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Promising Practices for Supporting Dually Eligible Older Adults with Complex Pain Needs

Operator: Ladies and gentlemen, thank you for standing by. Welcome to the Promising Practices for Supporting Dually Eligible Older Adults with Complex Pain Needs Conference Call. At this time, all participants are in a listen-only mode. If you should require assistance during the call, please press star and then 0. I would now like to turn the conference to your host, Kristin Corcoran. Please go ahead.

Kristin Corcoran: Thank you. My name is Kristin Corcoran and I'm with the Lewin Group. Welcome to today's webinar on meeting the needs of dually eligible older adults with complex pain needs. Next slide. Today's session will include 60 minutes presenter-led discussions followed up with 30 minutes for question and answer among the presenters and participants. This session will be recorded.

A video replay and a copy of today's slide will be available at resourcesforintegratedcare.com. A link to the website is provided at the bottom right of each slide.

The audio portion of the presentation will automatically stream through your computer. Phone lines for this presentation are also available. To access that number, you can click the black phone widget at the bottom of your screen.

Should you have any questions now or throughout the presentation, please feel free to enter them into the Q&A feature on the platform. We will be addressing your questions for our speakers at the end of the webinar. Next slide.

Continuing Medical Education and Continuing Education Credits are available at no additional costs of participant. The Lewin Group is accredited by NASW to provide continuing education for social workers. CMS is accredited by IACET to issue CEUs and also accredited by ACCME to issue CMEs. We strongly encourage you to check with your specific regulatory board or other agencies to confirm that courses taken from these accrediting bodies will be accepted by that entity. Next slide.

You'll see on this slide that we've laid out the various credit options. If you're a social worker, you can obtain Continuing Education Credits through NASW if you complete the pre-test at the beginning of the webinar and complete the post-test at the end. CMS is also offering CEUs and CMEs for other individuals looking to obtain credit for attending this webinar.

To obtain these credits, you must complete the post-test through CMS' Learning Management System. Additional guidance about obtaining credits and accessing the links to the pre-test and post-test can be found within the Continuing Education Credit Guide in the Resource List on the left side of your screen or at the Resources for Integrated Care website. Next slide.

This webinar is supported through the Medicare-Medicaid Coordination Office or MMCO at the Centers for Medicare & Medicaid Services. MMCO is developing technical assistance and actionable tools based on successful innovations and care models such as this webinar series.

To learn more about current efforts and resources, please visit our website or follow up on Twitter for more details at Integrate_Care. Next slide.

At this time, I'd like to introduce our speakers. Our first speaker, Dr. Beth Darnall, is an Associate Professor at Stanford University School of Medicine. Our second speaker, Katrina Profitt, is a Clinical Liaison at Aetna Better Health of Ohio. Melissa Myers is a Behavioral Health Care Manager at Inland Empire Health Plan. And Randy is a consumer who will talk about his lived experience complex pain. Next slide.

On this slide, you will see our learning objectives for today's webinar. We hope that you will learn about common causes and types of pain among dually eligible older adults, be able to recognize effective strategies and approaches for assessing older adults' pain management needs, recognize how to provide tailored pain management including appropriate opioid use and complementary and integrative care, and identifying new opportunities for collaboration. Next slide.

We are going to start today's webinar with a few poll questions, then we will move into the presenter-led discussions, followed by Q&A, and evaluation questions at the end of the webinar. Now, we will move into the poll questions.

Our first question is -- in what setting do you work? All right, I'm thinking about 10 or 15 seconds. Oh, here we go. All right. So it looks like almost 3-quarters of our attendees work in a health plan setting. Thank you.

Our second question is -- which of the following best describes your professional area? All right, I think we can move to the results now. And almost half of our participants work as a health plan case manager or a care coordinator and about 10% work as a medicine/nursing/physician assistant or other provider. Thank you.

Thank for everyone's participation on the poll. So I will now turn it over to Dr. Darnall.

Beth Darnall: Thank you, Kristin. Next slide, please.

So the experience of pain is prevalent among older adults, with roughly 40% of those age 65 or greater reporting chronic pain; 15% have high-impact chronic pain. And we define this as pain that limits life or work activities on most days for the previous six months. Among adults who are dually eligible for both Medicare and Medicaid, they report having higher rates of chronic pain as well as higher rates of high-impact chronic pain than adults who receive other types of insurance coverage and the pain that they experience is more frequent and more severe and more impactful.

So pain, again, a very big problem in this patient population and the negative effects of chronic pain are not just the physical and emotional suffering that they experience, but they also disrupt family and social relationships. Next slide, please.

So among dually eligible older adults who have chronic pain, they're also at risk for poor outcomes and also poor response to pain interventions that we try to treat their pain. They tend to have greater pain intensity, pain of longer duration, what we call overlapping pain conditions or experiencing pain in multiple bodily sites. They're more likely to be prescribed opioids and to have polypharmacy -- multiple drugs -- being prescribed to treat their pain. They have greater functional impairments, more likely to have depression, anxiety, or other psychological comorbidities, and to have limited social supports, and also mobility challenges. Next slide, please.

Common causes of pain include a variety of reasons. This can be -- increased prevalence can be due to chronic disease, injuries, other pain syndromes, and cancer for instance. Common causes include injuries from falls, with falls and fractures being the number one reason that older adults visit the emergency department, surgeries such as joint replacements, and painful medical conditions like diabetic neuropathy.

So geriatric pain assessments should include an assessment of the cause of pain, as that will inform the appropriate treatment pathway. And later on in my presentation, I'll discuss assessments. Next slide, please.

Common types of pain that are frequently experienced in older adults include nociceptive pain, pain caused by body tissue or damage such as arthritis, low back pain, or fractures. Neuropathic pain that is caused by nerve damage. Examples include diabetic neuropathy, shingles, or even certain types of back pain. And mixed and undetermined pain types. Examples include cancer, fibromyalgia, depression, or also just pain of unknown etiology.

Pain that is untreated is more likely to have detrimental consequences, like functional decline, incapacitation, and frailty. Treatments should be tailored to the type of the pain. So for instance, opioids should generally be avoided for migraine headaches. This is one example. Next slide, please.

A biomedical approach to pain treatment focuses on external solutions and medication, while a biopsychosocial approach helps older adults understand what they can do to keep their pain under better control and can minimize use of medications and medical treatments. So helping activate your patients' inner pain care process is one of the most important roles you can play. Opioids may be an important part of some individuals' pain care plans, but opioids are just one tool in the toolbox. And I'll be discussing a range of additional treatments in my presentation. Next slide, please.

