

**Pain Management Best Practices Interagency Task Force Draft Report
Comments to the Docket – April 1, 2019
Submitted by the following organizations:**

Center for Practical Bioethics
CHAMP (Coalition For Headache And Migraine Patients)
Chronic Pain Research Alliance
For Grace: Women In Pain
Global Healthy Living Foundation
Headache and Migraine Policy Forum
International Pain Foundation
Interstitial Cystitis Association
RSDSA (Reflex Sympathetic Dystrophy Syndrome Association)
The Pain Community
U.S. Pain Foundation

Introduction

On behalf of the Consumer Pain Advocacy Task Force (CPATF), a coalition of nonprofit organizations dedicated to improving the lives of patients with chronic pain, we applaud the work of the Pain Management Best Practices Inter-Agency Task Force and commend the recently published Draft Report. The importance of the Pain Management Best Practices Interagency Task Force cannot be overstated, particularly in light of two equally important public health crises: chronic pain and unintended deaths related to opioid use disorder.

We appreciate the understanding and acknowledgement that these two significant public health crises have been conflated and their management sometimes seen as adversarial, rather than synergistic.

This report is well thought out, with good recommendations. One of the first things we note, however, is that without funding and support and possibly legislation, few of the recommendations will be realized. ***We implore HHS to appoint a lead individual at OASH to oversee implementation of the recommendations and to work with our organizations and other patient and professional groups to advocate for implementation.***

We appreciate the focus on ***individualized care*** and would like to see additional emphasis on that premise throughout all of the sections. Every patient is different. Many who share the same diagnosis will react differently to different treatments. It is important to find the multi-modal, multidisciplinary treatment plan that works for each ***individual*** patient.

We appreciate the acknowledgement of the important limitations of the ***2016 CDC Guideline for Prescribing Opioids for Chronic Pain*** and the recognition of negative unintended consequences to people living with pain as a result of the widespread adoption of these

guidelines. ***We recommend the CDC Guidelines be revised and reissued based on these and the other specific recommendations in the PMTF Report.***

We View These Highlights of the Report As Most Important from a Patient-centered Perspective

1. Pain is an enormous public health problem with profound individual and societal consequences
2. Successful management of pain requires individualization of care in the selection of therapies tried, in the consideration of risks and benefits of therapies, in the duration of treatment, in the optimal dosing of medication and so on.
3. Best practice in pain management is achieved through a multi-modal, multidisciplinary, integrated model of care including a full range of pharmacological and non-pharmacological treatments.
4. Stigma is a major barrier to treatment; therefore, it is critical to provide education and awareness of the underlying disease process of pain and to offer empathy and a non-judgmental approach to treatment.
5. Public, patient, and provider education is critical to the delivery of effective, patient-centered pain management and is necessary for optimizing patient outcomes.
6. The risk-benefit balance for opioid management must be considered on an ***individual*** basis as there is wide variation in factors that affect the optimal dose of opioids.

As a coalition representing tens of thousands of patients combined, we urge the Task Force to carefully consider all of our feedback.

Specific Comments on the Draft Report

Please note:

- Text directly from the Draft Report which is included to show where our comments and/or suggested revisions are located appears in plain black text.
- Comments and explanations of suggested changes appear in blue text.
- Suggested additions and revisions are printed in red text.

1. Introduction

While the introduction raises the issue of suicide among chronic pain patients, it does not adequately identify ways to address it. We will suggest language to remedy this throughout various sections. Here, at the end of paragraph 7 and again in Clinical Best Practices, we recommend adding the red text below.

[Paragraph 7] Public comments submitted to the Task Force show growing consideration of suicide resulting from unrelieved pain and in some cases lack of access to treatment. According to a recent CDC report using data from the National Violent Death Reporting System, the percentage of people who died by suicide who also had evidence of chronic pain increased from 7.4% in 2003 to 10.2% in 2014. Numbers from this data set beyond 2014 are not yet available. This finding leads to the rising concern that a recent trend of health care professionals opting out of treating pain has contributed to an existing shortage of pain management specialists and is leaving some patients without adequate access to care. **It is consequently critical that the remaining physicians treating chronic pain screen their patients for suicidal risk.**

2. Clinical Best Practices

[Paragraph 1, second sentence] In pain management, a critical part of providing comprehensive care is performance of a thorough initial evaluation, including assessment of both the medical and the probable biopsychosocial factors causing or contributing to the pain, with a treatment plan to address the causes of pain and to manage pain that persists despite treatment. **It is of great importance that proper depression and suicidal risks assessments are done by all health care professionals treating people with chronic pain.**

2.1 Approaches to Pain Management

Lack of reimbursement is often the reason given by providers for not including these therapies.

Dollar-driven decision-making has led to inappropriate pain treatment, such as unnecessary surgeries, routine injections of questionable benefit, and over-reliance on prescription pain medications. It has also denied access to services such as physical therapy, diet and nutrition

counseling, chiropractic care, psychological counseling and other approaches which may provide significant benefit. Often the primary, even singular, treatment available is what the person's insurance covers as opposed to integrated pain management that often results in the best outcomes.

Under Gap 1, we propose adding three additional recommendations:

Gap 1: Current inconsistencies and fragmentation of pain care limit best practices and patient outcomes. A coherent policy for pain management within health systems is needed.

Proposed Recommendation 1b: Patients must be empowered to participate in their care plan and must be considered an active member of their care team. Patient preferences as well as limitations caused by factors such as geography, provider workforce, socio-economic status, transportation, work schedules, family responsibilities, etc., should be considered when making the care plan.

Proposed Recommendation 1c: Develop appropriate reimbursement and authorization policies, including bundled payments, to allow for an integrated multimodal, multi-disciplinary approach to chronic pain.

