

## Question & Answer (Q&A): Strategies for Non-Opioid Pain Management: A Panel Discussion

*Participants asked these questions during the November 2020 panel discussion event on strategies for non-opioid pain management. We have edited speakers' responses for clarity. The panel discussion recording, slides, and transcript can be found on the Resources for Integrated Care website by clicking the following link:*

[Strategies For Non-Opioid Pain Management: A Panel Discussion](#)

### Featured Speakers:

- Beth Darnall, PhD, Associate Professor, Stanford University School of Medicine, Department of Anesthesiology, Perioperative and Pain Medicine
- Eve Gelb, Senior Vice President, Member and Community Health, SCAN Health Plan
- Donna Lynn Foster, Peer Advocate, SCAN Health Plan

### Awareness and Access to Treatment Options

**Q1: Donna Lynn, as a peer advocate, how do you help members experiencing pain access the supports they need?**

**Donna Lynn Foster:** Much of what I do is inform people, help them to be aware of what resources are out there, and encourage them to follow up with their doctors. We can help a member ask their doctor questions and also encourage them to consider their doctor's recommendations.

One member I spoke with yesterday said that her doctor thought she was a miracle. She was ready for knee surgery and her doctor advised her to work out and get in better shape before the surgery to promote a better recovery. She started working out through water aerobics classes five days a week. In her final X-ray before surgery, the doctor found she did not need surgery after all. The doctor and his medical team are amazed at how well she is doing and she is euphoric. She attributes this to her physical activity and to learning how to exercise safely.

**Q2: What pain management strategies do you recommend for people with limited mobility?**

**Eve Gelb:** Even those with limited mobility can move, so safe physical activity and stretching can be effective. For example, SCAN Health offers members exercise bands to help them build flexibility and strength that can help reduce pain. Many of these exercises are low-impact and are great for members with limited mobility. Practicing mindfulness and socially engaging with others are also very effective interventions that are possible for people with limited mobility.

SCAN Health also offers Stanford University’s Living Well with Chronic Conditions workshop, which includes a focus on pain and how its associated emotions can hinder individuals’ pain management. The workshop teaches members how to manage other symptoms that can aggravate their pain. We also offer the Chronic Pain Self-Management Workshop with a focus on how certain exercises, healthy eating, effective communication with a care team, and appropriate use of medications can help individuals manage pain.

**Donna Lynn Foster:** I encourage members by reminding them, “Maximize what you got, and use what you can!” It sets the stage for exploring possibilities. Physical activity is one example of an effective tool to manage pain and the anxiety that often accompanies it. Too often, when one body part hurts, individuals tend to become immobile and focus only on the pain that demands our complete attention. In truth, that cranky joint may be only a small percentage of our entire body, which is aching to be moved, stretched, flexed, and used. Of course, injured and inflamed parts may need to be nurtured and immobilized, and it is a challenge to move around them, but it can often be done.

I encourage members to seek approval, advice, and strategies for movement and physical activity from their primary care provider, physical therapist, chiropractor, or other health professionals available to them. Then, I work with the member to determine what he or she can and is willing to do, and what will make it fun, until the benefit of movement itself becomes its own reward.

Together, the member and I also consider ways to arrange and use their homes and personal space as safely and efficiently as possible. This includes everything from falls prevention, to finding stable places to hold on to or sit while exercising, stretching, dancing and moving whatever they can move. I have used the extreme suggestion with members by saying that if all they can do is lay in bed and tighten their gluteal muscles to the beat of the music, do it! This usually gets a chuckle, and emphasizes the importance of moving everything possible.<sup>1</sup>

### Person-Centered Pain Management

#### **Q3: How can care managers support members in advocating for themselves with their physicians to access different treatment options?**

**Beth Darnall:** Create a handout with various available treatment options and include the evidence to support those options. Many non-pharmacologic pain treatment options are

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<sup>1</sup> Note: These responses reflect only a few of many situations and strategies in the large and complex issues of pain management, isolation, and mobility.

recommended by the U.S. Department of Health and Human Services, the Centers for Disease Control and Prevention (CDC) and the Centers for Medicare & Medicaid Services (CMS). At this point, the issue is access to those treatments because logistical and economic barriers exist. Care managers and members can request low-cost and low-burden non-pharmacologic pain treatment, which may be a more feasible option for them.

**Eve Gelb:** [Motivational interviewing](#) can be a helpful strategy to understand what is important to members and help them prepare to have a conversation with their doctor. Care managers can coach members and help them practice the conversations they will have with their physicians. Additionally, equipping members with data on the efficacy of alternative treatments is helpful. Some of our members have told us that they research studies and show the data to their doctors. If members do not have access to such data, we can provide that information for them.

**Q4: There is 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:** One of the most important things is to be aware of racial disparities for pain management in terms of the undertreatment of pain for Black individuals as well as other racial and ethnic minorities. With that awareness, we can then bring forward direct strategies. We must hold ourselves accountable to perform comprehensive pain assessments for each individual, as well as focus on building relationships and trust. We need to recognize that from the patient perspective, a history of bad experiences and racial bias in healthcare may cause distrust of the system and contribute to people being less likely to share information.

Providers should try to spend sufficient time with patients. Value the human relationship, engender trust, display your warm and caring personality. Recognize that it is crucial in these cases to help people trust and be at ease, so that you can receive necessary information and conduct truly collaborative, person-centered pain care planning with your patients to ensure parity in pain treatment.

