

“Integrating Non-Pharmacologic & Pharmacologic Pain Planning (NPPP) in Primary Care”

Presented by:

Tara Nichols, DNP, ARNP, RN-BC, CCRN, CCNS, AGCNS
on February 23, 2021

Webcast Questions and Answers

(Answers are in **bold**)

1. Do have any facilities within your network that had reach out programs for people who are low income in case if they are not able to find help within their community’s and what approach should u use if someone was reluctant to go to those facilities?
 - a. **Yes and No. Many non-medicine options were community based. Physical Therapy, Pharmacist, and Cognitive Behavior Therapist were network based and referrals were made from the primary care provider. The inpatient case study was at an organization with a wellness center that provided many of the services offered to the inpatient discussed during the presentation. The physician involved in this project was on the board of the community center which provided many of the services at an introductory promotional price. The Social Worker knew other community based integrative providers.**

I think you are missing the point of the project when you use the word “reluctant”. The point of the project was self-care and self-management guided by shared decision making. The providers and person in pain both took ownership for their part. When the three steps of NPPP protocol was followed: advancing understanding, pre-visit planning, and shared-decision making, there were no reluctance because the person in pain and provider is working together to create the plan of the best combination of medicine and non-medicine choices. This model requires a paradigm shift to *partnership* with people in pain and away from *domination* of telling people what to do. In a partnership model when people choose not to take the advice of “the expert” they are not labeled non-compliant or seen as reluctant, but the plan is adapted based on their values and needs.

So, to answer the question about reluctance, we partnered with the person in pain, focusing on their goal not numbers. Then helped them made small smart goals to facilitate the person in pain to become a better consumer of both medicine and non-medicine options in understanding their pain and planning for comfort. If the person tried something and decided that was not for them, they went on to something else. They were told the best NPPP would consist of 2-4 non-medicine choice with non-opioid medications or treatments.

2. Have you seen any evidence to support the efficacy of CBT in chronic pain control?
 - a. **Yes, CBT and Physical therapy are two of the most prescribed and used non-medicine choices for chronic pain and reviewed in the literature. There are several studies and white papers at the end of these questions and answers that review nonpharmacologic choices for pain. Many of the results of studies are low and moderate results of efficacy. However, we must remember integrative treatments effectiveness are heavily dependent on the clinician-patient relationship and many times it is a combination of treatments that bring the best result.**

Here is also another site and podcast about the importance of advancing understanding the first step in the NPPP. CBT helps advance the person in pain understanding of chronic pain and how non-medicine interventions work. These resources are for providers to help advance their understanding.

Neura.edu.au/health/pain

<https://www.neura.edu.au/health/pain/>

Biopsychosocial model of pain with Dr. Lorimer-Moseley

https://www.integrativepainscienceinstitute.com/latest_podcast/the-biopsychosocial-model-of-pain-with-dr-lorimer-moseley-2/

Here is also the video on Understanding Pain that we used to introduce NPPP protocol to people in pain. It provides a foundation for creating the right combinations of medicine and non-medicine choices:

https://www.youtube.com/watch?v=C_3phB93rvI

3. What non-pharmacological practice showed the most comfort for the patient?
 - a. **It depends on the person as to which non-pharmacologic practice will provide the most comfort. I have found in my practice setting providing both the premise and clear understanding of what the therapy offers brings the best result, least disappointment, and thus puts the person in the best possible mind-set for comfort to occur. In other words, how I show up as the provider, unwavering in my belief in comfort, presenting as the embodiment of comfort, giving up all rights to any pre-conceived result. Just showing that I have the courage to be with them. When I, the provider is authentic is when I see the highest manifestation of comfort. These are all assumptions in the Nichols-Nelson Comfort Theory.**
Reference

Nichols, T. (2018). Comfort as a multidimensional construct for pain management. *Creative nursing*, 24(2), 88-98.