Proposed Recommendation 1d: Develop outcome measures based on functionality and quality of life, rather than simply decrease in pain scores and/or amount of opioids prescribed.

Acute Pain

We could not agree more with the importance of the last sentence in this section and wish to underscore the importance of clinician reimbursement for the time required: "This finding further underscores the value and importance of initial clinician-patient time together as well as appropriate follow-up time to better assess risk and provide appropriate treatment for these complex pain conditions."

In the Acute Pain section and in other areas of the report, the CPTAF is concerned that various lists of therapies and treatments provided will be taken as all-inclusive and limited. This is problematic in the case that parts of the PMTF Recommendations are implemented or adopted on a broad scale, especially if done so by payors. We propose including language that recognizes the limitations of such lists and includes reference to a more comprehensive list of viable treatment options such as the one included as **Appendix A** of this letter.

2.2 Medication

We applaud this section and its emphasis that effective pain management, particularly for chronic pain, is best achieved using a *patient-centered, multidisciplinary, integrated approach* that may include pharmacotherapy.

Again, though, the Task Force must be careful that lists of medications, therapies, etc., are not interpreted as all-inclusive. Under “Opioids” where you provide a list of names of opioids, please consider including the following statement:

This list of opioid medications is offered as current examples and is **not** inclusive or exhaustive, as new treatments, including medication, continue to be developed.

While the **CDC Guideline** is mentioned later in the Draft Report, we suggest including a reference to it in this section, particularly related to the unintended consequences, the idea of a ceiling dose, and use of non-opioid medications (Recommendation 5b in Section 4).

On page 12, we believe the warning against benzodiazepines and opioid usage is too strong, making it sound as though these two important medications should never be prescribed together. We encourage an understanding of the value of each medication, sometimes in tandem together. We also see conflict between this warning and Item 6 under Section 4, which states that combining the two medications may have clinical value. We propose adding a recommendation under Gap 2: **Implement an education protocol for providers and patients about the potential dangers of benzodiazepines and opioids.**

Gap 3: There is often a lack of understanding and education regarding the clinical indication and effective use of non-opioid medications as part of a multimodal and multidisciplinary approach to acute and chronic pain management. Chronic pain is often ineffectively managed, which can in part be results of a variety of factors, including physician training, patient access and other barriers to care.

Regarding Gap 3 on the use of non-opioid medications, patients not responding favorably to medication treatment may be suffering from genetic variability and may be having adverse effects from the medications. We suggest adding

Recommendation 3d: Conduct CYP450 test for genetic variability.

A vital overall concern is that there is a lack of guidelines and/or resources for patients who experience forced tapering or are abandoned as a result of practitioners refusal to prescribe or refusal to continue to treat patients with chronic pain. We strongly encourage the Task Force to add language about these issues in this section, pulling specifically from Recommendations 4a, b and c in Section 4 on CDC Guidelines. This could be added under Gap 2, or included as its own Gap.

There is a lack of guidelines, resources and education for prescribing Nalaxone with opioids, often due to additional costs as well as stigma. It is important that this be addressed so that Nalaxone is widely available to prevent either intentional or accidental overdose. We recommend that Recommendations 1a, b and c, found in Section 2.2.2, be incorporated into this section as well.

Gap 6: Lack of guidelines and/or resources for prescribing Nalaxone with opioids, often due to additional costs as well as stigma.

2.2.1.1 Prescription Drug Monitoring Programs

Gap 1: PDMP use varies greatly across the United States, with variability in PDMP design; the state's health information technology infrastructure; and current regulations on prescriber registration, access, and use.

Recommendation 1a and 1d seem to be contradictory. 1a recommends checking PDMPs upon initiation of opioid therapy, while 1d recommends that the healthcare provider team should determine when to use PDMP data. This should be clarified.

Also, Recommendation 1b needs to happen first so that clinicians understand how to access and interpret the PDMP data. Suggest moving this above 1a.

2.2.1.2 Screening and Monitoring

The introduction of this section indicates that "Clinicians do not consistently use practices intended to decrease the risk for misuse...likely in part because of competing clinical demands, perceived inadequate time to discuss the rationale for UDT and to order confirmatory testing, and *feeling unprepared to interpret and address results* (emphasis added). To address this under Gap 1, we suggest the following Recommendation.

Recommendation 1c: Provide education and training to address barriers perceived by clinicians. Establish CPGs to instruct providers and patients of procedures around UDTs.

UDTs may be a deterrent for returning patients, is an additional cost, and is not a test which a positive or negative can universally be the "correct" answer. Some patients take the medication as needed while others may need it daily. Under Gap 2, add the Recommendation below.

Recommendation 2c: Establish guidelines to instruct providers and patients of procedures after an unwanted result shows on a test, including protections against the patient being automatically dismissed from practice.

2.3 Restorative Therapies

The CPTAF is concerned that various lists of therapies and treatments will be taken as all-inclusive. This is problematic in case that parts of the recommendations are implemented or adopted on a broad scale, especially in the case of payors. We propose including language that recognizes the limitations of such lists and includes reference to a more comprehensive list of

viable treatment options such as the one included as **Appendix A** of this letter.

2.5 Behavioral Health Approaches

The CPTAF encourages the Task Force to include more about implementation of the recommendations here, such as citing a model that is currently in use. We also ask the Task Force to consider concerns about scalability, to underscore that the overall report applies to metropolitan areas, with dense resource coverage as well as a rural area where the service is provided through telehealth, technology, a community model or by traveling a great distance.

Is there a set of common data elements for programs to be collecting that would identify trends in the care location AND inform (hopefully) ongoing research? Some sort of uniformity of evaluation, intake or progress measurements could become a goldmine of retrospective data for future research/clinical reviews if the data were standardized in some way.

