

PAIN MANAGEMENT

BEST PRACTICES

**PAIN MANAGEMENT BEST PRACTICES
INTER-AGENCY TASK FORCE REPORT**

Updates, Gaps, Inconsistencies, and Recommendations

DRAFT FINAL REPORT



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EXECUTIVE SUMMARY

Patients with acute and chronic pain in the United States face a crisis due to significant challenges in obtaining adequate care, resulting in profound physical, emotional, and societal costs. According to the Centers for Disease Control and Prevention (CDC), 50 million adults in the United States have chronic daily pain, with 19.6 million adults experiencing high-impact chronic pain that interferes with daily life or work activities. The cost of pain to our nation is estimated at between \$560 and \$635 billion annually. At the same time, our nation is facing an opioid crisis that, over the past decade, has resulted in an unprecedented wave of overdose deaths associated with prescription opioids, heroin, and synthetic opioids.

The Pain Management Best Practices Inter-Agency Task Force (Task Force) was convened by the US Department of Health and Human Services (HHS) in conjunction with the Department of Defense (DOD) and the Veterans Administration (VA) with the Office of National Drug Control Policy (ONDCP) to address acute and chronic pain in light of the ongoing opioid crisis. The Task Force mandate is to identify gaps, inconsistencies, and updates, and to make recommendations for best practices for managing acute and chronic pain. The 29 member Task Force included federal agency representatives as well as non-federal experts and representatives from a broad group of stakeholders. The Task Force considered relevant medical and scientific literature and information provided by government and non-government experts in pain management, addiction, mental health and representatives from various disciplines. The Task Force also reviewed and considered patient testimonials and public meeting comments, including approximately 6,000 comments from the public submitted during a 90-day public comment period and 3,000 comments from two public meetings.

The Task Force emphasizes the importance of individualized **patient-centered care in the diagnosis and treatment** of acute and chronic pain. This report is broad and deep and will have sections that are relevant to different groups of stakeholders regarding best practices. It is encouraged to see the table of contents and the sections and sub-sections of this broad report to best identify that which is most useful for the various clinical disciplines, educators, researchers, administrators, legislators and other key stakeholders.

The report emphasizes the development of an effective pain treatment plan after proper evaluation to establish a **diagnosis with measurable outcomes that focus on improvements including quality of life (QOL), improved functionality, and Activities of Daily Living (ADLs)**. Achieving excellence in acute and chronic pain care depends on the following:

- An emphasis on an **individualized patient-centered** approach for diagnosis and treatment of pain is essential to establishing a **therapeutic alliance** between patient and clinician.
- Acute pain can be caused by a variety of different conditions such as trauma, burn, musculoskeletal injury, neural injury, as well as pain due to surgery/procedures in the perioperative period. A **multi-modal approach that includes medications, nerve blocks, physical therapy and other modalities should be considered for acute pain conditions**.
- A **multidisciplinary** approach for chronic pain across various disciplines, utilizing one or more treatment modalities, is encouraged when clinically indicated to improve outcomes. These include the following five broad treatment categories. These categories have been reviewed with an identification of gaps/inconsistencies with recommendations for best practices:
 - **Medications: Various classes of medications**, including non-opioids and opioids, should be considered for use. The choice of medication should be based on the pain diagnosis, the mechanisms of pain, and related co-morbidities following a thorough history, physical exam, other relevant diagnostic procedures and a **risk-benefit assessment that demonstrates the benefits of a medication outweighs the risks**. The goal is to limit adverse outcomes while ensuring that patients have access to medication-based treatment that can enable a better quality of life and function. Ensuring **safe medication storage** and **appropriate disposal of excess medications** is important to ensure best clinical outcomes and to protect the public health.

- **Restorative Therapies** including those implemented by physical therapists and occupational therapists (e.g., physiotherapy, therapeutic exercise, and other movement modalities) are valuable components of multidisciplinary, multimodal acute and chronic pain care.
 - **Interventional Approaches** including image-guided and minimally invasive procedures are available as diagnostic and therapeutic treatment modalities for acute, acute on chronic, and chronic pain when clinically indicated. A list of various types of procedures including trigger point injections, radiofrequency ablation, cryoneuroablation, neuro-modulation and other procedures are reviewed.
 - **Behavioral Health Approaches** for psychological, cognitive, emotional, behavioral, and social aspects of pain can have a significant impact on treatment outcomes. Patients with pain and **behavioral health comorbidities** face challenges that can exacerbate painful conditions as well as function, QOL, and ADLs.
 - **Complementary and Integrative Health**, including treatment modalities such as acupuncture, massage, movement therapies (e.g., yoga, tai chi), spirituality, among others, should be considered when clinically indicated.
- Effective multidisciplinary management of the potentially complex aspects of acute and chronic pain should be **based on a biopsychosocial model** of care.
 - Health systems and clinicians must consider the pain management needs of the **special populations** that are confronted with unique challenges associated with acute and chronic pain, including the following: children/youth, older adults, women, pregnant women, individuals with chronic relapsing pain conditions such as sickle cell disease, racial and ethnic populations, military active duty and reserve service members and Veterans, and cancer and palliative care.
 - **Risk assessment** is one of the four cross-cutting policy approaches that is necessary for best practices in providing individualized, patient-centered care. A thorough patient assessment and evaluation for treatment that includes risk benefit analysis are important considerations when developing patient-centered treatment. Risk assessment involves identifying risk factors from patient history, family history, current biopsychosocial factors, as well as screening and diagnostic tools, including PDMP, laboratory data, and other measures. Risk stratification for a particular patient can aid in determining appropriate treatments for the best clinical outcomes for that patient. The final report and this section in particular emphasizes safe opioid stewardship with regular re-evaluation of the patient.
 - **Stigma** can be a barrier to treatment of painful conditions. Compassionate, empathetic care centered on a patient-clinician relationship is necessary to legitimize the suffering of patients with painful conditions and to address the various challenges associated with the stigma of living with pain. Stigma often presents a barrier to care, and is often cited as a challenge for both patient, families, caregivers, and providers.
 - Improving **education** about pain conditions and their treatment for patients, families, caregivers, clinicians and policymakers is vital to enhancing pain care. Patient education can be emphasized through various means including clinician discussion, informational materials and web resources. More effective education and training about acute and chronic pain should occur at all levels of clinician training, including undergraduate educational curricula, graduate professional training, and continuing professional education, including the use of proven innovations such as the Extension for Community Healthcare Outcomes (Project ECHO) model. Education for the public as well as for policymakers and legislators is emphasized to ensure expert and cutting-edge understanding is part of policy that can affect clinical care and outcomes.
 - Addressing **access to care** barriers is essential to optimizing pain care. Recommendations include addressing the gap in our **workforce** for all disciplines involved in pain management. Additionally, improved **insurance coverage and payment** for different pain management modalities is a critical component in improving access to effective clinical care, and should include coverage and payment for care coordination, complex opioid management and

telemedicine. It is also important to note that in many parts of the country patients will only have access to a primary care provider. Support for education, time and financial resources for primary care providers (PCPs) is essential to manage these patients with painful conditions.

- **Research and Development:** Continued medical and scientific research is critical to understanding the **mechanisms underlying the transition from acute to chronic pain**, to translating promising scientific advances into new and effective diagnostic, preventive and therapeutic approaches for patients, and to implementing these approaches effectively in health systems.

A review of CDC Guideline (as mandated by the Comprehensive Addiction and Recovery Act [CARA] legislation): The Task Force recognizes the utility of the 2016 Guideline for Prescribing Opioids for Chronic Pain released by the CDC and its contribution to mitigating unnecessary opioid exposure and the adverse outcomes associated with opioids. It also recognizes unintended consequences that have resulted following the release of the guidelines in 2016, which are due in part to misapplication or misinterpretation of the guideline including forced tapers and patient abandonment. The CDC recently authored a pivotal article in the New England Journal of Medicine (NEJM) on April 24, 2019, specifically re-iterating that the CDC Guideline has been, in some instances, misinterpreted or misapplied.¹ The authors highlight that the guideline does not address or suggest discontinuation of opioids prescribed at higher dosages. They note “policies invoking the opioid-prescribing guideline that do not actually reflect its content and nuances can be used to justify actions contrary to the guideline’s intent.” Educating stakeholders about the intent of the guideline (as it relates to the use of opioids for chronic pain by primary care clinicians), reemphasis of the core benefits of the guideline, and encouraging optimal application of this guideline are essential to optimizing acute and chronic pain care. (Please see Section 4 Review of the CDC Guideline in the attached Task Force report).

The Task Force, which included a broad spectrum of stakeholder perspectives, was convened to address one of the greatest public health crises of our time. The Task Force respectfully submits these gaps and recommendations, with special acknowledgement of the brave individuals who have told their stories about the challenges wrought by pain in their lives, the thousands of members and organizations of the public sharing their various perspectives and experiences through public comments, and the millions of others they represent in our nation who have been affected by pain.

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The Pain Management Best Practices Inter-Agency Task Force consists of 29 members – 12 public members, nine organization representative members and eight federal members based on criteria specified in the Comprehensive Addiction and Recovery Act of 2016.

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DEFINITIONS

Physical dependence is not the same as addiction and occurs because of physiological adaptations to chronic exposure to a drug. Someone who is physically dependent on medication will experience withdrawal symptoms when the use of the medicine is suddenly reduced or stopped or when an antagonist to the drug is administered. These symptoms can be minor or severe and can usually be managed medically or avoided by using a slow drug taper.^{2,3}

Tolerance is present when the same dose of a drug when given repeatedly produces a reduced biological response. Stated another way, it takes a higher dose of the drug to achieve the same level of response achieved initially.^{2,3}

Misuse of prescription drugs means taking a medication in a manner or dose other than prescribed; taking someone else's prescription, even if for a legitimate medical complaint such as pain; or taking a medication to feel euphoria (i.e., to get high). The term *nonmedical use* of prescription drugs also refers to these categories of misuse.^{2,3}

Addiction is a primary, chronic disease of brain reward, motivation, memory and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors. Addiction is characterized by inability to consistently abstain, impairment in behavioral control, craving, diminished recognition of significant problems with one's behaviors and interpersonal relationships, and a dysfunctional emotional response. Like other chronic diseases, addiction often involves cycles of relapse and remission. Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death.⁴

Opioid use disorder (OUD) is defined in the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5) as a problematic pattern of opioid use leading to clinically significant impairment or distress. OUD was previously classified as Opioid Abuse or Opioid Dependence in DSM-IV. OUD has also been referred to as "opioid addiction."

Hyperalgesia is a condition where patients have a hypersensitivity to pain caused by pain medications. Healthcare providers may consider opioid induced hyperalgesia when an opioid treatment effect dissipates and other explanations for the increase in pain are absent, particularly if found in the setting of increased pain severity coupled with increasing dosages of an analgesic.^{2,3}



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1. INTRODUCTION

The experience of pain has been recognized as a national public health problem with profound physical, emotional, and societal costs.⁵ Although estimates vary depending on the methodology used to assess pain, it is estimated that chronic pain affects 50 million U.S. adults and 19.6 million of those adults experience high-impact chronic pain that interferes with daily life or work activities.⁶ The cost of pain to our nation is estimated at between \$560 and \$635 billion annually.⁷ Pain management stakeholders have been working to improve care for those suffering from acute and chronic pain in an era challenged by the opioid crisis.⁸

An unprecedented rise in the number of deaths from overdose in the past two decades is associated with prescription opioids, heroin, and synthetic opioids.⁹ The practice of pain management and the opioid crisis have influenced one another as each has evolved in response to different influences and pressures. It is imperative to ensure that patients with painful conditions can work with their health care providers to develop integrative pain treatment plans that balance a focus on optimizing function, quality of life, and productivity while minimizing risks for opioid misuse and harms.

“The ongoing opioid crisis lies at the intersection of two substantial public health challenges — reducing the burden of suffering from pain and containing the rising toll of the harms that can result from the use of opioid medications.”

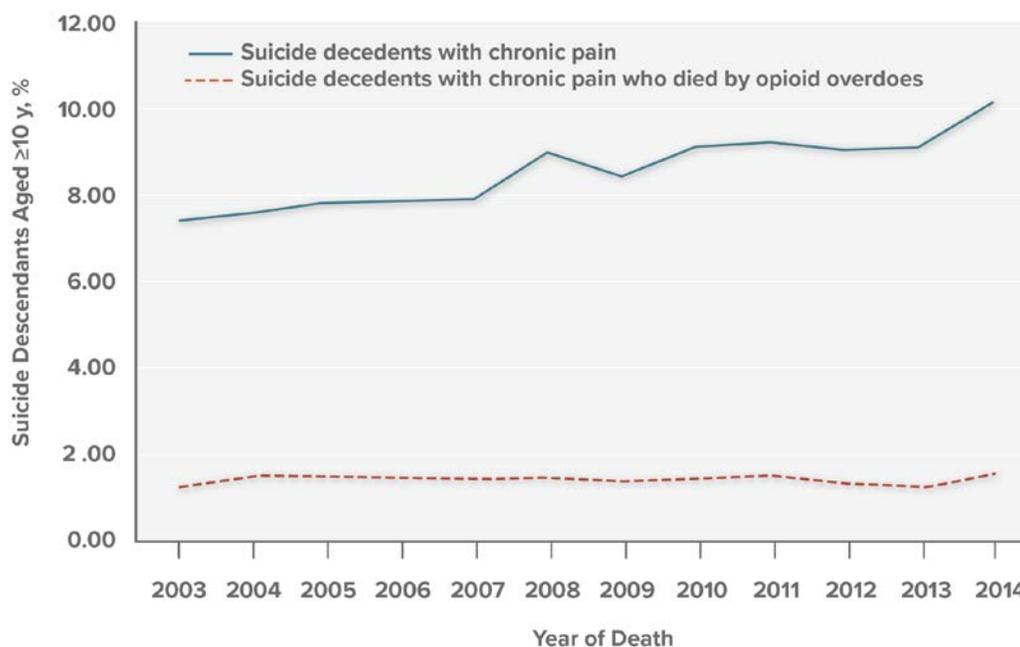
- *Pain Management and the Opioid Epidemic: Balancing Societal and Individual Benefits and Risks of Prescription Opioid Use; National Academies of Sciences, Engineering, and Medicine, 2017.*

This Report is the product of the Pain Management Best Practices Inter-Agency Task Force (Task Force) and intended to guide the public at large, federal agencies, and private stakeholders. The field of pain management began to undergo significant changes in the 1990s, when pain experts recognized that inadequate assessment and treatment of pain had become a public health issue.⁵ Recommendations for improving the quality of pain care¹⁰ were followed by initiatives that recognized patients' reported pain scores as “The 5th Vital Sign.”¹¹ Hospital administrators and regulators began to focus on pain scores, encouraging and incentivizing clinicians to aggressively treat pain to lower pain scores. In addition, increasing administrative burdens (e.g., required quality measures, electronic health records [EHRs], data management and government regulation requirements) led to less time for direct patient care. The administrative burden of using EHRs has contributed significantly to physicians' burnout, likely affecting their capacity to manage the complexity of pain care.^{12–14} As the mandate for improved pain management has increased, there was and is a need for better education and training of clinicians as well as more time and resources to respond to the unmet needs of patients with painful conditions.^{8,15} It is also important to note that in many parts of the country, patients will only have access to their primary care provider. Support for education, time and financial resources for PCPs is essential to manage patients with painful conditions.

Converging efforts to improve pain care led to an increased use of opioids in the late 1990s through the first decade of the 21st century.¹⁶ These initiatives included an overall effort for the lowering of pain scores, the more liberal use of opioids, and the aggressive marketing of new opioid formulations coupled with the continued limited coverage of non-opioid options. These trends resulted in a liberalization of opioid prescribing.^{3,11} Prescription opioids can and are used to treat acute and chronic pain and are often prescribed following surgery or injury and for a subset of patients with chronic pain with medical conditions such as cancer and inflammatory, neurological, and musculoskeletal conditions. Multidisciplinary and multimodal approaches to acute and chronic pain are often not supported with time and resources, leaving clinicians with few options to treat often challenging and complex underlying conditions that contribute to pain severity and impairment. As medical and policymaking organizations began to urge caution about the use of opioids for pain, the federal government has developed a multifaceted approach to the opioid epidemic, including the U.S. Department of Health & Human Services (HHS) 5-Point Strategy to Combat the Opioid Crisis.¹⁷ In addition, various efforts now address this public health problem across federal, state, and local governments as well as the community, private, and academic sectors, including the “Initiative to Stop Opioid Abuse and Reduce Drug Supply and Demand” issued in 2018 by President Donald J. Trump. A public health emergency was declared in October 2017 and subsequently renewed as a result of the continued consequences of the opioid crisis.

Significant public awareness through education and guidelines from regulatory and government agencies and other stakeholders to address the opioid crisis have in part resulted in reduced opioid prescriptions. Regulatory oversight has also led to fears of prescribing among clinicians, with some refusing to prescribe opioids even to established patients who report relief and demonstrate improved function on a stable opioid regimen.¹⁸ The Centers for Disease Control and Prevention (CDC) recently authored a pivotal article in the *New England Journal of Medicine* (NEJM) on April 24, 2019, specifically re-iterating that the 2016 Guideline for Prescribing Opioids for Chronic Pain (CDC guideline) has been, in some instances, misinterpreted or misapplied.¹ This increased vigilance of prescription opioids and the tightening of their availability have in some situations led to unintended consequences, such as patient abandonment and forced tapering. As a result, some established patients with pain may transition to using illicit drugs for pain control, including illicit fentanyl and heroin — a separate group of patients distinguishable from those with substance use disorders (SUDs) (as evidenced by Task Force public comments). The CDC has recently noted that the opioid crisis is quickly moving to a fentanyl crisis.¹⁹ This has coincided with an increase in the demand for illicit synthetic opioids as well as other substances,^{20,21} including a four-fold increase in the rate of death from heroin since 2010.²² Nationwide, nearly half of all opioid overdose deaths in 2017 involved illicitly manufactured fentanyl. Fentanyl is an opioid 50 times more potent than morphine. Illicit fentanyl (manufactured abroad and distinct from commercial medical fentanyl approved for pain and anesthesia in the United States) is a more potent synthetic opioid. Illicit fentanyl is sometimes mixed with other drugs (prescription opioids and illicit opioids, such as heroin, and other illegal substances, including cocaine) that further increase the risk of overdose and death.

A significant number of public comments submitted to the Task Force shared a growing concern regarding suicide due to pain and, in some cases, as a result of either a lack of access to treatment or a loss of treatment services. According to a recent CDC report using data from the National Violent Death Reporting System (NVDRS), the percentage of people who died by suicide and had evidence of chronic pain increased from 7.4% in 2003 to 10.2% in 2014.²³ Numbers from this data set beyond 2014 are not yet available. These findings are made more concerning when one considers the rising trend of health care professionals opting out of treating pain, thus exacerbating an existing shortage of pain management specialists,⁵ leaving a vulnerable population without adequate access to care.



Data from National Violent Death Reporting System (NVDRS). Limitations: Data is not nationally representative because the number of states involved varied, so this was not nationally representative. Additionally, “chronic pain” is not a standard variable collected by NVDRS, and therefore is limited by the lack of pre-event information. Certain diagnoses were assumed to indicate chronic pain, and assumption of this study erred on the side of undercounting chronic pain.

Figure 1: Percentage of Suicide Decedents With Chronic Pain Aged 10 Years or Older, by Year, in 18 States

Comprehensive pain management can be a challenge for various reasons. In the current environment, patients with chronic pain — particularly those being treated with opioids — can be stigmatized, a tendency exacerbated when their pain condition is complicated by mental health co-morbidities such as anxiety and depression or by substance use disorders. Because opioids can produce opioid use disorder (OUD) in at-risk populations, risk assessment and periodic reevaluation and monitoring are required for all patients in these populations and should be a part of the complex care management they need, particularly when there is an intersection of chronic pain, opioids, mental health, and addiction. There is strong evidence that because awareness of and education about these issues, prescription opioid misuse has since been decreasing, from 12.8 million individuals in 2015 to 11.4 million individuals in 2017.²⁴

The Department of Health and Human Services (HHS) is advancing a comprehensive approach that addresses improved pain management in both the acute and chronic pain setting. This effort is a part of the 5-Point Strategy to Combat the Opioid Crisis.¹⁷ This work includes execution of mandates set forth by the Comprehensive Addiction and Recovery Act (CARA), which establishes “an interagency task force, convened by HHS, in conjunction with the Department of Defense (DoD), the Department of Veterans Affairs (VA), and the Executive Office of the President’s Office of National Drug Control Policy.”²⁵ The CARA legislation instructs the Task Force to “determine whether there are gaps in or inconsistencies between best practices for pain management” and “propose updates to best practices and recommendations on addressing gaps or inconsistencies.”²⁵

The Task Force recognizes that comprehensive pain management often requires the work of various health care professionals, including physicians of various disciplines, dentists, nurses, nurse practitioners (NPs), physician assistants (PAs), pharmacists, physical therapists, occupational therapists, behavioral health specialists, psychologists, and integrative health practitioners. The complexity of some pain conditions requires multidisciplinary coordination among health care professionals; in addition to the direct consequences of acute and chronic pain, the experience of pain can exacerbate other health issues including delayed recovery from surgery or worsen behavioral and mental health disorders. Achieving excellence in patient-centered care depends on a strong patient-clinician relationship defined by mutual trust and respect, empathy and compassion resulting in a strong therapeutic alliance.²⁶ As required by congressional legislation, HHS has convened the Task Force, which consists of 29 members who have expertise in pain management, patient advocacy, addiction, mental health, minority health, as well as other organizational representatives from state medical boards and Veteran service organizations amongst others. The Task Force also includes representatives from federal agencies, including HHS, VA, DoD, and the Office of National Drug Control Policy (ONDCP).