However, in Nichols 2019, I list the most reviewed nonpharmacologic treatments in the literature. Whether if any of these will bring comfort to a person in pain will depend on the clinician-patient relationship, share-decision making, advancing understanding (both provider and person in pain), and focusing on a personal goal not numbers. I pose the personal goal question as follows “Realistically based on your current state, what has pain taken from you that you want to get back?” Most times initially this question renders the person speechless because no one has ever asked them this question. Actually, I prefer the silence because I know they are really thinking about it. When they reply, I try to help them formulate an achievable goal. That is when it becomes clearer what non-pharmacological practices may be best to start their journey to comfort. Remember pain is a perception and so is comfort, thus the goal is to place the person in the best possible mindset for comfort to occur.

Nichols, T. (2019). The Role of the Doctor of Nursing Practice in Promoting Nonpharmacologic Pain and Comfort Management. *Creative nursing*, 25(4), e28-e35.

4. Is the Choices for Pain and Comfort Form your form that you created or is this a generic form?
 - a. **Yes, it was created as part of my project. The provider felt we needed to find out if the person had used any nonpharmacologic treatment before recommending things that they had, had unfavorable results. Then we realized some of these people had been on opioids for over 20 years and their story was fragmented. The questionnaire served to summarize the patient story, what had been tried, what was working, what was not working, guide the conversation to development of a personal goal, and to introduce nonpharmacologic treatments including self-care and self-management.**

5. How long is this first visit with pain patients and how long are your follow-ups?
 - a. **Initially because we were developing the protocol the appointment could take 30-40 minutes (first 4 months), but this time included addressing what the patient came to see the provider for and introducing nonpharmacologic treatments. However after the workflow algorithm was in place, the initial appointment time was as scheduled depending on the patient (15 or 30 minutes) and the follow-up appointment time depended on if it was in person (15 minutes) or by message (email, call, or in the patient portal) which time would vary as with any follow-up. The most challenging aspect was follow-up without bringing the patient in for another appointment.**

6. I feel that PCP/NPs don't know how to first do all this, then how to find the time, and then find the resources. What is your advice for these providers who don't know where or how to start?

- a. **Start with taking inventory of what you do for pain. If what you are doing for pain is basically what the state requires as it relates to opioid prescribing which consist of controlled substance contracts, urine test, risk screening, and trying to not prescribe opioids then you have to be honest is this really pain management. Be honest, consider when you have a patient newly diagnosed with diabetes do you just give him a bottle of insulin and syringes. Or do you approach it holistically mind, body, and spirit talking to the person about diet and exercise (Dietary consult), reducing stress (meditation, mindfulness) and about medications; this has to be the same approach with pain management. Maybe you can pick 3-6 nonpharmacologic treatments, learn about them, and propose to your top three insurance you want to offer these for pain treatment then go from there. Here are articles that may help you get started:**

Nahin, R. L., Boineau, R., Khalsa, P. S., Stussman, B. J., & Weber, W. J. (2016, September). Evidence-based evaluation of complementary health approaches for pain management in the United States. In *Mayo Clinic Proceedings* (Vol. 91, No. 9, pp. 1292-1306). Elsevier.

Nichols, T. (2019). The Role of the Doctor of Nursing Practice in Promoting Nonpharmacologic Pain and Comfort Management. *Creative nursing*, 25(4), e28-e35.

Tick H, Chauvin SW, Brown M, Haramati A. Core competencies in integrative pain care for entry-level primary care physicians. *Pain Med*. 2015;16(11):2090-2097.

Everything takes time! Answer this question. How do you eat an elephant? One bite at a time. Take on what you can and when you start to see some results invite others. Decide on how you can partner with the person in pain, your staff, and other providers. Maybe two people can agree to be an expert on a treatment. During my 10-month project we had 4 lunch and learns that the providers paid for and all staff was invited to learn about the project. There were at least 30 people at each lunch. The MA's welcomed seeing the providers learn about offering other options for pain because they were tired of trying to explain to patients why their opioids were discontinued or stopped all together. Invite practitioner of integrative therapies from the community to partner with you and present to you how their therapy impact pain. The Agency for Healthcare Research & Quality has several publications on this topic from 2017-2020. They have done the literature review, so start here. If you click around on the sites you can find the spreadsheets where they evaluated each study.

