The Lewin Group
Strategies for Non-Opioid Pain Management: A Panel Discussion
November 10, 2020 – 2:00pm ET

Poorvi Soni: Great, thank you so much. Hi, everyone, and welcome to the webinar, Strategies for Non-Opioid Pain Management: A Panel Discussion. My name is Poorvi Soni, and I'm with The Lewin Group. Next slide, please.

Today's session will include a 45-minute presenter-led discussion, followed by 15 minutes for audience Q&A. This session will be recorded and we will post a video recording, along with today's slides, at ResourcesforIntegratedCare.com. The audio portion of the presentation will automatically stream to your computer. Phone lines for this presentation are also available. To access the number, click the black Phone icon at the bottom of your screen.

This webinar is supported through the Medicare/Medicaid coordination office at the Centers for Medicare and Medicaid Services. MMCO is helping beneficiaries dually eligible for Medicare and Medicaid have access to seamless, high-quality healthcare that includes the full range of covered services in both programs. To learn more about current efforts and resources, please visit our website or follow us on Twitter for more details. Our Twitter handle is @Integrate_Care.

At this time, it is my pleasure to introduce our speakers for today's webinar. First, we have Dr. Beth Darnall, who is an associate professor of anesthesiology, perioperative, and pain medicine at Stanford University, as well as the director of the Stanford Pain Relief Innovations Lab. Next, from SCAN Health Plan, we have Eve Gelb, who's the senior vice president of Member and Community Health, and we also have Donna Lynn Foster, who is a member and peer advocate at SCAN Health Plan.

Here, we have our learning objectives for today's webinar. Today, we will identify non-opioid pain management options available for individuals experiencing chronic pain, describe key considerations for implementing a person-centered approach to pain management, including multi-modal pain management that is interdisciplinary, evidence-based, and individualized, as well as identify barriers to treating chronic pain during the COVID-19 pandemic. Next slide.

And here, we have the agenda for today's webinar. To start us off, we will begin with two poll questions to get to know the audience a bit more. Move on to the poll questions. First, we'd like to know which of the following best describes your professional area. Please choose one of the options provided on your screen. Okay, I think we can flip to the results.

It seems like we mostly have representatives that are health plan case managers and care coordinators, but a good mix overall. And then the next question. In what setting do you work? Please choose one of the options on the screen. Great, I think we can go on to the

results. We have mostly individuals from health plans, as well as a few community-based organizations, and ambulatory care settings. Great. Thank you, everyone, for responding. I will now pass it off to our first speaker, Dr. Darnall. Dr. Darnall, go ahead.

Beth Darnall: Yes, thank you so much. It's a pleasure to be here. Next slide, please. In talking about pain from a clinical perspective, I wanna start with the definition of pain. While we tend to think about pain as simply being a negative sensory experience, it's actually a highly complex sensory and emotional experience. So I like to draw people's attention to the fact that psychology is actually built into the very definition of pain, and it's influenced by a whole host of psychosocial factors.

Pain is influenced by our thoughts, our emotions, our beliefs, and how distressing pain is for the individual. Now, this doesn't mean that pain is psychogenic. Pain has a medical basis. But it's influenced by all of these factors within a person, and these psychosocial factors can actually influence how much pain a person experiences, as well as their level of disability and how well pain treatments work for them. Next slide, please.

Now, pain prevalence in older adults is quite high. Up to 40% of older adults experience chronic pain, and if we just think about ongoing pain, that prevalence is even higher. Older adults who are dually eligible experience higher rates of chronic pain than adults from other types of -- with other types of coverage, such as private insurance or the VA.

And they also report more pain in terms of frequency and severity than other individuals. So it's important to know that both the prevalence is greater as well as the degree of suffering that people might experience. And chronic pain can be incredibly disruptive, as you know, to the individual, to the family, and also to an individual's social relationships. And this can have some compounding effects for the individual. Next slide, please.

Now the biopsychosocial approach to pain really considers the whole person, and this stands in contrast to the traditional biomedical approach that tends to focus on external solutions, such as medications or procedures. But the biopsychosocial helps older adults understand and stay focused on what they can do to better control their pain, their symptoms, and their need for medications.

So, a multimodal approach both assesses, considers, and provides treatments that address this range of factors within a person. And so this can include medical treatments, but also behavioral and integrative approaches. So, it's important to remember that this isn't an either/or equation. It's not medical treatment or psychosocial. That actually, things work best when they're applied in combination.