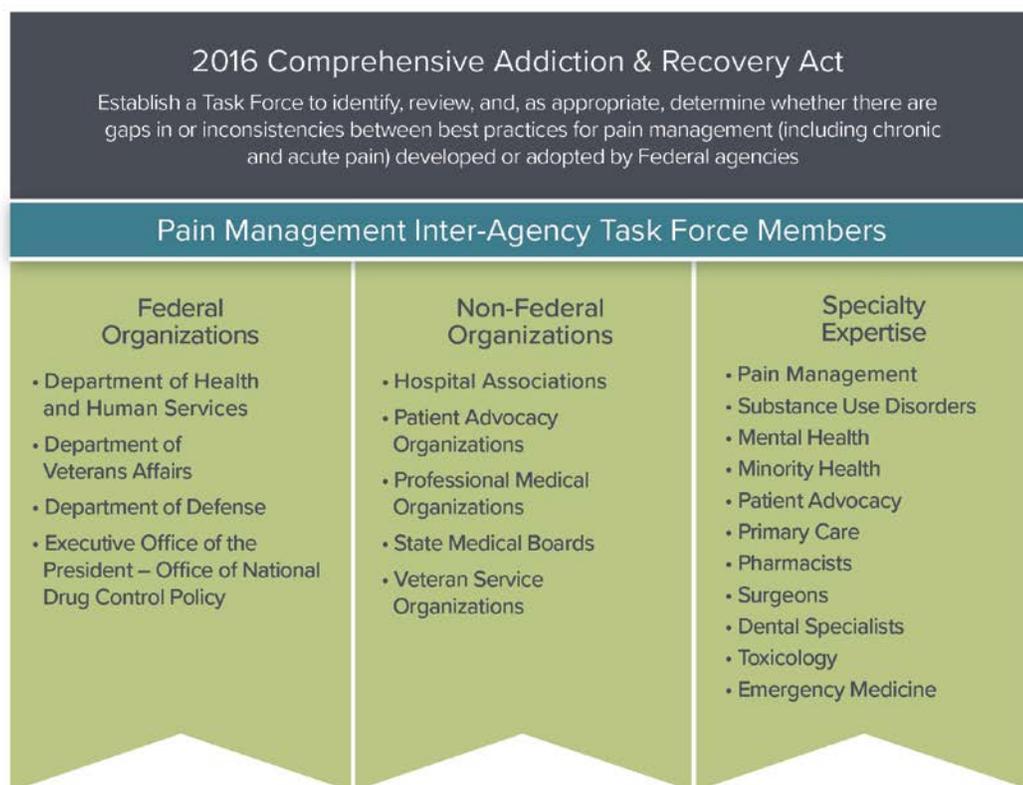


Figure 2: The Pain Management Best Practices Report was Framed by Congressional Legislation and Informed by Task Force Expertise

In 2018, the Task Force convened two public meetings that included extensive public comments and critical patient testimonials from various patient groups, including various special population presentations. The Task Force reviewed and considered public comments, including approximately 6,000 comments from the public submitted during a 90-day public comment period and 3,000 comments from two public meetings. Presentations to the Task Force included the Indian Health Services (IHS), the Defense Health Agency, Veterans Administration officials, HHS officials from the National Institute on Drug Abuse (NIDA), National Institute on Neurological Disorders and Stroke (NINDS), Food and Drug Administration (FDA), state health officials, private stakeholder organizations and experts. The Task Force reviewed extensive public comments, patient testimonials, and existing best practices and considered relevant medical and scientific literature. Task Force discussion and analysis resulted in the identification of gaps and inconsistencies, updates, and recommendations for acute and chronic pain management best practices described in this report, consistent with the CARA legislation. In the context of this report, the term “gap” includes gaps across existing best practices, inconsistencies among existing best practices, the identification of updates needed to best practices, or a need to reemphasize vital best practices. Gaps and recommendations in the report span five major treatment modalities that include medication, restorative therapies, interventional procedures, behavioral health approaches, and complementary and integrative health approaches. This report provides gaps and recommendations for special populations confronting unique challenges in pain management as well as gaps and recommendations for critical topics that are broadly relevant across treatment modalities, including stigma, risk assessment, education, and access to care. The report reviews the CDC Guideline as mandated by the statute.

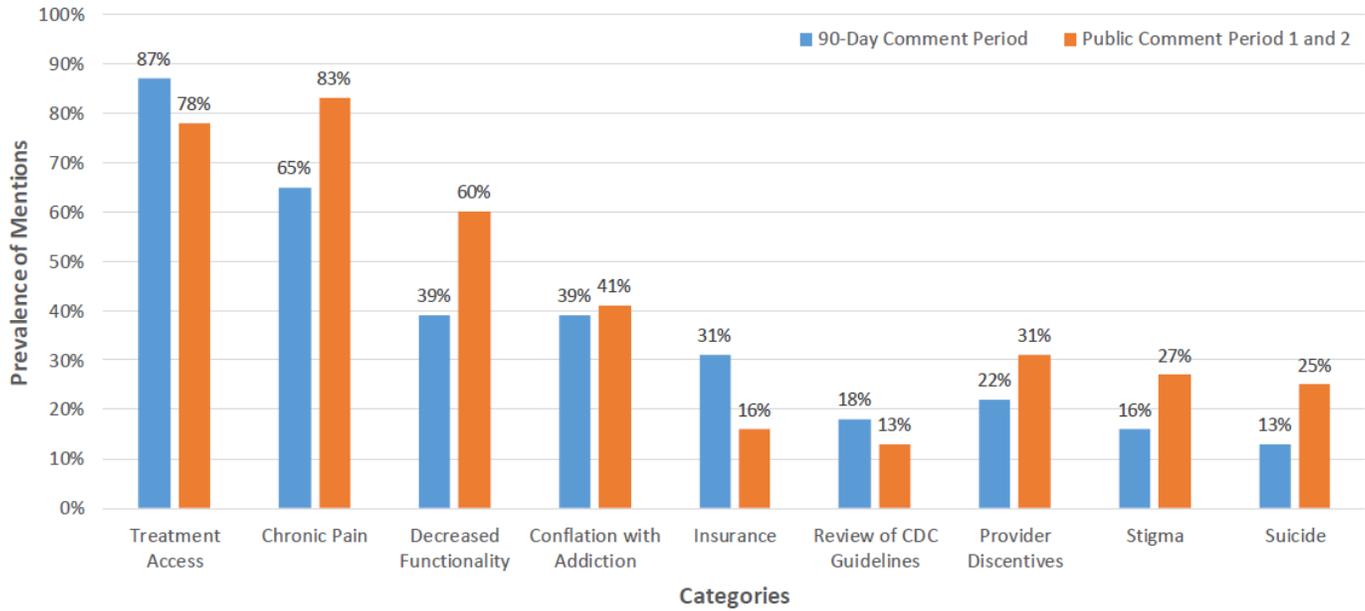


Figure 3 Legend. Categories (x-axis): Selected topic areas relevant to Pain Management. Prevalence of Mentions (y-axis): The percentage of public comments within each specified public comment period addressing each Category. 90-Day Comment Period dates: Dec 31, 2018 – April 1, 2019. Public Comment Period 1 and 2 dates, respectively: Apr 26, 2018 – Jun 15, 2018, Aug 9, 2018 – Sept 17, 2018.

Figure 3: Comparison of the 90-Day Comment Period to Public Comment Periods 1 and 2

*Because cannabis or marijuana remains a Schedule I drug in the United States and rigorous studies are lacking on the safety and efficacy of any specific cannabis product as a treatment for pain, the Task Force did not include cannabis as a specific focus of our recommendations. (According to the DEA, Schedule I drugs, substances, or chemicals are defined as drugs with no currently accepted medical use and a high potential for abuse and although cannabis or marijuana is legal for medical use in several states, it is illegal at the federal level). However, with the increased public interest in using some forms of cannabis as a means of pain treatment, more research and data are needed to ascertain the risk and benefits in order to make recommendations.²⁷

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2. CLINICAL BEST PRACTICES

In pain management, a critical part of providing comprehensive care is a thorough initial evaluation, including assessment of both the medical and the probable biopsychosocial factors causing or contributing to a pain condition. A second critical step is to develop a treatment plan to address the causes of pain and to manage pain that persists despite treatment. Quality pain diagnosis and management can alter opioid prescribing both by offering alternatives to opioids and by clearly stating when they may be appropriate.⁸ Several recent clinical practice guidelines (CPGs) for best practices for chronic pain management agree on specific recommendations for mitigating opioid-related risk through risk assessment, including screening for risks such as depression, active or prior history of SUDs, family history of SUD, and childhood trauma, among other issues, prior to initiating opioids; medication dosing thresholds; consideration of drug-drug interactions, with specific medications and drug-disease interactions; risk assessment and mitigation (e.g., patient-provider treatment agreements); drug screening/testing; prescription drug monitoring programs; and access to non-pharmacologic treatments. Clinical practice guidelines for best practices that only promote and prioritize minimizing opioid administration run the risk of undertreating pain, especially when the cause of the pain is uncertain or cannot be reduced through non-opioid approaches.

To continue improving quality of pain care in the current environment of opioid-related risks, experts have noted several key challenges associated with clinical best practices. First, there is the need to increase the use of CPGs, as indicated in specific patient groups delineated by their underlying diagnosis or cause of pain (e.g., arthritis, postoperative, neuropathic), comorbidities, psychosocial characteristics (e.g., social support, stress), demographics, and settings (e.g., hospital, perioperative, primary care, emergency department [ED]). Second, access to effective pain management treatments must be improved through adoption of clinical best practices in medical and dental practice and clinical health systems.²⁸ Third, clinical best practices for pain management should be better incorporated into the routine training of clinicians,²⁹ with special attention to residency training to meet the needs of patients treated in each specialty.^{8,15} Finally, quality care must be adequately reimbursed.

Pain management experts have also identified specific research gaps that are impeding the improvement of pain management best practices, including synthesizing and tailoring recommendations across guidelines, diagnoses, and populations. In addition, gaps and inconsistencies exist within and between pain management and opioid prescribing guidelines.^{30–32} This finding is also the result of demographic and other variances, because clinical best practices are developed in different regions around the country. A recent review of clinical opioid prescribing guidelines by Barth et al.³³ notes several needs — including the development of postoperative pain management guidelines for different surgical procedures, with the understanding of patient variability in physiology, drug metabolism and underlying disease processes. This research further emphasizes the need for an individualized patient-centered approach focused on achieving improved function, activities of daily living (ADLs) and QOL as well as pain control. In light of these gaps, pain management providers should consider potential limitations to evidence-based clinical recommendations.³⁴

A systematic review of CPGs for neuropathic pain³⁵ identified shortcomings across four evaluation domains: (1) stakeholder involvement (i.e., the extent to which the guideline was developed by the appropriate stakeholders and represents the views of its intended users); (2) the rigor of development (i.e., the process used to gather and synthesize the evidence and the methods used to formulate the recommendations); (3) applicability (i.e., likely barriers and facilitators to implementation of the guideline, strategies to improve its uptake, and resource implications of applying it); and (4) editorial independence (i.e., bias in the formulation of the recommendations), not to mention the knowledge and skill set of the clinician. Identified inconsistencies across guidelines for some painful conditions, such as fibromyalgia, have demonstrated a need for consensus in guideline development.³⁶ A review of state-level guidelines for opioid prescriptions found that a minority of states had guidelines specific to EDs.³⁷ Pain guidelines from the World Health Organization (WHO) are facing a lack of adoption, potentially because they lack incorporation of contemporary pain management practices.³⁸



EMILY'S STORY

PATIENT TESTIMONIAL

For the past eight years, I have lived with debilitating chronic pain as the result of Klippel-Feil syndrome, a rare spinal defect. Over the years, I have tried every possible treatment. I've had neurosurgery. I get regular injections, massages, and acupuncture. I do physical therapy and yoga daily. I wear braces. I buy expensive pillows. I meditate. I eat well. I do all the things you're supposed to do.

But I also need medications. For nearly a year after the pain began, I refused to take anything. I certainly had no interest in taking an opioid. But it was only after eight months of agonizing trial and error with other drugs that we tried Tramadol, as a last resort, and found that it worked.

And yet despite taking one of the safest opioids available, and taking it responsibly for a legitimate problem, I faced restrictions that made me feel more like a criminal than a patient. Once, a doctor refused to refill my Tramadol prescription, even while acknowledging that I showed no signs of abuse. I ended up in the ER where they told me they could only treat withdrawal. It was the most horrific and dehumanizing experience of my life. Another example was the time I wanted to consult a second pain specialist about injections. Although I wasn't asking for medications, I was berated just for asking for a second opinion and left the appointment in tears. Most recently, my health insurance suddenly refused to cover Tramadol. After much back and forth, they wanted proof I had signed an opioid contract. I had in fact signed one, but the doctor had lost his copy. It took over three weeks to resolve. These stories may sound like minor inconveniences, but keep in mind what it would be like to deal with this on top of debilitating pain.

I have sometimes wished I had cancer instead of a spine defect, knowing I would be treated with more respect and compassion. And let's not overlook that I am a middle-class Caucasian female with a strong support system and a background in health care. I cannot imagine how these restrictions are affecting people of color, or the elderly, or those from a lower socioeconomic status.

2.1 APPROACHES TO PAIN MANAGEMENT

A multimodal approach to pain management consists of using treatments from one or more clinical disciplines incorporated into an overall treatment plan. This allows for different approaches to address the pain condition (acute and/or chronic), often enabling a synergistic approach that addresses the different aspects of the pain condition, including functionality. Multidisciplinary approaches address different aspects of chronic pain conditions including biopsychosocial effects of the medical condition on the patient.^{39–41} The efficacy of such a coordinated, integrated approach has been documented to reduce pain severity, improve mood and overall QOL, and increase function.^{40,42–47}

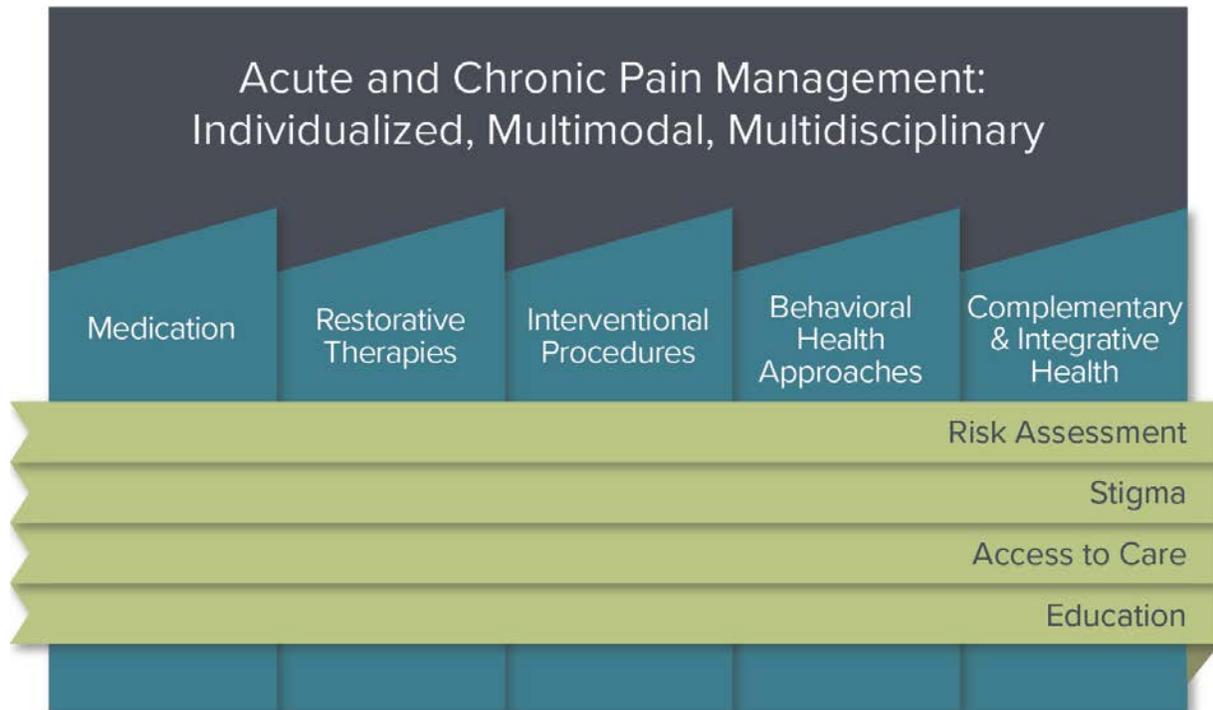


Figure 4: Acute and Chronic Pain Management Consists of Five Treatment Approaches Informed by Four Critical Topics

Recent clinical practice guidelines developed by the VA and DoD adopt the biopsychosocial model of pain.³² In this endeavor, they emphasize a collaborative, stepped care model.^{48,49} The biopsychosocial approach is applied clinically across pain experiences, including chronic pain,⁵⁰ and specifically to musculoskeletal pain,⁵¹ low-back pain,^{52,53} and HIV-related pain.⁵⁴ The development of a treatment plan should be preceded by a history and physical examination that aids in a proper diagnosis. When clinically indicated, clinicians should consider an integrative and collaborative approach to care. Specialty interdisciplinary pain medicine team consultation, collaborative care, and (when indicated) mental health and addiction services should be readily available in the course of treatment of pain to help ensure the best patient outcomes. Medical organizations and advocacy groups are encouraged to be involved in the development of clinical practice guidelines for the treatment of particular pain conditions. When clinically indicated, these can be utilized within the context of the multimodal and multidisciplinary approach to pain care.

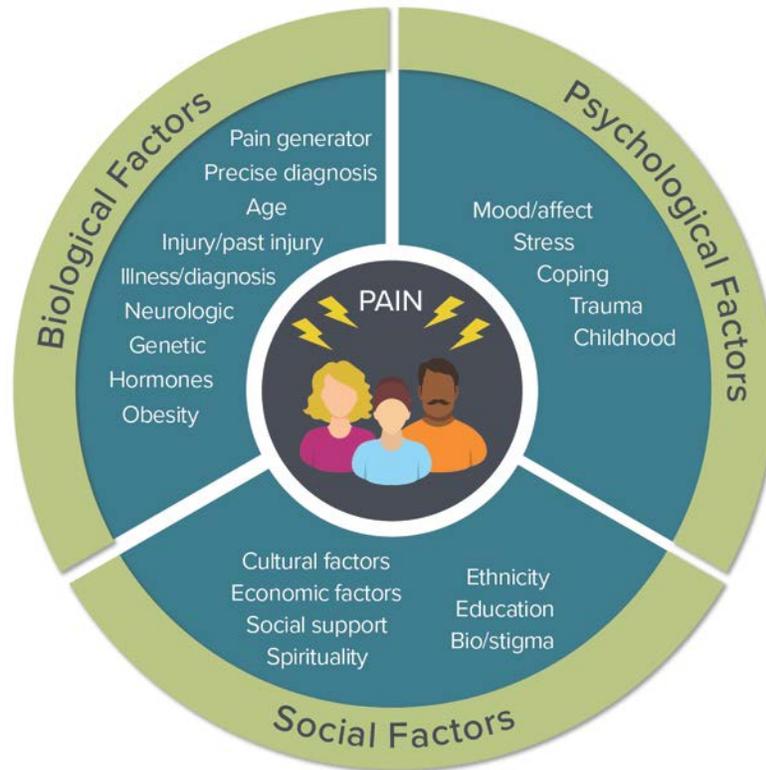


Figure 5: The Biopsychosocial Model of Pain Management

GAPS AND RECOMMENDATIONS

Gap 1: Current inconsistencies and fragmentation of pain care limit best practices and patient outcomes. A coherent policy for pain management for all relevant stakeholders is needed.

- **Recommendation 1a:** Encourage coordinated and collaborative care that allows for best practices and improved patient outcomes, when clinically indicated.
- **Recommendation 1b:** Encourage the use of guidelines that are evidence informed and created by specialty organizations and associations that are experts in the treatment of certain pain conditions that result from a variety of medical conditions or in different special populations.

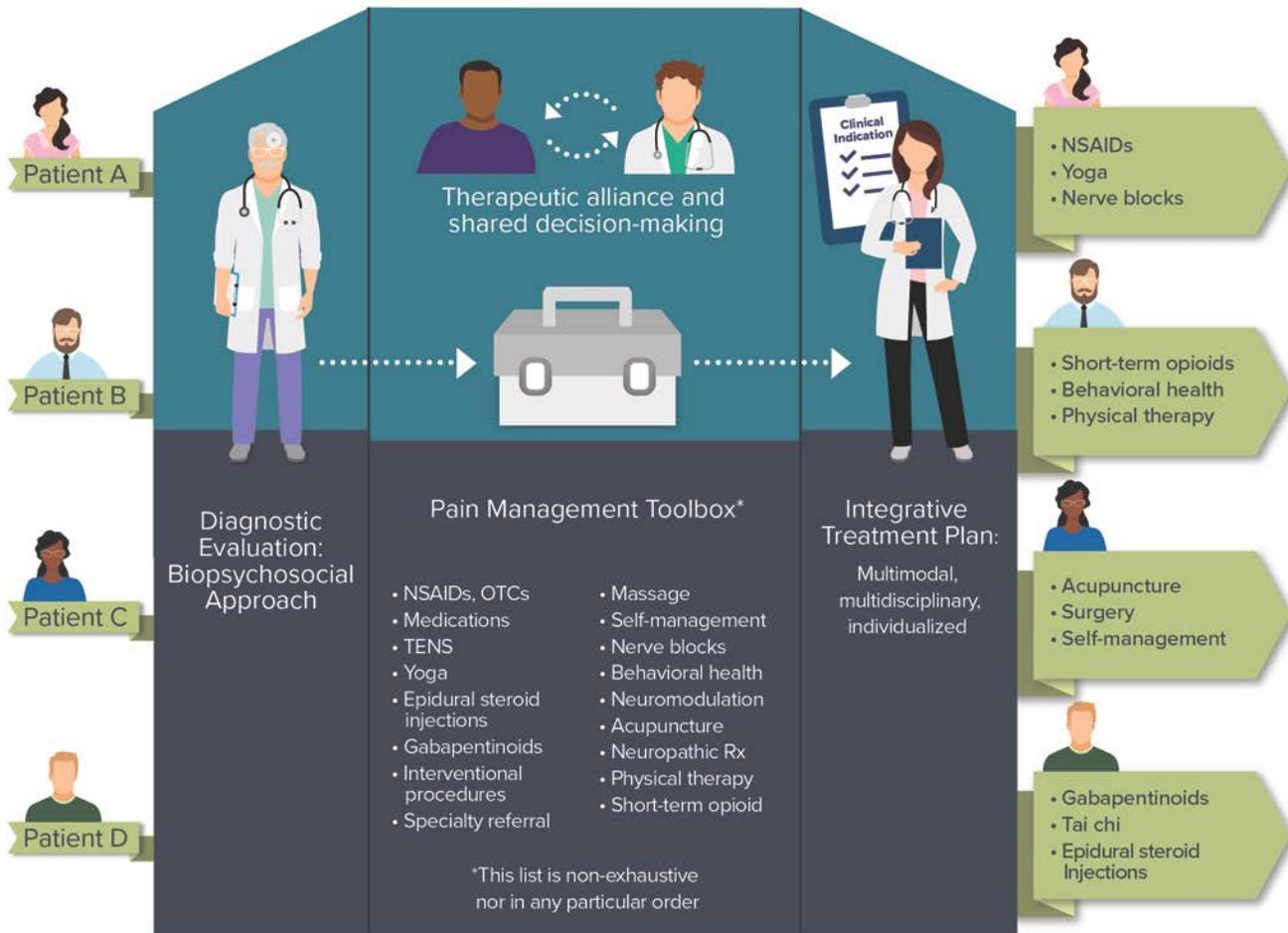


Figure 6: Individualized Patient Care Consists of Diagnostic Evaluation That Results in an Integrative Treatment Plan That Includes All Necessary Treatment Options

2.1.1 ACUTE AND CHRONIC PAIN

Acute pain is a ubiquitous human experience⁵⁵ that is a physiologic response to noxious stimuli that is sudden in onset and time limited.⁵⁶ Acute pain can occur after a burn, trauma or following surgery in the perioperative period. Acute pain and chronic pain are often interlinked, with nearly all cases of chronic pain beginning as acute pain.⁵⁷ Acute pain flares may recur periodically in chronic medical problems, including arthritis,⁵⁸ neuropathies,⁵⁹ spinal conditions, low-back pain,⁶⁰ sickle cell disease (SCD),⁶¹ migraine,⁶² multiple sclerosis (MS),⁶³ trigeminal pain or neuralgia,⁶⁴ and complex regional pain syndrome (CRPS).⁶⁵ As with acute pain flares in these and other conditions, it is important to perform a thorough evaluation that leads to a presumed diagnosis or differential diagnosis. The goal is to facilitate diagnostic accuracy and effective therapeutic plans, including a continuum of care plans into the non-acute care setting.⁶⁶ It is vital to consider a risk-benefit analysis to provide the best possible patient-centered outcome while mitigating unnecessary opioid exposure (see Section 3.1 Risk Assessment). To avoid the side effects associated with the prescription of opioids (e.g., nausea, vomiting, constipation, sedation, OUD), it is important to exploit the benefits of multimodal, non-opioid approaches in acute pain management in conjunction with possible opioid therapy.⁶⁷ Reevaluation of patients is critical in this setting because the use of medications to control acute pain should be for the shortest time necessary while also ensuring that the patient is able to mobilize and restore function. Opioids are effective in treating acute pain, but patients can be at risk of becoming new chronic opioid users in the

postsurgical setting. As one large study illustrated, among a population of opioid-naive patients who were given a course of opioids to treat pain following surgery, about 6% became new chronic users. Patients who were at higher risk for becoming chronic opioid users were those with a history of tobacco use, alcohol and substance abuse disorders, anxiety, depression, other pain disorders, and comorbid conditions.⁶⁸ This finding further underscores the value and importance of initial clinician-patient time together as well as appropriate follow-up to better assess risk and provide appropriate treatment for these complex pain conditions.