In terms of opioid use, these data from 2015 wherein about 1 in 5 older adults were prescribed at least one opioid prescription in the course of a year. And over on the right-

hand of this side of the slide, you see that overall, 7% of older adults filled 4 or more opioid prescriptions over the course of a year, with older adults with lower incomes, being more likely to be prescribed opioids. Next slide, please.

Now, there are advantages and disadvantages of opioid prescribing among older adults. Advantages include reduced pain for some people. They can be an essential part of a comprehensive care plan for some people when used along with self-management strategies, movement therapies, and other types of treatments. For some people, opioids may support increased function, but this varies by the individual and should be monitored.

Disadvantages include an array of negative side effects, such as memory and cognitive effects for some people, increased risk for falls and fractures, especially among those with cognitive impairment or those who are medically frail. Some individuals may find opioids highly rewarding which can cause depressed mood, passivity, and there is risk for addiction. Accidental overdose, sleep apnea, and respiratory depression are additional risks. Higher opioid doses increase all of the health risks described above. And then lastly, constipation and confusion are typical and common symptoms and side effects described by people taking opioids. Next slide, please.

So key considerations. Opioids should really be avoided as a first line analgesic for chronic pain. It shouldn't be the first line pain reliever, but they can be appropriate for some patients especially within the context of acute pain. Opioid stigma is common. So you may not be a prescriber, but you can play an important role in normalizing older adults' fears and concerns and provide non-judgmental support if they do need and use opioid medication. Person-centeredness is key, so tailoring a care plan based on the individual factors is critical. Next slide, please.

Always offer local behavioral treatments when available. So providing education and self-management, even when medications are prescribed. So these can include online, print and behavioral resources. You can reference in tip sheets that accompany this webinar.

The main point is to avoid binary thinking that it's either medications or behavioral treatment. It's actually both. We want to be aware that opioid guidelines and policies typically do not take individual needs into account. Some patients have been enduring forced opioid tapering or have decreased access to the pain medications that they need. This can occur at the point of the pharmacy.

Many older adults fear losing access to the medications and do not have effective alternatives. So be aware of this fear, provide compassionate support and also be aware that this decreased access to medications may drive illicit use, so you want to monitor your patients closely. Next slide, please.

Opioid tapering is the slow, reduced use of opioids over time or what we call opioid de-prescribing. Now opioid de-prescribing to a pre-set dose is not supported by the CDC and

we really want to take an individual approach to de-prescribing in cases where that's appropriate.

Forced opioid de-prescribing should always be avoided whenever possible. Opioid de-prescribing or tapering should be done in partnership, so you work with older adults to gain their trust and their willingness to try a slow opioid taper.

During the process of opioid de-prescribing, monitor patients very closely for changes in pain, mood and distress. The point of an opioid taper is to help the patients have better pain care. If they are observed to be deteriorating, you want to consider altering the treatment course. And for more information, you have resources provided to you here. Next slide, please.

Now previously I described a biomedical treatment approach, and now I'd like to talk about the biopsychosocial treatment model for pain. Next slide, please.

So we want to be mindful that we're assessing the needs of the whole person. Pain is a multidimensional experience that's impacted by an array of factors including sleep, mood and activity. We want to use validated pain assessment tools based on the older person's ability to communicate, so their verbal capacities. We want to include assessments that are both self-report and also observational in nature.

Be mindful that, as older adults have cognitive impairment, you want to engage caregivers and family members to do this whole-person assessment. And assessment should be re-administered consistently over time. Next slide, please.

In addition to assessing pain intensity, it's important to assess various characteristics of a person's pain. So these are just some of those examples including pain location, quality, limitations and the types of treatments the patient has tried. Next slide, please.

Now it's common for individuals who are experiencing pain to also have cognitive and emotional distress about their pain. And this is important to assess and treat, because a person's mindset and their psychological disposition has a capacity to amplify their pain. We want to help our patients get to the point where they feel a greater degree of control and they have tools and skills that they can use to better control their own experience. Next slide, please.

Cognitive behavioral therapy is the gold standard biopsychosocial treatment for chronic pain. This is a treatment typically delivered by a psychologist that is skills-based and often may integrate family members and spouses in the process so that patients can learn information and ways to help themselves better manage their pain. Next slide, please.

So then the individual will have developed greater self-efficacy to control their own pain experience. Next slide.

Oh, here we go. Okay, so it's important to be mindful that a passive approach to pain care does not work well. So this is where self-management is vitally important. If behavioral support is not available to your patients, you are their actual point of support. So at each visit, plug your patients into various resources that they can use and then ask them how they're doing with self-management. Minimize the focus on medication during your medical visits and instead focus on helping the patient with -- access self-management resources.

Here, I provide the information about the American Chronic Pain Association, the Pain Toolkit and also low-cost and free evidence-based self-management program that you can integrate into the care of your patients. Next slide, please.

Finally, Empowered Relief is a single-session, two-hour behavioral medicine class that is scalable, accessible and low-cost. You can access information about this treatment at the website. This is a treatment that any healthcare clinician can become certified to provide to your patients in group format. So this is both efficient and you can treat many patients at one time. Longer-course behavioral treatments include eight-week Cognitive Behavioral Therapy or the Chronic Pain Self-Management Program at this link. You may find that the Chronic Pain Self-Management Program is offered free of charge in various municipalities. So check your local resources. Next slide, please.

So we recommend inclusion of movement therapies, walking, gentle yoga and you may also choose to host a free American Chronic Pain peer support group in your clinic or healthcare organization with information here on how you can access that. Lastly, screen and monitor your patients for depression, as this can impede engagement in pain self-management. Next slide, please.

In terms of non-pharmacological pain management, first determine the cause of pain, focus on non-pharmacological pain management strategies and lifestyle interventions wherever possible. These can include ergonomics, adjustment in sensory stimuli, lifestyle techniques and relaxation techniques to better manage pain. Next slide.

And in terms of pharmacologic pain management, discuss with the older patients any concerns that they may have about using pain medications. Ensure that your patients understand what adverse effects may occur and have a plan to address them. Establish a process for discussing adverse effects and managing those. Encourage and provide access to behavioral treatments to avoid medication becoming the only pain relief strategy that your patients are using. And in terms of medications, always start low and go slow. If treatment goals are not met, advancing the dose is reasonable before trying another intervention. Next slide.

