analyses with an inter factor (intervention group versus control group) and an intra-factor (pre- versus post- intervention). We will examine correlations between provider measures, team effectiveness and changes that the teams rated a success to different patient measures. Before and after scores on a continuous scale for the cohort of chronic pain patients (e.g. pain severity) will be analyzed for statistically significant difference using paired t-tests. Analyses, where appropriate, will be performed for each site separately as well as for all intervention sites combined. An alpha level of 0.05 will be adopted as the criterion for significance. Lastly, qualitative data from the team reports and surveys will be analyzed in accord with established procedures. We will use standard qualitative content analysis with clustering techniques to identify the repetitive themes regarding providers' experiences participating in the different components of the initiative.

The amount of change expected from this intervention is a 10-20% increase in overall knowledge and self-efficacy scores for providers in the intervention group. For patients, we expect to see a 20-30% decrease in primary care utilization (average number of visits per year).

**Methods to control for other factors outside this intervention:** We will take the following steps to filter out confounding variables: we will identify primary care providers willing to serve in a control group from practices that are not participating in the intervention. These controls, along with the participants, will be asked to complete pre- and post-intervention survey questionnaires evaluating their pain management knowledge and self-efficacy. Subjects who decline to participate in the intervention will not be included in the control group. The intervention/control groups and outcome measures will be chosen before the intervention is delivered. Evaluation of the quality of chronic pain care delivered, as well as the participating providers' chronic pain management knowledge and self-efficacy will be made before and after the intervention. We will closely match the study's intervention and control groups prior to the intervention; the control group will not receive the intervention. If we find differences in the characteristics of participants in the intervention and control groups that might influence how they respond to the intervention, we will apply more sophisticated techniques that allow a correction of these differences.

Among quasi-experimental study designs, the pre/post control design is the most sound in terms of establishing causality. This design is an improvement on pre-experimental designs in that we can determine whether there is a change in provider knowledge and self-efficacy after the intervention and thus decrease the chances of confounding due to other factors. Therefore, there will be considerable confidence that any differences between intervention group and control group will be due to the intervention. The design allows for many comparisons (i.e. between groups, pre- to post-intervention in one group). Using pre/post control design is also a useful way of ensuring that the study has a strong level of internal validity because the pre-intervention ensures that the groups are equivalent, thus filtering out confounding variables.

**Dissemination of Project Outcomes:** This project brings together a powerful partnership of primary care and education leaders in Maine that will serve as an excellent mechanism for disseminating project outcomes. We will share outcomes, lessons learned, and best practices from this initiative using the wide array of existing education and communication channels available from QC, UNE, MMA, the Maine Primary Care Association, and other professional groups in the state, leveraging our collective roles as trusted quality leaders. We also aim to submit a summary of our work to at least one peer-reviewed journal for publication.

### 6. Detailed Work Plan and Deliverables Schedule

On notification of grant award, Maine Quality Counts and its partners will immediately initiate efforts to implement this 20-month initiative. Because of our previous efforts with the Maine CPC1, we currently have several of the structures and staff in place to facilitate rapid project start-up, with project launch on January 1, 2015. We plan to conduct the project using the following timeline:

- Rapid project planning and launch (3 mos): Jan 1 – March 31, 2015
- ME CPC2 Learning Collaborative (14 mos): April 1, 2015 – May 31, 2016

- Project wrap-up, data collection, and evaluation (3 mos): Jun 1 – Aug 31, 2016

The initial project planning period will include convening our established multi-stakeholder Chronic Pain Leadership Group, with the addition of UNE clinical faculty to provide guidance and direction for the project, including reviewing and potentially revising our current key change package; approving the application for practice participation; identifying criteria for practice selection; and providing input on educational content for Learning Sessions and monthly webinar sessions. Staff will support the practice application and selection process, with the goal of selecting selected 15-20 practices as participating sites by March 31, 2015.

Following this initial start-up phase, we will launch the ME CPC2 in April 2015, with initial efforts directed at on-boarding the selected practices, and conducting practice assessments and baseline data collection. By May 2015, the project team will conduct the first of three day-long ME CPC2 Learning Sessions, and will launch monthly webinars with our UNE interprofessional clinical faculty team and featuring a focus on interprofessional education. In addition, participating sites will be asked to identify a provider to participate in Project ECHO Pain video case conferencing sessions. Participating practices will participate in case presentations twice a month through a telehealth video connection to the Community Health Center (CHC) in Connecticut, linking with the multi-disciplinary team of pain management experts at the Integrative Pain Center of Arizona.

Throughout the 14-month intervention period, the project team will provide direct outreach and education to practice teams through site visits, email communications, telephone check-ins, and regular webinars and conference calls. Educational sessions will promote interdisciplinary and interprofessional methods, focusing on the 10 key changes for chronic pain management, as well as reflecting best practices from the participating practice sites. Sites will be supported in developing team-based workflow and systems using specific decision-support tools such as SOAPP; ORT, and dose and taper calculators. The project team will help the sites develop plans to collect real-time data to will provide feedback to providers.

Experienced researchers from CHC/WQI will lead the evaluation component of the project. At the outset of the project, the evaluation team will identify a control group of non-participating practices in Maine. CHC will be responsible for creating or adapting data collection tools including chart review, EHR data retrieval queries, survey instruments, and interview scripts. Once the participating sites are selected, CHC will collect baseline data by reviewing charts and EHR data. Throughout the project CHC will collect data on ECHO Pain Sessions (weekly) and Learning Collaborative data (quarterly). The evaluation team will collect post-intervention data collection and conduct project evaluation during the final 3-month period from Jun 1 – Aug 31, 2016. Results will be analyzed and summarized in a report on project outcomes to be delivered September 2016.

- **Work Plan & Deliverables Schedule Table - See <u>Appendix C</u>**

**Organizational Detail**

- **Leadership and Organizational Capability**

Maine Quality Counts will serve as the lead organization for this initiative, working in partnership with the University of New England and the Community Health Center (CHC) for Project ECHO support and with the CHC's Weitzman Quality Institute as our evaluation partner. Recognizing the value of building a strong statewide alliance to promote this initiative, we will also collaborate closely with key provider, consumer, and policy organizations in Maine. QC has strong working relationships with the provider organizations in the state including the Maine Medical Association, the Maine Osteopathic Organization, the Maine Academy of Family Physicians, the Maine Chapter of the American College of Physicians, the Maine Primary Care Association, and the Maine Hospital Association. Additionally, we have strong partnerships and will work collaboratively with consumer and community groups including Consumers for Affordable Health Care, Community Action Groups (CAP agencies), and Maine's five Area Agencies on Aging (AAAs). Specific qualifications and roles for each of the major partnering organizations include the following:

**Maine Quality Counts (QC):** QC will serve as the primary applicant for this proposal, leveraging our role as a regional health improvement collaborative committed to transforming health and health care in Maine. QC has strong provider relationships, and has led several statewide improvement initiatives, including the RWJF-funded Aligning Forces for Quality initiative and the multi-payer Maine Patient Centered Medical Home (PCMH) Pilot that includes 75 primary care practices statewide and 100 additional primary care practices participating in the Medicaid Health Homes initiative. QC provides PCMH transformation support to Pilot practices, providing quality improvement (QI) coaching services and sponsoring a statewide PCMH Learning Collaborative.