CMS models need to be updated to adequately provide access to mental health care and appropriately compensate providers for time spent with patients/clients.

Language matters. The use of the terms “maladaptive behaviors” and “catastrophizing” both have negative connotations that minimize the person’s pain and negate the experience of living with chronic pain. The terms are essentially pejorative and judgmental. It would be best not to use these terms even though they are popular. They stand in direct contradiction to the concept of chronic pain as a biopsychosocial disease, implying a degree of blame on the part of the person with chronic pain. In particular, we recommend deleting the sentence: “Chronic pain patients are at increased risk for psychological distress, maladaptive coping, and physical inactivity related to fear of reinjury” on page 26.

In the introduction of the report, the issue of suicide among individuals with chronic pain is raised. However, it is not well-addressed in the subsequent sections. We suggest adding the following language after the second paragraph of the introduction to the Behavioral Health section:

It is common among people with chronic pain to think of suicide and/or death. It is the **pain** people want to end, not their lives. Pain causes multiple losses that can overwhelm and trigger thoughts of being trapped, hopeless and without options. These experiences can trigger a major depressive episode and suicidal thoughts. These thoughts, while common for people with chronic pain, become dangerous when left untreated. People with chronic pain are often afraid to tell others about these thoughts. They fear being labeled “crazy.” Keeping these thoughts to oneself can amplify them, especially if someone already feels isolated, and suicide may be viewed as a reasonable option.

Suicide includes suicidal attempts, ideation, and successes. Any of the more than 19 million American adults (1 in 12)¹ living with high impact chronic pain can be in the position of being unprotected against suicidal and hopeless feelings when appropriate access to pain care is inaccessible. Family members and/or significant others are affected by loved ones' chronic pain and suicidal thoughts. Genetics may also play a role. Indeed, offspring exposed to suicidal behavior are four times more likely to report a lifetime suicide attempt compared with unexposed offspring.² Children learn from their parents how to deal with pain and are influenced by their parent behaviors and actions. Additionally, parents' pain exposure and reactions are cited as a lifecycle factor associated with the development of chronic pain in adulthood.³

We also recommend rewording the third and final paragraph of the existing introduction as follows:

The following paragraphs briefly describe psychotherapeutic approaches that need to be part of the multimodal approach to the management of chronic and acute pain, depending on the psychosocial stage the patient is in and their medical conditions. Before therapy can begin, proper depression and suicidal risk assessments must be done by all health care professionals treating people with chronic pain. This list is not inclusive or exhaustive, but instead describes just a few examples of common behavioral health approaches.

We recommend removing the entire section of **Behavioral Therapy**, which minimizes the experience of pain and criticizes legitimate, reasonable coping mechanisms.

We propose adding or rewording a number of the behavioral health approaches listed, as follows:

[Add] Pain Literacy is essential in teaching awareness that using language such as the terms “maladaptive behaviors” and “catastrophizing”, which have been cited in this report, have negative connotations that minimize the person’s pain and negate the experience of living with chronic pain. The terms are essentially pejorative and judgmental. It would be best **not** to use these terms even though they are popular. They stand in direct contradiction to the concept of chronic pain as a biopsychosocial disease, implying a degree of blame on the part of the person with chronic pain.

[Add] Psychotherapy is also known as talk therapy, counseling, psychosocial therapy or, simply, therapy. It treats mental health issues, problems and conditions by talking with a clinical social worker, psychologist, psychiatrist, or other licensed mental health provider. During a session (usually 45 minutes to an hour), clients express their concerns and learn about their emotions, feelings, thoughts and behaviors which leads to taking control of ones' life and learning

¹ <https://www.cdc.gov/mmwr/volumes/67/wr/mm6736a2.htm>

² <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2915586/>

³ <https://www.ncbi.nlm.nih.gov/books/NBK92525/table/ch1.t1/>

appropriate responses to challenging situations. There are many types of psychotherapy, each with its own approach, and a therapist may use many techniques within a session. Practitioners working with clients living with chronic pain need to educate themselves by attending workshops, watching webinars and reading books on the biopsychosocial disease of pain, psychosocial stages of chronic pain, neuroplasticity, developing a treatment plan, normalizing the pain experience, grief process, flare-ups and relapse prevention plan, pacing, previous trauma(s), suicidal thoughts and teaching mind-body techniques.

[Reword] Cognitive behavior therapy is a short term, focused, problem solving technique to help solve current problems. Cognitive therapy focuses on becoming aware of your beliefs, ex, “My life is over,” “I will never be happy living with this pain,” and how these beliefs affect ones’ thoughts, behavior and actions. The person learns to change these messages and replace them with positive and realistic thoughts that empower them. However, in addition to focusing on altering behavioral responses to pain, CBT focuses on shifting cognitions and improving pain coping skills. Learning pain strategy techniques such as, pacing oneself and how to plan out activities that you are able to do. The use of CBT for pain management is effective for a variety of pain problems. CBT can lead to long-term improvements in patients with low-back pain and fibromyalgia. The therapist needs to be sensitive to the psychosocial stages of chronic pain.

[Add] Support Groups

Support Groups are a critical component of helping people with chronic pain normalize their pain, learn about the grief process, create treatment and relapse prevention plans, learn new coping skills, develop a new community of people that is supportive and encouraging to make needed changes in their lives. It is important that these groups are run by trained facilitators (ex. mental health care professional, peer-peer) who know about the group process and keeps the group focused on the healing process. These groups can be either face to face, conference calls and/or internet based.