Finally, these key takeaways, asses the whole person and consider all biopsychosocial factors when conducting geriatric pain assessments. Account for the pain type and cause when identifying treatments. Provide patients education in local and online resources for self-management of pain and symptoms and provide this at the outset of care.

Screen for depression and refer when appropriate, as this can impede engagement in pain self-management. Encourage older adults to access these complementary approaches, which are really primary treatments for pain. Always start low and go slow when using pain medications and prescribing pain medications. And since opioids are likely to be prescribed in dually eligible older adults, be aware of the risks and benefits to select patients, monitor carefully and always employ an integrated approach to pain relief beyond opioids. Next slide.

And with that, I'd like to turn over the webinar to Katrina Profitt.

Katrina Profitt: Thank you. Good afternoon everyone. Next slide, please.

Here's a quick overview of the topics I'm going to cover today. Next slide, please.

Here I've listed six components to a comprehensive pain assessment. We want to look at how these areas are impacted by the individual's pain, as well as learn more about their beliefs and coping styles and how these areas can be incorporated into helping us create treatments goals that will work best for the individual. Next slide.

First, let's look at sensory. Utilizing a pain scale or thermometer, helps the individual communicate how sever their pain is and we can link that to specific coping strategies. A majority of elderly persons have significant pain problems that are under treated. Detection and management of chronic pain remain inadequate.

In one study, 66% of geriatric nursing home residents had chronic pain but almost -- in half of those cases it was not detected by the treating physician and was therefore going untreated. So using a pain scale thermometer is an excellent way to help someone verbalize their pain so you have a better understanding. Next slide, please.

And now we look at emotional impact, what is the impact -- emotional impact the pain is having on the individual. Pain is a complex sensory and emotional experience. The psychological branch of pain also explains why some patients with minimal disease may have excruciating pain and others with very severe disease may have minimal complaints.

Depression and anxiety often accompany pain. So we want to be aware of this risk and provide support in managing depression and anxiety, with psychotherapy, meditation and medication when indicated. We also want to support our older adults in establishing a solid support system that includes relatives, friends or caregivers. This is particularly important among the older dually eligible beneficiaries who may not have as many natural supports. We need to ask them, are they neighbors, friends in their building, or in their faith communities, peer support groups, who's available to help. Next slide, please.

Functional impact. The person's level of functioning is important as it affects their degree of independence, level of need for caregivers, as well as the overall quality of life. Activities of daily living should be assessed directly. After a diagnosis is made, a

treatment plan should be outlined that includes modalities to decrease pain perception and increase the level of function.

Focus on supports that can be put in place to help, is there a home aid, a church friend that can make meals a couple times a week, a housekeeper. Trust that these are temporary to help alleviate the stress and pain the individual is feeling. Some folks are resistant to these types of interventions because they feel threatened by the loss of independence. So it's important to stress that this is a temporary strategy that may help. Next slide, please.

Sleep, we all know how important that is. Getting enough good quality sleep helps maintain brain health, physical health and mood. If an individual is having difficulty sleeping, it's important to make sure that untreated pain isn't contributing to the problem.

And when assessing how much sleep someone's getting, don't ask -- How many hours of sleep do you get per night? Because you're going to get a general, probably unspecific answer, that's not very helpful. So instead ask -- What time do you get in bed? What show is on when you tend to doze off in your chair? Do you fall asleep before dinner? Do you ever miss medications at night because you fall asleep? More specific questions that are going to give you better insight into their sleep. Next slide, please.

Attitudes and beliefs. Individuals can have different attitudes that affect their pain intensity and their outcomes. I recommend coping strategies such as relaxation, meditation, prayer, attention-diversion techniques are great ways to help alleviate pain. Developing an attention-diversion plan in advance so that they have it on hand when they need it is important.

Adjustments to socio-environmental variables can also help individuals cope with pain. Environmental and social enrichment lessens the feelings of pain. Also, mind-body practices like yoga and meditation are helpful as they have a protective effect on the brain. Next slide, please.

Coping strategies need to be sensitive to cultural and ethnic issues, as well as values and beliefs of the individuals and their families. Beliefs and coping styles are impacted by age, culture and family dynamics. I recommend asking a lot of questions to understand how their age, culture and family affect their coping style. Things you can say, I mean -- What works for you? Are there things that your family does that helps you feel better? Is there anything that your friend does that helps you when you're feeling down? Coping strategies might include but aren't limited to mindfulness skills training, chair yoga, Silver Sneakers, meditation, prayer, online chat and support groups. Next slide, please.

Polypharmacy is a common concern for the dually eligible older adults. The purpose of a polypharmacy review is to identify negative drug interactions, excessive medication or dosing problems. You want to share the polypharmacy review results with the prescribers and have a discussion about whether any medication adjustments are needed. Next slide.

A polypharmacy review should be done by the pharmacist and the primary care provider or the specialist, whoever is primarily treating and prescribing for the individual. This type of review captures pharmacy claims which show all medications being covered by insurance. A review only by the primary prescriber may lead to missed medications because other clinicians could be prescribing for the individual that their primary care provider isn't even aware of. And also, don't forget to ask about other over-the-counter supplements like herbs or oils and things that they're using. Next slide.

These are all different theoretical approaches available to treat pain and related psychiatric distress from pain. CBT and mindfulness are two interventions that I have found to be most effective for the older adult population in conjunction with psychiatric medication as needed. So we're going to take a look more closely at CBT and mindfulness. Next slide please.

As I've mentioned earlier, CBT is one of the best treatment modalities for chronic pain. Cognitive-behavioral therapy helps provide pain relief in a few ways. First, it changes the way people view their pain. CBT can change the thoughts, emotions, and behaviors related to pain, improve coping strategies and put the discomfort in a better context. You recognize that the pain interferes less with your quality of life and therefore, you can function better. CBT can also change the physical response in the brain that makes pain worse. Pain causes stress and stress affects pain control chemicals in the brain such as norepinephrine and serotonin. CBT reduces the arousal that impacts these chemicals. This in effect may make the body's natural pain response more powerful. This is not a technique that an untrained person can implement with someone but what's important to know is having the knowledge to ask about it. Ask about CBT as a treatment option for individual, you know, your family member, whoever you're working with and make a referral authenticated. Next slide please.