AHRQ

<https://effectivehealthcare.ahrq.gov/products/nonpharma-treatment-pain/research-2018>

When you have put together a group of treatments you want to start with, then consider writing a proposal, see if your organizations offer small grants to help support advancing the project. Also, the most time intensive part of the project was follow-up, the grant funding could be to hire a part-time person to do the follow-up.

This website has more information about research grants in this area

NIH

<https://www.nccih.nih.gov/about/nonpharmacologic-management-of-pain>

7. Do you ever use AA, NA, SMART Recovery as non-pharmacological alternatives for SUD clients?
 - a. **No because only one of our patients was diagnosed with Opioid Use Disorder. We did start that patient on MAT and CBT. We discovered that not everyone that is a chronic opioid user also met Opioid Use Disorder diagnosis as defined by DSM V. Our focus was not SUD patients and it was at the end that we decided to see how many of the people we were working with was also diagnosed with SUD. When we tried to have the patients isolated, we learned that the methodology of assigning people OUD or SUD was arbitrary at best and did not follow the DSM 5 criteria. We also have one patient with a known substance use, and he was seeing an addiction counselor.**

8. Where did you find all the non-pharm providers? Affiliated credentialed hospital, community?
 - a. **See answer for question 1. We did provide community resources, websites, and referrals.**

9. Would "Ear seeds be something " you would suggest for those with needle fears--or if acupuncture were not available?
 - a. **If you are referring to Auricular Acupuncture this is what I suggest having patients try before full body if they are not sure.**

10. Do you attempt to taper using Suboxone since there are no credible studies proving that Opioids work for spinal pain?
 - a. **The focus of my project was to help providers introduce non-pharmacologic choices not weaning. What we found is as people got comfortable with building their Comfort Bundle®, they self-weaned and or stopped asking to have their opioids increased. The project was only 10 months from beginning to end and some people had only begun trying nonpharmacologic treatments. We started focusing on developing an opioid exit strategy at the end, meaning a weaning plan**

should be introduced at the start of initiation of opioids to prevent chronic opioid use.

11. Do you refer for diagnostics to get to the "root" cause of the pain and treat with needle guided injections or other modalities to address pain? Opioids should be the last resort.
 - a. **All people in the project were already diagnosed with chronic pain for years, none were newly diagnosed patients. The protocol is not meant to diagnosed pain related to a medical reason. While considering non-pharmacologic interventions all possible medical reason for pain should be addressed.**

12. Has there been any to study adjunct pain treatments and their effectiveness Example: Chiro, Tens, Acupuncture, Topicals etc.?
 - a. **I tend not to refer to these treatments as adjunctive in nature because they should be first line not added on if opioids are not working. Also, many providers still only think of adjunct treatments as only using medication to target different pain receptors. That is why I have started referring to these treatments as Comfort Bundles® the right combinations of medicine and non-medicine pain treatment options. The AHRQ has several systematic reviews from 2017-2020 including topical treatments. If you click around on their site, you will find the spreadsheets with the review of studies or the summary of the systematic review.**

AHRQ

<https://effectivehealthcare.ahrq.gov/products/nonpharma-treatment-pain/research-2018>

13. Have you used suboxone for pain?
 - a. **No**

14. Do you have any experience with incorporation of nonpharmacologic management for sickle cell patients after bone marrow transplant (to assist in managing opioid dependence and decreasing withdrawal)?
 - a. **No but I would start with what has the person tried and what are their personal goals.**

15. How do patients say they like this new approach?
 - a. **One patient wrote on her questionnaire to the provider that she was so grateful he was so concerned about her understanding pain and planning for comfort. Another patient asked me if I was going to talk his pain away. There was no resistance because the protocol was not presented as something to substitute their current pain treatment plan but as additive. All the patients that weaned from opioid was self-weaned when they came in and told the provider they had not been using all the pills he was prescribing. This is what can happen when a partnership approach to pain management is use with a goal to increase comfort. Were people skeptical? Of course, they were, even the providers were at first until**

they saw the transformation with how I engaged them and people in my belief about comfort.