Opioids, of course, can be one important part of an individual's pain care plan for some people. But these are just one tool, and they should be applied very selectively and never as a first-line treatment. Next slide, please.

So again, in terms of pain management options, there's a broad range. There's non-opioid pain managements, such as acetaminophen, NSAIDs, antidepressant medications. Also,

rehabilitative therapies, movement-based therapies, and occupational therapy. Self-management support, so that's very specifically in regards to chronic pain management. Behavioral interventions or psychological interventions such as cognitive behavior therapy for chronic pain.

Complementary therapy, such as acupuncture and massage; movement therapies, such as exercise, yoga, and tai chi. Interventional treatments, such as injections, nerve blocks, or even surgeries. And as I mentioned, opioids, but this is not recommended as a first-line treatment for most people. Next slide, please.

Now, behavioral interventions or psychological interventions for chronic pain -- these are considered the gold standard in terms of a biopsychosocial approach to pain management. So, this can include individual therapy or pain coaching, which can be done in person or online, which is particularly important during COVID. Eight-week cognitive behavioral therapy, or CBT, also can be received in person or online.

The chronic pain self-management program, a six-week peer-led program, also available online or in person. A single-session skills-based pain class, empowered relief, also available online or in person. Skills-based virtual reality, which can be home-based or available in the clinic. And a whole host of educational resources, as you see listed here. Next slide, please.

And briefly, provider considerations for treating pain. We want to provide comprehensive pain treatments that consider all of the factors that a person may be experiencing that are influencing their pain. We want to apply lowest-risk treatments first, recognize people as active participants in their pain care, and equip them with the skills and information that they need to better control their pain and symptom management. Thank you. Next slide.

Poorvi Soni: Great, thank you so much, Dr. Darnall, for that informative presentation. I'll now pass it on to Eve to describe the work that SCAN Health Plan is doing for pain management. Eve, go ahead.

Eve Gelb: Thank you. Thank you, Poorvi, and thank you, Dr. Darnall. Next slide, please. A little bit of background about SCAN Health Plan. We've been around for a long time, since 1977. We were founded by 12 angry seniors in the city of Long Beach who were not satisfied with the way older adults were receiving their care, and wanted to be able to live independently in the community.

So, our mission is keeping seniors healthy and independent. And we are very proud to serve about 215,000 members as a not-for-profit Medicare Advantage Plan, and to have received four and a half stars four years in a row. We can go to the next slide.

So, pain, as Dr. Darnall talked about, is incredibly common with seniors, and we thought it was very interesting -- one of us was watching Golden Girls. I don't know if you are all familiar with the Golden Girls, but one of my favorite TV shows. And back in 1989, one

of the lead characters, Dorothy, there was a sketch with her and her physician about experiencing pain.

And we found it interesting that, you know, older adults are sick and tired back then, and they're still sick and tired. And just as this example illustrates, many physicians look at chronic pain as normal or to be expected as part of aging. But that isn't acceptable to the patient, to the members, the beneficiaries.

They are experts in how they are feeling and how pain is impacting their lives, and they know what is normal pain versus what is intolerable pain. And they know that it is impacting their overall quality of life, and so when it gets written off by the provider, it creates mistrust and a struggle and a concern with the beneficiary, with the member, that their work is not being -- their needs are not being met.

And often, it's treated as something psychological. If they can't find a physical reason for it, then it's something, quote, unquote, psychological. You know, the line, Nobody believes me, I must be crazy. So, more than 30 years later, hopefully, we're finally beginning to understand the importance of pain, and using human-centered design principles, really seeing the patient as the expert in their own life, in addressing pain and figuring out how to help them in a really meaningful way.

So with that, I'm going to turn it over to one of SCAN's very own Golden Girls, Donna Lynn Foster. And if we could go to the next slide, Donna Lynn, who's graciously accepted being part of this presentation, will talk to you a little bit about her role and how she manages her own pain. Donna Lynn?

Poorvi Soni: Donna Lynn, you may be on mute.

Donna Lynn Foster: Hello? Yeah, Eve, thank you. Thank you, I'm getting this technology. Yeah, thank you very much. My role as a -- excuse me, I'm sorry. Here at SCAN, I help people with their current circumstances, how to access the system and the SCAN benefits, but mostly, we listen.

We listen to people, we find out what they're doing right, or what they're doing, period. We make sure they're following their physician's orders, and help them consider alternatives to run by their doctor -- alternatives that SCAN offers in managing their pain, such as physical activity, therapies such as acupuncture and chiropractic, and diet. But mainly, we listen.