Mindfulness. This is kind of a hot topic a lot of you have probably heard about but I can't stress enough the importance of it. Mindfulness is the basic human ability to fully present -- to be fully present, aware of where we are, and what we're doing and not overly reactive or overwhelmed by what's going on around us. While mindfulness is something we all naturally possess, it's more readily available to us when we practice it on a daily basis. Whenever you bring awareness to what you're directly experiencing via your senses, your state of mind, via your thoughts and emotions, you're being mindful.

There's growing research that shows that when you train your brain to be mindful, you're actually remodeling the physical structure of your brain. The goal of mindfulness is to wake up to the inner workings of our mental, emotional, and physical processes which. in turn, improve our ability to cope with stress and pain. Mindfulness is easy to learn and can be as simple as deep breathing exercises and focusing on gratitude over pain. There are endless mindfulness strategies readily available online. There are also some great free apps for engaging in mindfulness exercises. Next slide please.

Substance use assessment and interventions. More than one million older adults have a substance use disorder in 2014. Opioid use disorder is a particular concern among the

dually eligible older adults with chronic pain. Tips for supporting older adults with these issues include validating their feelings and struggles, asking the right questions -- Have you ever taken more of your medication than is prescribed? When does that happen? What usually leads up to you needing a higher dose? Education. A lot of folks don't understand how they can manage their chronic pain without opioids or with fewer opioids or in conjunction with opioids by adding in extra modalities.

It's important to provide other treatment options when appropriate. When possible, group older adults into age-specific cohorts for support groups. In other words, if you're referring an older adult to an addiction support group, you need to make sure that demographic makeup of that group is one that they can relate to, because if they show up with a bunch of young kids, it's not going to work for them. So just be cognizant of that. Next slide please.

Self-management programs address physical, psychological, and social dimensions. They teach participants specific strategies to reduce pain by changing their behavioral, cognitive, emotional responses. For example, exercise interventions with chronic pain are evidence-based and underutilized, and should be a core component of most long-term treatment plans. Silver Sneakers and gym memberships are often offered by the health plans that are serving the dually eligible older adult population at no charge. So this is a great resource. Next slide please.

Linking to resources. Senior centers are amazing. This serve as a gateway to the nation's aging network. They connect our older adults to vital community services that can help them stay healthy and independent. They offer a wide variety of programs and services like meals and nutrition programs, transportation, social, recreational activities all in one location. So if you're looking for a senior center in your area, the Eldercare location link is listed in this slide and is a great resource. Next slide please.

I'm going to walk through a case example of a gentleman I'll call Fritz. A little background, he's a 77 year old dually eligible male. He has chronic spine and shoulder pain. He lives alone in an independent living complex. He has some area aging services in place. He has challenges with transportation and frequently misses his appointments. He has poor nutrition. He has substance use issues and behavioral health issues that are not being treated. And he has no natural support involved in his life at this point. Next slide.

Okay, there we go. All right. It took time to establish rapport and get Fritz to trust a professional. Originally, he would just -- wanted nothing to do with anybody but repeated outreach attempts finally kind of got there. He refused a full medical work-up and a formal geriatric pain assessment, but he was able to identify what was causing his pain and that alcohol was great at dulling it. Isolation and loneliness were key barriers to improving his quality of life. Polypharmacy reviews showed he was at risk for serious complications by mixing his pain meds and muscle relaxers with alcohol. This was the likely call for several falls where he broke three ribs and his scapula. Also, he was on

aspirin regimen and was having excessive bleeding from skin cares. He had unsteady gait to begin with and adding the alcohol and the meds was not helping.

We identified he was not refusing to answer the door for providers. He actually had hearing loss and was not hearing them knock. He was not taking his meds as prescribed because he was drinking, and he could not read the small print on the bottles. Next slide.

The interventions we implemented included physical therapy to help with gait, and building strength, and decreasing pain. He got a hearing aid and we added a doorbell buzzer with a speaker so he could actually hear when his providers arrived. He got new glasses. He was still not thrilled with leaving for appointments so we set up as many in-home services as we could. So we had a visiting physician, a visiting behavioral health, and addictions counselor. We have his medications delivered in bubble packs to limit the confusion. He's visiting PCT reviewed -- the polypharmacy review and ended up adjusting some of his medications as a result. He learned to use waiver transportation benefits.

We utilized a harm reduction method to address his excessive alcohol use. He was not ready to quit but was willing to decrease use. So we set up a plan where he would drink before bed, limit of two drinks and he would not take pain meds or muscle relaxers on the nights he chose to drink. And after he drank, he went to bed. So we were decreasing his fall risk. He agreed to counseling to start addressing the addictions and the depression issues.

We found a niece who he was estranged from, who actually came back into his life and was a great support to him. And he still refused to leave for a senior center or go out but he did eventually agree to attend two group meals a week with the hope being he would meet some peers and want to do more in the future. Next slide please.

So the outcomes were that he improved his health and decreased his pain significantly. A number of the safety issues were addressed. His medical and behavioral health issues were being addressed with a lot of improvements at times and setbacks at other times. But we saw a definite overall improvement in his pain and quality of life. Next slide.

All right, that sums up my portion and now Melissa Myers will jump in.

Melissa Myers: Thank you so much. Next slide please. So I'm very excited to introduce Inland Empire Health Plan's Integrated Pain Program. IEHP has been very lucky to partner with Desert Clinic Pain Institute and Summit Institute to establish our Centers of Excellence to meet the needs of our dually eligible older adult members who have complex pain needs.

Our Integrated Pain program is based on the Biopsychosocial Model and this is for the treatment of chronic pain. And this interdisciplinary approach to pain management is associated with minimal adverse complications as compared to the traditional pain management approach. This is not to say that some of our members that do make it to our

Centers of Excellence have not undergone surgery and long term opioid therapy. And unfortunately need -- unfortunately maybe those approaches haven't worked. The Integrated Pain program also treats member whose pain is has not been treated appropriately through these other methods. Next slide.

So the pathway to our Integrated Pain program usually starts with our dually eligible members and a health risk assessment that's completed within the first 45 to 90 days of enrollment with our health plan. And this health risk assessment identifies our high-risk members. Generally, it is stratified by either an episodic, basic, general, or complex care plan. And this is where members with complex pain needs are generally identified in the very beginning. And from here, we'll talk more about how they transition over to the complex care team. Next slide.