QC is an IRS-approved 501(c) 3 organization incorporated in the state of Maine since 2006 and governed by a Board of Directors whose members include physical and behavioral health providers, commercial and government payers, state government and community based agencies; and consumers and consumer advocacy agencies. QC has over 100 supporting Members, representing a wide set of stakeholders statewide. QC has the proven and deep leadership, project management, and financial capacity to serve as the lead agency for this initiative. As both the direct and indirect recipient of foundation and government grants, QC has financial management expertise and technology to manage complex funding streams, and to comply with all grant management and auditing requirements.

QC leadership for this project will be provided by Lisa Letourneau MD, MPH, QC Executive Director. Dr. Letourneau serves as Executive Director of QC and serves as physician champion for several statewide quality improvement efforts. She has extensive experience in engaging providers in QI efforts, and has strong relationships with key stakeholders throughout the state. Dr. Letourneau will provide overall leadership and oversight of this project, including direction and support for the QI and learning activities with the participating primary care providers and practice teams.

**University of New England (UNE):** UNE is a comprehensive health sciences university located in southern Maine and is the largest educator of Maine healthcare professionals, emphasizing the primary care fields and conferring 13 health professional degrees. UNE is an excellent partner for this project given its expertise in interprofessional education (IPE) and interprofessional collaborative practice (IPCP). Its faculty have experience with IPE and IPCP education in both classroom and clinical settings. Faculty from UNE's Center of Excellence in IPE are well published on the field and recognized with multiple invited presentations at international conferences and grant awards. UNE also has expertise in pain treatment: its Center of Biomedical Research Excellence for the Study of Pain and Sensory Function has secured over $10M in federal funding and attracted faculty from across its colleges with expertise in the neurobiology of pain and pain management. Additionally, UNE is well versed in online education and technology to further health professions education. Approximately one-third of its students obtain accredited online health-related degrees, including a master of public health (MPH) and a master of social work (MSW). UNE's robust investment in multimedia technology, including instructional designers, makes it an ideal partner for developing sustainable educational resources.

UNE leadership for this project will be provided Dora Anne Mills MD, MPH, FAAP. Dr. Mills serves as UNE's Vice President for Clinical Affairs and oversees UNE's clinical interprofessional education and collaborative practice activities across their 17 professional education programs. She has extensive experience with interprofessional collaborative practice and interprofessional education, and will be responsible for providing direction and oversight for the IPIC and TeamSTEPPS training activities with participating primary care practice teams.

**Community Health Center (CHC) and the Weitzman Quality Institute** (Evaluation Partner): The Center for Health Care, Inc. (CHC) is a leading health-care provider in Middletown, Connecticut providing comprehensive primary care services in medicine, dentistry, and behavioral health and committed to caring special populations and building healthy communities. The Weitzman Quality Institute (WQI) in was established by CHC in 2012 and has served since its inception as the institutional home of CHCI's research, quality improvement, and knowledge dissemination work. The Institute is dynamic, interdisciplinary, and cross-institutional and welcomes the input and participation of interested clinical and non-clinical leaders from around the world. WQI promotes critical investigation, training, and innovation in areas that have direct implications to the day to day practice of primary care. WQI is committed to a research agenda focused on answering questions that arise in the daily practice of primary care. Adopting patient-centered strategies and promoting the implementation of evidence based care are among the Institute's top priorities. Research is cross disciplinary, involving medicine, dentistry, behavioral health, pharmacy, and nursing. Currently WQI has secured over $2.5 million dollars in funding to support research in a wide variety of areas a number of federal and private philanthropic sources.

CHC/WQI leadership for this project will be provided by Daren Anderson MD, MPH, VP and Chief Quality Officer of Community Health. Dr. Anderson will be responsible for providing

leadership and oversight of the Project ECHO Pain learning activities, and will lead evaluation efforts provided by the Weitzman Institute evaluation team.

- **Staff Capacity**

**Principal Investigators (PI)**

- **Co-PI: Lisa Letourneau MD, MPH** (U.S.): Dr. Letourneau serves as Executive Director of QC and serves as physician champion for several quality improvement efforts, including the Maine PCMH Pilot and the Maine CPC1. She has extensive experience in engaging providers in QI efforts, and has strong relationships with key stakeholders throughout the state. She will provide oversight and leadership to this effort, overseeing QC staff and contracted consultants.
- **Co-PI & Physician Peer Leader: Noah Nesin MD** (U.S.): Dr. Nesin serves as Chief Quality Officer at PCHC and has extensive experience in working with policymakers and providers to improve chronic pain management and safe prescribing. He has direct experience in working with primary care practices to address chronic pain, both in his practice leadership role, and having served as Co-PI on the Maine CPC1, as well as serving as Physician Peer Leader to several practices in that initiative. He will oversee the Physician Peer Leaders, and will have oversight of practice outreach and education efforts.

**Project Management**

- **Project Manager: Michelle Giliam BS** (U.S.) –Michele serves as QI Specialist for QC, providing direct support to primary practices in the PCMH Pilot and the Maine CPC1. She has strong QI and project management experience, and will implement the project plan in accordance with specified timelines and deliverables.
- **Project Coordinator: Eric Buch** (U.S.) – Eric currently serves as contracted staff supporting project management for the Maine CPC1, and has experience in project management, evaluation, and pain management. He will work closely with Michele in the role as Program Coordinator to support the technical aspects of the CPC2 learning efforts, and to ensure implementation of project deliverables.

**E. <u>Detailed Budget</u> & Narrative – see attached <u>Appendix D</u>**

**F. <u>Staff Biosketches</u>:**

**<u>Maine Quality Counts</u>:**

- **Co-PI: Lisa Letourneau MD, MPH, FACP:** Dr. Letourneau serves as Executive Director of QC and serves as physician champion for several quality improvement efforts, including the Maine Aligning Forces for Quality initiative and the multi-payer Maine PCMH Pilot. She has extensive experience in engaging providers in QI efforts, and has strong relationships with key stakeholders throughout the state. Dr. Letourneau is a graduate of Brown University and the Dartmouth-Brown Program in Medicine and is a board-certified internist who practiced emergency medicine for seven years before beginning her work in clinical quality improvement. Dr. Letourneau holds a Master's degree from the Harvard School of Public Health, and has a particular interest in helping to build connections between public health

and clinical care, and the role of physicians in helping to develop and lead health improvement efforts.