And it's interesting, and it's really wonderful how intimate you can become with people, because sharing pain is a very personal experience, and it's something that many people won't share, or even acknowledge for themselves. So, having an opportunity to discuss it freely and maybe consider other possibilities is -- it's important to them.

And for those of us that are able to help our members, it's really a pleasure. It's very satisfying to do, because there are some direct outcomes in considering how best to

manage pain for our members. I'm looking at the slide here -- oh, and some of my strategies, some of my talking points with our members is I move. I have to keep moving.

I remember my grandmother told me if I don't move it, I won't be able to. You know, move it or lose it. So, and to do that, I enjoy dance, I enjoy walking. I have really good shoes that I absolutely love, and which made all the difference in the world. But primarily, physical activity and being -- having the information that's needed to make good decisions is very important to our members, so they can feel like they're in control. And SCAN does everything they can to help them to do that and have positive outcomes with their families and their doctors. Oh, next slide, all right.

Eve Gelb: Thank you, Donna. So we'll hear more from Donna when we get into the discussion. But as Donna said, pain is a very personal experience for our members, and it significantly impacts their quality of life, their day-to-day activities. You know, people wake up in the morning, they see how they feel with respect to their pain, and then they make decisions about what they are able to do or not able to do that day.

And they often report to us that they are not feeling really heard by their providers and others when they're experiencing pain, and when they're trying to describe it. So, because pain impacts our members' lives and their quality of life, it was very important for us to get better at addressing pain, and in addition to just the quality of life that members experience, which is how they stay healthy and independent, pain also drives many of the five-star measures, particularly the five-star measure about maintaining physical health and the one about maintaining mental health.

How much pain impacts your life is one of the questions that is a component of that measure. And pain also drives utilization. It drives emergency room use, and it drives hospital utilization, as well as ambulatory care and specialty care utilization, as well as medications. So we thought that it was really important to get better at addressing it. If we can go to the next slide.

So the way we do this is by connecting with the members. So folks like Donna Lynn, who we call peer advocates, are SCAN members who are also employees, and they engage with our members, as she said, talking to them about the benefits that are available.

Many of our members, we can send them all the member materials that we want, but when it comes time for them to actually need them is when they need to know about it. So, we conduct a health risk assessment, we ask folks about their pain, and then based on that, we do outreach, and we talk to them about all the benefits that are offered, including acupuncture, chiropractic, massage, gym, and a Fitbit tracker, because physical activity is so important. Provider-driven services -- these are things like physical therapy; nutritionist referrals, our member-to-member program, which is the peer advocate program that Donna Lynn is part of.

And then care navigation and pain medication -- making sure that we do cover all the necessary medications to manage pain, as well as over-the-counter benefits, where folks can use that for medications like the acetaminophen and other medications, or to buy things like, you know, personal massagers and things that might help them manage their pain.

We've also really dug in deep and been working on a human-centered design project to better understand members as experts in their own pain, so that we can direct them to the appropriate interventions and really figure out interventions that are going to work for members as opposed to interventions that are designed by the health delivery system. We can go to the next slide.

So with that, I'm turning it back over to Poorvi.

Poorvi Soni: Great, thank you so much, Eve, and also thank you to Donna Lynn. With that, I'd like to turn to our panel discussion, and our first question -- go to the next slide. The first question is to all of our speakers. What are the most common challenges in pain management among older adults. Donna Lynn, I'll begin with you.

Donna Lynn Foster: Thank you. I believe just acknowledging it. People may downplay or dismiss their pain, so it's important to help them understand that their pain is really important, and to help them to acknowledge and feel safe in how they're feeling. We may try, but we really can't ignore pain, and dealing with it is a shared issue among families and medical professionals.

Having access to pain management options beyond the medications and therapies with which members may be most familiar. At our age, the Medicare age, many people have had years of dealing with pain, solely by using pain medications. Some may not have had an opportunity to try different medications or different treatments, due to the inability to access them, or even afford different types of care.

I believe that to address these challenges, we need to present information about those other plan options in a way that is easy to read and understand, in language that is readily accessible, to customize it to the audience. We need to let people know what's available, and how to access it -- things like durable medical equipment for mobility aids, electric beds to help them get in and out of bed easier, to access the alternative treatments, as Eve mentioned, like acupuncture and chiropractic, and the different mental health resources.