Our Centers of Excellence utilize interdisciplinary team approach under the Biopsychosocial Model to really look at the whole aspect of the person, not just their pain, not just their opioid use, and combines multidisciplinary approaches to pain with either -- well, including a pain specialist, the clinical psychologist, chiropractor, acupuncturist, nutritional specialist, addiction counselor, and the core of our teams are our nurse care managers and community health workers. The actual idea of the Center of Excellence is to really consider the wide range of potential approaches to take -- to optimize patient outcomes for individual treatment plans.

So we look at all the different areas of support that the person needs. And they may have all of these areas, the psychotherapy, behavioral health and medication-assisted treatment or just a few depending on their needs. The Center of Excellence then is providing close monitoring for members that are utilizing opioid therapy to include urine drug screens and consultations that are sometimes weekly. And as a Center of Excellence, all the providers are up to date on what the most evidence-based clinical guidelines are for the treatment of pain. They ensure that all the providers are trained in the newest interventions and our members participate in the program for one year. Next slide.

So the four essential areas of the program are medical treatment, behavioral therapy and support, physical reconditioning, and the complementary and integrative therapies. Next slide.

So in the medical area of treatment, this is where the treatment plan really is formulated and begins. A medical doctor will do an in-depth pain and opioid assessment as well as collaboratively working with the behavioral health provider to determine where the member has most need. They're looking at the medication management and maybe interventional treatments that may be utilized in a person's treatment plan and they help provide education to each of our members while they're in this in-depth assessment about the nature of their condition.

They find out about how the member has handled their own self-management up until now and talk about prognosis and treatment ideas. Next slide.

So our behavioral support is -- as was mentioned earlier, utilizes a lot of cognitive behavioral therapy both in individual therapy and in groups. We have pain psychologists that are working as part of the integrated team. They are also able to continually assess for depression and anxiety utilizing these different screening tools that you'll see on the slide.

They are also connecting members to support systems. So some of the groups are offered -- are inviting members, loved ones, significant others or support center identified as part of groups, and they're also looking out in the community to find supports for the members in their communities. Next slide.

Our physical reconditioning department is to dedicated to assessing members' functional ability and by utilizing passive modalities all the way to osteo-manipulative treatment, chiropractic care, really meeting the member where they're at in terms deconditioning or conditioning and starting very slow, pacing the member from day 1 throughout the 12-month program. Next slide.

Our complementary and integrative therapies are really the glue I think that holds this together and that's utilizing acupuncture, chiropractic care, naturopathic and homeopathic consults to round out the treatments.

One of the examples of how this really has benefited members is what they call their mind sessions. So on certain days the member will go to clinic and start with the mindfulness meditation, have an acupuncture session, and then see a therapist one-on-one or in a group, and we've had a really positive feedback from this session. Next slide.

So we have two teams. Our team here at IEHP and also the Point of Care Team that work together. We complement each other and that's -- of course the members is identified and that originates here at IEHP but we work very, very closely throughout the year-long program for each member. Next slide.

So IEHP's Team then will identify our dually eligible member, either through the health risk assessment that I mentioned earlier or through a pharmacy. Different departments here at IEHP may recognize that someone is struggling with a serious pain condition and those referrals are then sent to the IEHP pain team and we will reach out to the member and connect to them to the Center of Excellence if they meet criteria.

So some of the tips that we use for outreach and that has been really beneficial to developing relationships with our duly eligible members is to really approach with non-judgment and take time to listen to their story. Often the person on the other end of the phone is isolated and hasn't had somebody listen. Just having that skill is really, really valuable in helping the member be able to identify their needs. We utilize empathic communication and reflective listening, and always acknowledge that a member has autonomy.

This program is a voluntary program. We don't force anyone to attempt something that maybe they're not ready for and we want to know if they're ready to try something new. Next slide. Our team at IEHP continues to coordinate for our higher risk members and our higher risk members maybe identified by having behavioral health co-morbidities as well polypharmacy and the current pain condition. They might also have other complex needs outside of their pain condition such as diabetes, hypertension, COPD. So these are our members that may need a higher level of care coordination and we're providing that with our COE Team.

Some of our coordination tips really are sharing information. We do bi-weekly conference calls of anyone that appears to have barriers to being able to participate fully in the program and/or if we've identified someone that's -- will need surgery coming up or someone that may need to go in-patient for detox. So these are some of the areas that we coordinate with the team. Next slide.

Okay, reviewing and assessing, and monitoring the treatment plan on a monthly basis. The Point of Care Team at the Center of Excellence is part of helping us to identify where members are at. Some of our benchmarks then are provided to us at 3-, 6-, 9-, and 12-months areas. This is where we're creating discharge plans, setting up measurable short-term and long-term goals with the members.

Preparing for discharge is something that happens at all stages through the program. Getting the members thinking about what happens next -- How am I going to be able to carry this on in my everyday life? Utilizing pain and relapse prevention plan. This is incorporated in everyday clinic practice and carries over into the members -- hopefully, into their day to day.

The Point of Care Team is also conducting daily -- what they call a scrum, which is a beginning of the day standardized care review. And this is a treatment team that looks at what the member's needs are up to really the minute, up until they check in that day and this helps them -- guide them to the treatment that would be most beneficial for them at that time. Next slide.

And the Point of Care Team is really keeping members on track, engaging engagement. And so attendance is really important in the program. It's one of the conditions of continual enrollments. We've seen that at least four encounters a week is really beneficial for a member in the first stages and then four encounters a week during the months thereafter. So the Point of Care Team is motivating the members and helping schedule, helping arrange transportation if needed. Next slide.

So key engagement strategies and one that we've identified here at IEHP and I know it's also part of the Center of Excellence training is motivational interviewing. Utilizing motivational interviewing has been shown to really help build relationships with people, with members, with staff. So being able to engage with someone who is dealing with chronic pain with empathy by either asking open-ended questions, utilizing reflective

listening, acknowledging autonomy. These are all so important in assisting a member to recognize where they need help, where their barriers are, what they're willing to do.

Also utilizing motivational interviewing maybe using a 10-point scale about how a member is motivated is also very, very helpful in treatment planning. Next slide.

So we'll go ahead and look at Stacey who has been in the program for six months. Stacey is a 59 year old female. Her pain originated from a motor vehicle accident in 1999, where since she's been experiencing chronic low back pain, also identified as having co-morbid depression, hypertension, has identified some substance use disorder and also diagnosed with seizure disorder. In addition, she has mixed connective tissue disease and that of course is exacerbating her pain.