[Add] Guided Imagery

Guided imagery is a traditional mind-body technique that is also considered a form of hypnosis. Visualization and guided imagery offer tools to direct one’s concentration on images held in the mind’s eye. These therapies take advantage of the connection between the visual brain and the involuntary nervous system. When this portion of the brain (the visual cortex at the back of the head) is activated, without receiving direct input from the eyes, it can influence physical and emotional states. This, in turn, can help elicit physiologic changes in the body, including therapeutic goals. The Academy for Guided Imagery (AGI) classifies the therapeutic application of guided imagery into three categories:

1. Stress reduction and relaxation
2. Active visualization or directed imagery – for improving performance, changing behavior, or influencing an outcome
3. Receptive imagery – in which words and images are brought to consciousness to explore and give information about symptoms, treatments, moods or illnesses

2.5.1 Access to Psychological Interventions

To continue to adequately address issues of suicide in chronic pain populations, Gap 1 should mention “suicidal tendencies” in its list of mental health comorbidities.

Gap 1: Access to evidence-based psychological and behavioral health approaches for treating chronic pain and mental health comorbidities (e.g., post-traumatic stress disorder [PTSD], depression, **suicidal tendencies**, anxiety, mood disorders, SUD) is limited by geography, reimbursement, and education in primary care and specialty care settings.

Recommendation 1a should include "etc." after "telephone counseling" so as to avoid being taken as a conclusive list.

Recommendation 1a: Increase access to evidence-based psychological interventions through alternative treatment delivery (e.g., telehealth, Internet self-management, group, telephone counseling, **etc.**) and hub-and-spoke models.

Suicide should be more thoroughly addressed in this section. We recommend the following additions:

Gap 2: Additional research is needed regarding suicide among people with chronic pain including identifying who is at risk of suicide. That research should include review of SUD overdoses that may be intentional suicide to end unbearable pain.

Recommendation 2a: Fund and disseminate research to study suicide among people with chronic pain identifying who is at risk of suicide; look at how many SUD overdoses are intentional suicide to end unbearable pain.

Recommendation 2b: Engage and financially empower both the National Institute of Mental Health and the National Center for Injury Prevention and Control at the Centers for Disease Control and Prevention to gather statistics on suicide, suicidal ideation, and suicidal attempts in people living with chronic pain

Recommendation 2c. Educate healthcare providers about increasing suicidality in people with chronic pain. Medical schools need to incorporate this into their curriculum.

Recommendation 2d. Clinical social workers, psychologists, licensed counselors need to be incorporated into pain clinics and practices to serve this population.

Recommendation 2e. Provide resources to patients and caregivers regarding suicide.

2.5.2 Comorbidities

Gap 3: Research gaps exist on the effectiveness of existing psychological interventions for the treatment of psychological health and substance use in the subpopulation of patients with chronic pain and psychological health comorbidities.

Is there a set of common data elements for programs to be collecting that would identify trends in the care location AND inform (hopefully) ongoing research? Some sort of uniformity of evaluation, intake or progress measurements would become a goldmine of retrospective data for future research/clinical reviews if the data were standardized in some way.

Gap 4: There has not been sufficient validation of mobile and electronic health applications (apps) used for clinical treatment of pain patients with comorbid psychological conditions.

A benefit and a challenge of these apps is to align the treatment experience to all patients. Apps could potentially offer modalities and depth of treatment that were not available due to socioeconomic, financial or geographic limitations.

2.6 Complementary and Integrative Health

There are many definitions of complementary and integrative health. A 2017 Integrative Pain Policy Congress, attended by representatives from more than 50 organizations, defined this treatment as:

Comprehensive, integrative pain management includes biomedical, psychosocial, complementary health, and spiritual care. It is person-centered and focuses on maximizing function and wellness. Care plans are developed through a shared decision-making model that reflects the available evidence regarding optimal clinical practice and the person's goals and values.

This definition was affirmed again at the 2018 Policy Congress, the *only* collective of its kind to unite representatives from 75+ organizations and agencies -- including licensed and certified health care professionals, public and private payers, people living with pain, federal agencies, purchasers of health care, researchers, policymakers, and policy experts -- to improve access to comprehensive integrative pain management (CIPM) for all. We recommend that the PMTF Report adopt this definition of comprehensive, integrative pain management.

Gap 1: There is a large variety of complementary and integrative health approaches that remain unknown to the broader medical community and that are often overlooked in the management of pain.

Add a Recommendation 1c:

Recommendation 1c: As stated in the Introduction to the Draft Report, "it is imperative to strike a balance between ensuring that patients with painful conditions can work with their health care providers to develop an integrative pain treatment plan that optimizes function, quality of life, and productivity..."

Some complementary and integrative treatments may not pass the current threshold for “evidence-based” treatment. While a percentage of individuals may benefit from a particular treatment (i.e. acupuncture), a larger percentage may not see a decrease in their pain level from such treatment. However, improvements in functionality and quality of life for the former group should be considered as evidence base. The benefit received by the one group should not be discounted simply because 100% of the results do not show improvement in level of pain.

This is a perfect example of why the individualized, multi-modal, multi-disciplinary integrative approach is so vital.

2.7 Special Populations

We would encourage the Task Force to consider adding a section about "Caregivers" under "Special Populations." The text proposed is as follows:

2.7.X Caregivers

“Caregiver” denotes unpaid care given voluntarily to ill or disabled persons by their families and friends.⁴ Caring for patients with chronic pain has a meaningful impact on caregivers’ lives, as has been indicated in many studies which document how caring for chronically ill family members or significant others at home influences the physical, psychological and social aspect of the caregiver’s life.

