Ramezani, A., Roberto, L.K., Andrade Jr., A.L, DeMesa, C., Carver, R., Raheel, A. Khan, R.A., Aria, L., Rockers, D., Barry, L., Rasmussen, C., Malekafzali, S., Aurora, M.A., Cohen, C., Rogers, C.G., Lloyd, S./ Californian Journal of Health Promotion 2018, Volume 16, Issue 2, Pages 66-73.

Taking on a Community Solutions Process (Co-Solve) to the Pain and Opioid Epidemic: A Multi-disciplinary and Multi-institute Pain Panel and Community Response in Sacramento, California

Amir Ramezani[1,10,11], Lori K. Roberto[2,11], Alex L. Andrade Jr. [3,10,11], Charles DeMesa[1], Ryan Carver[4], Raheel A. Khan[5], Leslie Aria[4], Daniel Rockers[6,10,11], Lisa Barry[7,11], Cassandra Rasmussen[8,11], Saideh Malekafzali [9,11], Maji Singh Aurora[1], Catherine Cohen[6], Carrie G. Rogers [6,10], and Stacie Lloyd[12]

[1]*University of California, Davis*
[2]*Health Psychology Practice*
[3]*WellSpace Health*
[4]*Kaiser Permanente*
[5]*Sutter Medical Center, Sutter Center for Psychiatry*
[6]*Psychology Private Practice*
[7]*Inspiring Wellness*
[8]*Alliant International University*
[9]*San Juan Unified School District, Visions In Education*
[10]*California Psychological Association*
[11]*Sacramento Valley Psychological Association, Behavioral Medicine & Neuropsychology Section*
[12]*Fielding Graduate University*

Abstract

America's healthcare providers and patients are challenged by an overwhelming high prevalence of chronic pain and opioid misuse. Approximately 23.4 million adults suffer from daily pain and in 2014, nearly 61% of Americans who died from drug overdoses used an opioid analgesic. Unrecognized addiction, untreated psychiatric comorbidity, and lack of training/education for providers and patients are factors associated with chronic pain and opioid misuse. Communication strategies and structures are required to enhance collaboration between multidisciplinary providers and institutions. On September 28, 2017, an open panel discussion with pain specialists from three major academic and medical institutes in Sacramento, California initiated an integrative community solutions process to optimize pain education best practices and to protect public health. The attendees represented a wide range of healthcare disciplines. This commentary describes ideas derived from dialogue between community attendees and panelists, which considers both healthcare provider characteristics and patients' cultural backgrounds. Providers of most disciplines underscored the need to share information and institute cross-disciplinary training on pain and behavioral health treatments. In conclusion, we outline an integrative community-based framework, namely the Community Solutions Process (Co-Solve), to help other communities to implement and derive their own action-oriented solutions unique to their population.

Keywords: Community organization, community-based solutions, opioid misuse, multidisciplinary education, interdisciplinary pain, pain psychology.

Introduction

Current Pain and Opioid Crisis

Pain is widespread in the United States, with up to 50 million Americans reporting "a lot" or "daily" pain, resulting in high utilization of healthcare and disability (Freburger et al., 2009; Nahin, 2015). Problems associated with the use of opioids to manage pain have become

increasingly visible and death rates from opioid overdose have steadily increased. In one year alone, age-adjusted death rates increased by 15.6% from 2014 to 2015 (Rudd et al., 2016). A majority of such deaths appear to be with heroin and synthetic opioids, such as illicitly manufactured fentanyl (Hedegaard, Warner, & Minino, 2017; Rudd et al., 2016). Given the risks of opioid use, providers have started to examine how they treat individuals experiencing pain. It is increasingly clear that a multidisciplinary and collaborative approach is needed (Rudd et al., 2016).

Multidimensional Aspects of Pain

Pain is both objective and subjective with sensory and affective dimensions and can exist in the absence of an identifiable cause (Savage, Kirsh, & Passik, 2008). Pain is perpetuated and exacerbated by the complex interaction of physiological, psychological, and social factors (Gatchel, McGeary, McGeary, & Lippe, 2014). A multidimensional treatment approach, such as the biopsychosocial model, is recommended for pain (Ramezani, McCarron, Lashai, & Lenaerts, 2015) but often requires the coordination of providers across disciplines. Some notable challenges include minimal communication, lack of common philosophy of treatment and limited access to education about coordinated treatment approaches (Gatchel et al., 2014).