So when Stacey was identified and sent to the Center of Excellence, she identified her goals are to manage her pain, to correct her back alignment, and to reduce anxiety. Next slide.

So as part of the Integrated Pain Care program, Stacey has engaged in all the support groups. She seems to really benefit from chiropractic care and acupuncture. She's attending individual and therapy groups and also doing the mindfulness yoga and acupuncture combination and has had two naturopathic consults so far. She's seen bi-weekly for medication evaluation rather than going just on a monthly basis and this allowed her to check in, talk about how she's managing her symptoms as she is on a slow taper.

So since her engagement in the Integrated Pain program, Stacey has recorded that her pain has been reduced, her depression and anxiety has been reduced, and that acupuncture is a huge help is managing her pain. Also to note, she's reduced her morphine equivalent dose from 90 milligrams per day to 40 and this is in the 6 months and she's also managing her hypertension much better.

So her nurse care manager at the center of excellence will continue to monitor her ability to self-manage and also adjust any of her goals as she's progressing if she has, you know, more goals, more personal goals. Those will be noted and worked on -- working towards graduation. Next Slide. And now I'll introduce Randy.

Randy Rakim: Hello. Are you there?

Melissa Myers: We can hear you Randy.

Randy Rakim: Oh, okay. Hi, my name is [Randy Rakim]. I was diagnosed with MS when I was 36 and that is a very debilitating disease. Two years ago when I went to another doctor to just have another doctor look at me, she diagnosed me with MS progressive. She said all of the medication during that time that I was 36 and on, was doing me no good basically. And I got addicted to Oxcycontin when I was in a nursing home -- I was

in a nursing home for seven years because I couldn’t take care of myself at the time and the Oxcycontin was just wonderful.

I mean, it took care of the pain to the point where I actually broke eight toes in the nursing home, didn’t realize it, and just took Oxycontin and guess what, the pain disappeared and now, I’m not on the medication and it just helps do therapy on broken toes that they cannot straighten out. The other things I have to say about this when I was in the nursing home, it was like when it was time for my medication to come I set everything aside. Yeah, if I was doing something, oh, I had to be at that cart to get my pain medicine constantly.

And it was affecting my life. I lost contact with my children, which I’m trying to reestablish at this time but it has made me lose contact with my children. They were trying to get ahold of me and I wouldn’t answer their calls, yeah. And I don’t know what else to say about that.

That’s kind of like I’m dealing with a psychologist and psychiatrist and they’re helping me get contact with my children again along with my sister who has been very vigilant in taking care of me and we are very close as far as that goes.

I’m trying to think here -- I’m sorry. The biggest thing I can say to most of the physicians that are listening to me is, the first thing, if I had to go to the hospital for anything like if I have fallen, which is I have recently, but the first thing they ask me, “Do you want pain medicine? Do you want this?”

And yeah, I have to tell them, “No,” because I don’t do pain medicine anymore. I had a wonderful pain clinic doctor. Took him two years but I spoke to him and I said, “I want off this medication because it’s affecting my life.” I couldn’t take and do anything, I didn’t want to do anything except take that pain medicine. And when I was in the hospitals -- this was during the time when all the physicians out there were just prescribing it like 10 years ago.

And all I had to do was get to the hospital and say, “I’m hurting more, I’m hurting more,” and they would increase my dose for me, and this was the Oxycontin.

And when I finally said enough is enough, I ended up gaining almost -- I went from 180 to probably about 300 pounds just sitting there, eating, not paying attention to what I was doing, just feeling the pain, but not doing anything for it like therapy.

And therapy I feel is probably better than actually getting medication because therapy will loosen up the areas that you’re sore in and that’s one thing that I can tell you, is I had an occupational therapy and physical therapy come to my apartment and I feel much better with my body as far as that goes.

And I had finally got off the Oxycontin due to my doctor, took him two years to take me off of it because it was such a high dose. He had to adjust me down to two different other

medicines which was oxycodone and then the -- gosh, lost my sense here, the methadone. And he told me that it takes a while to get off the methadone, that he told me not to do it by myself. He said, he'll work with me, just follow his rules. And now, to this day, I haven't taken any oxycodone, Oxycontin. I deal with Tylenol now, I take Tylenol.

And I was listening to that doctor that was talking and a lot of what she said is true because I've gone into depression. I'm taking anti-depressants. I have anxiety and I take anxiety medicine. But I was able to get out of the nursing home, which changed everything. It was like a new lease on life for me.

And I would -- I'm just -- I'm sorry, I'm going to break down here. I'm just so happy to be out of there. I have friends at the place I'm at -- at senior center, living center, and I do have a bunch of friends here that if they don't' see me for a couple of days, which I'm in my apartment, they'll come knock on my door just to make sure I'm okay. And that's a great feeling to have people concerned about you.

And then, I mean, I owe a lot to one individual. She's been my rock throughout this whole thing and I hope I don't embarrass her, but it was Katie Profitt with that clinical liaison. I mean, if I need anything, all I have to do is call her and she will help me. And that's a big thing because when you're out here on your own, you're kind of like -- What do I do? How do I get here? How do I get there? And it was a scary feeling at first, but I've been out there for three years now. There's no way I'm going back.

But overall, I can say this, getting off the pain medicine, if people would just realize -- the older people, they get around my building to have any pain medicine, that they just realized what they're doing. I mean, you're saying you're hunting down on pain medicine like you're an addict. It's terrible. But I always tell them, don't look at me because I don't have them in my apartment. I don't have them. But I mean, that's about all I really can say. I mean, if anybody has any questions or anything like that, I don't really have anything else to say about that, if it's helpful what I told you.

Kristin Corcoran: Thank you so much, Randy. And thank you, Dr. Darnall, Katrina and Melissa for your presentations.

So with that, we now have a few minutes for questions from the audience and at this time, if you have any questions for our speakers, please submit them using the Q&A feature on the lower left side of the presentation. Make your comment at the bottom of the Q&A box and press Submit.

So our first question is for Katrina. How can a healthcare provider best engage family members and social networks in managing an older adults' complex pain?