We also have a gym program SCAN offers these members, and currently we're running one on Living Well With Chronic Pain, and I just got an email from a co-worker very excited that members are signing up for it. So, we get excited that people are taking action to help themselves. And also educate and assure individuals that the range of treatments can be safe and effective. Again, it's being fully informed so they can make those good decisions. Thank you, that's it.

Poorvi Soni: Thank you so much, Donna Lynn. Eve, same question to you.

Eve Gelb: Yeah, so the challenges are diverse, and it depends on the individual, of course, but more and more, as we talk to our members, they are not interested in medications. They are very concerned about the impact that medications have on their liver function, their kidney function, and their overall health, as well as the expense of the medications.

But it's hard, because clinicians haven't necessarily been taught the biopsychosocial model that Dr. Darnall pointed out, and so they want to do something to help, and they know that medications often work, and so it's often the first tool in the toolbox. But as Dr. Darnall pointed out, there are many other tools in the toolbox that could be used if our providers could have the training and the support that they need.

We also need to help our members have the conversation with their providers, because they go to the doctor, the doctor prescribes the medicine, they don't want the medicine, but they don't have the words to have the conversation with the provider, and sometimes, the provider is not receptive to the conversation.

So in our human-centered design project, we did some ethnographic interviews, and I remember very clearly the 85-year-old woman who is probably under five feet tall, and she doesn't wanna contradict her doctor. So she goes to the doctor, she talks to the doctor about her pain. The doctor writes her a prescription. She doesn't want to offend the doctor, but as she walks out of the office she throws the prescription into the trash, because she's not going to engage.

That's not what she wanted, but she didn't wanna offend the doctor. So, I think we need to help her communicate, but we also need to help our providers. Folks have told us that what really matters to them is nutrition and faith. And in a health system, faith is not always part of what we talk about, but it's super important. Spiritual practice, our members are telling us, whether it be in the form of prayer or meditation, or just the support one gains from being part of a supportive community, is often mentioned as being extremely helpful.

It gives them something positive to focus on, a distraction that they really enjoy. And our members have told us that nutrition is also something really important, but we have challenges in not having enough nutritionists to support folks. And dually eligible individuals in particular face challenges related to pain management, because a lot of the options are not necessarily covered by your health insurance or Medicare, and they don't have the resources to pay for it out out-of-pocket.

And, you know, with COVID happening right now, telehealth, which I think is great in many areas, is not always the best to address pain. And the technology is difficult for older adults in general, and in particular for our dually eligible population, who generally have less access to services.

It might be difficult because of sensory issues, vision and hearing issues, or cognitive impairments. There are language barriers. Some organizations have really figured out how to get translation services and other things through telehealth, others haven't. So I think both our beneficiaries and our providers are struggling now more than ever to address something so personal as pain.

Poorvi Soni: Thank you, Eve. And Dr. Darnall, what challenges do you see?

Beth Darnall: Yeah, well, there's so many barriers to access and pain management. So, this can, you know, come from the perspective of having the right benefits to access and pay for care. Older adults can have mobility, financial challenges, and also comorbidities that can prevent people from accessing effective resources. Eve noted that older, dually eligible individuals are more likely to experience these challenges, and they may have transportation gaps to receive in-person services, and this can be for a variety of reasons.

With COVID-19, we have an additional layer of challenge, but also an opportunity. So, we've seen really broadly across the United States much more of a focus on treating people remotely, and this can provide -- I mean, there are some challenges, and Eve was just mentioning some of the challenges.

There's also opportunities here to rapidly connect individuals with behavioral healthcare. So for instance, online chronic pain support groups, online chronic pain self-management program. We are conducting online cognitive behavioral therapy classes and online single-session classes, and we're seeing higher engagement rates in these online-delivered treatments than we've ever seen before.

So that's in part due to some people being socially isolated; there being a greater need for care, but also it can be incredibly convenient for people who no longer have to manage the transportation issues. And we can treat people across multiple states sometimes within one online class. So there is an opportunity there. Virtual reality for chronic pain -- these have now become home-based options, and clinicians are leveraging technology to treat older adults in their home environment.

So we're able to meet people where they are in this regard. Sometimes, people need a higher level of support to on-board or get going with the treatment, and others are just, you know, really ready to go. So I think it's critical for us to ensure that telehealth services and online options are available to dually eligible individuals, and be able to provide them with the support they need so that they can access this care at home going forward, and in particular during COVID. Thank you.