**University of New England:**

- **Co-PI and Leader for Interprofessional Education: Dora Anne Mills, MD, MPH, FAAP**, is UNE's Vice President for Clinical Affairs and oversees UNE's clinical interprofessional education and collaborative practice activities. Dora has practiced pediatrics in a number of settings, including at Children's Hospital of Los Angeles, rural Tanzania, and her hometown in rural Maine. She served as the public health director for the State of Maine for nearly 15 years, working on patient safety and chronic pain from a public health standpoint and since 2011 has worked at UNE. She is master trained in TeamSTEPPS, has worked with practitioners across Maine and spoken nationally on interprofessional collaborative practice and interprofessional education.

- **Shelley Cohen Konrad, PhD, LCSW**, is an associate professor in UNE's School of Social Work and Director of UNE's Center for Excellence in Interprofessional Education (IPE). She is nationally recognized as both a social worker and expert in interprofessional collaborative practice (http://www.une.edu/people/shelley-cohen-konrad). As such, she has not only widely published, but also presented at statewide, national and international conferences on interprofessional collaborative practice, interprofessional education, and on social work end of life treatment. She is a principal investigator or co-principal investigator of several HRSA grants on IPE as well as some foundation grants, such as from the Josiah Macy Jr., Arthur Vining Davis, and Bingham Foundations. She has co-led a statewide nurse leadership interprofessional course. She is also master trained in TeamSTEPPS. The recipient of a number of awards, she was inducted in 2014 as a Distinguished Scholar and Fellow in the National Academies of Practice and the Social Work Academy.

- **Stephen McDavitt, PT, DPT**, is a state and national leader in physical therapy. With a doctorate in physical therapy from Massachusetts General Hospital Institute of Health Professions, he has been a clinical instructor and practiced for over 30 years. He has served as a director of the American Physical Therapy Association and is currently the president of the orthopedic section. With a specialty in spine rehabilitation, he treats one of the most common causes of chronic pain, and teaches this to physical therapy students and professionals statewide.

- **MaryBeth Patenaude, MS, OTR**, is a graduate from Columbia University and over the past 17 years, has provided occupational therapy to patients with both chronic and acute pain, in all settings, from acute care to outpatient orthopedics. She has successfully employed various modalities to decrease pain, including meaningful activities, physical agent modalities and kinesiotaping. She also provides in-depth training to students in the UNE OT program and with her colleagues statewide, on pain management techniques.

- **Leslie Ochs, Pharm D, PhD, MSPH**, is a clinical pharmacist and assistant professor at UNE with a doctorate and masters in public health, the latter degrees focused on health outcomes research. She has over ten years' of experience working with adults with chronic

pain and other complex medical issues. As such, she has designed and implemented medication reconciliation programs for the Veterans Administration and served on the VA National Medication Reconciliation Initiative. She is

- **Maribeth Massie CRNA, MS, PhD**, is a UNE associate clinical professor in nurse anesthesia. With an MS from Columbia University and a PhD from Virginia Commonwealth University, she has over 12 years of experience in nurse anesthesia education and clinical practice. One of her areas of expertise is providing anesthesia and other forms of pain relief in rural and other remote locations.

**Community Health Center/ Weitzman Quality Institute:**

- **Daren Anderson MD, MPH** serves Dr VP/Chief Quality Officer of Community Health Center, Inc. In this role, Dr. Anderson is responsible for ensuring that CHC delivers the highest possible quality of care to its patients, developing a strong quality improvement infrastructure across CHC, promoting research and development, and supporting CHC's mission to become a nationally-recognized center of world-class healthcare. Dr. Anderson obtained his undergraduate degree at Harvard College and his medical degree from the Columbia University College of Physicians and Surgeons. He completed his residency training in internal medicine at Yale-New Haven Hospital and is a board-certified general internist. Previous to his role at CHCI, Dr. Anderson has served as Director of Primary Care for the VA Connecticut Healthcare System, Assistant Professor of Medicine at Yale School of Medicine, Chief Medical Officer of Community Health Center, Inc., and a consultant in the field of disease management, and a primary care provider at the Community Health Center of New Britain.

**Physician Peer Consultants:**

- **Co-PI & Provider Leader: Noah Nesin MD, FAAP :** Dr. Nesin is the Chief Medical Officer at Penobscot Community Health Center, Maine's largest FQHC, and has extensive experience in working with policymakers and providers to improve chronic pain management and safe prescribing. Dr. Nesin is a graduate of the University of Maine at Orono, and the Tufts University School of Medicine. He completed his family medicine residency at the University of Minnesota, and has completed several advanced leadership development programs. He helped lead in the development of the MPCA "White Paper" on management of chronic non-cancer pain in 2012, and has served on several state policy workgroups on this issue. Throughout his 27 year career as a family physician and in his leadership roles, he has pursued his passion for rational and evidence based prescribing, viewing it as fundamental to the role of a primary care provider as advocate for the best interests of his/her patients. He has implemented policies in his private practice which embraced evidence based use of controlled substances and carried that effort into his role as FQHC Medical Director the past years. He has implemented a robust controlled substance policy and processes and monitored and reported on individual provider and practice opiate prescription rates as well as compliance with required monitoring measures (contract, use of prescription monitoring program, random pill counts and random urine drug screens). He has served on two Maine Department of Human Services work groups to

help to develop clinically meaningful implementation of new legislation related to use of opioids and Suboxone for Maine Medicaid members. He serves as the chair of the Academic Detailing Advisory Committee, the body which oversees the Maine Independent Clinical Information Service, Maine's academic detailing program.

- **Elisabeth Mock MD, MPH:** is a family physician with extensive experience in education and academic detailing, including safe prescribing for chronic pain management. Dr. Mock received her doctorate from Vanderbilt University School of Medicine in Tennessee and her Master of Public Health in Health Policy and Administration from the University of North Carolina at Chapel Hill. She is Board Certified in Family Medicine, having previously practiced broad-scope Family Medicine and having served as a full-time faculty member of a Family Medicine Residency Program. For the past five years, Dr. Mock has practiced as an adult hospitalist at Eastern Maine Medical Center. For the past two years, she has served as an Academic Detailer with the Maine Independent Clinical Information Service (MICIS), bringing evidence-based prescribing and treatment recommendations to providers throughout the state of Maine by leading small seminars, giving hospital grand rounds and delivering CME lectures to state association meetings.

- **Richard Entel MD:** is a family physician experienced in addiction medicine, including experience leading development of opioid dependency programs. Dr. Entel is a family physician who has practiced family medicine and emergency medicine in a range of practice settings in Maine, and has extensive experience in addiction medicine. He is a graduate of Dartmouth College and Mount Sinai School of Medicine, and completed his residency in Family Medicine at the Maine-Dartmouth Family Practice Residency at MaineGeneral Medical Center, with additional training in addiction medicine. He has developed opioid addiction services in several clinical sites, and helped to develop a coordinated addiction and dual diagnosis counseling program in his role at the Islands Community Medical Center in Vinalhaven, Maine.