There are limited opportunities for communication about these issues as well as limited publication about dialogues focused on addressing such challenges as a bigger community. Furthermore, there is little known about how well community providers communicate with each other about specific biopsychosocial challenges and potential solutions for opioid and pain treatment. A solution-oriented discussion with community practitioners may be beneficial, as this can serve as a true "community-driven" biopsychosocial approach to pain management (versus the isolated practitioner applying the biopsychosocial approach without input from his or her colleagues).

Pain Education for Behavioral and Medical Providers

Pain specialists are generally aware that opioid treatment is ideally accompanied by behavioral non-pharmacological interventions, such as coping skills training, biofeedback, trauma therapy, cognitive-behavioral therapy, mindfulness-based psychotherapy, and physical therapy (McCarron, Ramezani, Koebner, & Sheth, 2017). They are also cognizant of assessing psychiatric and substance use disorders and appropriately documenting their risk assessment (Centers for Disease Control Prevention, 2012; Chen, 2013; Federation of State Medical Boards, 2015). However, there is uncertainty about whether community providers who treat chronic pain, but don't specialize in pain management, are aware of the aforementioned information. They may lack access to pain education, which may contribute to the opioid crisis (Loesera & Schatman, 2017; Ramezani, 2016). Thus, pain education at the community level is imperative.

Objective and Aim

The objective of this article is to report on challenges and solutions that were identified at an open forum pain panel discussion. In doing so, we also report on a general approach that helped community practitioners stimulate conversations, moderate discussion, and organize information about the multidimensional professional aspects of managing pain and opioid use. We refer to this approach as the Community Solutions Process (Co-Solve).

Benefits of Community Organization

The benefits of community organization and communication have been extensively discussed and researched by multiple social, community, political and philosophical scholars (Fisher, 1994; Gittell & Vidal, 1998; Putnam, 1993; Rothman, 1995). Benefits include the opportunity for helping professionals at all levels of education and training on a special topic to come together; promoting reciprocal learning and generating new ideas; enhancing interpersonal bonding and interprofessional connection; and starting a collective contribution to solve issues (Fisher, 1994; Gittell & Vidal, 1998; Putnam, 1993; Rothman, 1995). There are also multiple models

for community organization and communication. The benefits and framework of community organization are summarized in Table 1. Similarly, multi-disciplinary and multi-institutional communication in the local community can provide the same benefits.

Table 1.
Framework, Theory, and Shared Benefit of Community Organization

Community Framework	Shared Community Benefit
Putnam's Theory of Social Capital	● Promote community building on national issues that affect local practice and vise-versa ● Promotes new and diverse thinking around issues
Rothman's 3-Model of Community Organization	● Helps people contribute to and solve issues in a mutually beneficial partnership ● Increase community power, responsibility, pro-social actions, and social justice ● Activates people in power positions and those with less power positions
Fisher's Neighborhood Organization	● Increase social-community trust and partnership ● Increase bonding and bridging capital: bring people who either know each other (boding capital) or don't know each other (bridging) closer together in a positive and constructive way ● Increases interpersonal trust, sense of community, and ability to make decisions collectively

Community Organization Solutions for Pain and Opioid Problem

Multi-disciplinary and multi-institutional communication in a local community allows identification of issues salient to patients, institutional providers, community providers, and the healthcare system. This further allows the development and incorporation of the collective voice of the treating community and specialist community (both pain specialists and non-specialists). The first step in a community-based solution is to bring individuals from multiple disciplines and institutes in the local region together via a format that promotes education and open dialogue regarding unique matters specific to the community. Broader socio-cultural issues that give rise to opioid misuse, untreated addiction and psychiatric comorbidity can also be discussed and solutions can be generated in such a forum. Reciprocal learning and dialogue strengthens the treating community and promotes solution-focused collaboration. Simultaneously, pain specialists also learn pressing pain and opioid issues that are unique to their community and local demographic population, and they are better able to translate theory to the ground level.