Poorvi Soni: Thank you, Dr. Darnall. The next question is actually directed to you specifically. In order to provide person-centered pain management, what key considerations should clinicians and healthcare organizations keep in mind?

Beth Darnall: This is a great question. So, I started out by talking about how pain is a biopsychosocial phenomenon, and we need to address it in a comprehensive fashion. In

order to do that, we need to conduct whole-person assessments that really consider the biopsychosocial full, multidimensional perspective of pain. So it's through this assessment where an individual has the opportunity to report how they're thinking and feeling within the context of pain, how pain impacts their lives, how they're responding to pain.

And this assessment can screen for social and environmental factors that can also influence their pain experience. So ultimately, the goal of a whole-person pain assessment is to reveal the therapeutic opportunities and to truly deliver person-centered pain care so that the clinician then has the information that they need to provide each person with practical resources, tools, techniques for pain management.

So, some people could benefit from individual or group-based treatment with an actual pain psychologist, or they might be appropriate for autonomous, self-paced learning online, or through a book or a workbook. So there shouldn't just be one approach. Ideally, clinicians can offer two or three different approaches based on what's right for the person, and most importantly based on their interests and their desire to engage with the information.

So, some clinicians may be pressed for time and not able to conduct an in-depth, multidimensional assessment for each person. So organizations can ensure that these assessments and resources fit within clinicians' busy schedules, integrate it into the workflow, and automate it whenever possible, so that clinicians are unburdened to every extent possible.

And this can help clinicians have the information they need at their fingertips, readily assess the results of the intake, and use the time with the individual to discuss the best treatment options that are available and provide them with rapid access that addresses their needs and their wants. Thank you.

Poorvi Soni: Thank you, Dr. Darnall. Eve, the next question is for you. How do you incorporate members' diverse perspectives in providing person-centered pain management?

Eve Gelb: So I think the simplest thing is to ask and to listen. You know, we embrace the nothing about me without me philosophy as much as we can at SCAN, which is why we employ members to be peer advocates, but we also need to do outreach, whether it be through focus groups or ethnographic interviews. Surveys don't tell us everything, quality metrics don't tell us everything. You have to actually ask people about their lived experience and what interventions would they use, and then when you do the intervention, you have to follow up and see, individually, at the individual level, did it work.

So, really focusing on asking folks. We do focus groups, and in fact one of our focus groups we did in both Spanish and English with folks in the same room, which was really powerful. Because regardless of the language barrier, folks understood that they had a

common -- a shared issue with pain. So, it's really, I think, asking and listening, and not necessarily asking and listening to the middle, the folks who we usually hear from who answer the questions we want them to answer in the way we want them to answer.

But to -- I always talk about getting the input of the people on the edges, right -- listening to the people who may not be -- who might be reluctant to share, figuring out ways that you can really understand their needs and be active in getting their input. You know, that, I think, is the most important thing that we've been able to do, and it's really helped us shape some of our interventions to be ones that are meaningful and driven by the needs of the people we're serving.

Poorvi Soni: Thank you so much, Eve. The next question is for all speakers. What are some actionable strategies that you recommend providers and health plans use to incorporate non-opioid pain medications and treatment when appropriate? Eve, I'll start with you.

Eve Gelb: Thanks. As Dr. Darnall said, that whole-person assessment is super important in understanding how pain impacts people's daily lives. How it impacts the way they interact with the world. Because managing pain is not only –it is not the only important outcome. It helps people achieve their life outcomes, so it's important to understand that. And it also is important to understand that they live with the other comorbidities that Dr. Darnall talked about.

Offering low-cost options, simple options, to Donna Lynn's point, in language that folks can understand. Low-risk, non-clinical solutions first is what really our members are interested in, like walking, physical therapy, nutrition, cognitive behavioral therapy, social interactions.

You know, folks are open to the providers saying, well, let's try walking first, or do you belong to a religious community, let's try that first, see how it impacts your pain. And in addition, just basically I think having electronic health records, as Dr. Darnall talked about, include non-clinical protocols for pain would be really helpful.

Poorvi Soni: Thank you, Eve. Donna Lynn, I'll turn it to you.

Donna Lynn Foster: Thank you. I think moving well is essential to pain management and general good health. We have countless members who report wonderful outcomes just because they've gotten off their bottoms and started moving around. They feel better in many different ways. I would recommend showing people, in addition to telling them, how to be active and move safely in their own environments.