GAPS AND RECOMMENDATIONS

Gap 1: Multimodal, non-opioid therapies are underutilized in the perioperative, inflammatory, musculoskeletal and neuropathic injury settings.

- **Recommendation 1a:** Use procedure-specific, multimodal regimens and therapies when indicated in the perioperative period, including various non-opioid medications, ultrasound-guided nerve blocks, analgesia techniques (e.g., lidocaine and ketamine infusions), and psychological and integrative therapies to mitigate opioid exposure.
- **Recommendation 1b:** Use multidisciplinary and multimodal approaches for perioperative pain control in selected patients at higher risk for opioid use disorder (e.g., joint camps, Enhanced Recovery After Surgery [ERAS], Perioperative Surgical Home [PSH]).^{69,70} Key components for optimal pre-habilitation may include preoperative physical therapy, nutrition, and psychology screening and monitoring; preoperative and postoperative consultation and planning for managing pain of moderate to severe complexity; preventive analgesia with preemptive analgesic non-opioid medications; and regional anesthesia techniques, such as continuous catheter-based local anesthetic infusion.
- **Recommendation 1c:** Encourage Centers for Medicare and Medicaid Services (CMS) and private payers to develop appropriate reimbursement policies to allow for a multimodal approach to acute pain in the perioperative setting and the peri-injury setting, including preoperative consultation to determine a multimodal plan for the perioperative setting.
- **Recommendation 1d:** Use treatment regimens in the peri-injury setting that include various non-opioid and non-pharmacologic therapies to mitigate opioid exposure, when clinically indicated.

Gap 2: Guidelines for the use of multimodal clinical management of acute pain are needed.

- **Recommendation 2a:** Encourage public and private stakeholders to develop acute pain management guidelines for common surgical procedures and trauma management, carefully considering how these guidelines can serve both to improve clinical outcomes and to avoid unintended negative consequences.
- **Recommendation 2b:** Emphasize the following in guidelines, which provide an initial pathway to facilitate clinical decision making:
 - Individualized treatment as the primary goal of acute pain management, accounting for patient variability with regard to factors such as comorbidities, severity of conditions, psychosocial characteristics, surgical variability, geographic considerations, and community/hospital resources.
 - Improved pain control, faster recovery, improved rehabilitation with earlier mobilization, less risk for blood clots and pulmonary embolus, and mitigation of excess opioid exposure.

To reflect multidisciplinary approaches and the biopsychosocial model of acute and chronic pain management, the following sections are organized by five major approaches to pain management: medication, restorative therapies, interventional procedures, behavioral health approaches, and complementary and integrative health.

2.1.2 PERIOPERATIVE MANAGEMENT OF CHRONIC PAIN PATIENTS

Perioperative pain management in patients with chronic pain presents unique challenges,^{71,72} particularly for patients with opioid tolerance or those vulnerable to opioid-associated risks. It can be more challenging to manage patients on long-term opioid therapy in the perioperative period compared with patients who are opioid naive. Considerations for managing these patients include the use of multimodal approaches as well as preoperative consultation and planning. In addition, behavioral interventions show promise for use in the pre- and perioperative periods for the management of postsurgical pain.^{73–76} Other experts have suggested use of perioperative surgical homes (PSHs) for this patient population.⁷⁷ Patients with chronic pain whose pain is managed by a pain management clinician should have this clinician consulted and involved in the planning of their pain control during and after surgery.

GAPS AND RECOMMENDATIONS

Gap 1: Patients with chronic pain undergoing a surgical procedure often have complex issues that go unaddressed and may lead to suboptimal care.

- **Recommendation 1a:** The perioperative team should be consulted to form a treatment plan that addresses the various aspects that would be necessary for best outcomes in this patient population.

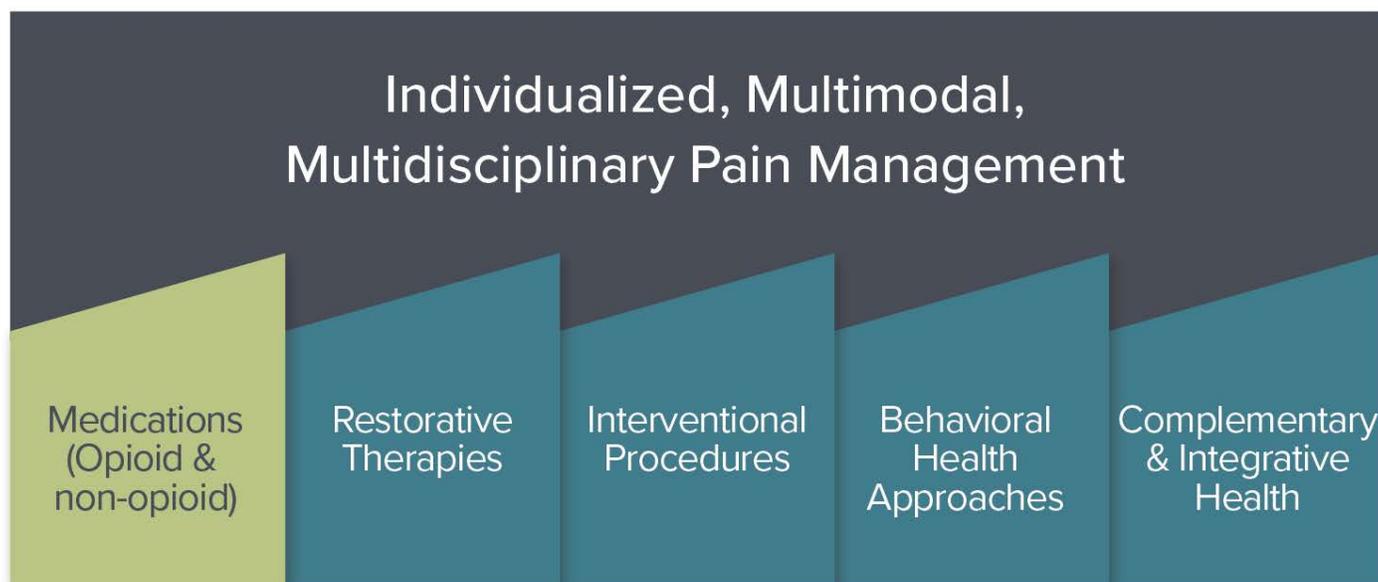


Figure 7: Medication is One of Five Treatment Approaches to Pain Management

2.2 MEDICATION

Effective pain management, particularly for chronic pain, is best achieved through a patient-centered, multidisciplinary approach that may include pharmacotherapy.^{49,52,78} In general, two broad categories of medications are used for pain management: non-opioids and opioid classes of medications.^{79,80}

In response to the public health crisis resulting from the current opioid epidemic, there is a surge of interest in non-opioid pharmacotherapies for chronic pain.^{81–83} Non-opioid medications that are commonly used include acetaminophen, nonsteroidal anti-inflammatory drugs (NSAIDs), antidepressants (e.g., serotonin-norepinephrine reuptake inhibitors [SNRIs], tricyclic antidepressants [TCAs]), anticonvulsants, musculoskeletal agents, biologics, topical analgesics and anxiolytics.^{83–86} Non-opioid medications can mitigate and minimize opioid exposure. Each medication has its own risks and benefits as well as mechanism of action. Different medications can complement one another, and their effects can be synergistic when used in combination. A risk-benefit analysis is always recommended based on the individual patient’s medical, clinical, and biopsychosocial circumstances (see Section 3.1 Risk Assessment).

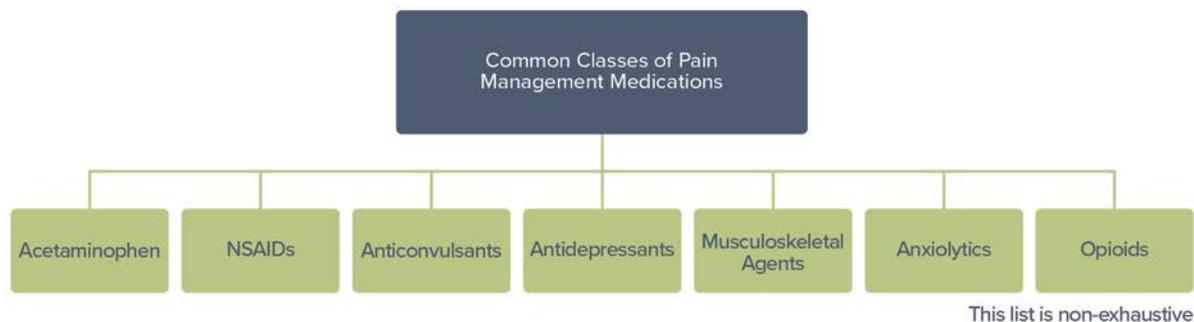


Figure 8: Medication Approaches Include Opioid and Non-opioid Options

The following paragraphs briefly describe non-opioid medications. This list is not inclusive or exhaustive; rather, it provides examples of common non-opioid medications. As a general rule, caution should be taken, particularly for over-the-counter medicine, to ensure that patients are aware of the individual side effects and risks of these medications. Over-the-counter analgesic medications can be present in or components of common cold and cough medicine; clinicians must ensure that patients are aware of and discuss all their medications with their doctor or pharmacist.

Acetaminophen can be effective for mild to moderate pain. Risks of acetaminophen include dose-dependent liver toxicity, especially when the drug is taken at high doses, with alcohol, or by those with liver disease.⁸⁷ This risk further illustrates why patients should be aware of the presence of acetaminophen in both over-the-counter and prescribed combination medications.

NSAIDs such as [aspirin](#), [ibuprofen](#), and [naproxen](#) can provide significant pain relief for inflammation, such as from arthritis, bone fractures or tumors, muscle pains, headache, and acute pain caused by injury or surgery. Nonselective NSAIDs (those that inhibit the activity of both the cyclooxygenase [COX]-1 and COX-2 enzymes) can be associated with gastritis, gastric ulcers, and gastrointestinal (GI) bleeding. Conversely, COX-2 inhibitors have fewer GI adverse effects. The use of NSAIDs may be associated with renal insufficiency, hypertension, and cardiac-related events.

Anticonvulsants are medications originally developed to treat seizures, but they are also commonly used to treat different pain syndromes, including post-herpetic neuralgia, peripheral neuropathy, and migraine.^{88,89} They are often used as part of a multimodal approach to the treatment of perioperative pain. Some of these agents can effectively treat the neuropathic components of pain syndromes. Anticonvulsants, which include gabapentinoids such as gabapentin and pregabalin, may cause significant sedation and have recently been associated with a possible risk of misuse.⁹⁰

Antidepressants are commonly used in various chronic pain conditions.^{88,91} TCAs are effective in a variety of chronic pain conditions, including neuropathic pain. As with other medications, they have risks and adverse effects, including dry mouth, dizziness, sedation, memory impairment, orthostatic hypotension, urinary retention and cardiac conduction abnormalities. Trials with different TCAs (e.g., desipramine, nortriptyline, amitriptyline) should be initiated at a low dose and gradually

titrated to optimal effect. SNRIs, such as venlafaxine and duloxetine, are effective for a variety of chronic pain conditions, including musculoskeletal pain, fibromyalgia, and neuropathic pain conditions, but have markedly fewer adverse effects (e.g., lower risk of drowsiness, memory impairment, and cardiac conduction abnormalities) than TCAs. There have been some reports of withdrawal reactions when these medications are suddenly stopped.⁹² Although selective serotonin reuptake inhibitors (SSRIs), such as fluoxetine, sertraline, citalopram, and paroxetine, are effective antidepressants, they have less analgesic effect compared with other antidepressant classes. Overall, the analgesic actions of antidepressants occur even in patients who are not clinically depressed, and their analgesic effect typically occurs sooner and at lower doses than those required for the treatment of depression.

Musculoskeletal agents commonly used for pain treatment include baclofen, tizanidine, and cyclobenzaprine. Carisoprodol is metabolized to meprobamate, which is both sedating and possibly addictive, so the use of carisoprodol is not recommended, particularly because alternatives are available.⁹³

Anti-anxiety medications are often prescribed to treat the anxiety that accompanies acute pain as well as anxiety resulting from fluctuations in chronic pain. They may also be prescribed for co-morbid anxiety disorders such as generalized anxiety disorder, panic disorder, post-traumatic stress disorder (PTSD) and agoraphobia, which as a group have a prevalence estimated in the range of 30% in patients with chronic pain.^{94,95} SSRIs and SNRIs may also help to manage the anxiety associated with co-morbid depression. It is important to recognize and treat anxiety effectively because it can worsen the severity of pain and can also interfere with a patient's coping skills for managing their pain. Several classes of medications can be used to treat anxiety. Benzodiazepines do not have independent analgesic effects but may have indirect pain-relieving effects.⁹⁶ Thus, they can be helpful when used briefly for the anxiety associated with pain in an acute medical setting (e.g., injury, hospitalization), but benzodiazepines should generally be avoided for regular or long term use for three reasons. First, benzodiazepines increase the risk of substance use disorder (SUD). Second, co-prescription of benzodiazepines and opioids is associated with enhanced risks of overdose, respiratory depression, and death.⁹⁷⁻⁹⁹ Third, the cognitive effects of benzodiazepines, when used chronically, may interfere with a patient's development of new coping skills needed to manage a chronic pain condition.¹⁰⁰ For chronic anxiety disorders, usually a combination of medications indicated for that specific condition plus evidence-based psychotherapy, such as cognitive-behavioral therapy (CBT) (see Section 2.5 Behavioral Health Approaches), works best. SSRIs and SNRIs are the medications most frequently used for generalized anxiety that often accompanies chronic pain conditions. Buspirone is another choice. SSRIs, because of their lower side effect profile, are generally first choice for panic disorder, but TCAs can also be used. Venlafaxine ER and prazosin are used for PTSD. For more severe cases of co-morbid anxiety disorders, psychiatric consultation for medication regimens is advised. (see Section 2.5 Behavioral Health Approaches and Section 4 Review of the CDC Guideline, Gap 6, Recommendations 6a and 6b). It should be noted that gabapentinoids have been useful in treating anxiety in patients with pain.¹⁰¹

The following paragraphs briefly describe opioid medications.

Opioids are a controlled substance group of broad-spectrum analgesics that provide pain relief for a variety of conditions. Administration of opioid medication can include short- or long-acting formulations¹⁰² and different delivery modalities, such as oral, buccal, sublingual, spray, intravenous, intramuscular, intrathecal, suppository, transdermal patches,¹⁰³ and lozenge formulation. Opioids bind to opioid receptors in the brain, spinal cord, and other sites, activating analgesic and reward pathways.¹⁰⁴ It is important to point out that opioid medications vary in the ratio of their analgesic potency and their potential for respiratory depression, the major cause of opioid overdose death.¹⁰⁵ For example, synthetic fentanyl and fentanyl analogues (e.g., carfentanil) are particularly potent for respiratory depression. Illicit fentanyl-related overdoses are now a leading cause of deaths from overdose in the United States, often because of its use in combination with alcohol or illicitly obtained heroin, cocaine, diverted prescription opioids, and other drugs such as benzodiazepines. Common prescription opioid medications that can be considered for management of acute and chronic pain include hydromorphone, hydrocodone, codeine, oxycodone, methadone, and morphine.¹⁰⁶⁻¹⁰⁹ Although effective for moderate to severe acute pain, the effectiveness of opioids beyond three months requires more evidence (see Section 4 Review of the CDC Guideline).¹¹⁰ A recent study demonstrated that treatment with opioids alone was not superior to treatment with trials of various combinations of non-opioid medications for improving pain-related function over 12 months; the authors concluded that the results do not support initiation of opioid therapy alone for moderate to severe chronic back pain or hip or knee osteoarthritis pain.¹¹¹ There are

challenges to completing long-term studies of any therapy for moderate to severe pain, particularly patient drop-out from intolerable pain.¹¹² Opioid medications can be associated with significant side effects, including constipation, sedation, nausea, vomiting, irritability, pruritis, and respiratory depression.^{113–115} Opioid medications can be associated with OUD¹¹⁶ and can be diverted.¹¹⁷ Buprenorphine, an opioid medication that the U.S. Food and Drug Administration (FDA) has approved for clinical use, is a partial agonist at the mu opioid receptor and therefore has a reduced potential for respiratory depression; it is thus safer than full agonists such as morphine, hydrocodone, and oxycodone.^{118,119} Buprenorphine also acts as an antagonist at the kappa receptor, an effect shown in experimental studies to reduce anxiety, depression, and the unpleasantness of opioid withdrawal. Buprenorphine is widely used and encouraged for treating patients with OUD and is approved for the treatment of pain. In some states, there is a significant challenge, however, for prescribing clinicians to get authorization for using buprenorphine for chronic pain management (see Section 2.2 Medication, Gap 4 and Recommendations)

Tapentadol is structurally similar to tramadol, and both have a dual mode of action as an agonist at the mu-opioid receptor and as a serotonin and norepinephrine reuptake inhibitor. Tapentadol is at least equivalent to oxycodone in terms of analgesia, with better GI tolerability.¹²⁰

As outlined in recent guidelines, including the VA/DoD Clinical Practice Guidelines for Opioid Therapy for Chronic Pain, the CDC guideline, and the American Society of Interventional Pain Physicians guidelines, risk assessment, close follow-up, and pain reevaluation are important aspects of the treatment plan prior to and throughout the duration of opioid therapy for pain management.^{32,121,122} Initiation of opioid therapy, when the benefits are deemed by the patient and the clinician to outweigh the risks, should be at a low dose and titrated upward to find the lowest dose required to optimally control the pain or improve function and QOL. Opioid treatment should be maintained for a period no longer than necessary for adequate pain control.^{32,49,121} Similarly, assessing for tolerance and consideration of adjunctive therapies, opioid rotation, tapering, and discontinuation should be considered.^{32,121,123} Safe opioid stewardship involves a proper history and examination, periodic reevaluation and risk assessment, with a focus on measurable outcomes, including function, QOL and ADLs.^{32,49,121} Accurate dose adjustment is critical because patients vary widely in the dose required for analgesic efficacy.^{124,125}

The idea of a ceiling dose of opioids has been recommended, but establishing such a ceiling is difficult, and the precise level for such a ceiling has not been established.¹²⁶ The risk of overdose increases with the dose, but the therapeutic window varies considerably from patient to patient. For example, the CDC guideline identified a dose limit of 90 morphine milligram equivalents (MMEs) per day. A more recent study evaluated the risk of death related to opioid dose in 2.2 million North Carolinians and found that the overall death rate was 0.022% per year.¹²⁷ The researchers noted that:

“Dose-dependent opioid overdose risk among patients increased gradually and did not show evidence of a distinct risk threshold. Much of the risk at higher doses appears to be associated with co-prescribed benzodiazepines. It is critical to account for overlapping prescriptions, and justifies taking a person-time approach to MME calculation with intent-to-treat principles.”

The U.S. Drug Enforcement Administration (DEA) has classified medications according to categories, or “schedules,” based on the perceived risk of addiction. These scheduled medications require prescribers to register with DEA. Opioids are mainly category CIII (relatively lower risk) or CII (higher risk). CIII medications include acetaminophen with codeine (T#3) and buprenorphine, while CII medications include hydrocodone (recently changed from a CIII to a CII classification), oxycodone, morphine, fentanyl, and methadone. CIV drugs are defined as drugs with a low potential for abuse and low risk of dependence, such as Tramadol. CI medications are those that are considered not to have medicinal value, including heroin, methamphetamine, and marijuana. (Although marijuana is legal for medical use in several states, it is illegal at the federal level.)



JONATHAN'S STORY

PATIENT TESTIMONIAL

I am a soon to be 50-year-old man that has sickle-cell anemia. And it runs in my family. I come from a family of 12 siblings. And out of the 12, five of us have sickle-cell anemia. I'm not an advocate by any way for opioids. But they are a part of our tool box that helps us maintain a quality of life. We get labeled as drug seekers. They don't think of us as fathers, husbands, sons, grandfathers. They just look at us as another number or as those patients coming in seeking drugs. In my life, opioids help me have a quality of life. I know how now not to get stressed out. I have all sorts of other things that I try before just taking medication. OxyContin is one of the medications that I take. And, yes, you have to take it every 12 hours daily. So, yes, that's part of my regimen. But I also do other things-- vitamins, try to eat healthy, try not to be stressed out-- just all sorts of things to help myself. I am a grandfather. I have two children. I have three grandkids. Please look at each case individually because everybody can't be lumped into one barrel together. I've been taking this medication since '95 and I take a really high amount. But I only take enough to be able to function. I'm not trying to get loopy and be out of my mind. That was never my intention. I take it because of the pain. But the main thing is, we need opioid medications to be an option in the tool box.

Opioids: Additional Considerations

The following paragraphs briefly describe additional considerations relevant to medications used for pain management.

Medicines play an important role in treating certain conditions and diseases, but they must be taken with care and stored securely where they cannot be misused by a third party or accidentally ingested by children or pets.¹²⁸ Unused portions of these medicines must be disposed of properly to avoid harm. Patients and caregivers can remove expired, unwanted or unused medicine from their home as soon as they are no longer needed to help reduce the chance that others accidentally or intentionally misuse the unneeded medicine and to help reduce drugs from entering the environment. There are various take-back options such as DEA National Takeback Days, pharmacy takeback (in some locations), drop boxes in many local law enforcement offices, drug deactivation systems, and mail back options. FDA maintains a list of medicines that are potentially dangerous if diverted and should be flushed in the toilet (see Federal Resource Center)¹²⁸ Practicing safe medication storage is important and patients, caretakers, providers, and pharmacists should be educated in the various ways to keep them safe at home (<https://www.cdc.gov/features/medicationstorage/index.html>).¹²⁹

Synthetic opioids other than methadone (a category that includes prescribed and illicit fentanyl and fentanyl analogues) are now the leading opioids involved in overdose deaths in the United States.^{106–108} The source of illicit fentanyl and its analogues has been identified as international and rarely from diverted fentanyl pharmaceuticals in the United States. These sources currently come through the U.S. Postal Service, borders, ports of entry, and other means. The illicit fentanyl analog used is not necessarily the same compound that is legally prescribed and used during surgeries; or in the transdermal and mucosal fentanyl preparations provided for moderate to severe pain. One illicit analog that has been seen is called carfentanil, which is 100 times more potent than fentanyl. The availability of naloxone as well as patient and family education about naloxone can mitigate the risks of fentanyl-related overdose.¹³⁰

Prescribers may offer a naloxone prescription to patients who are prescribed opioids (co-prescription) or to those with an addiction history who may be at risk for relapse. In many states, people may obtain naloxone without seeing their provider by obtaining a prescription through standing-order programs with pharmacies. Timely administered naloxone can reverse overdose from opioids whether the opioid is prescribed or illicitly obtained (see Section 2.2.1 Overdose Prevention Education and Naloxone).