Process of Community Discussion

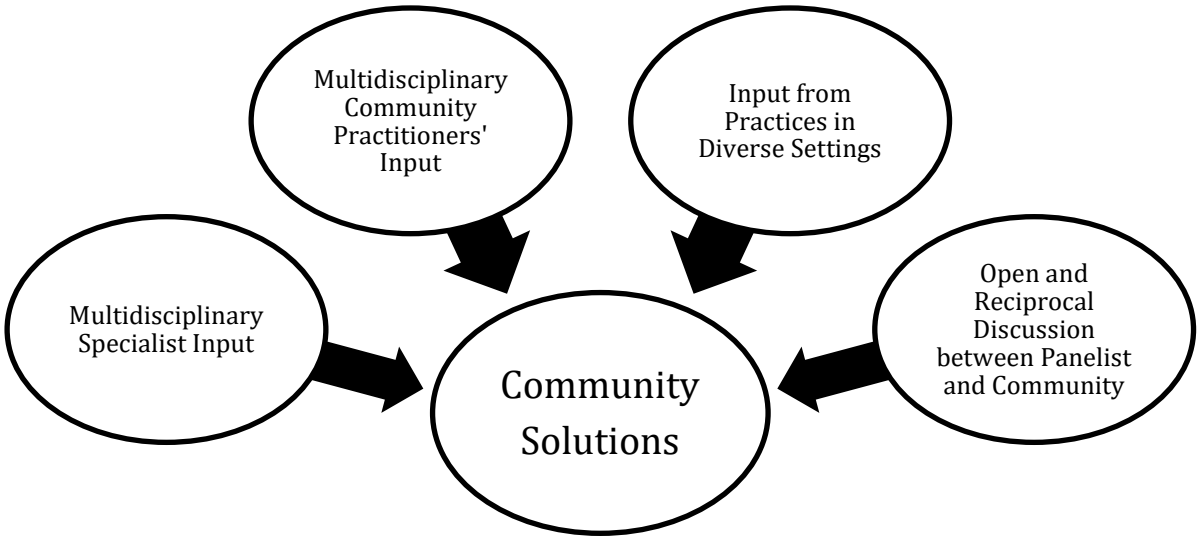
The Behavioral Medicine and Neuropsychology Section of the Sacramento Valley Psychological Association (regional chapter of the California Psychological Association) held an open panel discussion on September 28, 2017. The aim was to provide education for community providers and to initiate dialogue regarding pain and the rise of opioid use misuse across disciplines and institutes. The panel included four pain specialists representing pain psychology, pain medicine, physical medicine, and psychiatry from three major academic and medical institutes in the region. Attendees comprised a wide range of disciplines including school education administration, hospital administration, psychology, family medicine, social work, physical medicine and rehabilitation, physical therapy, addiction counseling, and marriage and family therapy. A moderator managed communication between panelists and attendees. Discussion covered topics related to the practice of pain management. These included opioid use, non-opioid pharmacological options, non-pharmacological interventions, psychological factors, the role that behavioral health plays in medical assessment and treatment, the role of medical assessment and treatment in behavioral health, health systems issues, education and training needs, and challenges for providers who treat patients with chronic pain. After the meeting, participants were emailed and invited to review and further contribute to the challenges and solutions outlined in this paper. Authors on

this paper were present at the meeting and further contributed their opinion to the derived challenges and solutions.

The process of moderating the discussion involved a semi-structured approach that ultimately flexed to the needs of community providers. Discussion included two parts. The first part explored individual provider challenges. Next, the scope of the problem was widened to include interprofessional and interdisciplinary challenges. The conversation was further expanded to include macro level issues at institutional, private practice, societal and cultural levels. The second part involved narrowing down the challenges and brainstorming solutions from different perspectives. Solutions generated by community providers were also commented on by pain panelists.

Pain specialty panelists and community attendees reciprocally posed questions and offered solutions throughout the process. A few key elements helped stimulate inclusive thinking, generation of ground level/practical solutions, and multidisciplinary collaborative solutions in the context of pain and opioid use. Discussion elements are depicted in Figure 1. The discussion was narrowed down to two areas that best captured the challenges and solutions: 1) health provider/patient factors and 2) systems/cultural factors. Both are detailed in the upcoming section.

Figure 1. Community Solutions Process (Co-Solve)



Outcome of Community Discussion

The following commentary represents the opinions of the authors and attendees as to the discussion. The following does not represent institution's or organization's opinions. Overall, there were two main sets of factors that were discussed and contributed to the pain and opioid misuse concerns in the community: health provider and patient factors, and systems and cultural factors. Summaries of challenges and solutions for each set of factors are described in Tables 2 and 3.

Table 2.

Health Provider and Patient Factors Playing a Role in the Pain and Opioid Misuse in the Community