For the ethnic minority caregiver, however, such specialty populations report worse physical health than white caregivers, including depression among Hispanic and Asian American caregivers. Caregivers from racial and ethnic populations, particularly Hispanic (non-white, non-African-American) and African American caregivers experience higher burdens from caregiving and spend more time caregiving on average than white or Asian-American peers. In some instances, caregiving may worsen physical health and impair social and family life, increase stress, anxiety and depression.

Caregivers of veterans report increased stress or anxiety and sleep deprivation.⁵ Also alarming is the consequence of caregiver grief, particularly among individuals caring for a veteran with traumatic brain injury (TBI). A study found high levels of TNF-alpha, a substance associated with inflammation and chronic disease; this may be an important indicator of which caregivers may be at risk for developing chronic health problems such as heart disease, cancer and diabetes.⁶

⁴ Definition was used in the ‘Informal Caregiving: Compassion in Aging’ booklet developed by the U.S. Department of Health and Human Services.

⁵ National Alliance for Caregiving and United Health Foundation. (2010). Caregivers of Veterans: Serving on the Home Front.

⁶ Edward Hines Jr. VA Hospital, Center of Innovation for Complex Chronic Healthcare, Hines, IL, USA Marcella Niehoff School of Nursing, Loyola University Chicago, Chicago, IL, USA ksaban@luc.edu.

Failure to offer support and intervention for caregivers of veterans may result in higher overall healthcare costs. Caregivers of combat veterans, much like any informal caregiver, experience burden of care, psychological distress and even suicidal ideation,⁷ all of which require medical and/or clinical attention.

Gap 1: Caregivers are vital to the health and well-being of people with pain. However, they often face undue stressors and a lack of support.

Recommendation 1a: Conduct more research into the overall quality of life, socioeconomic and psychological impact of caregiving. Identify beneficial and proactive services to reduce negative caregiver health outcomes. Research should take into consideration racial, cultural, religious, and gender differences amongst caregivers.

Recommendation 1b: Encourage insurance coverage for mental health screenings and related services for caregivers.

Recommendation 1c: Develop education and support programs for caregivers with special attention to differences in race, culture, religion and gender.

2.7.3 Unique Issues Related to Pain Management in Woman

This section does not strongly enough address the problems of gender discrimination among providers. Reword "gender insensitivity" in the introduction to be "gender discrimination."

Add

Recommendation 1c: Multiple studies have found that clinicians may interpret and treat pain differently based on gender. Encourage more training for clinicians around implicit gender bias.

2.7.4 Pregnancy

We recommend adding a Gap 2

Gap 2: Pregnancy can catalyze or exacerbate existing chronic pain. There is little research on why and how certain women develop new or worse pain postpartum.

Recommendation 2a: More research should be done in this area. Providers should have better access to data to help women make informed decisions when considering pregnancy in light of health risks, especially existing pain conditions.

⁷ Psychological Distress and Burden Among Female Partners of Combat Veterans With PTSD Manguno-Mire, Gina PhD*†; Sautter, Frederic PhD*†; Lyons, Judith PhD†‡; Myers, Leann PhD§; Perry, Dana MS†; Sherman, Michelle PhD†||; Glynn, Shirley PhD¶||; Sullivan, Greer MD, MPH#† The Journal of Nervous and Mental Disease: February 2007 - Volume 195 - Issue 2 - p 144-151 doi: 10.1097/01.nmd.0000254755.53549.69

2.7.5 Chronic Relapsing Pain Conditions

We recommend removing this section from the report. Most pain conditions vary in their intensity and “flares” and the selection of certain conditions to list as “Chronic Relapsing Pain Conditions” like CRPS and Migraine seems arbitrary.

2.7.7 Health Disparities in Racial and Ethnic Populations, Including African-Americans, Latinos, **Native Americans**, and Alaska Natives

Please change “American Indians” to “Native Americans” above in title.

This section does not adequately address the issue of implicit bias amongst providers. We suggest adding this text to the narrative:

One of many factors which can play a role in health disparities among minority populations are the attitudes and behaviors of health care professionals. Although in many circumstances such perception is not consciously acknowledged by the individual, such unconscious bias can impact the patient-provider relationship, treatment decisions and health outcomes. The Institute of Medicine’s report titled “Unequal Treatment” suggests that such disparities within healthcare emerge from prejudice against minorities and greater clinical uncertainty when treating patients from cultural and ethnic backgrounds.⁸

We recommend adding the following gaps and recommendations:

Gap 3: Minority populations face disparities within the healthcare system, due in part to unconscious bias, thoughts or feelings which exist outside of conscious awareness, which exist among medical professionals.

Recommendation 3a: Medical school curriculum should promote diversity and mitigate implicit attitudes and stereotyping towards minority populations. Curriculum which assists medical professionals in developing cultural sensitivity, patient-centered communication and partnership-building skills to level the playing field when creating the patient-clinician relationship allows the clinician-in-training to reduce their preconceived stereotypes and social categorizing of patients. Training related to the aforementioned areas of healthcare bias should be completed by anyone entering the medical field; accredited continuing education sessions should also be offered.

Recommendation 3b: Develop incentive programs to encourage more individuals from minority populations to enter the medical profession. One way to ensure children and adults with complex and/or chronic pain conditions are receiving optimum care and treatment is to enhance the workforce so that it reflects the patients being treated.

⁸ Smedley BD, Stith AY, Nelson AR, eds. Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care. Washington, DC: National Academies Press; 2003. [Google Scholar](#)

Gap 4: Research suggests minority and ethnic populations may be undertreated when compared to their white peers in certain medical settings or in the area of cancer pain management. Medical venues where such disparities have been cited include emergency rooms for acute and/or chronic pain and postoperative care for acute pain.