Interaction among multiple medications prescribed to patients (polypharmacy) can have significant clinical and symptomatic effects. **Poison control centers** are available 24/7 to health care professionals and the public to answer questions about medication interactions and adverse effects and to assess the need for emergency health care resources.^{131,132} Poison control

center engagement is associated with significant reductions in unnecessary use of emergency medical services, EDs, and hospital resources, resulting in significant cost savings for the U.S. health care system.^{133,134} Increased provider and patient awareness and education of the complex and variable interactions of prescribed medications as well as homeopathic, supplemental, and/or over-the-counter medications is needed.¹³⁵

Abuse-deterrent technologies are being developed with the goal of preventing alterations of prescription opioid formulations and the extraction of the active ingredient by users.^{136,137} For example, some abuse-deterrent formulations (ADFs) have a hardened tablet surface that prevents crushing, while others turn into a gooey substance upon crushing; both formulations are designed to limit the potential for injecting the core substance.¹³⁸ ADFs also include the addition of pharmaceutical or chemical compound to the opioid to decrease the user's response to the abused substance or to provide an adverse reaction when the medication is altered.¹³⁷ To address misuse of prescription opioids, the FDA released guidance in 2015 for the development of opioids formulated to meaningfully deter abuse.¹³⁶ A challenge to the development of opioid ADFs is the need to maintain the same safety and efficacy profile as the opioid without the ADF for FDA approval.^{137,139,140} ADFs are not widely used and more research is needed for better product development to reduce opioid misuse (The review of ADT/Fs is mentioned specifically for review in the CARA legislation).

GAPS AND RECOMMENDATIONS

Gap 1: Clinical policies tend to treat the large population of patients with multiple conditions causing chronic pain with simple medication rules. Guidelines for medication use for specific populations of patients (e.g., different ages, genders, medical conditions, comorbidities) with chronic pain need to be developed for each specialty group and setting.

- **Recommendation 1a:** Develop condition-specific treatment guidelines that guide physicians to have a more individualized approach for common pain syndromes and conditions. A multidisciplinary approach that integrates the biopsychosocial model is recommended when clinically indicated.
- **Recommendation 1b:** Primary care and non-pain specialists should have timely, early consultation with pain specialists and other members of the pain management team for the assessment of patients with complex pain to prevent complications and loss of function and to improve QOL, as clinically indicated.
- **Recommendation 1c:** Develop a collaborative, multimodal treatment plan as clinically indicated among the referring physician, the pain medicine team, and the patient.
- **Recommendation 1d:** Pharmacies should collaborate with area health care providers to develop more effective and patient-friendly delivery systems to meet the needs of their patients.

Gap 2: Opioids are often used early in pain treatment. There has been minimal pain education in medical school and residency programs, and little guidance for primary care providers (PCPs) on appropriate pain treatment approaches (see Section 3.3.3 Provider Education; see Section 3.4 Access to Pain Care).

- **Recommendation 2a:** Non-opioids should be used as first-line therapy whenever clinically appropriate in the inpatient and outpatient settings.
- **Recommendation 2b:** If an opioid is being considered, clinicians should use evidence-informed guidelines.
- **Recommendation 2c:** The type, dose, and duration of opioid therapy should be determined by treating clinicians according to the individual patient's pain condition, while using the opioid medication at the lowest effective dosage and shortest duration appropriate to achieve adequate pain control for improved function and QOL.
- **Recommendation 2d:** Opioid therapy should be initiated only when the benefits outweigh the risks; and/or the patient is experiencing significant acute or chronic pain that interferes with function and QOL; and the patient is willing to continue to engage with the team on a comprehensive multidisciplinary treatment plan, as clinically indicated, with established clear and measurable treatment goals, along with close follow-up and regular risk assessment and reevaluation.

- **Recommendation 2e:** The Centers for Medicare & Medicaid Services (CMS) and private payers should provide reimbursement that aligns with the medication guidelines the Task Force has described. Private payers and CMS should provide more flexibility in designing reimbursement models.
- **Recommendation 2f:** Pharmacy Benefit Managers (PBM) and payers should be more transparent about non-opioid pharmacologic options in their formulary and we encourage state and federal regulators to review payer and PBM formularies to ensure that non-opioid options are on low-cost tiers.
- **Recommendation 2g:** As part of a comprehensive pain curriculum, it is important and should be required for providers to have appropriate opioid training.

Gap 3: There is often a lack of understanding and education regarding the clinical indication and effective use of non-opioid medications for acute and chronic pain management. Chronic pain is often ineffectively managed for a variety of reasons, including clinician training, patient access, and other barriers to care (see Section 3.3 Education):

- **Recommendation 3a:** Clinicians who treat chronic pain should understand the full complement of options, including the use of non-opioid medications and their mechanism-based pharmacology for managing different components of pain syndromes (See Section 2.3 Restorative Therapies, Section 2.4 Interventional Procedures, Section 2.5 Behavioral Health Approaches, and Section 2.6 Complementary and Integrative Health).
- **Recommendation 3b:** For neuropathic pain, as a first line therapy consider anticonvulsants (e.g., gabapentin, pregabalin, carbamazepine, oxcarbazepine); SNRIs (e.g., duloxetine, venlafaxine); TCAs (e.g., nortriptyline, amitriptyline); and topical analgesics (e.g., lidocaine and capsaicin). Regardless of the route of medication, education regarding the side effects and risks and benefits is vital in terms of understanding clinical indications and patient outcomes.
- **Recommendation 3c:** For non-neuropathic, non-cancer pain, use NSAIDs and acetaminophen as first-line classes of medications following standard dosing schedules when clinically appropriate. Other classes of medication can be used depending on the patient's response and may include (depending on specific pain syndromes) anti-spasticity medications (e.g., tizanidine, baclofen) and topical preparations of various classes of medication in addition to other multimodal approaches. Additional consideration may be given to SNRIs or TCAs.

Gap 4: Barriers include lack of coverage and reimbursement for buprenorphine, as well as the lack of education and training on the proper usage of buprenorphine. There has been a lack of access to buprenorphine treatment for chronic pain.¹⁴¹

- **Recommendation 4a:** Make buprenorphine treatment for chronic pain available for specific groups of patients, and include buprenorphine in third-party payer and hospital formularies.
- **Recommendation 4b:** Encourage CMS and private payers to provide coverage and reimbursement for buprenorphine treatment, both for opioid use disorder and for chronic pain. Encourage primary use of buprenorphine rather than use only after failure of standard mu agonist opioids such as hydrocodone or fentanyl, if clinically indicated.
- **Recommendation 4c:** Encourage clinical trials using buprenorphine for chronic pain to better understand indication, usage and dosage.

Gap 5: Education is currently inadequate for patients and clinicians regarding safe medication storage and appropriate disposal of excess medications targeted at reducing outstanding supplies of opioids that others can misuse or that children and other vulnerable members of the household can inadvertently access.

- **Recommendation 5a:** Increase public awareness of poison center services as a resource that provides educational outreach programs and materials; referral to treatment facilities; links to take-back facilities; and resources for safe drug storage, labeling, and disposal.

- **Recommendation 5b:** HHS in partnership with DEA and other federal and state agencies should increase opportunities for safe drug disposal and drug disposal sites (e.g., pharmacies, police departments).
- **Recommendation 5c:** Adopt neutralization technologies and methods that may make safe disposal more readily available for opioids and other relevant medications.
- **Recommendation 5d:** Educate all providers, including veterinarians, on the importance of safe storage and disposal of opioid medications in their practice. In addition, educate patients and pet owners about the importance of safe storage and disposal of opioid pain medication prescribed for their pets.



Figure 9: Value of Poison Control Centers

2.2.1 OVERDOSE PREVENTION EDUCATION AND NALOXONE

Naloxone is a medication designed to rapidly reverse opioid overdose.^{142,143} It is an opioid antagonist that binds to opioid receptors and can reverse and block the effects of other opioids. It can quickly restore normal respiration to a person whose breathing has slowed or stopped as a result of overdosing with illicit fentanyl, heroin, or prescription opioid pain medications.

The use of naloxone to treat those who have overdosed on opioids by family members, bystanders, and first responders can save lives,¹⁴⁴ and both intramuscular and nasal formulations are available. Widespread, rapid availability of bystander and take-home naloxone rescue kits, coupled with enhanced education on naloxone's proper use, is essential, particularly in cases where higher doses of opioids are to be prescribed or there is evidence of underlying OUD, as emphasized by the Surgeon General of the U.S. Public Health Service, VADM Jerome Adams' advisory on naloxone and opioid overdose.^{145,146}

GAPS AND RECOMMENDATIONS

Gap 1: Bystander/take-home naloxone distribution is associated with a cost-effective reduction in mortality; however, its optimal use is not widely understood, and it is not widely distributed.

- **Recommendation 1a:** Provide naloxone co-prescription/dispensing and education for certain patients and family members/caregivers when the patient is on chronic opioid therapy.
- **Recommendation 1b:** Increase naloxone distribution programs and education for first responders.
- **Recommendation 1c:** Encourage FDA and other entities to research the potential risks and benefits of making naloxone available over the counter.
- **Recommendation 1d:** Educate health care providers and the public on the importance of identifying individuals at higher risk of overdose harm because of their history or findings consistent with substance abuse, co-prescription or illicit use of drugs or substances that cause sedation or respiratory depression, or evidence of respiratory compromise.



Figure 10: Restorative Therapies Are One of Five Treatment Approaches to Pain Management

2.3 RESTORATIVE THERAPIES

Restorative therapies include treatments provided by physical therapy (PT) and occupational therapy (OT) professionals, physiotherapy, therapeutic exercise, and other movement modalities that are provided as a component of interdisciplinary, multimodal pain care. Restorative therapies play a significant role in acute and chronic pain management, and positive clinical outcomes are more likely if restorative therapy is part of a multidisciplinary treatment plan following a comprehensive assessment. Restorative therapies can be administered by physical therapists, occupational therapists, and others in a variety of settings. Patient outcomes related to restorative and physical therapies tend to emphasize improvement in outcomes, but there is value in restorative therapies to help maintain functionality. Use of restorative therapies is often challenged by incomplete or inconsistent reimbursement policies. The Task Force asks healthcare reimbursement policymakers to closely evaluate and advocate for payers to improve access to a range of restorative therapies.

The following paragraphs briefly describe restorative therapies, which can be considered singularly or combined with other therapies as part of a multimodal approach to the management of chronic and acute pain, depending on the patient and his or her medical conditions. This list is not inclusive or exhaustive but instead provides examples of common restorative therapies

Therapeutic exercise and its role in the treatment of pain is tied to the underlying diagnosis for the pain. Bed rest was scientifically recognized and prescribed as a treatment for low-back pain as recently as the 1980s,¹⁴⁷ but high-quality scientific evidence has since emerged establishing the superiority of movement therapies over rest.¹⁴⁸ The majority of pain-related PT guidelines exist for the treatment of spinal pain. In addition to improving physical functioning, a more contemporary biopsychosocial treatment approach to therapeutic exercise helps patients understand and overcome “secondary pathologies,” including fear of movement and anxiety that contribute to pain and disability.”⁵¹

Transcutaneous electric nerve stimulation (TENS) has been applied to treat pain, but studies of its efficacy are lacking in number and design, with high risks of bias commonly reported.¹⁴⁹ An evaluation of 49 systematic reviews, randomized controlled trials (RCTs), and observational studies found insufficient evidence to assess the effectiveness of TENS for acute low-back pain.¹⁵⁰ More recent individual studies have investigated the effectiveness of TENS for postpartum pain,¹⁵¹ phantom limb pain,¹⁵² and knee osteoarthritis.¹⁵³ Despite the overall limited evidence of efficacy, partially stemming from a lack of large RCTs, TENS is considered a safe self-care option for patients with appropriate education.¹⁵⁴

Massage therapy can be effective in reducing pain.¹⁵⁵ There are a variety of types of massage therapy, including Swedish, shiatsu, and deep tissue (myofascial release).^{156,157} In Swedish massage, the therapist uses long strokes, kneading, and deep circular movements. Shiatsu massage uses the fingers, thumbs, and palm to apply pressure. Deep tissue massage focuses on myofascial trigger points, with attention on the deeper layers of tissues.

Traction is a PT technique used to treat spinal pain. Review of the evidence has failed to demonstrate the clinical effectiveness of traction as an effective, evidence-based best practice; however, the field in general lacks high-quality RCTs that examine effectiveness of traction as an isolated treatment modality for low-back^{150,158} or neck pain.¹⁵⁹

Cold and heat have been used in the treatment of symptoms of a variety of acute and chronic pain conditions. The application of cold has long been a component of the RICE (rest, ice, compression, elevation) paradigm for the treatment of acute pain syndromes. Because it treats only symptoms, the effects and duration of this therapy are mitigated by the initial cause of the pain. For instance, cold therapy has been shown to decrease the pain of hip arthroplasty on the second but not the first or third day after surgery and did not decrease blood loss from the surgery.¹⁶⁰ Evidence is not robust for all locations and types of pain, but significant evidence exists for the efficacy and safety of heat wraps in specific conditions, most notably for acute low-back pain. In fact, a review of nonpharmacologic therapies found that superficial heat had good evidence of efficacy for treatment of acute low-back pain.¹⁶¹ Another review found moderate evidence for heat wraps for both symptom and functional improvements.¹⁵⁰

Therapeutic ultrasound (TU) is thought to deliver heat to deep tissues for improved injury healing.^{162,163} A 2001 review concluded that there was little evidence that TU is more effective than placebo for pain treatment in a range of musculoskeletal conditions.¹⁶⁴ More recent reviews of specific pain syndromes available through the Cochrane Database of Systematic Reviews reveal similar findings, although there is some evidence for TU in knee osteoarthritis.^{165,166}

Bracing has sometimes been discouraged in pain management because of fears of deconditioning and muscle atrophy. However, there is evidence that, for at least short periods of time, bracing (especially non-rigid bracing) may improve function and does not result in muscle dysfunction.¹⁶⁷ Bracing should be part of the clinician tool box.

GAPS AND RECOMMENDATIONS

Gap 1: There is a lack of clarity on which restorative therapy or treatments are indicated in the various pain syndromes.

- **Recommendation 1a:** Conduct further research to provide data on which restorative therapy or treatments are indicated as part of a multidisciplinary approach to specific pain syndromes.

- **Recommendation 1b:** For those modalities for which clear indications for benefits in the treatment of chronic pain syndromes (e.g., treatments used by OT and PT professionals; aqua therapy; TENS; movement-based modalities, including tai chi, Pilates, and yoga), there should be minimal barriers to accessing these modalities as part of a recommended multidisciplinary approach to the specific pain condition.
- **Recommendation 1c:** Make harm-free, self-administered therapies such as TENS freely available (e.g., over the counter) to support pain management treatment plans.

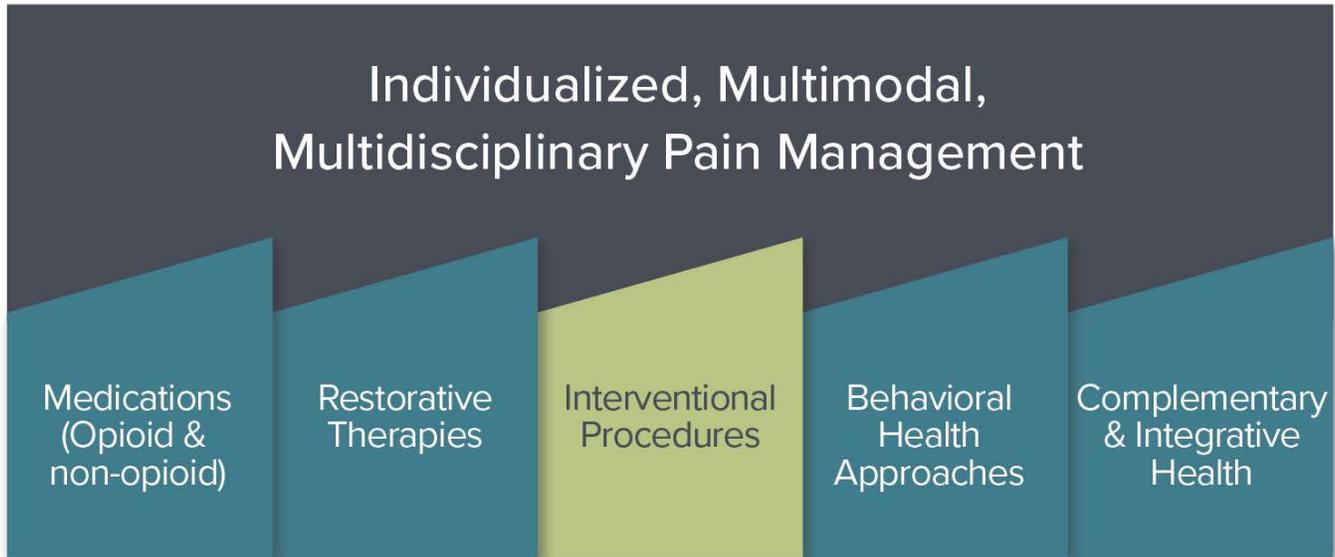


Figure 11: Interventional Procedures Are One of Five Treatment Approaches to Pain Management

2.4 INTERVENTIONAL PROCEDURES

Interventional pain management, or interventional pain medicine, is a medical subspecialty of pain medicine that diagnoses and treats pain with minimally invasive interventions that can alleviate pain and minimize the use of oral medications. Most interventional pain physicians offer interventional therapies for acute and chronic pain conditions as part of a comprehensive treatment program.¹⁶⁸ Many interventional pain procedures have been around for decades, and they vary in their invasiveness. Image-guided interventional procedures (using ultrasound, fluoroscopy, and computed tomography) can greatly benefit comprehensive assessment and treatment plans by identifying the sources and generators of pain.¹⁶⁹ Diagnostic and therapeutic interventional techniques can be valuable options prior to the initiation of extensive surgery, initiation of opioid treatment, or in concert with other treatment modalities. Additional research and more specific data establishing the clinical benefits of specific interventional procedures for specific pain conditions would be beneficial and can further identify various procedures for specific clinical conditions,¹⁷⁰ particularly for certain populations, such as children.¹⁷¹ Many interventional pain procedures are available on an outpatient basis, which is vital to ensuring cost-effective access to care. Some minor interventional procedures can be performed in the primary care setting, while other more, advanced procedures require specialty training. The measure of a successful outcome depends on whether the intervention is used to treat short-term, acute flares or is part of a long-term management plan that will depend on the individual patient and his or her unique medical status.

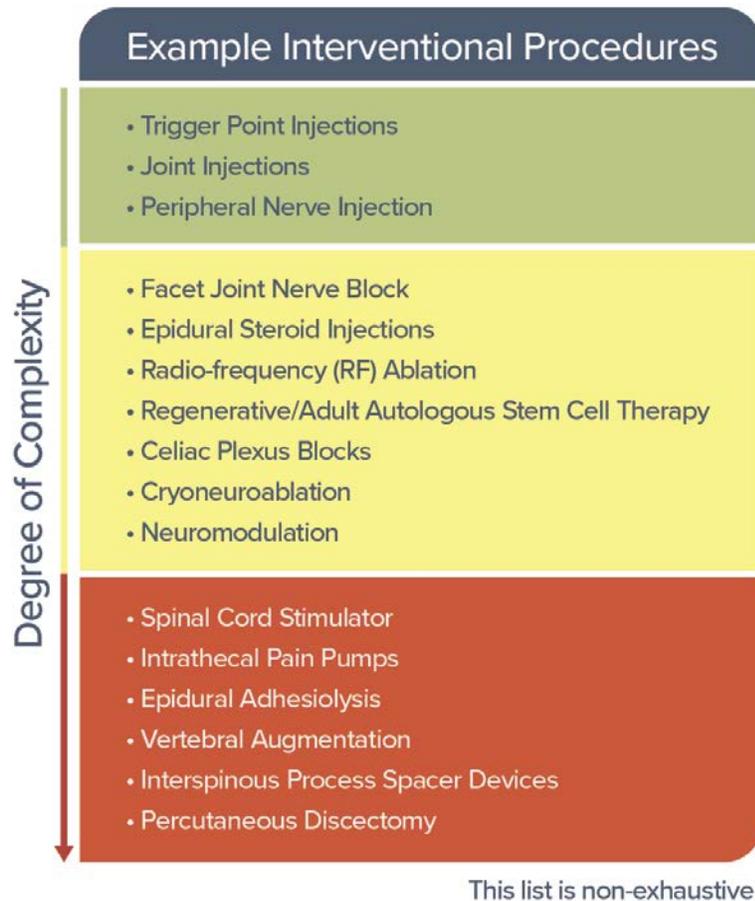


Figure 12: Interventional Procedures Vary by Degree of Complexity and Invasiveness

The following paragraphs briefly describe interventional procedures that can be considered singularly or as part of a multimodal approach to the management of chronic and acute pain, depending on the patient and his or her medical conditions. This list is not inclusive or exhaustive but instead provides examples of common interventional procedures.

Epidural steroid injections (ESIs) deliver anti-inflammatory medication directly into the epidural space — the region outside the sac of fluid surrounding the spinal cord. Lumbar epidural injections treat back pain and radicular pain resulting from chemical irritation of nervous tissues by eliminating the inflammatory compounds mediating nervous tissue irritation in the epidural space.¹⁷² ESIs are one of the most common procedures in pain management and, in well-selected patients, can provide significant pain relief as part of a pain management plan.¹⁷³ Although risks are associated with ESIs, they offer significant advantages to the patient, notably in that they may potentially reduce health care costs, health care utilization, and the need for future surgical intervention.¹⁷⁴ Transforaminal ESIs and selective nerve root injections are specialized approaches to the epidural space that target specific nerve root pathology.