**G. Letters of Commitment:** See letters of commitment from the key project partners, attached (See Appendix E):

- Maine Quality Counts
- University of New England
- Community Health Center / Weitzman Institute

---

[i] Katzman JG, G Comerci, et al, "Innovative Telementoring for Pain Management: Project ECHO Pain", Journal of Continuing Education in the Health Professions, 34(1):68–75, 2014

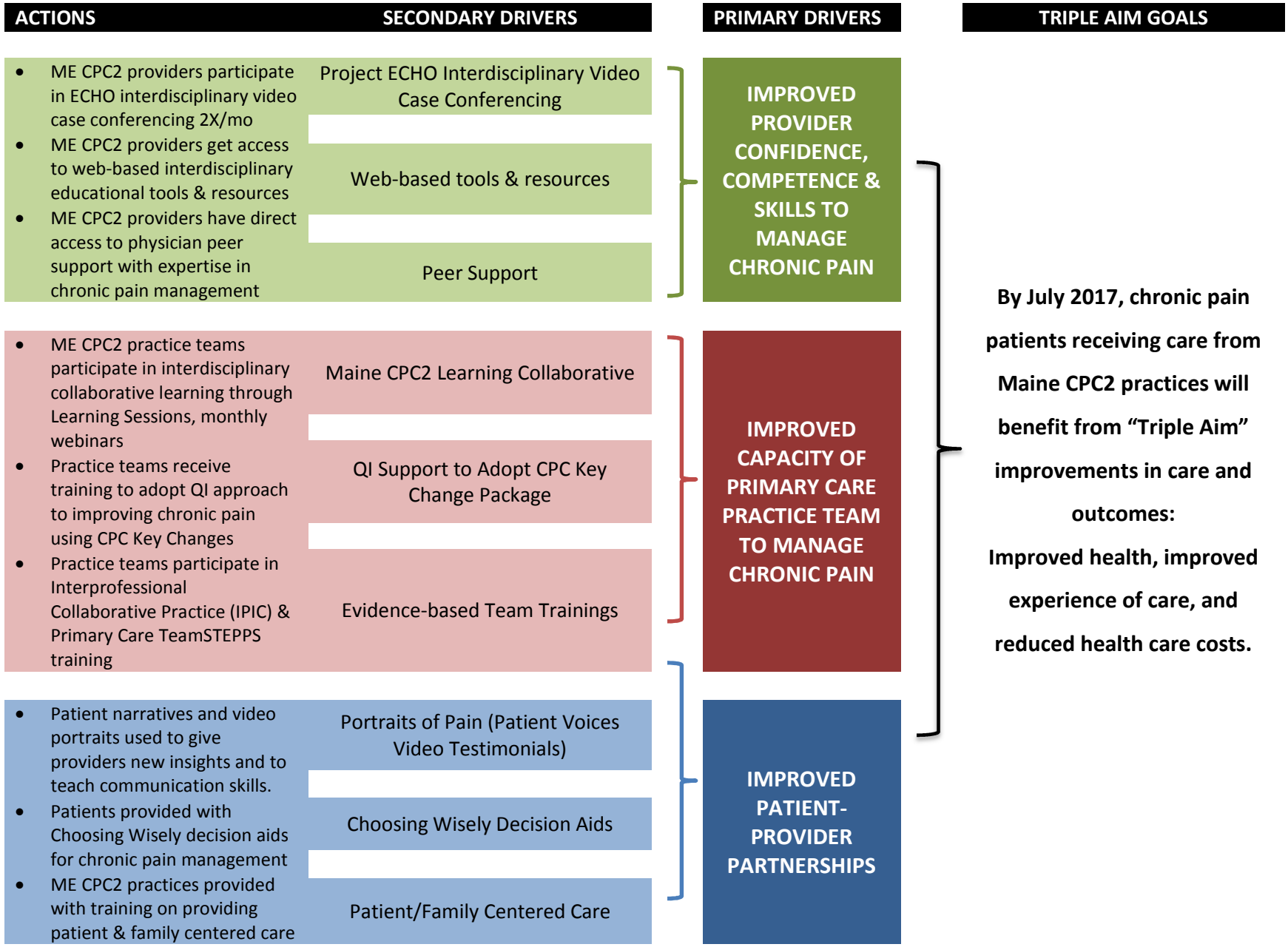
[ii] Institute for Healthcare Improvement, The Breakthrough Series: IHI's Collaborative Model for Achieving Breakthrough Improvement, 2003, accessed online at www.ihi.org

[iii] Ovretveit, J., Bate, P., Cleary, P., et al, Quality Collaboratives: lessons from research. Quality and Safety in Health Care 2002; 11:345-351

[iv] MMWR, Vol. 60, No. 43 (Nov. 4, 2011) available at www.cdc.gov/mmwr/PDF/wk/mm6043.pdf)

[v] Maine 2013 Prescription Monitoring Program Survey Results: http://www.maine.gov/dhhs/samhs/osa/pubs/data/2013/PMPSurveyResultsFINALJul2013.pdf

# APPENDIX A MAINE CHRONIC PAIN COLLABORATIVE 2 (ME CPC2) – CHANGE MODEL & DRIVERS



**Appendix B**
**Maine Chronic Pain Collaborative**
**Chronic Pain Management**
**Change Package for Primary Care Practices**

**These 10 change components are intended to support enhanced safety and improved patient care for managing non-cancer chronic pain in the primary care setting.**

For the purposes of this Change Package, chronic pain is defined as "an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage." – *International Association for the Study of Pain (IASP)*

## Component 1: Leadership and Culture of Safety

1. Demonstrated Leadership – Build a culture of safety and use evidence-based practices in the management of chronic pain
    a. Formally adopt and commit to implement the Chronic Pain Management Change Package elements
    b. Provide ongoing education and support to appropriate care team members
2. Setting Standards for Care – Establish and maintain structures that support accountability and consistency with applying practice policy
    a. Practice has written policies & procedures to ensure compliance with Board of Licensure in Medicine (BOLIM) Chapter 21 Regulations[1] - i.e.
        a. Patient evaluation documented in medical record
        b. Documented treatment plan
        c. Informed consent & patient agreement that includes
            1. Urine/serum medication levels screening when requested;
            2. Pill count when requested;
            3. Number and frequency of all prescription refills;
            4. Reasons for which drug therapy may be discontinued (e.g., violation of agreement).
            5. Periodic review of PMP
        d. Opioid prescribing evidence-based guidelines (periodic review of treatment efficacy)

## Component 2: Team-based Approach to Care

1. Implement a team-based approach to care delivery that includes expanded roles of non-physician providers and staff (e.g. nurse practitioners, physician assistants, nurses, medical assistants) to improve clinical workflows. All members of the team can identify their specific role and responsibilities as well as the goals of the approach.

2. Provide education to team members on Chronic Pain Change Package and provide clear delegation of roles for team members.