Help them to customize their homes and yards as safe places for physical activity and movement. There might be fall hazards around the home and yard, such as rugs or uneven outdoor terrain. And I encourage members to play their favorite music and just keep a beat with whatever body part they can. Movement is what is not only good for our bones and muscles, but it's good for our spirits as well.

I also teach people what is available in the community, indoors and outdoors, for physical activity -- senior and community centers, parks, walking paths. And I counsel people on diet and supplements, including the anti-inflammatory diets, and I encourage referrals to dieticians.

Many people are asking about these kinds of supplements, like turmeric. I advise them to run it by their doctor and do their research, but never take things without clearing it first with your medical professionals. And be attentive to people's emotional wellbeing, which we learn how to mask pretty well. Chronic pain can cause or exacerbate depression, which can also be treated with multiple options.

People grieve the loss of normal function and independence. It can make you feel gloomy, you know, when you can't be the person you think you are or you want to be. And many people feel shame if they have pain. It means they're less than, and then there's that loss of independence. And pain medication also affects our emotional wellbeing and mental function.

And very importantly, not wanting to be a burden. Many people isolate, and they limit social activities and social contact when they're in pain. I would encourage people in self-comfort and nurture. Our members are really receptive to this. You're hurting, your body's shouting at you. What can you do? So, we have professional or self-massage, some SCAN plans offer massage.

I encourage them to take time for self-care. Your personal hygiene and grooming, especially for caregivers with pain, and seek positive distractions, comprehensive distractions -- healthy options for favorite foods, hobbies, social activities, and recreational activities.

Finally, and I think hugely important, is to help people have successes with self-advocacy, and teach them how to be well-informed and feel empowered to make decisions for themselves related to pain management. I really believe that this is a core to the biopsychosocial model, as is people feeling in control.

The benefits of self-advocacy help people to just feel good about yourself when you've accomplished something and had these successes. I would also refer people to additional treatment such as the physical therapy and acupuncture and chiropractic, if they're able to access them. For example, I have used physical therapy referrals to have my posture and my gait and my stretching techniques evaluated to make sure I was moving properly. I've also had a referral to a podiatrist to analyze my feet and recommend orthotics and some good shoes to make it easy to walk, to get comfortable to move my body.

So yeah, there are a lot of things that people can do to help them feel like they're in control, and then be more receptive to treating the cause of the pain, if they have some perspective that they're a lot more than their pain. Thank you.

Poorvi Soni: Thank you so much, Donna Lynn. And Dr. Darnall, I'll turn the same question to you.

Beth Darnall: Yeah, thank you. So, we can look at how to best manage pain, but it really depends on the individual person and their wants and their needs. So, providers can have tailored conversations with individuals, develop care plans, and coordinate with that person. If our care plans are tailored to the people we're working with, and if we're factoring in their needs and their wants, then they're gonna be much more likely to engage. So, bringing in that level of specificity and collaboration is really important.

Providers and health plans can focus on integrated approaches, such as chronic disease self-management programs, group-based treatments, patient education for skills-based pain management strategies. Individuals may be willing to engage in a range of treatments. At Stanford University, we offer a single session, very brief, skills-based intervention for pain management, and it rapidly equips individuals with pain management skills.

So, this can be ideal for people who may be disinterested in the intensive or longer-course treatments, but might be interested in just, you know, attending a single-session class. This intervention's called empowered relief, and has demonstrated positive early results for pain management.

Healthcare organizations should recognize that one treatment modality will never meet the needs of everyone, so what we really need is a portfolio of options so that we can attend to patients' individual preferences, conditions. Some people may want that higher level of care. They may want multi-session support, while others may find it impractical. And so, meeting people where they are is really critical.

And so offering that range of treatment also provides people with a critical level of choice, and as Donna Lynn was just mentioning, helping people feel and be in control is so critical, and giving them those choices is just such a nice and easy way to do that.

Lastly, it's important to include friends, caregivers, and family, so that the whole system becomes educated on how to best help the person living with pain manage their condition to the extent to which that they can be folded into education, treatment classes, and even treatment plans can be highly advantageous. Thank you.

Poorvi Soni: Thank you, Dr. Darnall. And our final questions is what recommendations do you have to address the additional challenges that have emerged for pain management during the COVID-19 pandemic for both people with pain and providers. This is directed to all speakers, and Eve, I'll begin with you.