Facet joint nerve block and denervation injection are common fluoroscopy-guided procedures for facet-related spinal pain of the low back and neck area in which local anesthesia with or without steroids is injected onto the medial branch nerves that supply these joints (medial branch blocks or less commonly directly into the facet joint). These injections are primarily diagnostic but can also be therapeutic, providing long-term relief. If there is only temporary relief, these nerves can be ablated by using radio-frequency (RF) ablation^{175,176} or cryoneuroablation.¹⁷⁷ Facet pathology is a common cause of lower back pain as well as cervical neck pain caused by facet joint sprain (cervical whiplash) or degenerative changes and have proven effective in

the treatment and diagnosis of cervical neck pain, axial back pain, and chronic spinal pain originating from facet joints.^{175,178-180} Compared with some intraspinal interventional treatments, procedures related to the facet joints can be simpler and carry lower risk.¹⁷⁸

Sacroiliac pathology is a type of spinal pain that can mimic herniated disc pain.¹⁸¹ These joints are not well imaged on standard magnetic resonance imaging views, and diagnosis is made by precise injections of local anesthesia and corticosteroids into the joint using fluoroscopy, ultrasound, or CT, while long-term relief can often be obtained denervating the nerves going to these joints.¹⁸²

Cryoneuroablation (also known as cryoneurolysis and cryoanalgesia) is a specialized interventional pain management technique that uses a cryoprobe to freeze sensory nerves at the source of pain and provide long-term pain relief.^{183,184} Cryoneuroablation is indicated for numerous persistent and intractable painful conditions; including paroxysmal trigeminal neuralgia, chest wall pain,¹⁸⁵ phantom limb pain,¹⁸⁶ neuroma, peripheral neuropathy,¹⁸⁵ knee osteoarthritis,¹⁸⁷ and neuropathic pain caused by herpes zoster.^{183,188}

Radiofrequency Ablation. Conventional RF lesioning and pulse RF (PRF) are both ways to ablate certain nerves that have been identified as contributing to chronic pain syndromes, and they continue to have great value as a treatment modality in the management of a variety of pain syndromes. Furthermore, studies have shown that conventional RF provides benefits in appropriate patients.^{184,189} PRF uses short, high-voltage bursts of energy produced by needles inserted next to nerves to “stun” them, thereby blocking transmission of pain signals.^{190,191} Although more research is required to better understand both the exact mechanism of action of PRF and its efficacy in treating various chronic pain syndromes, PRF has already demonstrated its potential as a promising interventional modality in the treatment of cervical radicular pain,¹⁹² though there is no Current Procedural Terminology (CPT) code for the technique, and insurance typically does not cover it.

Peripheral nerve injections, commonly referred to as peripheral nerve blocks (PNBs), are injections of local anesthetics frequently mixed with anti-inflammatory steroid medication or clonidine for both diagnostic and therapeutic pain relief purposes.¹⁹³ Administered either through a single injection or in a continuous infusion by catheter, PNBs are often employed in the perioperative and postoperative period for acute pain care.^{194,195} PNBs are advantageous in that they allow for quicker discharge times in ambulatory settings, less postoperative nausea and vomiting because less opioid medication is used, and improved patient satisfaction. There has been a growth in this area as part of improved perioperative pathways and the use and advancements in ultrasound-guided nerve blocks that allow for more effective anesthetic blocks.^{196,197} Ultrasound has also improved the ability to diagnose and treat peripheral neuropathies and nerve entrapments,^{198,199} and PNBs can also have a role in potentially diminishing or preventing the development of chronic pain syndromes^{200,201} such as CRPS,²⁰² headaches,²⁰³ pelvic pain,²⁰⁴ and sciatica.²⁰⁵

Sympathetic nerve blocks (SNBs), similar to PNBs, are injections of local anesthesia at the sympathetic nerve chain that can be used to diagnose or treat pain that involves the sympathetic nervous system.²⁰⁶ SNBs have been used to treat neuropathic pain, Complex Regional Pain Syndrome, CRPS 1 (reflex sympathetic dystrophy) and CRPS 2 (causalgia) as well as manage chronic abdominal, pelvic pain, and perineal pain.²⁰⁷⁻²⁰⁹

Neuromodulation techniques use device-based electrical or magnetic stimulation to activate central or peripheral nervous system tissue associated with pain pathways to produce analgesia or reduce sensitivity to pain. This is an area of growth and innovation for chronic pain treatment, including neuropathic pain, and for both the central and peripheral nervous systems.^{210,211} Spinal cord stimulation using a variety of waveforms and frequencies and dorsal root ganglion stimulation, collectively, have five level-1 studies demonstrating their efficacy in low-back and lower extremity pain.²¹²⁻²¹⁶ Peripheral nerve stimulation has gained popularity and effectiveness with the recognition of peripheral nerve entrapments, increased use of ultrasound, and improvement in technology. More recently, noninvasive neuromodulation therapies have been studied in headache disorders. Multiple level-1 and level-2 studies have demonstrated that noninvasive vagus nerve stimulation can be effective in ameliorating pain in various types of cluster headaches and migraines.²¹⁷⁻²¹⁹ These therapies provide an electric field to the brain, cranial nerves, or peripheral nerves without actually requiring a surgical procedure or implant.

Intrathecal Medication Pumps. Because there are opioid receptors on the spinal cord and at specific areas of the brain, significantly small doses of opioids in the spinal fluid can provide significant analgesia at much lower doses than oral opioids. Implanted intrathecal pumps with catheters in the spinal fluid can supply medication continuously, and they have been used for both cancer and non-cancer pain.²²⁰ The largest trial ever performed in cancer patients demonstrated improved pain control and fewer side effects and a trend toward improved life expectancy with implantable pumps.²²¹ However, there are significant side effects, including delayed respiratory depression, granuloma formation, and opioid-induced hypogonadism.²²² Other medications, such as ziconotide (a calcium channel blocker made from a cone snail venom), baclofen (to treat spasticity) and clonidine (an alpha agonist agent) can also be used in these pumps.

Vertebral augmentation stabilizes the spine through the application of cement to vertebral compression fractures that are painful and refractory to medical treatment;²²³ this approach can include vertebroplasty (injecting cement into a fractured vertebra) or balloon kyphoplasty (using an inflatable balloon to create injection space). Evidence suggests that balloon-assisted kyphoplasty is one of the most effective vertebral augmentation procedures.^{224,225} Vertebral augmentation has also been combined with RF ablation to manage pain resulting from vertebral damage secondary to fractures from various conditions or as a result of spinal metastases.²²⁶

Trigger points are palpable, tense bands of skeletal muscle fibers that, upon compression, are capable of producing both local and referred pain.²²⁷ Using either dry needling or injections of local anesthesia, trigger points can be disrupted, resulting in relaxation and lengthening of the muscle fiber, thereby providing pain relief.^{227,228} Trigger point injections can be used to treat pain associated with headaches, myofascial pain syndrome, and low-back pain.^{229–231} Other types of direct injections include intramuscular, intra-bursal, and intra-articular injections for muscle pain, bursitis, and joint pain, respectively.

Joint Injections. In addition to the facet joints, corticosteroid injections into other joints (e.g., shoulder, elbow, wrist, knee, ankle) are common interventional procedures, particularly in the treatment of inflammatory arthritis and basal joint arthritis.^{232,233} When local anesthesia is combined with corticosteroids, the joint injection can also be used therapeutically to treat joint pain resulting from injury or disease or diagnostically to identify the source of joint pain.²³⁴

Interspinous Process Spacer Devices. Research has shown that interspinous process spacer devices can provide relief for patients with lumbar spinal stenosis with neuroclaudication.^{235,236}

Regenerative/adult autologous stem cell therapy may show promise in the treatment of multiple painful conditions.^{237–239} Further research is needed and encouraged to investigate the potential of these therapies.

The risk of interventional therapies varies by procedure. Interventional treatments have some associated risk (e.g., small risk of infection or nerve injury), but the overall safety and efficacy of interventional therapies make them attractive alternatives to long-term opioid therapy when performed by properly trained and certified clinicians.



FARSHAAD'S STORY

PATIENT TESTIMONIAL

I was diagnosed with ulcerative colitis and eventually complex pain. Additionally, I had an allergy to a medication that made things worse. I had surgical removal of my colon and it was replaced with a J-pouch. Two years later, I had surgery again, which resulted in severe pain. At that time, we left Canada and moved to the USA.

Ultimately, I [was] referred to the pain management clinic at my hospital. I was offered trigger-point injections and they turned out to be a breakthrough. The physical therapy helped me a lot and was coordinated with the trigger point injection. I regained my life. It was an extremely bad and very challenging situation. I don't have as much uncontrolled pain as I used to.

My doctor helped me, by pinpointing the exact area of the pain and the neuroma, the pinched nerve. I also have severe pain from migraines. Botox injections on my neck and forehead were a huge breakthrough too. Every four months I'm totally pain free. As it gets closer and closer to that four months, I need another injection.

Reiki, or touch healing, also helped me. It doesn't cure anyone, but it gives you power to face problems and calm you. I also, very rarely, take a pain opioid pill, Tylenol Number 3, for severe acute flares of my pain. However, not everybody who takes that kind of pill should be considered addicts.

GAPS AND RECOMMENDATIONS

Gap 1: Interventional pain procedures can provide diagnostic information when evaluating patients in pain and provide pain relief. A comprehensive assessment by a skilled pain specialist is necessary to identify which procedure is indicated for a given patient's pain syndrome. Unfortunately, pain specialists are typically not involved in the multidisciplinary approaches of diagnosing and treating a pain patient early enough in his or her treatment, which can lead to suboptimal patient outcomes.

- **Recommendation 1a:** Adopt well-researched interventional pain guidelines to guide the appropriate use of interventional pain procedures as a component of a multidisciplinary approach to the pain patient. Guidelines are particularly important for guiding the collaboration of PCPs and pain medicine specialists.
- **Recommendation 1b:** Conduct additional clinical research that establishes how interventions work in conjunction with other approaches in the process of caring for patients with chronic pain, especially early in the process, when combined appropriately with goal-directed rehabilitation and appropriate medications.
- **Recommendation 1c:** Establish criteria-based guidelines for properly credentialing clinicians who are appropriately trained in using interventional techniques to help diagnose, treat, and manage patients with chronic pain.

Gap 2: Inconsistencies and frequent delays exist in insurance coverage for interventional pain techniques that are clinically appropriate for a particular condition and context.

- **Recommendation 2a:** Encourage CMS and private payers to provide consistent and timely insurance coverage for evidence-informed interventional procedures early in the course of treatment when clinically appropriate. These procedures can be paired with medication and other therapies to improve function and QOL.
- **Recommendation 2b:** CMS and other payers must restore reimbursement to non-hospital sites of service to improve access and lower the cost of interventional procedures.

Gap 3: There is a trend of inadequately trained clinicians performing interventional procedures. This trend can potentially lead to serious complications and inappropriate utilization.

- **Recommendation 3a:** Establish credentialing criteria for minimum requirements for training clinicians in interventional pain management.
- **Recommendation 3b:** Only clinicians who are credentialed in interventional pain procedures should perform interventional procedures.



Figure 13: Behavioral Health is One of Five Treatment Approaches to Pain Management

2.5 BEHAVIORAL HEALTH APPROACHES

In recent decades, pain management experts have recognized the important relationship between pain and psychological health.^{40,240,241} Psychological factors can play an important role in an individual's experience and response to pain^{242,243} and can affect treatment adherence, pain chronicity, and disability status.^{240,244} Undiagnosed and untreated psychological concerns in individuals with pain are associated with increased health care utilization and readmissions, decreased treatment adherence, and increased disability.^{245–247} Patients with chronic pain are at increased risk for psychological distress, maladaptive coping, and physical inactivity related to fear of reinjury.⁴⁰ Individuals with chronic pain are also more likely to have disabilities than patients with other chronic health conditions, such as stroke, kidney failure, cancer, diabetes, and heart disease.²⁴⁸ High-impact chronic pain is especially disruptive to multiple aspects of patients' life, including their relationships, work, physical activity, sleep, self-care, and self-esteem. Psychological interventions, following proper evaluation and diagnosis, can play a central role in reducing disability in these patients. Furthermore, preliminary evidence indicates that psychological interventions administered prior to surgery have been shown to reduce postsurgical pain and opioid use.^{74,249}

Behavioral health approaches as part of pain management should be considered a key component of the biopsychosocial model and multidisciplinary pain management. These approaches aim to improve the overall pain experience and restore function by addressing the cognitive, emotional, behavioral, and social factors that contribute to pain-related stress and impairment.^{240,244,250} They target a variety of domains, including physical functioning, pain medication use, mood, cognitive patterns, and QOL.²⁴⁰

The following paragraphs briefly describe behavioral health approaches. This list is not inclusive or exhaustive, but instead provides examples of common behavioral health approaches.

Behavioral therapy (BT) for pain focuses largely on applying the principles of operant conditioning to identify and reduce maladaptive pain behaviors (e.g., fear avoidance) and increase adaptive or “well” behaviors. This improvement is achieved by minimizing reinforcement of maladaptive behaviors, providing reinforcement of well behaviors, and reducing avoidance behaviors through gradual exposure to the fear-provoking stimuli (e.g., exercise). The overall goal of BT in the treatment of pain is to increase function.^{251,252} BT has demonstrated effectiveness for reducing pain behaviors and distress and for improving overall function, and it can be more cost-effective than active physical treatment.^{252,253}

Cognitive behavioral therapy (CBT) aims to reduce maladaptive behavior and improve overall functioning. However, in addition to focusing on altering behavioral responses to pain, CBT focuses on shifting cognitions and improving pain coping skills.²⁵⁴ CBT includes psychoeducation about the relationship between psychological factors (e.g., thoughts, feelings) and pain; cognitive restructuring of maladaptive thought patterns; and training in a variety of pain coping strategies, including activity pacing and pleasant activity scheduling.²⁴⁰ CBT is effective for a variety of pain problems²⁵⁵ and can help improve self-efficacy, pain catastrophizing, and overall functioning.^{256,257} The AHRQ found that CBT can lead to long-term improvements in patients with low-back pain and fibromyalgia.²⁵⁸

Acceptance and commitment therapy (ACT) is a form of CBT that emphasizes observing and accepting thoughts and feelings, living in the present moment, and behaving in a manner that serves an individual’s chosen values. Unlike traditional CBT approaches, ACT focuses on creating psychological flexibility through acceptance of psychological and physical experiences rather than by challenging them.^{259,260}

Mindfulness-based stress reduction (MBSR) is a mind-body treatment typically delivered in a group format and focuses on improving patients’ awareness and acceptance of their physical and psychological experiences through intensive training in mindfulness meditation.²⁶¹ Mindfulness meditation teaches patients to self-regulate their pain and pain-related comorbidities by developing nonjudgmental awareness and acceptance of present moment sensations, emotions, and thoughts.^{262,263} Research suggests that MBSR is an effective intervention for helping individuals cope with a variety of pain conditions, including rheumatoid arthritis, low-back pain, and MS.^{264,265} MBSR also has a positive impact on pain intensity sleep quality, fatigue, and overall physical functioning and well-being.^{261,266–268}

Emotional awareness and expression therapy (EAET) is an emotion-focused therapy for patients with a history of trauma or psychosocial adversity who suffer from centralized pain conditions.²⁶⁹ In this approach, patients are taught to understand that their pain is exacerbated or maintained by unresolved emotional experiences that influence neural pathways involved in pain. Patients are taught to become aware of these unresolved experiences, which include suppressed or avoided trauma, adversity, and conflict, and to adaptively express their emotions related to these experiences. Patients learn that control over pain can be achieved through emotional awareness and expression. Enhancing the patient’s capacity to approach an experience rather than inhibit or avoid important emotions and interpersonal interactions leads to increased engagement in life activities. Research indicates that EAET has a positive impact on pain intensity, pain interference, and depressive symptoms.²⁷⁰

Self-regulatory or psychophysiological approaches include treatments such as biofeedback, relaxation training, and hypnotherapy. These approaches use the mind-body connection to help patients with pain develop control over their physiologic and psychological responses to pain.²⁴⁰ **Biofeedback** entails monitoring and providing real-time feedback about physiologic functions associated with the pain experience (e.g., heart rate, muscle tension, skin conductance). The overall goal of biofeedback is to improve awareness and voluntary control over bodily reactions associated with pain exacerbations.²⁷¹ Biofeedback training has proven effective for chronic headache and migraine in adults and children.²⁷² **Relaxation training and hypnotherapy** involve altering attentional processes and heightening the experience of physical and psychological relaxation. Relaxation training is often used in conjunction with biofeedback to increase physiological awareness and enhance relaxation skills.²⁴⁰ Both of these approaches have empirical support in pain management.^{273,274} Empirical evidence also supports the use of hypnotherapy to manage cancer pain, low-back pain, arthritis, pain from SCD, temporomandibular joint pain, fibromyalgia,

and other pain conditions.²⁷³ Similar to relaxation training, hypnotherapy induces an altered state of consciousness guided by a hypnotherapist that focuses the individual's attention to alter his or her experience of pain.

Behavioral health interventions can be effective in improving clinical outcomes for pain,^{244,269,275} but treatment should be tailored to address patient preferences and needs. This tailoring requires careful assessment of patients' pain perceptions, cognitive and emotional responses, coping skills, and social and environmental status.²⁷⁶ It also requires accurate diagnosis of comorbid psychosocial concerns.

2.5.1 ACCESS TO PSYCHOLOGICAL INTERVENTIONS

Despite widespread understanding of the importance of psychological interventions in the management of pain, many patients with pain receive inadequate care.^{277,278} Many factors contribute to this problem, including clinical barriers (e.g., treatment accessibility, knowledge gaps, provider attitudes), health care system-related barriers (e.g., cost and reimbursement issues), and patient-related barriers (e.g., stigma, attitudinal variables). When access to providers and costs are limiting factors, evidence-based low-cost and scalable approaches delivered through telehealth and internet technologies may provide a low-burden, effective alternative to traditional treatment approaches.^{73,279} Research suggests that brief telehealth and digitally delivered treatments allow for broad patient access and yield outcomes similar to traditional in-person psychological interventions for chronic pain.²⁸⁰



Figure 14: Overcoming Barriers to Behavioral Health Approaches

To further enhance patient acceptance and engagement in psychological treatment, patients and providers need to know about psychological treatments. Health professionals should have sufficient understanding of the biopsychosocial model of pain and how to appropriately assess and refer patients for behavioral health treatment.^{250,281} This can be accomplished by improving training and education in pain management^{26,282,283} and initiating public campaigns to reduce stigma and enhance public awareness of the biopsychosocial aspects of pain.²⁸⁴ As noted in other sections of this report, the lack of health insurance coverage for psychological services has also been cited as a significant barrier to adequate pain management (see Section 3.4.2 Insurance Coverage for Complex Management Situations). Both a need for trained pain psychologists and appropriate incentives are required to fill the work gap. Although several organizations have identified policy recommendations to close gaps in access to pain management services,^{285,286} coverage barriers persist. These barriers continue to hinder patients' access to skilled behavioral health providers, integrated and multidisciplinary care, and (for OUD and SUD) co-morbid treatment, as required.²⁸⁷⁻²⁹⁰

GAPS AND RECOMMENDATIONS

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

- **Recommendation 1a:** Increase access to evidence-based psychological interventions including alternative treatment delivery (e.g., telehealth, internet self-management, mobile applications, group sessions, telephone counseling) and hub-and-spoke models.
- **Recommendation 1b:** Educate physicians, dentists and health care providers on the benefits of psychological and behavioral health treatment modalities in the multidisciplinary approach to acute and chronic pain management.
- **Recommendation 1c:** Improve reimbursement policies for integrated, multidisciplinary, multimodal treatment approaches that include psychological and behavioral health interventions through traditional and nontraditional delivery methods (e.g., telehealth, internet self-management, mobile applications, group sessions, telephone counseling).

2.5.2 PATIENTS WITH CHRONIC PAIN AS WELL AS MENTAL HEALTH AND SUBSTANCE USE COMORBIDITIES

The occurrence of pain and mental health comorbidities, including depression, PTSD, and SUD, is well documented.^{291–295} Psychosocial distress can contribute to pain intensity, pain-related disability, and poor response to treatment. Untreated psychiatric conditions and current or historical SUD also increase the risk of both unintentional and intentional medication mismanagement, OUD, and overdose.²⁹⁶ Given the intersection between psychiatric/psychological symptoms and chronic pain, it is important that the behavioral health needs of patients with pain are appropriately and carefully evaluated and treated with the concurrent physical pain problem.

Although the literature exploring the effectiveness of interventions for patients with painful conditions and comorbid psychiatric concerns is limited, research suggests that regular monitoring and early referral and intervention can improve pain and psychiatric outcomes and prevent negative opioid-related outcomes.^{74,240,288,297} Many CBPs recommend screening and regularly monitoring the psychological health concerns and substance misuse risk of all patients with pain, using multidisciplinary approaches and referring patients to behavioral health and substance use specialists as clinically indicated (see Section 3.1.2 Screening and Monitoring).^{40,298} Technological advances in the delivery of clinical tools (e.g., mobile applications) may improve assessment, monitoring, and treatment delivery,²⁹⁹ although further research is needed.

GAPS AND RECOMMENDATIONS

Gap 1: CBPs for chronic pain do not adequately address how to treat individuals with comorbid psychological health concerns.

- **Recommendation 1a:** Screen for psychological health and SUDs in patients with acute or chronic pain, and consider early referral to behavioral health providers when clinically indicated.
- **Recommendation 1b:** Use an integrated multidisciplinary approach that may include existing evidence-based psychological and behavioral interventions (e.g., CBT, coping skills, stress reduction, mindfulness-oriented recovery) to address chronic pain when clinically indicated.
- **Recommendation 1c:** Refer patients to both pain and addiction specialists when OUD is suspected and ensure an integrative approach to healthcare.
- **Recommendation 1d:** Buprenorphine may be considered and appropriate for pain treatment in this population when clinically indicated.
- **Recommendation 1e:** When considering buprenorphine and other opioids, use the lowest effective dose in conjunction with nonopioid treatment modalities, with enhanced monitoring and collaboration with addiction

specialists. Conduct regular reevaluation and assessment, with a treatment plan and established goals, to achieve optimal patient outcomes.

Gap 2: Many CBPs for chronic pain do not adequately address barriers to acceptance of psychological treatments.

- **Recommendation 2a:** Enhance and inform patient, clinician, and public understanding of the importance of a biopsychosocial model approach for chronic pain conditions.

Gap 3: Research gaps exist in 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.

- **Recommendation 3a:** Conduct research on the applications and indications of existing evidence-based psychological health interventions for patients with chronic pain and psychological health or substance use comorbidities.
- **Recommendation 3b:** Conduct research on the efficacy of novel and innovative psychological and behavioral health treatments (e.g., biofeedback, hypnosis, relaxation therapies).

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

- **Recommendation 4a:** Conduct peer-reviewed validation research to guide the use of mobile and electronic health (e-health) applications within the context of the biopsychosocial treatment modalities for chronic pain.
- **Recommendation 4b:** Add a category for electronic and mobile treatments to the Substance Abuse and Mental Health Services Administration's (SAMHSA's) Evidence-Based Practices (EBP) Resource Center and a designation for pain for target audiences when evidence of benefit exists.
- **Recommendation 4c:** Establish a validation process for apps used for biopsychosocial treatments to better inform physician, provider, and patient users of these apps that are evidence-based and effective for the management of various chronic pain syndromes.



Figure 15: Complementary and Integrative Health is One of Five Treatment Approaches to Pain Management

2.6 COMPLEMENTARY AND INTEGRATIVE HEALTH

Clinical Best Practices may recommend a collaborative, multimodal, multidisciplinary, patient-centered approach to treatment for various acute and chronic pain conditions to achieve optimal patient outcomes. For improved functionality, activities of daily living, and quality of life, clinicians are encouraged to consider and prioritize, when clinically indicated, non-pharmacologic approaches to pain management.^{54,300–305} Complementary and integrative health approaches for the treatment or management of pain conditions consist of a variety of interventions, including mind-body behavioral interventions, acupuncture and massage, osteopathic and chiropractic manipulation, meditative movement therapies (e.g., yoga, tai chi), and natural products, amongst others.³⁰⁶ The National Institutes of Health (NIH) National Center for Complementary and Integrative Health defines “complementary approaches” as those non-mainstream practices that are used together with traditional medicine; it defines “alternative approaches” as those used in place of conventional medicine, noting that most patients who use non-mainstream approaches do so with conventional treatments.³⁰⁷ There are many definitions of “integrative” health care, but all involve bringing together conventional, complementary, and integrative health approaches in a coordinated way.