[1] Chapter 21 PDF

3. Implement a proactive, pre-visit planning approach to patient visit and use of team – e.g.
    a. PMP review by providers & sub-users (RNs, MAs)
    b. Regular review and maintenance of patient-provider agreement
    c. Follow up to consultations

## Component 3: Risk Stratification & Population Management

1. The practice has a process in place for proactively identifying and stratifying patients across their population who are at risk for chronic pain and/or opioid misuse
    A. The practice makes special considerations with the following populations in both the management of chronic pain and opioid prescribing
        a. Pregnant women / prenatal care
        b. Adolescents and young adults (ages 12 – 18)
        c. Patients with trauma history
    B. Identify direct resources or care processes to help reduce risk and increase prevention
    C. Provide resources to patients

## Component 4: Comprehensive Assessment & Evaluation of Chronic Pain

1. Applying the Evidence - Adopt and systematically implement evidence-based guidelines for the evaluation of chronic pain
    a. Complete an assessment of daily living skills (ADLs) and functionality
    b. Complete an appropriate medical assessment of pain (including differential diagnosis/ assessment of trauma history)
    c. Review potential use of analgesics and pharmacological interventions, adverse drug effects and aberrant drug behaviors and addiction risk – e.g.
        i. Screener and Opioid Assessment for Patients with Pain (SOAPP)[2] - assessment tool for new patients; document risk of misuse or diversion
        ii. Opioid Risk Tool (ORT)[3] (for patients already using opioids)
        iii. Current Opioid Misuse Measure (COMM)[4] (for patients already using opioids)
        iv. D.I.R.E. score

## Component 5: Comprehensive Approach to Co-management of Chronic Pain

[2] SOAPP
[3] ORT
[4] COMM

**Appendix B**
**Maine Chronic Pain Collaborative**
**Chronic Pain Management**
**Change Package for Primary Care Practices**

1. Review treatment modalities, and consider use of complimentary therapies – e.g. behavioral health therapy, including cognitive behavioral therapy; physical therapy, occupational therapy, acupuncture, osteomanipulatory therapy, chiropractic therapy)
2. Develop care plan that outlines patient pain treatment agreement
3. Establish frequency of review based symptoms and response to therapy along with risk factors
4. Communicate and document what will happen if the co-management agreement is broken.

## Component 6: Mindful Approach to Initiating Opioids for Pain Control

1. Consider case review/ consultation with colleague or peer
2. Provide education to providers regarding appropriate use of opioids
3. Assess drug:drug interactions that have a significant impact on patient safety
4. Provide education for new patients on aspects of opioid use and risk (informed consent)*
5. Consider Appropriate populations to consider for use
   - Key points for providers to review
   - Risk addiction tools
   - Evidence-based guidelines
6. Use an evidence-based, patient centered approach when initiating opioid therapy

   A. When initiating opioid treatment with new patients, use limited trial of opioid use (2 week trial) and jointly agree to an explicit exit strategy

   B. Use a written informed consent that includes specific goals for treatment and parameters for the exit strategy

   C. Assess implications of watchful waiting or holding off ("what happens if I don't do anything?")

   D. Assess impact and behaviors around the prescription

## Component 7: Safety First with Patients Receiving Opioid Therapy

1. Come to an agreed upon/ commonly understood and applied definition of Opioid Therapy (long term)
   a. Defined as: Patient using *any* dose of opioid on a daily basis (including Tramadol) by patient report or refill history (pharmacy report)
2. Assess drug:drug interactions that have a significant impact on patient safety
3. Use an evidence-based approach to
   a. Calculate morphine equivalent daily dose/dosage ceilings using a dosage table[5]

[5] AMDG Dosing Guidelines

i. Equal or more than 100 mg daily dose engage the patient in a plan to taper to a safe dose[6][7] and assess whether the patient has reasonable indications for opiate use and evaluate contraindications
ii. Less than 100 mg daily assess whether the patient has reasonable indications for opiate use and evaluate contraindications.

## Component 8: Inclusion of Patients & Families

1. Engage patients and care givers as part the comprehensive approach to managing chronic pain
    a. Support patient & care givers to assess patient functionality
    b. Provide information and effective education tools to enhance patient and care giver understanding of chronic pain (alternative modalities)
    c. Use informed consent to discuss impact of treatment[8]
2. Assess risk of the family unit
    a. With the assistance of CPC Staff, consultants and partners, practice participates in identifying tools and resources to assess family risk.

## Component 9: Integration of Community & Clinical Resources

1. Connect with other members of the medical neighborhood to promote effective chronic pain management & safe prescribing
    a. Connect with ED and specialists to coordinate prescribing
    b. Connect with specialists to coordinate timely receipt of alternative therapies (physical therapy, occupational therapy, acupuncture, osteomanipulatory therapy [OMT], massage therapy)
    c. Connect with community-based organizations and programs (HMPs, AAAs, Chronic Pain Self Management Program)
    d. Connect with addiction services to establish timely referral and follow up process
    e. Appropriately use Maine Diversion Alert Program (DAP)[9]
    f. Establish connection with law enforcement resources (drug collection, lock boxes, etc.)

## Component 10: Optimal Use of Health Information Technology to Support Effective Chronic Pain Management & Safe Prescribing

---

[6] Washington State Taper Calculator
[7] REMS Education
[8] Informed Consent Example
[9] Maine Diversion Alert Program

## Appendix B
## Maine Chronic Pain Collaborative
## Chronic Pain Management
## Change Package for Primary Care Practices

1. Develop or ensure basic reporting and tracking capacity to identify and track patients w/ Chronic Pain (registry functionality)
2. Embed clinical decision support tools –e.g.
    a. Dose calculator
    b. Risk assessment
    c. Identification & tracking functions (automated follow up)
    d. Tapering calculator
3. Link EMR to Maine Prescription Monitoring Program[10]

[10] Maine Prescription Monitoring Program

**Appendix C**
**Maine Quality Counts: Improving Chronic Pain Management with Interprofessional Teams: The Maine Chronic Pain Collaborative 2**

**SECTION 6: MAINE CHRONIC PAIN COLLABORATIVE 1: WORKPLAN & DELIVERABLES SCHEDULE**

**GOALS:** The primary goals of the second round of the Maine Chronic Pain Collaborative (ME CPC2) are to provide support to 15-20 primary care practice teams across Maine to improve the "Triple Aim" outcomes for patients with chronic pain – i.e. to improve the clinical outcomes and enhance quality of life for patients with chronic pain, and ensure value in health care delivery through team-based care, specifically by building provider knowledge and skills and helping primary care practice teams deliver improved interprofessional team-based, patient-centered, collaborative care. We will achieve these goals by working with primary care practice teams committed to improving chronic pain management, and bringing together a powerful partnership of organizations experienced in interdisciplinary and interprofessional education, chronic pain management, quality improvement, and system change.