Recommendation 4: While it is unclear if ethnicity was the primary driving factor influencing how emergency doctors manage chronic pain in these settings or in the treatment of cancer pain, interaction between patient and provider should take place without racial bias. Physicians who practice in highly minority populated settings should have access to a wide range of pharmacologic and non-pharmacologic therapies; nearby hospitals and pharmacies should not limit analgesic prescriptions more than those hospitals and pharmacies located in dominantly white populated areas.

Gap 5: The significant impact of chronic pain on overall health and quality of life in racial and ethnic minorities has been overlooked; the exact prevalence of chronic pain within this population remains unknown and has received little attention, funding or research. There is also little known about patient-level influences, such as cultural beliefs, preferences and decision making within racial and ethnic populations have on adaptations to chronic pain.

Recommendation 5a: Funds should be awarded for researchers to identify whether pain is reported differently among minority and ethnic populations (pain levels/tolerance), how non-white chronic pain patients view their experiences in the healthcare system as it relates to having their chronic pain condition diagnosed, treated and managed, if there are differences in pain sensitivity and how unconscious bias, along with the area in which they reside, play a role in access to pain treatment. Further investigations into the nature and differences of pain perception may not only enhance our understanding of racial and ethnic differences in pain, but assist us in developing new ways to reduce disparities in pain.

Recommendation 5b: Pain assessment measures that are culturally and linguistically sensitive are needed in all hospital and medical settings.

Gap 6: Despite increased psychological conditions (depression, anxiety, panic, post-traumatic stress disorder) being associated with chronic pain, minority populations are often reluctant to seek mental health care. Whether due to lack of insurance coverage, financial strains, cultural stigma, location or transportation barriers, limited resources to make available services known within ethnic and racial communities, or a combination of variables, the psychological impact chronic pain can have on an individual should receive special attention within minority populations.

Recommendation 6: Barriers that exist for minority populations to receive adequate mental health services deserve particular attention. By understanding the obstacles,

specific recommendations can then be developed to lessen the barriers to mental health services.

Gap 7: Children and adults with chronic pain from minority populations tend to lack a primary care physician, have less access to specialty care and seek health services in higher numbers through emergency room settings.

Recommendation 7a: Encouraging the workforce to include more physicians from varied racial and ethnic backgrounds, as was suggested in recommendation 3b, will encourage families and individuals from racial and ethnic populations to secure a primary care physician and seek pain management specialists to assess and manage their chronic pain condition and related symptoms.

Recommendation 7b: Create a pilot program which would offer a discounted insurance premium rate to enrollees from a minority population who purchase state insurance from the open exchange and have selected a primary care physician through a list of participating physicians. Such a program would increase the number of patients seeking medical advice and treatment from a primary care physician, increase the demand of primary care physicians needed within that state (or participating pilot program states), while decreasing number of visits and emergency costs to the insurers within that state.

Recommendation 7c: Patients from racial and ethnic populations can benefit from education on pain management and on how to effectively describe and discuss their pain with their health care providers. Educational pain management brochures, online webinars, websites or community events, where the materials are printed and/or presented in a number of languages is a first step towards providing patients from this vulnerable population with necessary knowledge to play a more active role in their pain management plan.

2.7.8 Military Personnel and Veterans

The experience of pain is prevalent in military and veteran populations. Pain management can be more complex in military populations, who sustain severe battlefield injuries (e.g., blasts) in addition to complications from accompanying conditions such as PTSD and traumatic brain injury (TBI), both of which are more prevalent in veterans than in the civilian population. Delayed pain treatment following injury may lead to the increased likelihood of acute to chronic pain change in service members and veterans.

The new approaches of “Battlefield Medicine” have helped more wounded on the field survive yet unfortunately have long lasting chronic pain. The best and quickest treatments are usually given to returning service members back from combat. For others in chronic pain, there are long waits to get appointments for pain management doctors and then to receive treatments. Service members and veterans claiming to have chronic pain are stigmatized, considered and labeled “broken” by their superiors and comrades. Many refuse to go to military or veteran

hospitals or clinics either due to the stigma, not wanting to get demoted, perception of poor quality of medical services or they want to disassociate themselves from the military.

Gap 1: Active-duty service members and veterans have unique physical and mental health challenges related to their military service that contribute to the development of or exacerbate acute and chronic pain conditions. Medical and mental health comorbidities such as TBI, PTSD, limb loss, and musculoskeletal injuries often interfere with successful treatment outcomes. Assessment and treatment of pain conditions in active-duty service members and veterans require military-specific expertise and a coordinated, collaborative approach between medical and mental health providers.

Recommendation 1a: Educate medical personnel on the neurobiological mechanisms of chronic pain to destigmatize myths and misconceptions in diagnosis, treatment and aftercare.

Recommendation 1b: Physicians and other health care providers taking care of active-duty service members, regardless of practice setting, should consider prior military history and service-connected health factors that may contribute to acute or chronic pain in their pain care plan, as relevant to the clinical presentation.

Recommendation 1c: Physicians and other health care providers should work collaboratively to deliver comprehensive pain care that is consistent with the biopsychosocial model of pain.

Recommendation 1d: Conduct research to better understand the biopsychosocial factors that contribute to acute and chronic pain in active-duty service members and veterans, with a focus on TBI, PTSD, and other mental health and substance use disorders.

Recommendation 1d: Conduct studies to better understand the contributing factors predisposing these patients to movement along the spectrum from acute pain to persistent pain.

3. Cross-Cutting Clinical and Policy Best Practices

3.1 Stigma

It is essential that the public recognize chronic pain as a neurobiological disease and a major public health issue. It is critical to provide empathy and a non-judgmental approach to treatment of chronic pain. It is crucial to accurately articulate the relationship between chronic pain care and the opioid crisis. **Chronic pain ≠ opioid addiction.** Stigma is a major barrier to treatment of both chronic pain and substance use disorder (SUD), including opioid use disorder (OUD).