Katrina Profitt: This is Katrina. I think it's important -- I always stress the importance of reaching out to folks when somebody is doing well, and not waiting and trying to engage people when somebody is not doing well. So if you're working with somebody, establishing rapport with their family and their natural support, if they're open to that

from day 1 is extremely helpful, in forming that relationships so when they aren't doing well and you need to really seek their support, they know who you are, it's not a call out of the dark. I know it can be challenging particularly with this population if you're trying to engage the natural supports in a therapeutic interventions and sometimes they're not open to that and so outside of -- invite them in and education for the family, that's the best resources.

Kristin Corcoran: Thank you, Katrina. So the next question is for Randy. Randy, we received a lot of notes from attendees that have expressed their appreciation for you for sharing your story, and that it makes a really big difference for them to hear your story. And one of questions that we received were, what were some of the things that providers did to assist you in managing your pain that was the most helpful?

Randy Rakim: The biggest thing was -- to make my pain subside, was therapy. I mean, therapy -- I realized when I was taking all those pain medicines, I wasn't moving around. I was stiffening up, and that's a bad thing with MS. But I had occupational therapy and physical therapy at my place to keep me going. And that does help more with the pain than the pain medicine because I'm stretching my muscles in getting them back.

Kristin Corcoran: Thank you, Randy. So our next question is for Dr. Darnall. How can you best bring up pain management option such as CDC to older adults who might be skeptical of non-pharmacologic options?

Beth Darnall: This is a great question. I think one of the best ways to initiate a conversation about behavioral treatments is to provide older adults with a definition of pain. So we tend to think of pain as just being the hurt that we feel in our body, but pain is both a negative sensory and an emotional experience. And so psychology is building the definition of pain. And once that's normalized, and really understood, that pain is just cycle behavioral experience, it's such a foundation for people to understand that it's normal to address pain comprehensively, because if we just address pain as if it's a purely biomedical condition, we're leaving half of the definition of pain untreated. And if we only treat half of anything, we really can't expect to have great results.

What the research tells us is that what's even more important than the medical treatments for pain are the daily behaviors that people engage with to self-manage their pain and other symptoms. So think about it this way, we could give somebody a medication for sleep, but if the person is drinking caffeine at night and they are watching TV late, and eating the wrong foods, that medication is going to have minimal effect because the daily -- those behaviors and those choices of the person really are the most impactful. So a person's psychology, as well as their daily choices are the most important components of a pain care plan.

And another selling point for cognitive behavioral therapy or these behavioral treatments is it puts the patients in the driver seat so they're not just at the mercy of the treatments the doctor will try, or the medications that may be prescribed, but it gives them control to focus on what they can do everyday or several times a day to begin gaining better control

over their experience of pain. This leads to a sense of self-efficacy, to improved mood and ultimately it moves the patient towards the goals that are meaningful to them so that they are self-selecting those goals and are in control of moving themselves towards them. Thank you.

Kristin Corcoran: Thank you, Dr. Darnall. And our next question is for Melissa. How can you best engage older adults in participating in goal setting for themselves?

Melissa Myers: Thank you, that's a great question. Really, it's focusing on each individual and what they identify as being important in their lives. My personal experience -- and most of my interactions with our members is telephonic and so building trust and rapport with someone over the phone can sometimes be difficult. However, it's just asking the right questions -- What is important to you? What has worked for you in the past? As I said in my presentation, motivational interviewing is really a way of communication that I think really values the individual. And so by being non-judgmental, by being open to what is important to the member, from drinking less, not mixing medications with pills, to being able to bend over and hold my grandchild's hand, these are things that we wanted to listen to and incorporate in a self-management plan.

Giving the power back to the person, just as the presenter before me mentioned, people need to understand that they do have a say in how they're feeling and what they do and in their healthcare and in their mental health. So I think that's really the most important thing is empowering someone to say what they need and identify their needs and listen.

Kristin Corcoran: Thank you so much, Melissa. So our next question is for Katrina. Can you expand a little more on some of the cultural and ethnic factors in addressing pain assessment and therapies?

Katrina Myers: Sure, I think it's important to have a good understanding what someone's background is, and what works for them because what works for me doesn't work for you or someone else. And a lot of those -- their culture can play into that.

I found individuals that are very resistant to having folks in their home so they don't want someone coming in to do physical therapy, and some of them may look at that and go -- oh, they're just not adhering or they don't want to get better. But when in fact the individual I worked with, in their culture, it was not okay to have outsiders coming to your home. It wasn't something they were comfortable with. So when we -- I thought you're doing something to make it easier, but really I was doing something that was never going to work for them. So then when I recognized that, then we set them up with services in an office, it worked fine.

So really just figuring out what's okay in their culture, with their family, with their beliefs, what they're comfortable with. People have all kinds of different family makeups as well. And asking -- What works for you? What doesn't? What do you like? What you're not? And not taking them role of assuming somebody's non-compliant or non-adherent because they were refusing something, when they're maybe a lot more to it.

And if we take time to really kind of look and figure out what that is, we can devise goals to work around, to work within what they're comfortable with so that we improve the likeliness of success.

Kristin Corcoran: Thank you, Katrina. Dr. Darnall, do you have anything to add?

Beth Darnall: No. I think that was a great and comprehensive response.

Kristin Corcoran: Great. Thank you. Melissa, do you have anything to add?

Melissa Myers: I agree. Cultural competence is really, really important, very well said.

Kristin Corcoran: Thank you. So our next question is for Randy. What advice would you give an older adult dealing with complex pain?

Randy Rakim: I'm sorry, could you say that one more time?

Kristin Corcoran: Of course. What advice would you give an older adult dealing with complex pain?

Randy Rakim: I would tell them when they're dealing with complex pain, is to realize -- is it the pain or is it your surroundings, is it conditions? I know a lot of mine was psychosomatic, in the brain, saying, okay, I need this medicine to make me feel better, but it was actually bringing me down. And I think a lot of older adults get to the point where if I can have the pain medicine, I'm going to take it.

And as far as helping them get to realize that information, I tell them my own story all the time. I tell them what I've gone through and how I got out of it. I takes determination, but it was like I was saying, I was 300 pounds, I'm down to 184 right now, because I was determined to take and get off that pain medicine and get back to life. The pain medication runs your life.

That's what I would tell them, because I do have friends here that are AA, Alcoholic Anonymous, and they'll tell me the same thing, you got to want to do it. I have one friend here, he said, "I don't want to hear your sissified story, I want you to get better." And he's a great friend, he'll tell me, "You're making excuses, those are excuses. Do something about it."

But I would just tell him my story and let him see what I've gone through, and hopefully, that would help them.