**Project Planning & Launch**

| Strategies & Action Steps | Deliverables | Timeline |
|---|---|---|
| 1. Develop project plan and educational content & plan; recruit and select practices for participation in ME CPC2 | | |
| a. Convene expanded ME Chronic Pain Leadership Group to review ME CPC key change package for comprehensive management of chronic pain & advise on development of educational plan | • Group meets & reviews Maine CPC key change package for comprehensive chronic pain management, advising on updates as needed | 1/15 - 1/31/15 |
| b. Develop application for practice sites | • Finalized ME CPC2 key change package<br>• Practice application posted | 1/31/15<br>2/1/15 |
| c. Launch application, communicating opportunity broadly to primary care practices in Maine | • Practices selected for participation | 3/1/15 |
| d. Convene Leadership Grp/Subgrp to define educational plan, select practices | • Memoranda of Agreement obtained | 3/31/15 |
| e. Confirm practice participation | • Educational and evaluation plan finalized | 3/31/15 |
| f. Finalize ME CPC2 educational plan | | |
| g. Draft evaluation plan and timeline, data collection and analyses models | | |

**Appendix C**
**Maine Quality Counts: Improving Chronic Pain Management with Interprofessional Teams: The Maine Chronic Pain Collaborative 2**

| **Objective 1 (continued): Improve provider confidence, competence, knowledge and skills to manage chronic pain using interdisciplinary and interprofessional educational activities:** | | |
|---|---|---|
| **Strategies & Action Steps** | **Deliverables** | **Timeline** |
| 1.1 Engage ME CPC2 providers in Project ECHO for Chronic Pain Management<br>a. Identify providers and other members of practice teams from each site to participate in Project ECHO Pain, convened by Community Health Center (CHC)<br>b. Conduct Project ECHO Pain sessions bi-monthly to provide participating practice sites with support and education from multi-disciplinary chronic pain specialist expert team and members of UNE faculty team; conduct video case conferencing sessions | • At least one providers and additional member of each CPC2 practice team identified from each site to participate in Project ECHO Pain<br>• Participating practice sites participate in bi-monthly ECHO Pain sessions | 4/1/15<br><br>Bi-monthly beginning 4/1/15 |
| 1.2 Spread provider interdisciplinary and interprofessional education and skills training by creating enduring web-based resources<br>a. Identify and assemble web-based resources for providers – i.e. recordings of previous ME CPC1 Project ECHO Pain sessions, Learning Session presentations, and webinars<br>b. Communicate these resources to CPC2 practice teams; support development of systems, workflows to promote their use with other members of practice team<br>c. Identify system for continually adding to and expanding these resources | • Web-based resources made available for ME CPC2 providers<br>• Ongoing communications send to CPC2 practice teams highlighting web-based resources<br>• Systems, workflows developed with CPC2 teams to promote their use with other members of practice team<br>• Web resources continually expanded | 3/1/15<br><br>4/1/15<br><br>5/1/15<br><br>Throughout project duration |

**Appendix C**
**Maine Quality Counts: Improving Chronic Pain Management with Interprofessional Teams: The Maine Chronic Pain Collaborative 2**

| Strategies & Action Steps | Deliverables | Timeline |
|---|---|---|
| 1.3 Provide support to ME CPC2 providers through Physician Peer Leaders<br>a. Confirm participation, finalize contracts with three Physician Peer Leaders<br>b. Identify, confirm practice assignments for each Physician Peer Leader<br>c. Physician Peer Leaders conduct ongoing check-ins with CPC2 practice provider leaders (minimum of monthly) | • Contracts finalized with three Physician Peer Leaders<br>• Practice assignments identified for each Physician Peer Leader<br>• Physician Peer Leaders conduct regular check-ins with CPC2 practice provider leaders (minimum of monthly) | 1/31/15<br><br>3/31/15<br><br>Beginning 4/1/15, at least monthly throughout project duration |
| **Objective 2 : Improve systems of care and the capacity of primary care practice teams to manage chronic pain** | | |
| **Strategies & Action Steps** | **Deliverables** | **Timeline** |
| 2.1 Offer structured system of collaborative learning – i.e. sponsor Maine Chronic Pain Collaborative 2 (ME CPC2)<br>a. Develop educational plan and content for ME CPC2, to include three day-long Learning Sessions and monthly webinars<br>b. Conduct Learning Sessions, webinars, and between-session outreach to CPC2 practices | • Educational plan and content finalized for ME CPC2, to include three day-long Learning Sessions and monthly webinars<br>• ME CPC2 Learning Sessions held<br>• ME CPC 2 monthly webinars held | 4/1/15<br><br>Learning Session dates TBD (likely May 2015; fall 2015; and May 2016) |
| 2.2 Support practice teams in implementing team-based, multidisciplinary systems change using a quality improvement approach and a set of standardized key changes for chronic pain management:<br>a. Identify specific decision-support tools that support ME CPC2 key change package<br>b. Develop clinical information systems for monitoring reliable use<br>c. Assist practices with developing plan to build EHR workflows that support the ability to | • Project team introduces ME CPC2 key changes and provides practice teams with written materials and tools; conducts site visits; and hosts regular conference calls with teams to offer education and promote adherence to best practice guidelines<br>• Standard screening tools made available for use in participating site workflows – e.g. SOAPP; ORT; dose and taper calculators<br>• Sites use team-based workflows and system for monitoring reliable use and adherence to key | 4/1/15 and through ME CPC2 duration – i.e. 4/1/15 – 5/31/16 |

| | | |
|---|---|---|
| routinely track and provide reporting to support quality of care for chronic pain management and safe opioid prescribing | change guidelines, including ad hoc chart reviews and staff interviews regarding adherence to internal policies<br>• Plan developed to implement EHR reporting to collect real-time data and provide data feedback to providers | <br><br><br>9/1/15 |
| 2.3 Provide practice teams with evidence-based interprofessional trainings<br>a. Conduct Interprofessional Collaborative Practice (IPCP) trainings<br>i. Build IPCP trainings into ME CPC2 Learning Collaborative educational plan, including plan for holding trainings during Learning Sessions<br>ii. Conduct trainings<br>b. Conduct TeamSTEPPS for primary care trainings<br>i. Develop plan for offering TeamSTEPPS training for ME CPC2 practice teams using AHRQ TeamSTEPPS for primary care<br>ii. Conduct TeamSTEPPS trainings | • Plan for conducting IPCP trainings developed<br>• Training sessions with ME CPC2 practice teams conducted during Learning Sessions<br>• Plan for conducting TeamSTEPPS trainings developed<br>• TeamSTEPPS training sessions with ME CPC2 practice teams conducted | 3/31/15<br>Ongoing during ME CPC2 Learning Sessions<br>3/31/15<br>10/31/15 |
| **Objective 3: Build compassion and empathy for treating chronic pain by strengthen patient-provider partnerships:** | | |
| **Strategies & Action Steps** | **Deliverables** | Timeline |
| 3.1 Incorporate patient voice using narratives using UNE Portraits of Pain web-based narratives<br>a. Create plan for incorporating patient narratives into ME CPC2 educational curriculum & Learning Collaborative structure<br>b. Regularly offer patient voice as part of CPC2 | • Plan developed<br>• Portraits of Pain patient narratives shared with ME CPC2 practice teams | 5/1/15<br>6/1/15 and periodically for CPC2 duration |