Under Gap 1 we recommend adding two additional recommendations.

Gap 1: Chronic pain patients may face barriers in access to pain care due to being stigmatized as people seeking medications to misuse. Contributing to this stigmatization are the lack of objective biomarkers for pain, the invisible nature of the disease, and societal attitudes that equate acknowledging pain with weakness.

Recommendation 1e: Increase education about the uniqueness of each individual’s pain journey. For some it is straightforward, while for others it is a difficult, stressful path.

Recommendation 1f: Provide grants to patient groups to develop patient education and support materials that teach patients how to counter stigma.

For recommendation 1d, we ask the Task Force to consider whether common data elements have been identified.

Recommendation 1d: Encourage research aimed at discovering biomarkers for neurobiological mechanisms of chronic pain.

For Gap 2, we recommend adding an additional recommendation.

Gap 2: The national crisis of illicit drug use, with overdose deaths, is confused with appropriate therapy for patients who are being treated for pain. This confusion has created a stigma that contributes to raise barriers to proper access to care.

Recommendation 2a: Educate professionals, the public and patients so they understand that the vast majority of people living with pain who use opioids as part of their treatment plan do not misuse or abuse their medications.

Recommendation 2b: Identify strategies to reduce stigma in opioid use so that it is never a barrier to patients receiving appropriate treatment, with all cautions and considerations for the management of their chronic pain conditions.

3.2 Education

3.2.1 Public Education

Under Gap 1, Recommendation 1b, we recommend adding the red text below.

Gap 1: National public education about pain is needed.

Recommendation 1b: Establish a mechanism to finance a large-scale, systematic, coordinated public campaign to address pain awareness.

Public campaigns should include the important messaging in this report as well as components for every age group (early childhood through geriatric populations).

3.2.2 Patient Education

For recommendation 1a, we encourage the Task Force to define the word “prioritize.” For recommendation 1b, we recommend adding "and fund" to the list that includes "explore" and "test."

Gap 1: Current patient education is lacking for both acute and chronic pain.

Recommendation 1a: Prioritize time and patient access to educational tools that include clinician visits, patient handouts, Web resources, and support groups to optimize patient outcomes.

Recommendation 1b: Explore, test **and fund** innovative methods of delivering patient education and support for acute and chronic pain patients using technology, particularly in rural areas that have little access to multimodal treatment. Examples of means to provide patient access in such situations include telemedicine, the Project ECHO hub and-spoke model, online support groups, networks of in-person support groups with training and guidance of leaders, and applications easily accessible on mobile phones.

We recommend adding language to recommendation 2a in red text below.

Gap 2: Patient expectations regarding the management of their pain in the perioperative arena are frequently not aligned with current surgical practices or procedures that require pain management.

Recommendation 2a: Emphasize discussions about pain control after surgery during the preoperative visit. This discussion should be conducted by both the surgical team and the preoperative team. **Conversations should include the GP team who will be handling follow-up related to the overlap with addressing ongoing healthcare needs after discharge. At minimum, discussion notes should be charted for the GP to access. Ideally, there is back and forth consultation between surgical and GP teams.**

CPATF strongly and enthusiastically supports Recommendation 3b.

Recommendation 3b: Convene a chronic pain expert panel that includes experienced patients, patient advocates, and clinicians to develop a set of core competencies and other essential information specific to patient pain education. Provide grants for the creation of patient education programs and materials based on these core competencies, and disseminate them widely to patients and their families and caregivers through clinics, hospitals, pain centers, and patient groups.

3.2 Education

3.2.3 Provider Education

The gap between provider knowledge and need is enormous. At best, this lack of basic education contributes to wavering confidence and uncertainty about available, safe and effective treatment options. Combined with cultural biases and attitudes toward people with pain and confusing and unclear policy that attempts to regulate pain care options, it creates an environment ripe for pain patient abandonment.

CPATF encourages collaboration with the NIH Pain Consortium's Centers of Excellence in Pain Education.

3.3 Access to Pain Care

CPTAF supports these recommendations; however, the Draft Report should go further and provide specific plans of action for addressing these critical issues, including identifying what government agency or private sector organizations should be charged with the implementation of these recommendations where a responsible entity is not named.

3.3.2 Insurance Coverage ~~for Complex Management Situations~~

We recommend deleting "for Complex Management Situations" from the title. These challenges face the majority of patients with pain, regardless of whether their condition is complex.

As stated in the Draft Report, balanced pain management should be based on a biopsychosocial model of care. Such a balanced model is extremely difficult to achieve under existing conditions.

CPTAF fully endorses the recommendations in the Draft Report regarding access to pain care and in particular to the importance of making non-pharmacological therapies more widely available.

Individuals with pain may struggle to access appropriate pain care due to lack of or inadequate insurance coverage for pain management options, especially non-pharmacological strategies and interventions. There are inconsistencies and frequent delays in insurance coverage for interventional pain techniques that are clinically appropriate for a particular condition and context.

CPTAF agrees with the importance of improved reimbursement for restorative movement therapies, complementary and integrative health and behavioral health/psychological interventions. Access to such therapies is severely restricted by the current reimbursement system.

We are concerned that this section of the report does not do enough to address high out of pocket expenses including both deductibles and copays. For instance, health plans may require a \$30 - \$50 copay for physical therapy or acupuncture treatment, which means that a course of ten sessions would cost \$300 - \$500, far exceeding the budget of most people living with pain who may only be able to work part time or who may be disabled by pain. The result is that access to such treatments, even where covered by health plans, is practically limited by cost.