Challenges	Solutions
Referrals and Access: High volume of patients; lack of awareness of referral options for multidisciplinary team care.	**Provider Identification:** Directory of local pain specialists across behavioral, medical, and integrative disciplines.
Lack of Provider Communication: Limited coordination, terminology, methodology and case management resources across disciplines and institutes. Provider access to and use of a prescription drug monitoring program.	**Foster Provider Communication**: Coordination of care within and across institutes via phone calls, peer-to-peer coaching, and mentorship. Improve access to statewide database to monitor refills and notify prescribing providers.
Provider Training: Limited provider awareness of cross-disciplinary pain treatments. Overall lack of training for all providers in substance abuse, dual diagnosis, pathophysiology of pain, and pain management.	**Establish Protocols**: Disseminate local "Best Practices" guidelines. Identify provider roles, tools, and terminology with patients. Emphasize pain management in professional healthcare and behavioral sciences curriculums.
Patient Variables: Unrealistic assumptions regarding the nature and physiology of pain, opioids, and the expectation for a "cure." Variety of family systems, personality structures, and coping styles which impact treatment and outcomes. Patient isolation and lack of competency due to pain and/or disability.	**Patient Care and Education**: Teach pain physiology, coping tools, and resilience. Encourage "paradigm shift" of beliefs around pain and opioid use. Discuss expectations and treatment options with patients. Utilize family systems approach and patient support groups to ameliorate loneliness and increase competency.
Lack of Prevention: Low emphasis on prevention of pain and opiate misuse compared to treatment. Unused opiates that lead to inappropriate use at a later time or by an unintended user.	**Patient Proactivity**: Encourage patient strength, flexibility, and conditioning to prevent pain. Set boundaries and expectations for opiate use and disposal before patient discharge.

Table 3.

Systems and Cultural Factors Playing a Role in the Pain and Opioid Misuse in the Community

Systems Challenges	Systems Solutions
● Cost and time required for complex patients. External referrals and patient follow-through.	● Models that utilize multiple, short visits. Use of telehealth options. Cost savings with integrated, multidisciplinary health as standard of care.
● Cross-institutional variability in systems and protocols. Lack of spaces and protocols for cross-disciplinary interaction.	● Field trips to local institutes to identify protocols and modes of communication. Multidisciplinary, team-based treatment approaches and models.
● Institution-specific practices and restrictions regarding use of medication assisted treatments. Graduate education practices and training.	● Train appropriate use of medication assisted treatments in various settings. Foster cross-disciplinary teaching in graduate education.

Table 3. (cont'd)

Cultural Challenges	Cultural Solutions
● Media and entertainment industry portrayal of and normalization of opiate use. The stigma associated with seeking psychological and addiction treatment.	● Enlist entertainers and media to change the narrative on opioid use. Integrate culturally bound health beliefs, social, and spiritual systems in patient assessment and treatment. Discuss addiction, mental illness, pain and pain management in community settings.
● Affordability of care issues and lack of insurance coverage for non-pharmacological or complementary treatments.	● Increase private and public funding of dual-diagnosis treatment centers. Identify grants to support lower cost services for mental health and addiction treatment. Policy change to increase insurance coverage of preventive and non-pharm/CAM modalities.
● The effect of the "war on drugs" on prescription prices/access, resulting in the diversion of medications illegally.	● Lobby to use the money from the "war on drugs" on rehabilitation and appropriate reimbursement of specialty pain providers.

Discussion

Healthcare providers in the community are faced with a increase rise of pain complaints and lethal opioid misuse. The problem is complex and multifaceted, requiring creative solutions that include specialist and community practitioners. Local providers must work together to improve healthcare options and to identify the unique systemic and cultural issues in their community.

Using the Co-Solve approach, the panelist and community providers shared dialogue and addressed salient factors related to pain management and opioid use. At the local level, community providers must work together to identify collaborative methods to improve healthcare provider factors, and to take into consideration the unique systemic and cultural issues present in their community. We identified both challenges and barriers including the difficulty of working and communicating across institutes, disciplines, and professional organizations; cross-disciplinary specialty education across varied levels (e.g., high school); behavioral science practitioners teaching presence in medical settings and medical institutes; systems involving prevention, adoption of integrative approaches; leverage of technology; access to opioid databases for providers; participation in grant writing and lobbying focused on pain, health disparity, and community education and training.

The challenges and solutions in Tables 2 and 3 are considered knowledge from the "frontlines" of providers, which represent clinical practice at the ground level of our professional community. This represents a first step towards better care and increased collaboration amongst the pain and opioid provider community. The next step is to implement community-based actions and develop community-informed policy, increase inter-institutional communication, and improve communication across various professional organizations (e.g., societies, associations). These are aspiring solutions and should be considered with one's own professional ethical practice guidelines.

Subsequent steps may involve research studies replicating the practical application and changes in practice outcomes in different communities. Clinical pain management and opioid use guidelines can arise from professional community-base discussions and reports. Community dialogue should not be viewed as a replacement for consensus building, task force committee decisions, or political and

organizational activities; rather, as another data point of information that represents the "frontlines" of the treatment community, which is a strong voice for community change.