**Appendix C**
**Maine Quality Counts: Improving Chronic Pain Management with Interprofessional Teams: The Maine Chronic Pain Collaborative 2**

| | | |
|---|---|---|
| 3.2 Offer Choosing Wisely decision aids that promote the patient-provider partnership<br>a. Identify appropriate Choosing Wisely decision support tools for chronic pain and create plan for incorporating these into ME CPC2 educational curriculum & Learning Collaborative structure<br>b. Assist practice teams with incorporating Choosing Wisely decision aids into practice workflows | • Plan developed<br><br>• Choosing Wisely decision aids for chronic pain incorporated ME CPC2 practice team workflows | 5/1/15<br><br>9/1/15 |
| 3.2 Provide enduring resources for interprofessional trainings that support patient-and family-centered care<br>a. Identify and assemble web-based resources for practice teams – i.e.Portaits of Pain, UNE IPCP "COMPTime" training modules, etc<br>b. Communicate these resources to CPC2 practice teams; support development of systems, workflows to promote their use with other members of practice team<br>c. Identify system for continually adding to and expanding these resources | • Web-based resources made available for ME CPC2 providers<br>• Ongoing communications send to CPC2 practice teams highlighting web-based resources<br>• Systems, workflows developed with CPC2 teams to promote their use with other members of practice team<br>• Web resources continually expanded | 3/1/15<br>4/1/15<br>5/1/15<br>Throughout project duration |
| **Objective 4: Evaluate impact of interventions** | | |
| **Action Steps** | **Deliverables** | Timeline |
| 4.1 Identify control group of non-participating primary care practices in Maine<br>4.2 Create and/or adapt data collection tools:<br>• EHR data retrieval queries<br>• Chart review protocols | • Identification control/comparison group cohort<br><br>• Templates for data collection tools identified | 3/31/15<br><br>4/1/15 |

**Appendix C**
**Maine Quality Counts: Improving Chronic Pain Management with Interprofessional Teams: The Maine Chronic Pain Collaborative 2**

| | | |
|---|---|---|
| • Survey instruments<br>• Interview scripts<br>4.3 Collect baseline data from participating practice and control sites<br>4.4 Evaluate participation<br>i. Collect ongoing data on participation in ECHO Pain sessions and ME CPC2 Learning Sessions<br>ii. Assess data collected on ECHO Pain sessions and Collaborative sessions<br>4.5 Collect post-intervention data<br>4.6 Analyze all gathered data to determine effectiveness of intervention | • Baseline data collected from ME CPC2 sites and control sites<br>• Report summarizing ECHO Pain session and Collaborative Learning Session data<br>• Assess data collected on ECHO Pain sessions and Collaborative sessions<br>• Post-intervention data collected<br>• Report summarizing post-intervention data and project outcomes | 6/30/15<br>Bi-monthly for ECHO sessions<br>Monthly/quarterly for Collaborative activities (4/1/15-5/31/16)<br>6/1/16 – 8/31/16<br>9/2016 |

October 18, 2014

To: Consortium for Education and Research in Chronic Pain

On behalf of **Maine Quality Counts**, I am pleased to submit our proposal "Improving Chronic Pain Management with Interprofessional Teams: The Maine Chronic Pain Collaborative 2". We recognize the tremendous need for action to address the growing challenges of chronic pain management, and applaud Pfizer and the Consortium for taking on this critically important issue, particularly in the setting of primary care.

Our effort will build upon our successful track record of supporting primary care practice transformation and implementing provider educational and QI strategies including leading the Maine Chronic Pain Collaborative. We will partner with experienced faculty at the University of New England (UNE) and leverage their experience with interprofessional education and pain management to improve the care practices are delivering to patients with chronic pain.

I will serve as the principal contact person for the proposal and will serve as the Project Director and Principal Co-Investigator for this initiative, along with Dr. Dora Anne Mills, VP for Community Health at UNE, and Dr. Noah Nesin, Chief Medical Officer at Penobscot Community Health Care and current Co-PI on the Maine Chronic Pain Collaborative.

Additionally, Maine Quality Counts (QC) will serve as the lead organization for administering the grant, including convening project partners and leading quality improvement efforts with participating practices. Other QC key/senior staff include Lisa Tuttle MPH, Program Director for Practice transformation, and Michele Gilliam who will serve project manager. QC has extensive experience managing complex, multi-stakeholder processes and has the organizational capacity, experience, relationships needed to successfully lead and support this initiative.

We appreciate the opportunity to submit this proposal for your consideration, and look forward to working with our project partners to improve the health and outcomes for patients. Please contact me directly if there are questions or concerns, lletourneau@mainequalitycounts.org, or tel. 207.415.4043.

Sincerely,

L Letourneau MD

Lisa Letourneau, MD, MPH, FACP
Executive Director

UNIVERSITY OF NEW ENGLAND

**Dora Anne Mills, MD, MPH, FAAP**
Vice President for Clinical Affairs

**Portland Campus**
716 Stevens Avenue
Portland, ME 04103
(207) 221-4621 T
(207) 523-1930 F

October 20, 2014

Lisa M. Letourneau MD, MPH
Executive Director
Maine Quality Counts
16 Association Dr., PO Box 190
Manchester, ME 04351

Dear Dr. Letourneau,

The University of New England (UNE) is pleased to provide this letter of commitment for Maine Quality Count's proposal, "Improving Chronic Pain Management with Interprofessional Teams:The Maine Chronic Pain Collaborative 2". We recognize the enormous challenges faced by primary care practices in safely managing chronic pain, and believe that this proposal to engage interdisciplinary and interprofessional teams in improving care provides a critically important opportunity to not only improve care, but to identify best practices for other learners and providers to address this challenge. We are fully committed to providing our expertise, knowledge, and resource to partner with Maine Quality Counts on this important effort.

UNE is a comprehensive health sciences university located in Maine and is the largest educator of Maine healthcare professionals, emphasizing the primary care fields and conferring 13 health professional degrees. UNE is an excellent partner for this project given our expertise in interprofessional education (IPE) and interprofessional collaborative practice (IPCP). UNE faculty have experience with IPE and IPCP education in both classroom and clinical settings. Faculty from UNE's Center of Excellence in IPE are well published on the field and recognized with multiple invited presentations at international conferences and grant awards.

UNE also has extensive expertise in pain treatment: its Center of Biomedical Research Excellence for the Study of Pain and Sensory Function has secured over $10M in federal funding and attracted faculty from across its colleges with expertise in the neurobiology of pain and pain management. Additionally, UNE is well versed in online education and technology to further health professions education. Approximately one-third of its students obtain accredited online health-related degrees, including a master of public health (MPH) and a master of social work (MSW). UNE's robust investment in multimedia technology, including instructional designers, makes it an ideal partner for developing sustainable educational resources.