**Eve Gelb:** It is really important to engage Black consumers in solution design to ensure that interventions work for them and meet their needs and preferences. It is also important to increase awareness of bias in treatment among providers and clinical staff.

**Q5: What is important to consider when evaluating pain management treatments for someone who may have a history of past substance use disorder?**

**Beth Darnall:** People with past substance use disorder have a great need for non-pharmacologic pain treatment. Untreated pain is a major risk factor for relapse and also

continued substance use. It is vitally important that we equip all individuals with actionable pain management strategies, in particular people with active substance use disorder. For some individuals with active substance use disorder behaviors, an addiction medicine specialist can connect them with appropriate resources and care. However, we must remember that regardless of whether someone has an addiction or not, accessible and effective pain self-management treatment is critical.

### Additional Consideration and Resources

#### **Q6: What effect does social isolation have on chronic pain?**

**Beth Darnall:** Social isolation often means less support – less support for one’s mood, less inclusion in mood-boosting activities, and less support for everyday activities such as rides to medical appointments, financial support, and help with things that one may not be able to accomplish around the house because of pain. It is important for people with chronic pain to remain connected with others however they can, even if just by phone or an online support group.

**Eve Gelb:** Many of our members share that social engagement relieves their pain. Those who do not have the ability to engage socially are likely to have increased pain. This can be a vicious cycle, however. People with pain may have barriers to engaging socially, particularly now during the COVID-19 pandemic, and become more isolated, and in turn experience greater pain.

**Donna Lynn Foster:** The negative effects of social isolation and potential loneliness on physical, emotional and cognitive well-being are well documented.<sup>2,3</sup> For example, during isolation, there are fewer distractions, diversions, and social interactions, which can cause one’s perception of pain to increase. This can cause extreme emotional distress and puts people at risk of overusing prescription pain medicines or self-medicating with alcohol or other substances. Mental and emotional health interventions are essential tools in effective pain management.

Chronic pain alone can result in social isolation, and the additional social isolation due to the COVID-19 pandemic may affect chronic pain. People who engage other people to help them with activities of daily living, paying bills, chores, and housekeeping are particularly at a disadvantage as their caregivers may no longer be available due to the risk of COVID-19 infection. People facing these circumstances require creative alternative arrangements, which

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<sup>2</sup> Kosharsky, B. (2020). How Social Distancing May Hurt People With Chronic Pain. Psychology Today. Retrieved November 28, 2020, from <https://www.psychologytoday.com/us/blog/getting-through-the-pain/202004/how-social-distancing-may-hurt-people-chronic-pain>.

<sup>3</sup> Smith, T. O., Dainty, J. R., Williamson, E., & Martin, K. R. (2018). Association between musculoskeletal pain with social isolation and loneliness: Analysis of the English Longitudinal Study of Ageing. *British Journal of Pain*, 13(2), 82-90. doi:10.1177/2049463718802868.

includes collaboration with the individual, family members and friends, and medical professionals.

Another possible response to chronic pain and the tendency to self-isolate is that people can become more independent, as they seek comfort and relief. This can be a productive coping mechanism and a successful strategy to deal with chronic pain, as many people value their independence, and do not want to worry others or be a burden. This tendency may actually be helpful in coping with the current restrictions imposed by COVID-19.

**Q7: How did SCAN Health develop the peer advocate role, and what suggestions would you have for health plans interested in adding a similar role?**

**Eve Gelb:** We developed the peer advocate position because we learned through CMS star reporting that our members needed additional assistance managing common geriatric conditions such as urinary incontinence, physical activity, and falls. We also learned that our members are more likely to be comfortable speaking to someone in their primary language and who shares a common background (e.g., an 85-year-old, Spanish-speaking man may be more open to speaking with another older Spanish-speaking male) about sensitive or difficult subjects like urinary incontinence. We did research on peer supports and found that fostering a peer-to-peer connection is important.

I suggest starting small – find members who are engaged, innovative and willing to try new things as peers for whatever the issue is that you are trying to address. Focus on training for peers, and then ongoing daily support. [SCAN Health](#) is happy to talk to other health plans about peer job descriptions and other steps needed to add this role.

Not only is the peer program beneficial for our members who engage with our peers, but it is also beneficial for the peers themselves, as the program can provide a sense of purpose through helping others.

**Q8: What guidance can you provide clinicians for working with individuals interested in tapering the use of opioids?**

**Beth Darnall:** I advocate for person-centered opioid tapering that is consensual and collaborative. Providers should give individuals a choice and share resources to help them manage any anxiety related to tapering, and to manage pain differently long-term using multi-modal approaches (e.g., physical therapy, exercise, over-the-counter pain medications, etc.). For example, Stanford University’s EMPOWER study works with individuals to achieve their “lowest comfortable dose over 12 months.” Focus on the individual and their comfort, not the opioid dose. Give individuals as much control in the taper as possible and encourage them to pause their taper or stop as needed. Give ample time for adjustment between dose decreases.

Tapering is not right for everyone. Sometimes, it is only through the taper process that it becomes clear an individual may benefit from the medication. For more information on person-centered tapering, the U.S. Department of Health and Human Services developed a [guide for clinicians](#) that details appropriate dosage reduction or discontinue opioids.