Eve Gelb: Thanks, Poorvi. So, one of the concerns we have is that a lot of the pain treatment delivered by providers is dependent on in-person care. For example, we've noticed that our physical therapy visits have dropped off significantly since the pandemic began. Interestingly, opioid prescriptions have not; they've stayed pretty level. So, we

really think that there are some options for people, and Dr. Darnall mentioned them, where physical therapy could be done remotely with guidance and coaching.

Many of our members go online, they find exercises on YouTube to help them with their knee problems, et cetera. I think the struggle is that they -- it's not necessarily a doctor-recommended activity, so somehow, they've gotta balance communicating with their doctors and showing them this and figuring out if it's all right for them, which is super important.

Another thing is that, you know, folks who need more invasive protocols, those right now are often deprioritized because of COVID. So, being able to get the surgery that you needed or get the procedure done you needed is really impacted now. So one of the things I would recommend is for the health plans who, you know, the folks who are working for health plans that are listening, is look at your data and figure out who are the people who were needing pain management, and what has happened to those -- to their treatments since COVID, and how can you intervene in order to ensure that they get the care that they need.

It's not, you know, the first priority for an in-person visit when we're in the situation that we're in. And then the other thing is paying attention to the mental health strain, because of course, pain in itself creates mental health strain and depression and other things that folks have mentioned on the call already, but then coupled with the social isolation, the stress that we've all gone through with an election, with COVID, not knowing about whether the vaccine is coming and whether it's going to work -- people are just in a lot -- you know, experiencing a lot of emotional distress. So, being able to address that, whether it's through cognitive behavioral therapy or support groups or other things that can be done virtually I think is super important.

Poorvi Soni: Thank you, Eve. Donna Lynn, I'll turn it to you.

Donna Lynn Foster: Yeah, thank you. I think people who typically receive in-person pain care, either at home or through outside support services, find they are having to care for themselves at home, which can add to the burden of pain. This is another reason why self-advocacy is important. I'm impressed with the number of members I have talked with who have really rallied during COVID.

They've rallied with creativity and perseverance, resilience, and they're really doing well. And it has to do with the attitude going into it, because they know they can. They know they aren't -- that yeah, we're all stuck in this. But people need the encouragement that they can do well, that they can function, and as back in a strategy would be the same one -- to help people adapt and use their personal spaces as safe and peaceful environments for physical activity and emotional wellbeing.

You know, it might include improving the general safety and fall prevention, and creating those specific spaces inside their home for exercise and hobbies, self-care, and any

spiritual practices they may value to create a sense of control, to create a peaceful, workable environment that's a sanctuary, that's a safe place to be. Thank you.

Poorvi Soni: Thank you, Donna Lynn. And Dr. Darnall, same question to you. Dr. Darnall, you may be on mute.

Beth Darnall: Oh, thank you, sorry. COVID-19 has shattered some stereotypes in healthcare, so historically it's believed that people were disinterested in receiving healthcare online. But there's been incredibly high engagement rates and the convenience factor has been enjoyed, definitely, by a segment of people. So, recognizing that piece that there's a good receptivity for certain individuals.

There's another perception that older individuals are less technologically inclined. There are subgroups of individuals, and some of our research has suggested that there really aren't age-related differences, per se. We need to do a dive into the individual, understand their comfort with technology, and also assess whether they have internet access and the resources needed to engage with those resources.

Last thing I'll say is that it is--I mentioned previously it's important to integrate family members and caregivers as much as possible. And this can be particularly true during COVID, when we're considering pain care of the individual. It's a nice opportunity to treat the whole support system, recognizing that pain does not impact just the individual, but it's really the broader system, including the family and social support.

Also recognizing that family members are also under stress, and that the tools that we provide the individual patient, extending that to the family, can help the whole system cope better. And thank you.

Poorvi Soni: Thank you so much. Thank you so much to all of our speakers for sharing their valuable insights. With that, we now have a few minutes left for audience Q&A. Thank you to everyone in the audience who has already submitted questions through the Q&A feature or even through your registration form. If you have any additional questions, please submit them using the Q&A feature on the lower left of the presentation screen. You can type in your comment at the bottom of the Q&A box, and press Submit to send.

So, our first question is actually for Eve. This is a question regarding the peer advocate role. How was Donna Lynn's role as a peer advocate developed, and what suggestions would you have for health plans interested in adding a similar role?

Donna Lynn Foster: Yeah, so we developed those positions in response to our five-star quality metrics, particularly the ones around common geriatric conditions like urinary incontinence, physical activity, falls. And we did it because we felt that the peer connection that exists, particularly when you're talking about a difficult subject like urinary incontinence, an 85-year-old Latino is going to be more open to another older

adult, Spanish-speaking male when talking about things like that. So, we did research on peers and really found that that was important.