CORY'S STORY

PATIENT TESTIMONIAL

I joined the Marines in 2005 and was deployed to Afghanistan. In 2009, my team was hit by an IED. I was about 10 feet away and it launched me in the air. I sustained numerous shrapnel injuries. My right arm was ripped open down to my hand and I had some shrapnel in both of my legs and my left arm. Overall, I had 26 surgeries over 3 1/2 years in the hospital, where I started receiving alternative therapy.

After I got out of being an inpatient, I told myself I was going to get off of all my meds and I did that. I watched too many fellow service members, comrades, turn into zombies just being pumped full of medications. It was not something that I wanted to do with my life.

So I wanted to try something new. I tried acupuncture and it seemed to work very well. Recently I received a different type of therapy called digital medicine. I was having some pain in my foot. If my foot stays down for a long period of time, it gets swollen, and I have limited feeling from my left knee down to my foot. I went through a form of visual and audio therapy and somehow that triggered those nerves to kick back in. Within 15 minutes, I had regained feeling in my leg and foot. It was a 30-minute session. We did three sessions. That lasted for about a month. It's not forever, but in my opinion it beats taking medications.

I think a combination of acupuncture and digital medicine is, in a sense, the way of the future. That's what I've been doing and it's worked for me and it's worked for many other people.

The current opioid crisis has spurred intense interest in identifying effective non-pharmacologic approaches to managing pain. The use of complementary and integrative health approaches for pain has grown within care settings across the United States over the past decades. As with other treatment modalities, complementary and integrative health approaches can be used as stand-alone interventions or as part of a multidisciplinary approach, as clinically indicated and based on patient status. Examples of complementary and integrative health approaches to pain include acupuncture, hands-on manipulative techniques (e.g., osteopathic or chiropractic manipulation, massage therapy), mindfulness, yoga, tai chi, biofeedback, art and music therapy, spirituality, and the use of natural or nutritional supplements. These therapies can be provided or overseen by licensed professionals and trained instructors. The use of complementary and integrative health approaches should be communicated to the pain management team.

Overall, most complementary and integrative health approaches can provide improved relief, when clinically indicated, when used alone or in combination with conventional therapies such as medications, behavioral therapies, and interventional treatments, although more research to develop evidence-informed treatment guidelines is needed.³⁰⁶

Improved reimbursement policies for complementary and integrative health approaches as well as improved education for medical professionals and a greater workforce of pain management specialists can address key barriers to acceptance and implementation of complementary and integrative health approaches for pain.³⁰⁶ Additional research, greater patient and clinician education — including clinical guidance and indications for use — and expanded coverage of complementary and integrative health approaches are essential for a comprehensive solution to reduce the reliance on opioids.

The following paragraphs briefly describe complementary and integrative health approaches, which can be considered singularly or as part of a multimodal approach to the management of chronic and acute pain, depending on the patient and his or her medical conditions. This list is not inclusive or exhaustive but instead provides examples of common complementary and integrative health approaches.

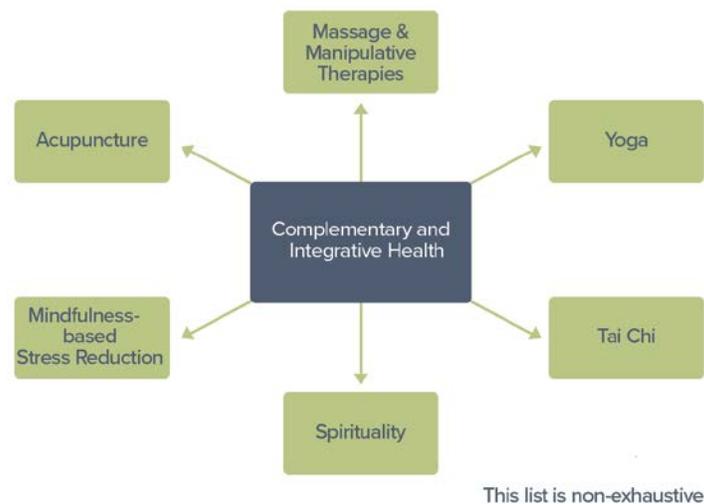


Figure 16: Complementary and Integrative Health Approaches for the Treatment or Management of Pain Conditions Consist of a Variety of Interventions

Acupuncture is a recognized form of therapy that has its origins in ancient Chinese medicine. It involves manipulating a system of meridians where “life energy” flows by inserting needles into identified acupuncture points. An estimated 3 million American adults receive acupuncture each year.³⁰⁸ It is generally considered safe when performed by a licensed, experienced, well-trained practitioner using sterile needles, and although there are risks as with any intervention, the risks are minimal. The therapeutic value of acupuncture in the treatment of various pain conditions, including osteoarthritis; migraine; and low-back, neck, and knee pain has growing evidence in the form of systematic reviews and meta-analyses.^{309–316} Existing CPGs concerning the use of acupuncture for pain are inconsistent and often differ regarding the evidence-based science and accepted mechanisms by which acupuncture has persisting effects on chronic pain.^{54,300–305,312,317–320} As with all medicine, a risk-benefit analysis, consideration of clinical indications, and patient acceptance need to be considered.

Massage and manipulative therapies, including osteopathic and chiropractic treatments, are commonly used for pain management. Such interventions may be clinically effective for short-term relief^{321,322} and are best accomplished in consultation with the primary care and pain management teams. Studies on massage have considered various types, including Swedish, Thai, and myofascial release, but these studies do not provide adequate details of the type of massage provided. Systematic reviews note that the few studies looking at the effect of massage on pain use rigorous methods and large sample

sizes.^{155,323} Other reviews recognize positive clinical effects on various pain conditions, including postoperative pain; headaches; and neck, back, and joint pain.^{324–327}

MBSR, also discussed above in the Behavioral Health Approaches section, is a program that incorporates mindfulness skills training to enhance one's ability to manage and reduce pain. Mindfulness enables an attentional stance of removed observation and is characterized by concentrating on the present moment with openness, curiosity, and acceptance. This approach allows for a change in one's point of view on the pain experience. Studies support statistically significant beneficial effects for low-back pain.^{328,329} A meta-analysis demonstrated that mindfulness meditation significantly reduces the intensity and frequency of primary headache pain.³³⁰

Yoga, a practice rooted in ancient Hindu practice and a way of life that incorporates mind, body, and a spiritual approach, has shown improved outcomes for a variety of medical and nonmedical conditions. Yoga has become popular in Western cultures as a form of mind and body exercise that incorporates meditation and chants. Yoga's use of stretching, breathing, and meditation has also been therapeutic in the treatment of various chronic pain conditions, especially low-back pain.^{331–335} Although there have been limited reports of pain symptoms becoming more severe with yoga, overall, the risk-benefit analysis suggests that yoga is generally safe, beneficial, and cost-effective, especially when administered in the group setting.³³⁶

Tai chi originated as an ancient Chinese martial art used to balance the forces of yin and yang. Modern tai chi has become popular for core physical strengthening through its use of slow movements and meditation. It has demonstrated long-term benefit in patients with chronic pain caused by osteoarthritis and other musculoskeletal pain conditions.^{337,338} Like yoga, tai chi appears to be safe; demonstrates positive results, especially over the long term; and can also be cost-effective in the group setting. Both yoga and tai chi can be delivered remotely via telemedicine/telehealth.

Spirituality is a broad concept and generally includes a sense of connection to something bigger than the individual. It typically involves a search for meaning in life. Spiritual or religious beliefs can influence a person's lifestyle, attitudes, and feelings about pain. People living with pain may use religious or spiritual forms of coping, such as prayer and meditation, to help manage their pain. Growing evidence indicates that spiritual practices and resources are beneficial for people with pain.³³⁹ As a result, clinicians may consider the role of spirituality in pain management.

GAPS AND RECOMMENDATIONS

Gap 1: There is a large variety of complementary and integrative health approaches that are often overlooked in the management of pain.

- **Recommendation 1a:** Consider complementary and integrative health approaches, including acupuncture, mindfulness meditation, movement therapy, art therapy, massage therapy, manipulative therapy, spirituality, yoga, and tai chi, in the treatment of acute and chronic pain, when indicated.
- **Recommendation 1b:** Develop CPGs for the application of complementary and integrative health approaches for specific indications.

Gap 2: There is a gap in the understanding of complementary and integrative health approaches.

- **Recommendation 2a:** Conduct further research on complementary and integrative health approaches to determine their therapeutic value, risk and benefits, mechanisms of action.
- **Recommendation 2b:** Consider the inclusion of various complementary and integrative health approaches as part of an integrated approach to the treatment of chronic pain.
- **Recommendation 2c:** Conduct further research on nutritional supplements such as alpha lipoic acid, L-carnitine transferase, and vitamin C and their effect on acute and chronic pain management.

2.7 SPECIAL POPULATIONS

Painful conditions and pain management are complex in part because various populations have unique issues that affect acute and chronic pain. Special populations in pain management that the Task Force identified include children, older adults, women, pregnant women, individuals with SCD, individuals with other chronic relapsing pain conditions, racial and ethnic minority populations, active-duty service members and Veterans, and patients with cancer and those in palliative care. The special populations section in this report was included to highlight several special populations' considerations for pain management. The populations highlighted here are non-exhaustive and the special populations section on chronic relapsing conditions is intended to serve as a general category that applies to many painful conditions not specifically mentioned. No special population was purposefully excluded from the Report.

2.7.1 UNIQUE ISSUES RELATED TO PEDIATRIC PAIN MANAGEMENT

Chronic pain is estimated to affect 5% to 38% of children and adolescents.³⁴⁰⁻³⁴² These pain conditions can be from congenital diseases (e.g. sickle cell disease [SCD]), where pain begins in the infant or toddler age period, chronic non-congenital diseases (e.g., juvenile idiopathic arthritis, fibromyalgia, inflammatory bowel disease), or primary chronic pain conditions (e.g., headaches, chronic abdominal pain, chronic musculoskeletal pain, CRPS). The origin of pain conditions in the pediatric age group is important because the developing pediatric nervous system can be especially vulnerable to pain sensitization and development of neuroplasticity.³⁴³ Data support the finding that early neonatal and childhood pain experiences can alter pain sensitivity in later life.³⁴⁴ Poor pain management in children can put them at risk for persistent pain and increased impairment as they transition into adulthood and may even be linked to the development of new chronic pain conditions.^{345,346} The application of the biopsychosocial model to pediatric pain care is therefore vital. Psychological conditions resulting from chronic disease and pain syndromes can contribute to long-term pain. These psychological conditions can include difficulty coping, anxiety, and depression. Incorporation of parents and family into pain care is especially important in the pediatric population because childhood pain can be affected by family and parental factors, including family functioning and parental anxiety, and depression. Appropriate pain management in childhood is imperative because children's early pain experiences can shape their response to pain as adults. Overall, there is a substantial need for more trained pediatric pain specialists to address the often complex aspects of pediatric pain. There is a greater challenge in attracting top physicians to further specialize in pediatric pain fellowships, and this aspect of medical education would address an ongoing gap in this area. It is of utmost importance to introduce comprehensive pain care early in the pediatric age group to optimize their QOL now and in the future.³⁴⁷

GAPS AND RECOMMENDATIONS

Gap 1: The significant shortage of pediatric pain specialists and comprehensive pain service centers presents a barrier to addressing the needs of pediatric patients with acute and chronic pain. This limited access is further compromised by lack of reimbursement and coverage for services related to comprehensive pain management, including non-pharmacologic evidence-based pain therapies.

- **Recommendation 1a:** Increase access to pediatric pain services with pain expertise, which can likely be achieved through an increase in the workforce and novel care delivery models.
- **Recommendation 1b:** Deliver and appropriately reimburse and cover pediatric pain care in the context of comprehensive, multidisciplinary treatment.

Gap 2: Pediatric patients with chronic pain conditions eventually transition to adult care, during which time they may experience gaps in care, increased health care utilization, poor patient outcomes, and other health care vulnerabilities and morbidities.

- **Recommendation 2a:** Develop models of care for appropriate transition for pediatric patients with acute or chronic pain conditions to ensure seamless care delivery as well as decreased morbidity and mortality.

Gap 3: Most physician pain specialists are not credentialed in pediatric pain and therefore, are not permitted by their institutions to take care of children with chronic pain.

- **Recommendation 3a:** Encourage and assist pain physicians in obtaining the necessary training for credentialing in pediatric pain. This is a significant step toward improving pediatric patient access.

Gap 4: Many current CBPs do not address pediatric opioid prescribing best practices. Further, RCTs and real-world evidence of non-opioid pharmacologic therapies in pediatric patients for chronic pain are lacking.

- **Recommendation 4a:** Develop pediatric pain management guidelines that address appropriate indications for opioids and responsible opioid prescribing.
- **Recommendation 4b:** Conduct pediatric pain research to inform national guidelines using multimodal approaches to optimize pain management for children and adolescents.

2.7.2 OLDER ADULTS

Chronic pain is one of the most common, costly, and incapacitating conditions in older adults.³⁴⁸ Managing pain in older adults can be complex because of age-related physiologic changes, associated medical and mental health comorbidities, polypharmacy, increases in pain thresholds, decreases in pain tolerance, and alterations in pharmacokinetics and pharmacodynamics that increase the risk of side effects from pharmacologic treatment.^{302,349} Effective pain management for older adults requires an understanding of the special considerations associated with the physiology of aging, validated assessment tools, common pain presentations in the older adult population,³⁵⁰ and the use of evidence-informed CPGs for common conditions such as low-back pain.³⁵¹ Older patients may have increased risk of GI bleeding and renal damage from NSAIDs.

GAPS AND RECOMMENDATIONS

Gap 1: There is a need for opioid prescribing guidelines for the aging population provided the potential for increased risk of falls, cognitive impairment, respiratory depression, organ metabolism impairment, and age-related and non-age related pain issues.

- **Recommendation 1a:** Develop pain management guidelines for older adults that address their unique risk factors. However, a risk factor of a medication should not necessarily be an automatic reason to not give this medication to an elderly patient. Clinicians must assess the risk versus benefit of utilizing medications while considering other modalities in this patient population.
- **Recommendation 1b:** Consider utilizing a multidisciplinary approach with non-pharmacological emphasis given the increased risk of medication side effects in this population.
- **Recommendation 1c:** Establish appropriate pain management education for physicians and health care providers who treat older adults.

2.7.3 PATIENTS WITH CANCER-RELATED PAIN AND PATIENTS IN PALLIATIVE CARE

Cancer pain affects millions of Americans.^{304,352} In addition, there are more than 14 million cancer survivors in the United States as a result of remarkable advances in cancer diagnosis and therapy. An estimated 40% of cancer survivors continue to experience persistent pain as a result of treatment such as surgery, chemotherapy, and radiation therapy. Persistent pain is also common and significant in patients with a limited prognosis, as often encountered in hospice and palliative care.³⁵³

GAPS AND RECOMMENDATIONS

Gap 1: These patient populations are frequently managed by practitioners who do not specialize in pain or palliative care. Many oncologists and primary care physicians are not trained to recognize or treat persistent pain associated with cancer or other chronic medical problems with limited prognosis.

- **Recommendation 1a:** Clinicians should assess and address pain at each patient encounter. Causes of pain such as recurrent disease, second malignancy or late onset treatment effects should be evaluated, treated, and monitored.

Gap 2: Patients with persistent pain associated with cancer and/or cancer treatment or other chronic medical problems with limited prognosis in palliative care often receive less optimal care with restricted treatment modalities.

- **Recommendation 2a:** When clinically indicated, utilize multimodal and multidisciplinary treatment as part of cancer-related pain management and palliative care.

2.7.4 UNIQUE ISSUES RELATED TO PAIN MANAGEMENT IN WOMEN

Central to the unique issues women face in pain management are the differences between men and women with respect to pain sensitivity, response to pain medication, and predisposition to clinical pain conditions.³⁵⁴ Data and recent literature suggest that women experience more pain than men, have greater sensitivities to painful stimuli compared with men, and report experiencing more intense pain.^{355,356} In addition to the response to pain medication, there exist sex differences in the patterns of nonmedical use and abuse of prescription opioids.^{357,358} Research has identified that women are more likely than men to misuse prescription opioids.³⁵⁹ Furthermore, from 1999 to 2010, the percentage increase in opioid-related overdose deaths was greater in women than in men.³⁶⁰ Finally, women face unique pain management challenges in the pregnancy and postpartum periods. To mitigate the heightened risk associated with pain management in these periods, it is important to emphasize the importance of obstetricians and gynecologists (OB-GYNs) on the multidisciplinary pain management team.

GAPS AND RECOMMENDATIONS

Gap 1: Women face unique challenges regarding their physical and mental health, interactions with the health care system, and roles in society. Women use the health care system as patients, caregivers, and family representatives and can be particularly affected by costs, access issues, and gender insensitivity from health care providers and staff. Several diseases associated with pain — in particular, chronic high-impact pain — have a higher prevalence in women or are sex specific, including endometriosis, musculoskeletal and orofacial pain, fibromyalgia, migraines, and abdominal and pelvic pain.

- **Recommendation 1a:** Increase research to elucidate further understanding of the mechanisms driving sex differences in pain responses and research of mechanism-based therapies that address those differences.
- **Recommendation 1b:** Raise awareness in the public and health care arenas to the unique challenges that women face during pregnancy and in the postpartum period, including various pain syndromes and psychosocial comorbidities.

Gap 2: Women may experience increased pain sensitivity. Of note, OB-GYNs may be one of the first health care providers a woman with pain encounters, yet they are not often included as part of a multidisciplinary care team.

- **Recommendation 2a:** Include OB-GYNs as part of multidisciplinary care teams because they are likely to play an important role in the treatment of pain for women.

2.7.5 PREGNANCY

Managing pain in pregnant women is uniquely challenging because clinical decision making must account for the pregnant mother and the developing fetus.³⁶¹ Further complicating pain management in the peripartum period is the lack of CPGs for non-pharmacologic treatments that may decrease the potential adverse outcomes for newborns associated with opioid therapy, such as neonatal abstinence syndrome. Greater research into chronic pain management in pregnancy is needed.^{362–364}

GAPS AND RECOMMENDATIONS

Gap 1: There is a need for evidence-based CPGs for the use of analgesics during pregnancy and the postpartum period.

- **Recommendation 1a:** Improve evidence for pain management of pregnant and postpartum women with greater research and innovation, in collaboration with the national specialty societies (the American College of Obstetricians and Gynecologists, neonatologists, obstetricians, perinatal pediatricians, and other specialists).

- **Recommendation 1b:** Counsel women of childbearing age on the risks of opioids and non-opioid medications in pregnancy, including risks to the fetus and newborns.

2.7.6 CHRONIC RELAPSING PAIN CONDITIONS

Chronic pain with periods of remission and frequent relapses defines “chronic relapsing pain conditions.” Examples of such conditions include various degenerative, inflammatory, immune-mediated, rheumatologic, and neurologic conditions such as MS, trigeminal neuralgia, Parkinson’s disease, CRPS, porphyria, systemic lupus erythematosus, lumbar radicular pain, migraines, and cluster headaches. Acute pain flares on top of the chronic pain condition can be a common occurrence that may affect daily routines and overall functionality, resulting in additional morbidity and the need for comprehensive pain care.

GAPS AND RECOMMENDATIONS

Gap 1: There is sometimes a lack of partnership between the disease specialist (i.e., the hematologist, oncologist, rheumatologist, or neurologist) and providers of comprehensive multidisciplinary pain programs.

- **Recommendation 1a:** Provide referrals to a comprehensive pain program early in the course of the chronic disease (e.g., MS, porphyria, systemic lupus erythematosus, migraine, Parkinson’s disease, neuropathic pain syndromes) to determine the optimal approach to managing acute or chronic pain exacerbations, including potential non-opioid, alternative therapies and non-pharmacologic therapies. Establish a partnership between the disease specialist (e.g., the hematologist, oncologist, neurologist, or rheumatologist) and the pain team to optimize care.



ANNE’S STORY

PATIENT TESTIMONIAL

My name is Anne. I’m a 19-year-old girl and college sophomore. I have struggled with sickle-cell disease my whole life. My dad always told me that sickle cell does not have me – I have sickle cell. I have learned to persevere through the pain.

I found that my passions were the one thing that kept the pain away. Even though I would be in pain, I would still go out and dance. I would still sing. I was even a cheerleader at one point. I think that with sickle cell, it’s also about what you can handle mentally.

I struggled with depression for a while and as recently as last February, I went through a period of depression. It was the hardest thing, but I kept telling myself, OK Anne, you’re going to get better. Just keep pushing. Just keep pushing.

I have been through six surgeries in my 19 years. I have had brain surgery due to Chiari I malformation from sickle cell, which caused multiple migraines every day. I was shocked because I would still go to school. I would still get my homework done. I would still go out and have fun with my friends, even though I was still going through all this pain.

My brother told me that I am one of the strongest people he’s ever met. And that was so touching because at that time I didn’t believe I was a strong person. It was hard because my parents never dealt with a child with sickle cell. I’m their last child. And I’ve seen them cry. I’ve seen them persevere with me.

My family is one thing that keeps me going; I can’t let anything stop me. I can’t even let one little crisis stop me. I barely go to a hospital for my crisis now because I try to find ways at home to get rid of my pain.

2.7.7 SICKLE CELL DISEASE

Sickle cell disease (SCD) is a group of inherited disorders characterized by complex acute and chronic symptoms, including pain.³⁶⁵ An estimated 90,000 people in the United States have SCD, which disproportionately affects minority populations, particularly African-Americans.³⁶⁶ Acute pain episodes, or “pain crises,” associated with SCD are abrupt in onset, unpredictable, and drive patients to seek care in the ED and inpatient unit, with estimated health care costs of almost \$2 billion per year.^{367,368} Chronic, severe, daily pain also occurs in approximately 30% to 40% of adolescents and adults with SCD, significantly impairing their functioning and increasing in incidence and severity with age.^{369–371} Pain in SCD is unique in that it occurs throughout the patient’s lifespan, from infancy to adulthood, and develops directly from the disease.³⁷² The biology of SCD pain is complex, varied, and likely arises from multiple mechanisms depending on whether an individual is suffering from acute or chronic pain.³⁷³ Pulmonary,³⁷⁴ orthopedic,³⁷⁵ psychosocial,³⁷⁶ and other comorbidities of SCD can also give rise to painful complications in adults and children.

GAPS AND RECOMMENDATIONS

Gap 1: There is a lack of evidence-based management guidelines for the treatment of acute and chronic pain in children and adults with SCD.

- **Recommendation 1a:** Develop comprehensive, evidence-based guidelines for the treatment of acute and chronic SCD pain in children and adults.
- **Recommendation 1b:** Conduct research to understand underlying mechanisms of acute and chronic pain and develop mechanistic non-opioid pharmacologic therapies and non-pharmacologic approaches for SCD pain management.