16. Are your worksheets available for general use?

a. **Yes, email me tara.nichols@waldorf.edu**

17. What kind of help for people who do not have insurance or Medicaid?

a. **Most of the participants were Medicaid and Medicare. This is where smart goals came in to help the person understand the concept of self-care and self-management. What can the person afford, they had to figure this out? Does their insurance offer gym membership which may offer some of the services (e.g. Yoga, Tai chi, strengthening, stretching, sport massage)? What services does the community centers or community education classes offer that are usually inexpensive? Some web-based exercise classes offer a free trial membership which would be long enough for them to learn 4 or 5 Yoga moves. YouTube has everything and we found several mindfulness, Yoga, Progressive Muscle Relaxation videos. We found free classes at churches. Several people call their insurance company and got coverage for acupuncture, massages, TENS unit, and found that their insurance covered gym memberships. If you are engaging in shared decision making, then what is realistic financially should always be at the forefront of the plan. The patient's personal goals empowered the patient to take charge of planning for comfort. This is the person in pains work not the provider, the provider is advisor and teacher in the partnership. One of the patients who was on Medicaid kept telling me how expensive all of the nonpharmacologic treatments were, but I suggested maybe he could use half of the money he was using for his illicit drug use on a massage. When I suggested this, I was not being judgmental but authentic in price comparison of what he thought he could afford based on what he was spending on illicit drug use.**

Coverage is changing here is an article explaining how:

Nielsen, A., Tick, H., Mao, J. J., Hecht, F., & Consortium Pain Task Force. (2019). Academic Consortium for Integrative Medicine & Health Commentary to CMS; RE: National Coverage Analysis (NCA) Tracking Sheet for Acupuncture for Chronic Low Back Pain (CAG-00452N). *Global advances in health and medicine*, 8, 2164956119857648.

At the end of the project the provider and I was convinced that things are not going to change as long as people accept what is instead of advocating for what should be.

18. How do your patients (afford) non-pharmacologic treatments? Insurance usually does not cover esp. (Medicaid population).

a. **See answers from question 1, and 17.**

Additional readings about how to get start, moving toward comfort, and insurance coverage

Eaves, E. R., Hsu, C. W., DeBar, L. L., Livingston, C. J., Ocker, L. E., McDonald, S. J., ... & Ritenbaugh, C. (2019). Whole Systems Within Whole Systems: The Oregon Health Plan's Expansion of Services for Back and Neck Pain. *The Journal of Alternative and Complementary Medicine*, 25(S1), S61-S68

Davis, R. (2017). Vermont policy makers assess the effectiveness of acupuncture treatment for chronic pain in Medicaid enrollees. *The Journal of Alternative and Complementary Medicine*, 23(7), 499-501.

Nichols, T. (2019). The Role of the Doctor of Nursing Practice in Promoting Nonpharmacologic Pain and Comfort Management. *Creative nursing*, 25(4), e28-e35.

Nichols, T. (2018). Comfort as a multidimensional construct for pain management. *Creative nursing*, 24(2), 88-98.

Nielsen, A., Tick, H., Mao, J. J., Hecht, F., & Consortium Pain Task Force. (2019). Academic Consortium for Integrative Medicine & Health Commentary to CMS; RE: National Coverage Analysis (NCA) Tracking Sheet for Acupuncture for Chronic Low Back Pain (CAG-00452N). *Global advances in health and medicine*, 8, 2164956119857648.

Tick, H., Nielsen, A., Pelletier, K. R., Bonakdar, R., Simmons, S., Glick, R., ... & Zador, V. (2018). Evidence-based nonpharmacologic strategies for comprehensive pain care: the consortium pain task force white paper. *Explore*, 14(3), 177-211.