CPTAF urges the Committee to stress the need for affordability for non-pharmacological treatments, without which balanced pain management will remain practically unavailable for most of the population. With that in mind, we suggest the following addition:

Gap 5: High out of pocket expenses (copays and deductibles) frequently create a de facto barrier for access to restorative movement therapies, complementary and integrative health and behavioral health/psychological interventions.

Recommendation 5a: Guidelines should be enacted to reduce copays and deductibles for restorative movement therapies, complementary and integrative health and behavioral health/psychological interventions to an affordable level.

4. Review of the CDC Guideline

CPATF is very supportive of this section of the report. However, what is not stated and should be stated as the first recommendation in this section is:

The CDC Guideline should be revised and reissued based on these and other specific recommendations in the PMTF Report.

CPATF would like to see these clear statements included in the following recommendations:

4a) Where benefits outweigh risks, maintain opioid therapy for patients on long-term stable regimens; where risks outweigh benefits, undertake opioid tapering in collaboration with the patient whenever possible.

7a) Opioid dosages should be decided by balancing benefits, risks and adverse reactions for each individual patient; dosage guidance should not be applied as strict limits.

8a) Duration of opioid therapy for an acute, severely painful event should be determined by the treating physician based on the individual condition and needs of the patient.

Appendix A.

Acute Treatments

Therapeutic Exercises

- Restorative Therapies

Cognitive Behavioral Therapy

- Psychological and Integrative Therapies to Mitigate Opioid Exposure

Complementary and Alternative Medicine

- Perioperative Period, Including Various Non-opioid Medications

Surgical/Procedure

- Ultrasound-Guided Nerve Blocks

Infusion Therapies

- Analgesia Techniques (E.G., Lidocaine and Ketamine Infusions)

Perioperative Pain Control

Therapeutic Exercises

- Occupational Therapy (OT)
- Restorative Therapies
- Therapeutic Exercise

Physical Therapy

- Physical Therapy (Traditional Pre-Post-surgical and/or injury)
- Physiotherapy

Cognitive Behavioral Therapy

- Monitoring
- Psychology Screening

Supplement/Nutrition/Medication (non-opioid)

- Exparel (during surgery)

Surgical/Procedure

- Regional Anesthesia Techniques

Infusion Therapies

- Analgesia Techniques (E.G., Lidocaine and Ketamine Infusions)

Other

- Multimodal Pain Care

- Pain Medication

Chronic Pain Management

Therapeutic Exercises

- Acupressure
- Acupuncture
- Calmare
- Cold and Heat
- Compression
- Dry Needling
- Hawaiian Massage
- Hyperbaric Oxygen
- Meditative Movement Therapies (E.G., Yoga, Tai Chi)
- Mind-Body Behavioral Interventions
- Mindfulness
- Music Therapy
- Occupational Therapy
- Osteopathic Manipulation
- Osteopathy
- Restorative Therapies
- Therapeutic touch

Physical Therapy

- Aqua Therapy
- Chiropractor/Structural Manipulation
- Craniosacral Therapy
- Feldenkrais Method
- Massage Therapy (Swedish, Shiatsu, and Deep Tissue (Myofascial Release).
- Physical Therapy (Traditional)
- Physiotherapy
- Reflexology
- Therapeutic Ultrasound (Tu)
- Traction
- Transcutaneous Electric Nerve Stimulation (Tens)

Cognitive Behavioral Therapy

- Biofeedback
- Cortical Integrative Therapy
- Creative Visualization
- Equine Therapy
- Faith healing

- Hypnotherapy
- Journaling
- Neuro-linguistic Programming
- Sound Therapy
- Virtual Reality
- Visualization

Complementary and Alternative Medicine

- Aromatherapy
- Art Therapy
- Chinese Medicine
- Energy Therapies
- Functional Medicine
- Holistic Living
- Holistic Medicine
- Homeopathy
- Prayer
- Self-Hypnosis
- Spirituality
- Support Group (social support)
- Transcendental Meditation

Supplement/Nutrition/Medication (non-opioid)

- CBD
- Electromagnetic Therapy
- Fasting
- Herbal Therapy
- Herbology Medicine
- Home Remedies
- Ketamine Nasal or Lozenges
- Medication (found in other sections)
- Natural Products
- Naturopathic Medicine
- Nutritional Dietary Changes
- Nutritional Supplements
- Orthomolecular Medicine
- Vitamin Therapy

Surgical/Procedure

- Botox Injections
- Caudal Epidural Steroid Injection
- Celiac Plexus Block

- Cervical Epidural Steroid Injection
- Denervation
- Diagnostic Medical Branch Block
- Epidural Steroid Injections (ESIS)
- Intraarticular Facet Joint Injections
- Joint Injections
- Lumbar Discography
- Lumbar Epidural Injections
- Lumbar Sympathetic Block
- Nerve Block
- Neuromodulation / Spinal Cord Stimulation
- Radio-Frequency (Rf) Ablation and Cryoneuroablation
- Sacroiliac Joint Steroid Injection
- Sonopuncture
- Spinal Cord Stimulator Implant
- Stellate Ganglion Block
- Stem Cell Injections
- Trigger Point
- Trigger Point Injections
- Urology/Lithotripsy

Infusion Therapies

- IVIg Therapy
- Ketamine Infusion Therapy
- Lidocaine Infusion Therapy
- Pilates Infusion Therapy
- Plasma Infusion Therapy
- Stem Cell Infusion

Devices

- Bed Cradle
- Interspinous Process Spacer Devices
- Intrathecal Pumps
- Laser Light Therapy
- Magnet Therapy
- Oral Orthotic
- Posture Apparel