Kristin Corcoran: Thank you, Randy. Our next question is for Dr. Darnall. Do all the providers address an older adult scare of losing access to opioid medication while bringing up pain management alternatives?

Beth Darnall: Yeah, thank you, that's a great question. And I actually just want to start out by acknowledging Randy's response to the last question and underscore that Randy's story really illustrates that one person's poison, is another person's medicine. So for Randy, opioid medications were really toxic. And there are people that have complex medical conditions where opioids prescribed appropriately, and when they have a good response to the medication, can be absolutely lifesaving in terms of allowing them to be more functional.

So this really underscores the need to prescribe appropriately, and to monitor very closely to ensure that the patient is benefiting from the medication, versus deteriorating, or becoming unduly dependent on the medication.

So we are currently in an era in the United States with a large focus on de-prescribing of opioids. And this can be necessary for some individuals for whom opioids have been mis-prescribed, or misused, or are non-beneficial. But for other patients, this can be a very threatening proposition because they will lose access to a medication that may be allowing them to engage with their grandchildren, or attend family events, just do basic self-care on a daily basis.

So it is important to know that regardless of where a person is on the spectrum with appropriate use or misuse of opioids, there is likely to be great fear and trepidation around opioid de-prescribing, losing access to medications or even some of the difficulties individuals are experiencing accessing medications at pharmacies.

So providing that supportive environment to both validate their fears, provide non-judgmental support around their concerns of losing access, and this can potentially be used, leveraged as a moment to initiate a discussion about the important of engaging or re-engaging in behavioral pain medicine strategies, because those put the control in the hands of the patients, rather than in the pharmacy or the prescriptions.

So again, it's not either or, often patients will utilize both treatment pathways, but this is where CBT, mindfulness, some of these core evidence-based behavioral treatment can allow emotional and cognitive support to patients who are highly fearful.

Thank you.

Kristin Corcoran: Thank you, Dr. Darnall. Our next question is for Katrina. A participant said, "I find the most difficult part of pain management is making the member aware, that there are other effective methods of treating pains besides the use of medication. What's the best way for providers to educate about other methods? Are there resources providers can use to help assist them with educating on the biopsychosocial treatment for chronic pain?"

Katrina Profitt: Thank you. As far as resources, I think -- I mean there's a ton online resources that you can do with mindfulness techniques and even -- people will often don't

even think of physical therapy, that's an option for their pain, have they ever tried that, if so, when was the last time?

I find a lot of folks, particularly older population, the idea of mindfulness is very foreign to them, they think of it, when you say meditation, they have all kinds of pre-conceived ideas and concepts about what that it, and they want to part of that.

But even changing your verbiage can help. And I've engaged folks with a deep breathing exercise, I just call it, really, it's mindfulness, but really, just asking them to try it one time. And it's really just a deep breathing exercise, with them inhaling through their nose, and out through their mouth very slowly, through a count of 10 or 12, and doing that repeatedly, while they think of something positive in their life.

And I found that folks that are really resistant, like, just try it with me, and they do it once, and then they're like, wow, that really did help.

And so I call it deep breathing, because if I called it something else, it would turn them off, but something as simple as a deep breathing exercise, is an example that -- how much that can actually lower your heart rate and focus your mind on something other than your pain, has been helpful when I'm trying to engage folks that are -- think it's kind of creepy. And so that has been helpful to me.

There are a ton, as I mentioned before, of apps you can use, there are free mindfulness apps and there are a lot of resources online if you just Google mindfulness, how many things will pop up. As far as other strategies like CBT and therapy, that might be beneficial to the person again, just again, identifying the health providers and resources in your area is important so that you have a resource list, because everybody's got different ones, for counseling services or counselors that specifically specialize in pain management.

Kristin Corcoran: Thank you. Our next question is for Melissa. How do you encourage older adults to participate in group activities?

Melissa Myers: That's a really good question. I think it's really at each member's pace, and I know that at the Centers of Excellence, that's really kind of made known that people are not forced to do anything that they're not willing to do. It's interesting because I've had the opportunity to talk to several members who, over the course of their pain, had become really isolated.

And even the ones that don't want to participate, sort of warmed up after a while. So I think to really answer that question, it's just more about making it available, and not forcing anybody to move too quickly out of their comfort zone, and just keep inviting the older adults to join.

I think that's it.

Kristin Corcoran: Thank you, Melissa. So we have time for one more question, and Randy, this question is for you. What would you say to someone who has tried and failed to stop using opioids and is discouraged?

Randy Rakim: I'm sorry, what was that one more time? I'm sorry.

Kristin Corcoran: That's okay. The question is, what would you say to someone who has tried and failed to stop using opioids and is discouraged?

Randy Rakim: Yeah, I don't have an answer to that. The only thing I would do, would be to support them, make sure that they know that I'm here, and it's really -- I want to say, when you're on opioids, I don't know if anybody has been, or whatever, is such an addiction, I want that medicine, because it's going to make me feel better. But actually, it doesn't. And I think I would constantly tell that person that, you might want that medication, your brain is telling you, you might want that medication or your body is, but your brain is actually saying, you don't need it because you tried it before, you tried to get off it before.

It's really hard to say on that one.

Kristin Corcoran: Thank you, that was really helpful. Alright, so that ends our question and answer session, thank you so much to all of our speakers, and thank you for the participants for sending us your questions.

Next slide please?

At this time, if you have any additional questions or comments, please email RIC@lewin.com, and we'd also like to invite everyone to visit our website to view reporting of our upcoming webinars, general webinars that aired earlier this year.

You can view the topics of these webinars on the slide.

The slides for today's presentation, a recording, and a transcript, will be available on the Resources for Integrated Care website.

At this time, the post-test for his webinar, are now open. As a reminder, the deadline for NASW credit is midnight of June 28, and the deadline for CMS credits is July 15.

Additional guidance about obtaining credits, and accessing the links to the post-test can be found within the continuing education credit guide on this slide, or at the Resources for Integrated Care website.

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Thank you so much for joining us today. Please complete our brief evaluation for our webinar, so that we can continue to deliver high quality presentations. If you have any questions for us, please email us at RIC@lewin.com

Thank you again, to all the speakers. Have a wonderful afternoon, and thank you so much for your participation.

Operator: Ladies and gentlemen, that does conclude your conference for today. Thank you for your participation and for using AT&T executive teleconference.

You may now disconnect.