Gap 2: Unpredictable, episodic exacerbations of acute pain pose a challenge for SCD pain management, and the majority of patients have failed non-opioid pain medications prior to presentation for acute care. Constraints on opioid treatment duration can make individualization of pain management difficult. Further, limited access to oral opioids at home for the treatment of unplanned acute pain can result in increased use of health care services that could have been avoided.

- **Recommendation 2a:** Protect access to the appropriate and safe use of opioids for patients with SCD, with consideration for exemption from prescribing guidelines and state prescribing laws that do not specifically address patients with SCD because of the complex nature and mechanism of acute and chronic sickle cell pain.
- **Recommendation 2b:** Consider the lowest effective dose of opioids to treat acute pain crises and prescribe within the context of close follow-up and comprehensive outpatient pain care.
- **Recommendation 2c:** Develop an individualized approach to pain management that includes consideration of opioid and non-opioid therapies, such as behavioral health strategies and multimodal approaches.
- **Recommendation 2d:** Provide patient education on the risks and benefits of opioids.

Gap 3: The SCD patient population faces significant health care disparities that affect access to and delivery of comprehensive pain care and mental health services. Further, stigma, negative provider attitudes, and perceived racial bias are associated with SCD pain,^{377,378} which may compromise care, thus leading to increased suffering from pain and pain care delivery.^{379–383}

- **Recommendation 3a:** Develop comprehensive care delivery models for SCD pain management, including collaborative partnerships among pain medicine, SCD specialists and advocates, and multidisciplinary teams.
- **Recommendation 3b:** Develop outpatient infusion clinics/day hospitals for SCD pain management to decrease reliance on the ED for pain treatment.
- **Recommendation 3c:** Increase access to and reimbursement for mental health services for patients with SCD.
- **Recommendation 3d:** Provide education focused on stigma, negative provider attitudes, and perceived racial bias at all levels of health care to optimize delivery of pain treatment to patients with SCD.

2.7.8 HEALTH DISPARITIES IN RACIAL AND ETHNIC POPULATIONS, INCLUDING AFRICAN-AMERICANS, HISPANICS/LATINOS, AMERICAN INDIANS, AND ALASKA NATIVES

Considerable evidence exists documenting health disparities in racial and ethnic minority populations, particularly substantial disparities in the prevalence, treatment, progression, and outcomes of pain-related conditions.³⁸⁴ These disparities in care are attributed to factors related to social disadvantage as well as factors within health systems.³⁸⁵ Health disparities contributing to suboptimal pain management in these special populations may be related to such factors as barriers to accessing health care, lack of insurance, discrimination, lack of a PCP, lack of child care, a lower likelihood to be screened or receive pain treatment, and environmental barriers that impede effective self-management. Effective strategies and plans to address these issues specifically in these disparate communities are necessary to address these gaps to improve patient outcomes.

GAPS AND RECOMMENDATIONS

Gap 1: Socioeconomic and cultural barriers may impede patient access to effective multidisciplinary care. Evidence exists of racial and ethnic disparities in pain treatment and treatment outcomes in the United States, yet few interventions have been designed to address these disparities. Lower quality pain care may be related to many factors, including barriers to accessing health care, lack of insurance, discrimination, lack of a PCP, lack of child care, lower likelihood to be screened or receive treatment, and environmental barriers that impede self-management.

- **Recommendation 1a:** Develop intervention programs informed by the biopsychosocial model to reduce racial and ethnic disparities in pain.

Gap 2: Research shows that ethnic minorities may have greater pain sensitivity and are at increased risk for chronic pain, yet they remain underserved.

- **Recommendation 2a:** Develop biopsychosocial interventions for pain that are scalable and culturally enhanced.

2.7.9 MILITARY ACTIVE DUTY, RESERVE SERVICE MEMBERS AND VETERANS

The experience of pain is prevalent in military and Veteran populations.³⁸⁶ Pain management can be complex in military populations, who experience combat-related injuries (e.g., ballistic wounds, burns, over-pressurization, blunt trauma) in addition to complications from accompanying conditions such as post-traumatic stress disorder (PTSD) and traumatic brain injury (TBI), both of which are more prevalent in Veterans than in the civilian population.^{48,387,388} Delayed pain treatment following injury can increase the likelihood of acute pain becoming chronic pain in service members and Veterans.⁴⁸

As a Nation, we must do better in fulfilling our solemn obligation to care for all those who have served our country and to improve the quality of life of our Nation's Veterans – many of whom have risked their lives to protect our freedom while deployed, often multiple times, to areas of prolonged conflict. Veterans die by suicide at higher rates when compared to civilians in the U.S..³⁸⁹ Among Veterans, pain conditions are associated with an increased risk of suicide.³⁹⁰ Clinicians can discuss suicide risk with Veterans and recognize that public health approaches to suicide prevention include addressing pain.

GAPS AND RECOMMENDATIONS

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

- **Recommendation 1b:** Physicians and clinical health care providers should work collaboratively to deliver comprehensive pain care that is consistent with the biopsychosocial model of pain.
- **Recommendation 1c:** 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, other mental health issues, and SUDs.
- **Recommendation 1d:** Conduct studies to better understand the contributing factors predisposing these patients to movement along the spectrum from acute to chronic pain.

Gap 2: The transition from military service to Veteran status can be complicated. A multitude of factors may affect a successful transition, including incomplete integration of EHRs and imposed changes or delays in access to primary care, pain specialty, and mental health physicians and health care providers.

- **Recommendation 2a:** The integration of DoD and Veterans Health Administration (VHA) health systems is important for effective and timely pain care. This integration should include coordination of the transition from active duty to Veteran status and care coordination across the health care spectrum that includes a smooth transition to primary care, mental health and pain specialty physicians, and health care providers.

Gap 3: Military active duty, reserve service members and Veterans increasingly receive care in the community (including care provided through external payment systems and DoD- or VHA-purchased care). A fragmented health care system results in lack of coordinated care in the community, within the Military Health System (MHS), and in VHA as well as differing care standards (such as the implementation of opioid risk-mitigation strategies). Within MHS, access to primary care and specialty care — and multidisciplinary pain specialty care in particular — is difficult for some Veterans because of geographical factors, limited availability of providers, and the need for specialized pain care treatment.

- **Recommendation 3a:** To improve care coordination across health care systems, streamlined access to medical records and collaboration across systems are needed to provide more timely and effective pain care.

3. CROSS-CUTTING CLINICAL AND POLICY BEST PRACTICES

3.1 RISK ASSESSMENT

The selection of the most appropriate medication-based treatment approach for an individual with pain involves a careful analysis of risk and benefit. Risks of side effects and toxicity must be balanced against the benefits, including improved function with improved QOL, ADLs, and ability to work, as well as with improvement in medical condition. Clinicians evaluating pain, whether acute or chronic, must conduct a thorough history, physical exam, and risk assessment, especially when considering medications such as opioids in the treatment plan. Identifying patients at risk of SUD will help minimize potential adverse consequences and facilitate treatment or referral for treatment of active SUDs.



Figure 17: A Risk Assessment Is Critical to Providing the Best Possible Patient-Centered Outcome While Mitigating Unnecessary Opioid Exposure

3.1.1 PRESCRIPTION DRUG MONITORING PROGRAMS

Prescription drug monitoring programs (PDMPs) are state-managed electronic databases of controlled substances dispensed (typically schedule II-IV drugs), with the majority of the data being reported by community-based pharmacies.³⁹¹ PDMPs enable prescribers and pharmacists (and in some states, insurers, researchers, and medical licensing boards) to access the data, monitor use by patients, monitor prescribing practices by practitioners, and check population-level drug use trends. Forty-nine states and most of Missouri and the District of Columbia have operational PDMPs.^{392,393}

Prescribers may be required to use PDMP data at the point of care, enabling them to identify patients who have had multiple provider episodes or potentially overlapping prescriptions that place them at risk. PDMPs can support safe prescribing and dispensing practices and help curb opioid prescription by detecting patterns that can alert clinicians to patients who may be at risk of a SUD. PDMPs can alert clinicians to provide potentially lifesaving information and interventions. The information found in the PDMP can prompt the clinician to take action to improve patient safety by having a conversation about safety concerns and understanding the patient's goals and needs. Providers who identify uncertain medication behavior can respond clinically, making referrals to mental health or substance abuse treatment.^{394,395} McAllister et al.³⁹⁶ found that all prescribers who were surveyed indicated that accessing PDMP data altered their prescribing patterns. Caution is needed when using PDMPs as a

tool to aid in the proper dispensing of medications. However, PDMPs are not to be used as tools to stop dispensing medications appropriately to those in need. For example, it is important for pharmacists to know that doctors often work as teams and to ensure that the conclusion of inappropriate multiple provider use is made only after the pharmacist has communicated directly with the prescribing clinician. Concerns that physicians, nurses, dentists, pharmacies might have should be communicated amongst one another or to the relevant state regulatory agencies, including state medical boards, nursing boards, dental boards, and pharmacy boards when appropriate.

PDMPs can assist in determining whether a patient is obtaining medications from multiple providers and filling prescriptions at multiple pharmacies, especially when prescriptions are filled in quick succession or on the same day. As a tool to help inform clinical decisions, PDMPs' potential utility was highlighted in CDC's Guideline for Prescribing Opioids for Chronic Pain.³⁹⁷ Clinicians should consider reviewing PDMP data when starting patients on opioid therapy and periodically during chronic opioid treatment.³⁹⁷

Prescribers are more likely to use PDMPs that present data in real time, are used by all prescribers, are technically easy to use without time constraints, and actively identify potential problems such as multiple prescribers or multiple prescriptions.³⁹⁸ Requiring PDMP checks also has a positive effect. Buchmueller and Carey³⁹⁹ found stronger effects when providers are required to access the PDMP, and PDMPs significantly reduced measures of misuse in Medicare Part D. In contrast, they found that PDMPs without such provisions had no effect. PDMPs can also bolster provider confidence. For example, in one study, ED providers report feeling more comfortable prescribing controlled substances when they receive information from a PDMP.³⁹⁶

Baehren et al.⁴⁰⁰ found that when PDMP data were used in an ED, 41% of cases had altered prescribing after the clinician reviewed PDMP data, with 61% of the patients receiving fewer or no opioid pain medications than the physician had originally planned prior to reviewing the PDMP data and 39% receiving more opioid medication than previously planned because the physician was able to confirm that the patient did not have a recent history of controlled substance use. The effective use of PDMP data is beneficial to both health care professionals and patients.

The need to modernize and enhance the functionality of PDMPs is widely acknowledged.^{401–404} For example, Colorado favors the integration of automatic queries and responses that obviate time-consuming manual data entry and also recommends that PDMPs be optimized with improvements, links to ED registration, and data population in EHRs.⁴⁰⁵ EHRs should work to integrate PDMPs into their system design at minimal to no additional cost to providers (to eliminate barriers to accessing PDMP data), especially when these data points are mandated. States should individually provide links to their PDMPs from major, certified EHR platforms. Maryland also recommends enhanced user interfaces and interstate data sharing for PDMPs.⁴⁰² Provider PDMP adoption has been shown to fall when interoperability is low and use is not mandated.⁴⁰⁶ Accessing PDMP data also affects VA and IHS. VA physicians noted that incomplete or unavailable data was a significant barrier to increasing PDMP use.⁴⁰⁷ In 2016, HHS issued a policy requiring IHS prescribers to query the PDMP before prescribing opioids and pharmacists to report their dispensing activity to the PDMP; it also directed IHS to ensure that memorandums of understanding were signed with the appropriate state offices.^{49,408} Links to and use of PDMPs varies across IHS service areas.

GAPS AND RECOMMENDATIONS

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:** Consider checking PDMPs, in conjunction with other risk stratification tools, upon initiation of opioid therapy, with periodic reevaluation.
- **Recommendation 1b:** Provide clinician training on accessing and interpreting PDMP data.
- **Recommendation 1c:** Clinicians should engage patients to discuss their PDMP data rather than making a judgment that may result in the patient not receiving appropriate care. PDMP data alone is not error proof and should not be used to dismiss patients from clinical practices.

- **Recommendation 1d:** If already preformed upon admission in the inpatient hospital setting, the health care provider team should not be mandated to repeatedly check PDMP if already performed upon admission and pending discharge.
- **Recommendation 1e:** Conduct studies to better identify where PDMP data are best used (e.g., inpatient versus outpatient settings). Adjust PDMP data use based on the findings of the recommended studies to minimize undue burdens and overuse of resources (i.e., streamline PDMP data use).
- **Recommendation 1f:** States are encouraged to have interoperability between PDMP and EHR platforms (Code of Federal Regulations 170.315). EHR vendors should work to integrate PDMPs into their system design at minimal to no additional cost or burden to providers (to eliminate barriers to accessing PDMP data), especially when these data points are mandated.
- **Recommendation 1g:** Enhance the interoperability of PDMPs across state lines to allow for more effective use, along with reporting to PDMP by the VA and military health system on a consistent basis.
- **Recommendation 1h:** Clinicians within and outside federal health care entities should have access to each other's data to ensure safe continuity of care.
- **Recommendation 1i:** Allow access to PDMPs by all opioid prescribers.
- **Recommendation 1j:** Encourage funding programs, such as the Harold Rogers Prescription Drug Monitoring Program and the National All Schedules Prescription Electronic Reporting Act of 2005, to link interstate PDMP programs to each other.

3.1.2 SCREENING AND MONITORING

Screening and monitoring in pain management seeks to identify and reduce the risk of substance misuse, abuse, and overdose as well as improve overall patient care. Evaluations of patient physical and psychological history can screen for risk factors and characterize pain to inform treatment decisions. Screening approaches include efforts to assess for concurrent substance use and mental health disorders that may place patients at higher risk for OUD and overdose. This includes screening for drug and alcohol use and the use of urine drug testing, when clinically indicated.^{84,409} These approaches allow providers to identify high-risk patients so that they can consider substance misuse and mental health interventions, ADFs, and education materials to mitigate opioid misuse.⁴¹⁰

Screening tools can help clinicians identify risks and help determine which medication classes may be appropriate for the patient, including for long-term opioid therapy. Effective screening can include single questions, such as, "How many times in the past year have you used an illegal drug or used a prescription medication for nonmedical reasons?"⁴¹¹ Other validated screening tools include the Drug Abuse Screening Test⁴¹² and the Alcohol Use Disorders Identification Test.⁴¹³ Clinicians must recognize the limits of screening tools in detecting prior or developing SUD or OUD.

Urine drug tests (UDTs) can provide information about drug use that the patient does not report, including not using prescribed medications as intended and unreported drug use. UDTs can also potentially inform treatment decisions by assessing an individual's drug metabolism rate. However, according to a systematic review by the Agency for Healthcare Research and Quality (AHRQ), evidence demonstrating the effectiveness of UDTs for risk mitigation during opioid prescribing for pain is lacking.^{414,415} UDT results can be subject to misinterpretation and may sometimes be associated with practices that can harm patients (e.g., stigmatization, inappropriate termination from care). Clinicians do not consistently use practices intended to decrease the risk for misuse, such as UDTs⁴⁰⁹ and opioid treatment agreements,⁴¹⁶ likely in part because of competing clinical demands, perceived inadequate time to discuss the rationale for UDTs and order confirmatory testing, and feeling unprepared to interpret and address results.⁴¹⁷

To mitigate the risks of prescription opioid misuse, medical societies, in conjunction with state and federal regulatory agencies, have recommended specific risk-reduction strategies, including written treatment agreements for patients with

chronic pain who are prescribed opioids.⁴¹⁶ Pain agreements or treatment agreements can be useful in defining the responsibilities of the patient and the provider, and they create a structure to guide and evaluate opioid use. The agreement should be viewed as an opportunity for ongoing dialogue about the risks of opioids and what the patient and clinician can expect from each other.³⁶¹ The agreement should not be about simply getting a form signed or a means to “fire” a patient for breaking the terms of the agreement; rather, it is a tool for facilitating a conversation between the clinician and the patient.⁴¹⁶

Monitoring approaches should be applied transparently and consistently in a manner that emphasizes safety so that miscommunication and accidental stigmatization are minimized.⁴¹⁸ At follow-up, doctors should assess benefits in function, pain control, and QOL using tools such as the three-item “Pain average, interference with Enjoyment of life, and interference with General activity” Assessment Scale⁴¹⁹ or asking patients about progress toward functional goals that have meaning for them. Clinicians should also screen for factors that predict risk for poor outcomes and substance abuse, such as sleep disturbance, mood disorder, and stress, either by using a pain rating scale such as the Defense and Veterans Pain Rating Scale, which includes brief questions, or by routinely asking about these factors on clinical examination.⁴²⁰ Clinicians should ask patients about their preferences for continuing opioids, given their effects on pain and function relative to any adverse effects they experience.³⁹⁷ These factors illustrate the importance of health care providers having sufficient time with the patient for a thorough evaluation.

GAPS AND RECOMMENDATIONS

Gap 1: Comprehensive screening and risk assessment of patients is time-consuming but vital for proper evaluation of their chronic pain conditions. Lack of sufficient compensation for time and payment for services have contributed to barriers in best practices for opioid therapy.

- **Recommendation 1a:** Encourage CMS and private payers to provide sufficient compensation for time and payment for services to implement the various screening measures (e.g., extensive history taking, review of medical records, PDMP query, urine toxicology screenings, when clinically indicated). These are vital aspects of risk assessment and stratification for patients on opioids and other medications.
- **Recommendation 1b:** Consider referral to pain, mental health and other specialists, including addiction medicine trained physicians when high-risk patients are identified.

Gap 2: UDTs are not consistently used as part of the routine risk assessment for patients on opioids.

- **Recommendation 2a:** Use UDTs as part of the risk assessment tools prior to the initiation of opioid therapy and as a tool for reevaluating risk, using the clinical judgment of the treatment team.
- **Recommendation 2b:** Clinicians should educate patients on the use of UDTs and their role in identifying both appropriate and potentially inappropriate use.

Gap 3: Variability exists in what is included in opioid treatment agreements and should be based on common principles and reflect provider, practice, and patient demographics.

- **Recommendation 3a:** Conduct studies to evaluate the effectiveness of the different components of opioid treatment agreements. Treatment agreements should include the responsibilities of both the patient and the provider.
- **Recommendation 3b:** Use opioid treatment discussions as an educational tool between providers and patients to inform the patient about the risks and benefits of and alternatives to chronic opioid therapy.

3.2 STIGMA

Stigma associated with having chronic pain, especially when opioid therapy is used as a treatment modality, is a major concern and has far-reaching effects on patients and all those involved in their care.⁴²¹ The different facets of stigma — at the patient, provider, and social levels — collectively serve as a significant barrier to effective treatment of chronic pain.⁴²² There is a growing body of empirical research into stigmatization and the resulting barriers to care. Studies suggest that patients

who are receiving or who have previously received long-term opioid therapy for nonmalignant pain face both subtle and overt stigma from their family, friends, coworkers, the health care system, and society at large for their opioid treatment modality.^{421–424} Compassionate, empathetic care in a provider-patient partnership is best for countering the stigma, isolation, and psychosocial challenges of living with pain.

Feelings of guilt, shame, judgement, and embarrassment resulting from such stigma can increase the risk for behavioral health issues, such as anxiety and depression, which can further contribute to symptom chronicity.⁴²⁴ Reducing barriers to care that exist as a consequence of stigmatization is crucial for patient engagement and treatment effectiveness.⁴²²

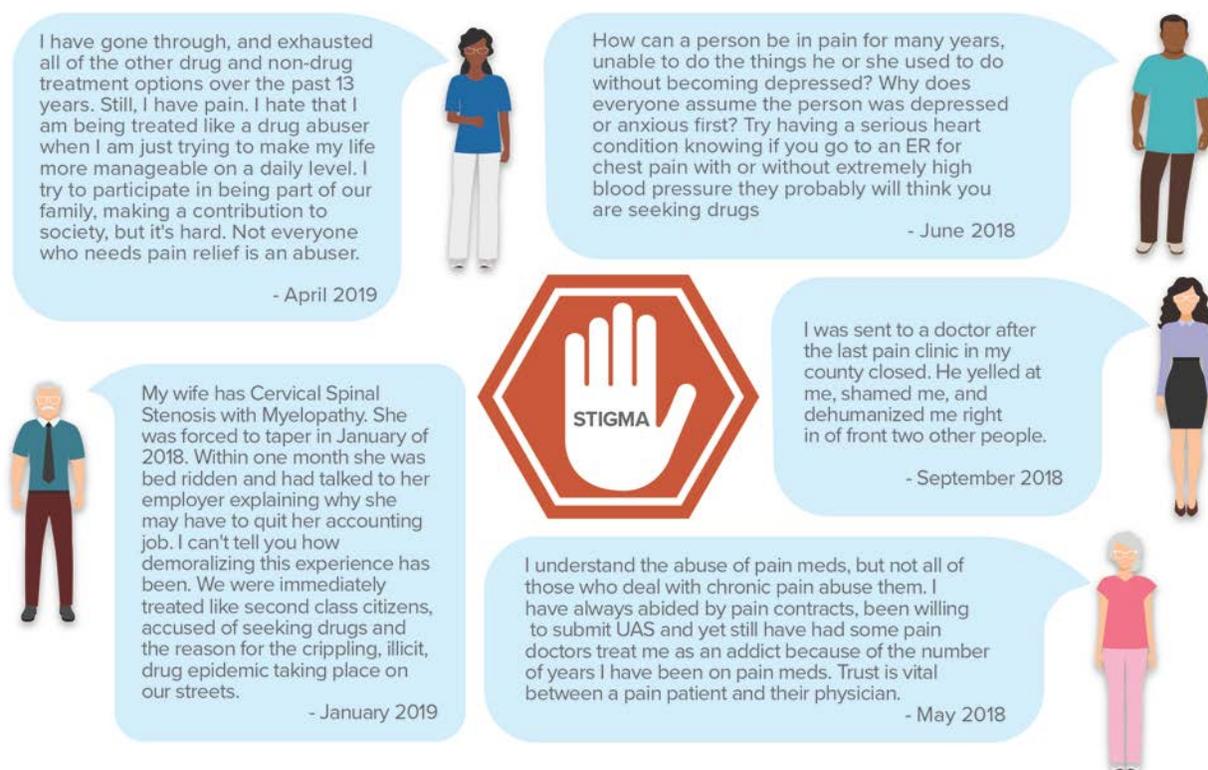


Figure 18: Public Comments to the Task Force Affirm the Barriers Stigma Creates

Furthermore, the sub-population of patients with painful conditions and comorbid SUD face additional barriers to treatment because of stigmatization of both chronic pain and addiction.⁴²⁵ Chronic pain is common among individuals with SUD, including opioid misuse,⁴²⁶ yet stigma remains a significant barrier to implementation of programs and treatments for OUD, such as medication-assisted treatment^{427,428} and naloxone.⁴²⁹ Patients with comorbid problematic opioid use and chronic noncancerous pain report significant perceived stigma associated with methadone and buprenorphine treatment.⁴²³ Clinicians who treat acute and chronic pain, particularly with opioids, may experience stigma from colleagues and society in general that — in addition to fear of scrutiny from state medical boards and the DEA — may also dissuade them from using opioids appropriately. Clinicians are overburdened with time constraints, EHR demands, and other administrative tasks, which has led to unprecedented levels of burnout among physicians. Stigma, combined with the enhanced time required to effectively evaluate and treat pain, leads to over-referral and patient abandonment.⁴³⁰ According to one study, only 12.2% of individuals who require treatment for a SUD actually seek treatment. Additionally, stigma is found to be a significant barrier with 20.5% not seeking treatment because negative consequences associated with their work and around 17% being concerned about negative judgements by friends or community.⁴³⁰



JULIA'S STORY

PATIENT TESTIMONIAL

Eight years ago, through a series of relatively minor events, I ended up with multiple herniated and bulging disks in my lumbar and cervical spine and nerve-root impingement in my neck. I also have two painful disc-spur complexes in my thoracic spine. This is how my nightmare began.