The Co-Solve approach can be a model for other treating communities. Local communities can invite professional and community specialists to discuss both challenges and solutions in an open manner that stimulates cross-disciplinary dialogue, connection, and community action. There are multiple benefits to this model, including fostering treatment provider cohesion; exploring healthcare disparity; identifying novel solutions, increasing cross-disciplinary and cross-institutional communication, and ultimately transmitting specialty information to local treating providers. These benefits can help to strengthen community consensus and optimize healthcare delivery. The solutions and process of deriving community-based discussion may also help to reduce morbidity and mortality starting at the ground level.

References

Centers for Disease Control Prevention. (2012). CDC grand rounds: Prescription drug overdoses-a US epidemic. *Morbidity and Mortality Weekly Report*, *61*(1), 10.

Chen, L., Vo, T., Seefeld, L., Malarick, C., Houghton, M., Ahmed, S., … Mao, J. (2013). Lack of correlation between opioid dose adjustment and pain score change in a group of chronic pain patients. *The Journal of Pain: Official Journal of the American Pain Society*, *14*(4), 384–392.

Federation of State Medical Boards. (2013). Model policy for the use of opioid analgesics in the treatment of chronic pain. Retrieved from http://www.fsmb.org/Media/Default/PDF/FSMB/Advocacy/pain_policy_july2013.pdf

Fisher, R., & Kling, J. (1994). *Mobilizing the community: Local politics in the era of the global city*. Newbury Park, CA: Sage.

Freburger, J. K., Holmes, G. M., Agans, R. P., Jackman, A. M., Darter, J. D., Wallace, A. S., Castel, L. D., Kalsbeek, W. D., … Carey, T. S. (2009). The rising prevalence of chronic low back pain. Archives of internal medicine, 169(3), 251-8.

Gatchel, R. J., McGeary, D. D., McGeary, C. A., & Lippe, B. (2014). Interdisciplinary chronic pain management: Past, present, and future. *American Psychologist*, *69*, 119-130.

Gittell, R., & Vidal, A. (1998). *Community organizing building social capital as a development strategy*. Thousand Oakes, CA: Sage.

Hedegaard, H., Warner, M., & Minino, A.M. (2017). Drug overdose deaths in the
United States, 1999-2015. NCHS data brief, no. 273. Hyattsville, MD: National Center for Health Statistics.

Loesera, J. D., & Schatman, M. E. (2017). Chronic pain management in medical education: A disastrous omission. *Postgraduate Medicine*, *129*(3), 332-335.

McCarron, R. M., Ramezani, A., Koebner, I., & Sheth, S. J. (2017). Integrated chronic pain and psychiatric management. In Feinstein, R., Connelly, J.V., Feinstein, M.S., *Integrating behavioral health and primary care*. New York, NY: Oxford University Press.

McWilliams, L. A., Cox, B. J., & Enns, M.W. (2003). Mood and anxiety disorders associated with chronic pain: An examination in a nationally representative sample. *Pain*, *106*(1–2), 127-133.

Nahin, Richard, L. (2015). Estimates of pain prevalence and severity in adults: United States, 2012. *The Journal of Pain: Official Journal of the American Pain Society*, *16*(8), 769-780.

Putnam, R. D., R. Leonardi and R. Y. Nanetti. (1993). *Making democracy work: Civic traditions in modern Italy*. Princeton, NJ: Princeton University Press.

Ramezani, A. (2016). Teaching pain psychology and neuropsychology: What do medical trainees want to learn? *Journal of Psychology and Clinical Psychiatry*, *6*(8), 1-4.

Ramezani, A., McCarron, R. M., Lashai, B., & Lenaerts, M. E. P. (2015). Head pain and psychiatric illness: Applying the biopsychosocial model to care. *Current Psychiatry*, *14*(9), 12-26.

Rothman, J. (1995). Approaches to community intervention. In. J. Rothman J. Erlich & J. Tropman (Eds.), *Reflections on community organizing: Enduring themes and critical issues* (3rd ed., pp. 26-63). Itasca, IL: F.E. Peacock Publishers.

Rudd, R. A., Seth, P., David, F., & Scholl, L. (2016). Increases in Drug and Opioid-Involved Overdose Deaths — United States, 2010–2015. MMWR Morb Mortal Wkly Rep, *65*, 1445-1452.

Savage, S. R., Kirsh, K. L., & Passik, S. D. (2008). Challenges in Using Opioids to Treat Pain in Persons With Substance Use Disorders. *Addiction Science & Clinical Practice, 4*, 4–25.

Author Information
Amir Ramezani, PhD
Department of Surgery and Physical Medicine and Rehabilitation
University of California, Davis
2221 Stockton Blvd, Sacramento,
CA 95817
916-734-4948
aramezani@ucdavis.edu