As a key partner in this effort, if funded, we have committed to bringing a set of resources and supports, including (1) commitment of my time, along with at least four additional faculty with expertise in interprofessional practice, to deliver IPCP education and training to participating practice teams: (2) commitment of time from a set of interprofessional clinical faculty and pain experts (i.e. Pharmacy, Occupational Therapy, Physical Therapy, Nurse Anesthesia, and Social Work) to serve as faculty and clinical experts for practice teams and participating in the Maine Chronic Pain Collaborative Learning Collaborative; and (3) commitment of resources to support the development of enduring resources to promote the patient perspective in improving chronic pain management,

including the online "Portraits of Pain" video testimonials that can provide new insights to providers and to teach skills for listening and communicating effectively.

We look forward to collaborating with on this important initiative, and working together to improve chronic pain management in primary care.

Sincerely,

Dora Anne Mills MD, MPH, FAAP
Vice President for Clinical Affairs

**Administrative:**
635 Main Street
Middletown, CT 06457
860.347.6971

**Locations:**

**CHC of Bristol**
395 North Main Street
Bristol, CT 06010
860.585.5000

**CHC of Clinton**
114 East Main Street
Clinton, CT 06413
860.664.0787

**CHC of Danbury**
8 Delay Street
Danbury, CT 06810
203.797.8330

**CHC of Enfield**
5 North Main Street
Enfield, CT 06082
860.253.9024

**CHC of Groton**
481 Gold Star Highway
Groton, CT 06340
860.446.8858

**CHC of Meriden**
134 State Street
Meriden, CT 06450
203.237.2229

**CHC of Middletown**
675 Main Street
Middletown, CT 06457
860.347.6971

**CHC of New Britain**
85 Lafayette Street
New Britain, CT 06051
860.224.3642

**CHC of New London**
One Shaw's Cove
New London, CT 06320
860.447.8304

**CHC of Old Saybrook**
263 Main Street
Old Saybrook, CT 06475
860.388.4433

**CHC of Waterbury**
51 North Elm Street
Waterbury, CT 06702
203.574.4000

**Day Street CHC**
49 Day Street
Norwalk, CT 06854
203.854.9292

**Franklin Street CHC**
141 Franklin Street
Stamford, CT 06901
203.969.0802

**www.chc1.com**
**Facebook/CHCInc**
**Twitter(@CHCConnecticut)**



Where health care is a right, not a privilege, since 1972
Community Health Center, Inc.

Lisa Letourneau, MD, MPH
Executive Director
Maine Quality Counts
6 Association Dr.
PO Box 190
Manchester, ME 04351

October 17, 2014

Dear Dr. Letourneau,

The Weitzman Institute and the Community Health Center, Inc. (CHCI) are pleased to offer support to Maine Quality Counts to ensure that the required resources are available to carry out your proposal, "**Improving Chronic Pain Management with Interdisciplinary Teams**".

The Weitzman Institute (WI) is the research and quality improvement arm of Community Health Center, Inc. (CHCI), one of the nation's largest and most innovative Federally Qualified Health Centers (FQHCs). CHCI is a NCO, a Certified Level 3 Patient-Centered Medical Home as well as a Joint Commission Certified Primary Care Medical Home serving 130,000 patients. WI is a unique organization embedded in an FQHC, dedicated to reducing health disparities and improving the primary care delivery system through research and application of formal quality improvement methods. Our institute promotes critical investigation in a wide range of areas, with emphasis on system redesign, innovation and technology to improve care delivery. In addition, we offer training and support for health centers interested in adopting formal quality improvement methods in their own setting.

WI has extensive experience managing projects, conducting scientific evaluations and operating Project ECHO. Currently we are conducting a controlled trial of Project ECHO for Pain Management which aims to measure the effect of the intervention on knowledge, competence and self-efficacy of the primary care providers of two community health centers. In addition, we have conducted multiple research projects focused specifically on chronic pain management, including developing and validating an algorithm which identifies patients with chronic pain from the EHR and implementing and studying the VA's Stepped Care Model for Pain Management in a community health center. WI has been operating Project ECHO Pain Management for two years and is the only FQHC that has replicated the Project ECHO Model.

Weitzman Institute is pleased to work with Maine Quality Counts to build the capacity of interdisciplinary primary care teams and their community partners to improve the care of patients with chronic pain. For this project, WI will provide staff and expertise to conduct a comprehensive evaluation that will include provider, patient, and operational outcomes designed to measure interdisciplinary and interprofessional collaboration. WI staff will provide consultation and guidance regarding study design, outcome measures, and data collection. In addition, WI will provide access to its two hour weekly Project ECHO for Chronic Pain Management sessions, which will enable interdisciplinary teams of providers from participating sites access to a forum for specialty consultation with

**Administrative:**
635 Main Street
Middletown, CT 06457
860.347.6971

**Locations:**

**CHC of Bristol**
395 North Main Street
Bristol, CT 06010
860.585.5000

**CHC of Clinton**
114 East Main Street
Clinton, CT 06413
860.664.0787

**CHC of Danbury**
8 Delay Street
Danbury, CT 06810
203.797.8330

**CHC of Enfield**
5 North Main Street
Enfield, CT 06082
860.253.9024

**CHC of Groton**
481 Gold Star Highway
Groton, CT 06340
860.446.8858

**CHC of Meriden**
134 State Street
Meriden, CT 06450
203.237.2229

**CHC of Middletown**
675 Main Street
Middletown, CT 06457
860.347.6971

**CHC of New Britain**
85 Lafayette Street
New Britain, CT 06051
860.224.3642

**CHC of New London**
One Shaw's Cove
New London, CT 06320
860.447.8304

**CHC of Old Saybrook**
263 Main Street
Old Saybrook, CT 06475
860.388.4433

**CHC of Waterbury**
51 North Elm Street
Waterbury, CT 06702
203.574.4000

**Day Street CHC**
49 Day Street
Norwalk, CT 06854
203.854.9292

**Franklin Street CHC**
141 Franklin Street
Stamford, CT 06901
203.969.0802

**www.chc1.com**
**Facebook/CHCInc**
**Twitter|@CHCConnecticut)**

Where health care is a right, not a privilege, since 1972
Community Health Center, Inc.

a multidisciplinary team of pain management specialists. We will oversee all administrative components of Project ECHO and will provide all participants with access to the Project ECHO website and all recorded sessions.

WI is excited to support the planned project, which will help promote best practices for pain care by combining process improvement work and evidence-based medicine with pain consultation via Project ECHO. Given our past research in the field of chronic pain, we have no doubt that this multifaceted intervention will help promote evidence-based and patient-centered pain care. We need programs such as the one you have proposed to create substantial and long terms changes to the healthcare system. We will provide whatever organizational support you require in order to carry out the activities described in the proposal.

Please contact me at 860-347-6971 x 3740 with any questions,

Sincerely,

Daren Anderson, MD
Chief Quality Officer/VP
Director, Weitzman Quality Institute
Community Health Center, Inc.
AndersD@chcl.com