Then what we -- well, we were fortunate to have the most amazing human who can really manage an older adult workforce. Her name is Lisbeth Roberts, and she has really been able to work with older adults to create a work environment that is suitable for them, as well as training programs to support them, and then provide them ongoing support and interaction.

So, what I would say is start small, find a population of folks who are innovative and willing to try new things as older adults who are innovative or peers for whatever the issue is that you are trying to address. Focus on training, and then ongoing daily support. And we are happy to talk to folks about job descriptions and things like that, because we think that not only is it really beneficial for our members who engage with our peers, but it's beneficial for the peers themselves, as I'm sure Donna Lynn can attest to -- that sense of purpose and being able to really help folks. I hope I answered that well enough.

Poorvi Soni: Great, thank you so much, Eve. Donna Lynn, do you have a story of how you've helped a member access the support they needed in regards to pain management that you can share with us?

Donna Lynn Foster: Yeah, several. Much of it is just informing people, helping them to be aware of what is out there, and encouraging and following up with their doctors. If a member isn't doing this, we can help facilitate that on conference calls. We can get together, we can ask the doctor the questions, and encourage the members to be in compliance with what their doctor has wanted them to do.

But many of our doctors are receptive to having well-informed patients, and are willing to accommodate referring people to, like, physical therapy and any other benefits that we have, the other treatment modalities. Most of the members are benefiting by physical activity. I have one member I spoke with yesterday, actually, she said that her doctor thought she was a miracle.

She was going to aerobics through the gym membership five days a week for a bum knee, and she was ready for surgery. Doctor says, work out, get yourself in shape before the surgery; you'll do better. So she's working out in her water aerobics, and she gets back into the -- gets a final X-ray, and she doesn't need it. The doctor and his medical team are amazed at how well she's doing, and she's euphoric. She attributes this to her physical activity, to learning how to use her body properly and to work through pain, and this seems to have helped her.

There are several examples with physical activity. Others, I've had people speak very highly about the successful outcomes of acupuncture -- amazed, sometimes, when they've gone in and their results are immediate to free up cranky joints and to improve their flexibility and mobility. I could go through the list of benefits and cite members who have had positive outcomes using all of them, individually or in combination.

Because it usually is a combination. And again, a lot of it is the member thinking that, okay, this is a possibility that I can do, and being hopeful that this is something that's going to work for them. Yeah, thank you.

Poorvi Soni: Wonderful, thank you so much, Donna Lynn, for sharing. I think we have time for one more question. This is directed to Dr. Darnall. There's been evidence of disparities in pain management treatment for minorities. Black individuals in particular are disproportionately undertreated for pain. What additional considerations do you have for addressing these disparities?

Beth Darnall: That is an excellent question, and the data are really clear, I think. One of the most important things that we can do is A, be aware of the disparities that exist racially, the undertreatment of pain for African-American individuals, and just racial minorities in general.

So, with that awareness, we can then bring forward directed strategies, and that's really twofold. It's ensuring, holding ourselves accountable, to do comprehensive assessments in each individual, and in particular in minorities, building relationships and trust. So, we can come at this from the perspective of ensuring that we are asking the right questions and doing deep assessments, but also recognizing that from the patient perspective they may be less likely to share information, be forthcoming, because they may have had bad experiences previously within healthcare. They may be distrusting.

So, spend more time with patients. Value the human relationship, engender trust, telegraph, you know, your warm, caring personality, but recognize that it's crucial in these cases, so that, you know, we can receive the information and conduct truly collaborative, person-centered pain care planning for individuals to ensure parity in treatment.

Poorvi Soni: Thank you so much, Dr. Darnall. We can move to the next slide. Thank you again to all of our speakers for sharing. It was all very valuable and informative information. At this time, for our audience, if you have any additional questions or comments, please email RIC@lewin.com. The slides for today's presentation, a recording, and a transcript will be available on the Resources for Integrative Care website shortly. Next slide, please.

Thank you so much for joining us today. Please complete our brief evaluation of our webinar so that we can continue to deliver high-quality presentations. Next slide. For more information, we have additional resources here on the slide, including a link to the Empowered Relief Pain Management workshop that Dr. Darnall previously mentioned.

Thank you again to all of our speakers, and thank you to our audience. Have a wonderful afternoon, and thank you so much for joining us today.