I ended up going to multiple doctors to find help for my pain -- orthopedists, physiatrists, a neurologist, and four top neurosurgeons. I was told that I was not a candidate for surgery, but few other solutions were given.

I was accused of drug seeking, belittled for having a low pain threshold, which was not true, and dismissed as a patient. I was unable to work and take care of my family because of the constant pain. I was reduced to lying in bed, crying from the pain, and being emotionally devastated. It was as if I had to prove my pain.

This was also the most vulnerable time for my family, who were my caregivers, because they had no knowledge or understanding or tools to deal with me and my pain.

Understandably I became severely depressed. I had no prior psychiatric history and had never been to a psychiatrist in my life. I was hospitalized three times for suicidal ideation. Each time I would return home, but nothing had changed. My family didn't know what to do to help me and the situation caused a lot of family stress.

My doctors at the time didn't help either. When I couldn't stand the pain anymore, I went to the ER several times and was treated like an addict. During one hospital stay, I was labeled chemically dependent and recommended for a 30-day drug-rehabilitation program. I refused to go because all I wanted was for the pain to stop and to go back to my normal life. About two years later, I finally ended up in a pain management clinic headed by fellowship-trained pain management anesthesiologists. I was treated with understanding and respect and given the medical care that I needed to help improve my quality of life.

GAPS AND RECOMMENDATIONS

Gap 1: Patients with chronic pain 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 1a:** Increase patient, physician, clinician, non-clinical staff, and societal education on the underlying disease processes of acute and chronic pain to reduce stigma.
- **Recommendation 1b:** Increase patient, physician, clinician, non-clinical staff and societal education on the disease of addiction.
- **Recommendation 1c:** Counter societal attitudes that equate pain with weakness through an awareness campaign that urges early treatment for pain that persists beyond the expected duration for that condition or injury.
- **Recommendation 1d:** Encourage research aimed at discovering biomarkers for neurobiological mechanisms of chronic pain.

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 barriers to proper access to care.

- **Recommendation 2a:** 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.

3.3 EDUCATION

Public, patient, provider, and policymaker education is critical to the delivery of effective, patient-centered pain management and necessary for optimizing patient outcomes, promoting appropriate use of pain medication, and reducing the risk associated with prescription opioids. This common theme is underscored across many federal reports, including the Institute of Medicine's (IOM's) report, "Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education, and Research"; HHS's National Pain Strategy; and other pain management and opioid-related consensus documents.^{5,49,126,431} These reports consistently describe the extent to which pain and SUD education is insufficiently covered in medical education and training programs, which has a downstream impact on the extent to which patients are educated about pain and SUD.

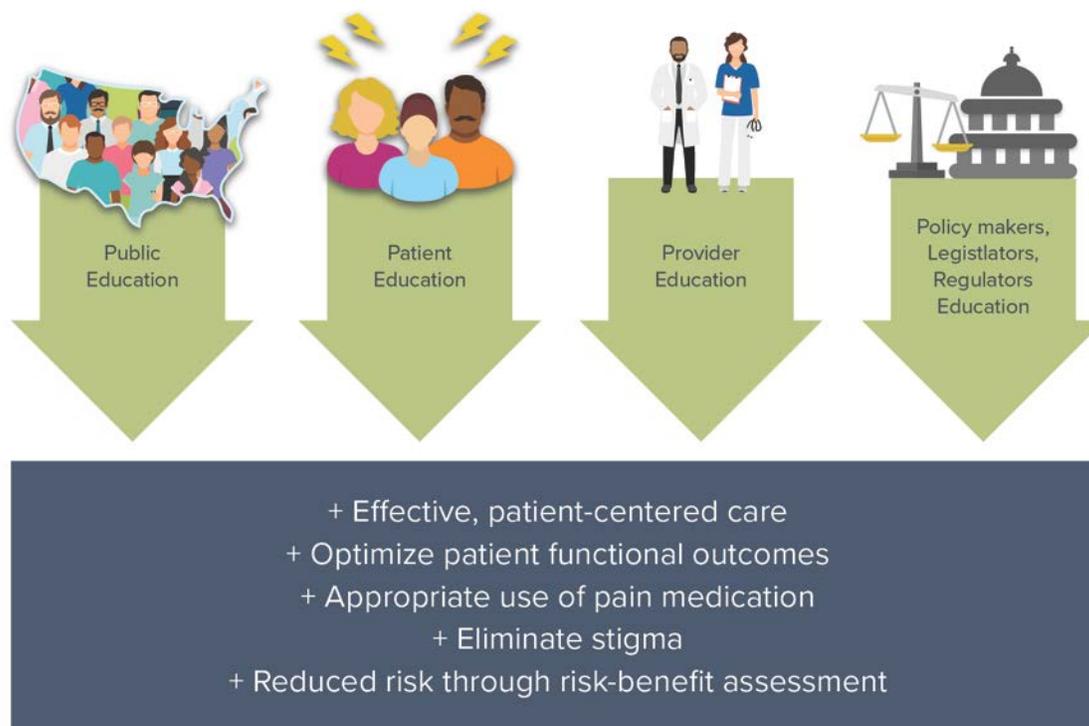


Figure 19: Education Is Critical to the Delivery of Effective, Patient-Centered Pain Care and Reducing the Risk Associated With Prescription Opioids

To begin to address the growing need for educational initiatives, multiple entities, including government agencies, nonprofit organizations, pharmaceutical manufacturers, academic institutions, and health systems, have developed and disseminated pain- and opioid-related patient education programs, toolkits, pamphlets, and other interventions. Similarly, state-level continuing education requirements have been established for several provider types (e.g., physicians, dentists, nurse practitioners [NPs], physician assistants [PAs], pharmacists) that mandate education about appropriate opioid prescribing and dispensing. Addressing multiple education gaps simultaneously will likely be necessary to optimize patient outcomes tied to public, patient, and provider education. Other programs that could be considered are the development and effectiveness testing of a reimbursable pain self-management training program that incorporates a pain educator, or evaluation of the role of a certified pain educator, in optimizing pain care and improving patient education.

3.3.1 PUBLIC EDUCATION

The evidence base for public education about pain is limited. Whereas some evaluation of mass media campaigns for low-back pain have been conducted in other countries, analyses in the United States are lacking.^{432–434} The gaps and recommendations specific to public pain education, as outlined below, that will inform best practices in public pain education are consistent with those described elsewhere.⁴⁹ There is a significant need for improved public education on and understanding of the distinction between acute and chronic pain — notably, that chronic pain, regardless of its etiology, can become a chronic disease itself, with measurable changes in the nervous system, spinal cord, and brain.⁵ An estimated 50 million to 100 million people have chronic pain, making it the most prevalent, costly, and disabling health condition in the United States.^{5,6} Yet, despite its pervasiveness, it remains largely unknown to the broader public.

GAPS AND RECOMMENDATIONS

Gap 1: National public education about pain is needed.

- **Recommendation 1a:** Develop a national evidence-based pain awareness campaign that emphasizes the public’s understanding of acute and chronic pain syndromes.
- **Recommendation 1b:** Establish a mechanism to finance a large-scale, systematic, coordinated public campaign to address pain awareness.

3.3.2 PATIENT EDUCATION

Patient education is another key component of any best practice model for outcomes. Patients benefit from a greater understanding of their underlying disease process and pain triggers as well as knowing how to seek appropriate professional care. It is important for patients to know that pain as a symptom is typically a warning of injury or disease that can affect the body and mind. Finding the precipitating and perpetuating causes of the pain and addressing them with appropriate multi-modal therapy is considered the best management strategy for improving patient outcomes. It is also important for patients to understand that pain can be a disease in its own right, particularly when pain becomes chronic and loses its protective function. In this context, pain is often detrimental to the patient’s health, functionality, and QOL. A category of diseases is characterized by chronic debilitating pain (e.g., trigeminal neuralgia, CRPS, post-herpetic neuralgia). In such conditions, there is rarely a cure, but appropriate assessment; accurate diagnosis; and patient-centered, multidisciplinary treatment can optimize pain relief, improve function, and enhance QOL. Self-management skills training may include relaxation, pacing, cognitive restructuring, maintenance planning, and relapse prevention.^{42,43,47,435} Innovative delivery systems, including telehealth and other Web-based applications, can offer technology-based education and self-management support to further engage and empower patients in their care plan.^{436–438}

GAPS AND RECOMMENDATIONS

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

- **Recommendation 1a:** Prioritize access to educational tools for patients, families and their caregivers that include clinician visits, patient handouts, Web resources, and support groups to optimize patient outcomes.
- **Recommendation 1b:** Explore and test innovative methods of delivering patient education and support for patients with acute or chronic pain using technology, particularly in rural areas that have limited access to multimodal treatment. Examples of means to provide patient access in such situations include telemedicine online support groups, networks of in-person support groups with training and guidance from leaders, and applications easily accessible on mobile devices.

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

- **Recommendation 2a:** During the preoperative visit, discuss pain control after surgery. This discussion should be conducted by both the surgical team and the preoperative team.
- **Recommendation 2b:** For major surgeries, use models such as the PSH or ERAS protocols to emphasize the importance of patient education in the management of pain and rehabilitation activities.
- **Recommendation 2c:** CMS and private payers should recognize that the time spent educating and managing patients' expectations is cost-effective and provides a significant value that reduces the length of hospital stays and improves patients' postoperative pain management, allowing for faster recovery through earlier PT and mobility that decreases the risk for postoperative complications (e.g., blood clots). CMS and other payers should compensate according to physician-patient time spent.

Gap 3: Current educational materials and interventions for patients with chronic pain lack consistency, standardization, and comprehensive information.

- **Recommendation 3a:** Establish an online resource of evidence-informed educational materials for common pain conditions and appropriate treatment modalities.
- **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, their family, and caregivers through clinics, hospitals, pain centers, and patient groups.

3.3.3 PROVIDER EDUCATION

Experts have noted the benefits that could be realized from the development of a more comprehensive pain curriculum for training and continuing education of providers.¹⁵ Encouraging licensing and education practices that do more to emphasize safe and effective pain assessment and management has the potential to improve pain management and mitigate factors that contribute to the current opioid crisis.^{26,439} Health care professionals who prescribe opioids are in a key position to balance the benefits of analgesics against the risk of adverse clinical outcomes. It is estimated that “apart from federal prescribers who are required to be trained, fewer than 20% of the over one million health providers licensed to prescribe controlled substances have training on how to prescribe opioids safely and effectively.”⁴⁴⁰ Providers can access educational resources, receive accreditation, or renew existing licenses through public- or private-sector enterprises.⁴⁰² National stakeholders have recommended that accrediting organizations develop, review, promulgate, and regularly update core competencies for pain care education, licensure, and certification at the pre-licensure (i.e., undergraduate professional) and post-licensure (i.e., graduate) levels.^{49,289}

Educational interventions for pain should be guided by core competencies and target both the training and practice levels.²⁶ Provider education research specific to patient outcomes is limited, but systematic reviews on CME indicate interventions that include multimedia, multiple instructional techniques, and multiple exposures are associated with improved provider knowledge outcomes compared with alternatives (e.g., print materials, one-time interventions).^{441–443} Likewise, regardless of whether educational interventions are targeted at clinicians in training or in practice, aligning educational interventions with core competencies (i.e., outcomes) for pain care education^{15,439} is a best practice.⁴⁹ In addition, while Frank et al.⁴⁴⁴ demonstrated the effectiveness of a longitudinal distance learning approach that uses telemedicine to change clinical pain practice in primary care (e.g. Extension for Community Healthcare Outcomes (Project ECHO)), a recent systematic review by Rochfort et al.⁴⁴⁵ found a scarcity of studies on the effectiveness of educational interventions implemented by a PCP designed to promote optimal patient outcomes. Results do indicate that education and skills training of PCPs may positively affect patient performance of self-management pain-reduction activities, improve patient lifestyle behaviors, and increase perceived QOL. This finding underscores the importance of further training for health care professionals in patient self-management support as part of patient-centered care and as a mechanism for improving pain outcomes.

Chronic Pain and Headache Management TeleECHO (ECHO Pain), with Project ECHO, is a telehealth approach that supports clinicians' education and training regarding treating patients with chronic pain and safe opioid management.⁴⁴⁶ The model is based on workplace learning, with cases selected by participants from their patient panels combined with short lectures by experts (referred to as a "hub-and-spoke model").

GAPS AND RECOMMENDATIONS

Gap 1: Gaps exist in pain management understanding and education throughout the health care provider community. There is a need for further education regarding acute and chronic pain for all health care providers in professional school curricula, post-graduate education, and further clinical specialty training.

- **Recommendation 1a:** Further develop biopsychosocial educational models for clinicians at all levels of training.
- **Recommendation 1b:** Develop effective educational resources for PCPs to improve the current understanding and knowledge of pain treatment modalities, initially available treatments, and early referral to pain specialists.
- **Recommendation 1c:** Explore intensive continuing pain education for PCPs, including telehealth, tele-mentoring, and the Project ECHO model, as a means of providing pain education for PCPs by pain specialists. Consider the State Targeted Response Technical Assistance Consortium model for pain training as it currently exists for addiction training.

Gap 2: Pain is generally treated as a symptom of another illness, disease, or injury; it is not commonly recognized as a separate category of disease.^{5,447} The lack of education on pain syndromes and pain mechanisms limits the ability to recognize chronic pain as a category of disease.

- **Recommendation 2a:** The Task Force supports WHO's recognition of chronic and acute pain as a category of disease, with its revisions to the "International Classification of Diseases 11th Revision."⁴⁴⁸
- **Recommendation 2b:** Conduct further education on pain syndromes and mechanisms through clinician training, such as CME, the Project ECHO model, telementoring, and other continuing education programs.

3.3.4 POLICYMAKER, REGULATOR AND LEGISLATOR EDUCATION

Policymakers, regulators and legislators at both the federal and the state level play an important role in formulating policy, issuing guidelines and direction, and passing legislation on issues related to acute and chronic pain management, payment mechanisms, and the use and regulation of controlled medications. The issue of pain management is complicated, so every decision made, law passed, or guideline issued has a cascading effect on many aspects of pain management. As such, a deep understanding of the issues, especially the potential for unintended consequences of these decisions, is essential in formulating effective comprehensive policy.

GAPS AND RECOMMENDATIONS

Gap 1: Current education for policymakers at the state and federal level has significant opportunities for improvement for both acute and chronic pain.

- **Recommendation 1a:** Strongly encourage education by key and relevant expert stakeholders from the appropriate professional associations, clinicians, and patient advocacy groups prior to effecting policy on acute and chronic pain.
- **Recommendation 1b:** Establish criteria for evaluating legislation and regulation based on the principles in the preamble of this report ensuring an understanding of all potential unintended consequences of guidelines, policies, regulations, or legislation that is being considered.

3.4 ACCESS TO PAIN CARE

In the United States, the estimated number of patients with chronic daily pain is 50 million, with 19.6 million having chronic, high-impact pain.⁶ Several factors act as barriers to adequate care, including inadequate insurance coverage for pain management services,²⁷⁸ shortages of medical and behavioral pain management specialists,⁵ provider underestimation of patients' reports of pain,⁴⁴⁹ poorly functioning drug supply systems,⁴⁵⁰ lack of research on innovative and effective pain management approaches,²⁸ and — more recently — widespread fear among providers of regulatory scrutiny. The recent advent of retail pharmacies limiting the duration of prescriptions, making unrequested changes to dosages, or placing barriers to obtaining properly prescribed pain medications has had the unintended consequence of limiting access to optimal pain care. Without such access many patients face significant medical complications, prolonged suffering, and increased risk for psychiatric conditions.⁴⁵¹ Medical complications from inadequately treated acute pain may include prolonged recovery time, unanticipated hospital readmissions, and transition to chronic and persistent pain.⁴⁵² Unremitting and inadequately treated pain is also associated with increased anxiety, depression, disability, unemployment, and lost income.²⁹³

In addition to experiencing medical and psychiatric consequences, individuals who receive inadequate pain treatment may transition to illicit opioid or other substance misuse. Although the pathway to illicit substance use in pain is not well understood, a small but growing number of individuals who misuse prescription opioids without the supervision or oversight of a medical provider transition to using illicit substances, such as heroin, within a year of use.⁴⁵³ The nonmedical and illicit use of opioids may increase an individual's risk for substance use problems, accidental or intentional overdose, or death.⁴⁵⁴ Heroin, fentanyl, and other illicit synthetic opioids continue to drive increasing numbers of overdose deaths.⁹ Understanding the indicators associated with inappropriate opioid use may improve the ability of health care providers to tailor treatments and surveillance without placing arbitrary limitations on all patients who are prescribed opioids. This understanding could also potentially improve access to effective care.

There is a concern as to the definition of what an 'outlier prescriber' is and to avoid arbitrary limitations without taking into account the provider expertise and the patient demographic. Careful consideration of how outliers will be defined is needed to avoid patient harm. Patient care should be based primarily on the clinical context and the patient-clinician interaction. Opioid stewardship programs can provide a holistic, efficient, comprehensive, multidisciplinary approach to address safer opioid prescribing within a health system and thus empowering cross-disciplinary collaboration and inclusion with the development of measures to guide implementation and successful efforts. Quality measures should include function, quality of life and activities of daily living. CMS is currently implementing sections of the SUPPORT Act. The SUPPORT Act requires CMS to convene a Technical Expert Panel, make recommendations regarding quality measures for opioids, identify outlier prescribers and furnish technical support regarding proper prescribing practices, implement minimum standards for states' Drug Utilization Review programs regarding opioid prescribing, including safety edits on refills and daily dosage policies. It is essential to ensure that careful consideration of clinical context is always considered.

3.4.1 MEDICATION SHORTAGE

Shortages of pharmacologic and biological products, including opioid and non-opioid analgesics, can have severe and immediate consequences for patient care. Appropriate treatment can be delayed or denied because of unavailability and, in other cases, result in the use of second-line, less effective alternatives.^{455,456} Several underlying factors have contributed to national shortages, including manufacturing problems that affect the drug supply chain and quality control, as well as regulatory changes in response to the opioid overdose public health crisis.^{450,456} Tracking data from the FDA show that drug shortages peaked in 2011, with more than 250 new drug shortages, and although the number has steadily declined, 2017 saw 39 new shortages and a failure to adequately address existing shortages.⁴⁵⁶

Health care systems and providers, along with clinical pharmacists are responding to the drug shortages by identifying therapeutic alternatives and prioritizing supplies. Patient safety events — namely, medication errors — are more likely to occur during times of shortages because of the increased prescribing of less familiar pharmacologic agents.^{450,457} Use of compounded products or alternative preparations is a common underlying cause of errors.⁴⁵⁸ An investigation by the Institute for Safe Medication Practices into shortage-related patient safety events cited that use of an alternative drug or alternative

dosage form/strength of a substitute drug accounted for up to 27% of reported harmful outcomes.^{457,459} Advance notice of shortages, communication and education, consultation with clinical pharmacists, and standardized management algorithms help mitigate the effects of drug shortages. For instance, a retrospective chart review of patients admitted to the pediatric intensive care unit during a 2011-2012 peak shortage of injectable benzodiazepines (e.g., midazolam, lorazepam, diazepam) and fentanyl reported no significant increase in rates of prescribing error and adverse patient outcomes because of well-established guidelines for prioritized and alternative analgesic and sedative management protocols.⁴⁶⁰

Current widespread shortages of several key parenteral opioids used for fast and reliable analgesic effects, including morphine, hydromorphone, and fentanyl, are affecting hospitals and cancer centers nationwide, leading to compromised acute pain management in the critical care and postoperative settings. Morphine, hydromorphone, and fentanyl are the most commonly used opioid injectables because of their fast and reliable analgesic effects and because they offer a viable option for patients unable to tolerate oral administration.^{450,455} Other potential analgesic shortages include the NSAIDs ketoprofen and ketorolac tromethamine, methocarbamol, methadone, promethazine, and remifentanyl. In July 2018, the FDA established the Agency Drug Shortages Task Force charged with identifying the causes of medication shortages and proposing solutions. The results will be summarized in a report to Congress, informed by input from the pharmaceutical and health care industries, patient representatives, the FDA's federal partners, and Congress.⁴⁶¹

GAPS AND RECOMMENDATIONS

Gap 1: Recurrent shortages in opioid and non-opioid pain medications have created barriers to the proper treatment in patients with pain.

- **Recommendation 1a:** The Task Force strongly supports the FDA's ongoing efforts to monitor, report, and prioritize the availability of key opioid and non-opioid medications, including injectables such as local anesthetic agents.
- **Recommendation 1b:** The FDA should make available alternative sources for these medications when critical shortages are anticipated.
- **Recommendation 1c:** Support the Agency Drug Shortages Task Force in its endeavors to find solutions to the critical challenges of drug shortages.

3.4.2 INSURANCE COVERAGE FOR COMPLEX MANAGEMENT SITUATIONS

Patients with complex and persistent pain often experience barriers to care related to nonexistent or insufficient insurance coverage and reimbursement for evidence-based medical, behavioral, and complementary pain management services. Although the HHS National Pain Strategy calls for greater coverage for pain management services, there is a lack of uniformity in insurance coverage and lack of coverage alignment with current practice guidelines for pain management.^{278,462} This is particularly true for non-pharmacologic²⁷⁸ and behavioral health interventions.^{278,463}

The process for determining insurance coverage for pain management services is lengthy and complex, often requiring product testing, assessment against evidence-based protocols, determination of medical necessity, evidence-based coverage determination processes, and review by physician networks and stakeholders. Moreover, there is substantial variability in the availability and structure of guidance regarding the data needed to qualify for coverage provided to developers working on innovative non-pharmacologic treatments.²⁷⁸ For example, CMS uses national coverage determinations (NCDs) to determine whether to cover a particular item or service. In the absence of a national coverage policy, an item or service may be covered at the discretion of the Medicare contractors based on a local coverage determination. Such practice leads to variation in coverage of items and services that can impact medical care. In addition, CMS requires testing of products in the Medicare-aged population for NCDs. Guidance to medication and product developers working on alternatives to opioids and opioid-sparing technologies; procedures concerning data needed to qualify for CMS coverage determinations; and innovation payments under CMS programs, especially for Medicare-eligible Americans in pain, is limited to basic statutory language. In contrast, the FDA provides extensive guidance on data needed to qualify for labeling for products like "abuse deterrent" medicines.

The inconsistencies in insurance policies, the variability in guidance regarding coverage determinations, and the variability in utilization management tools that coverage providers use can cause delays in service delivery, provision of inadequate treatment, and added financial and psychosocial burden for patients with pain.²⁸⁸ Requiring patients and health care professionals to navigate burdensome and variable coverage policies may contribute to slow development, adoption, and implementation of timely and effective pain treatments and may force providers to treat patients in a less-than-optimal fashion. Consistently forcing providers to try a series of non-first-line treatments prior to authorizing treatment plans can be problematic, hindering appropriate patient care, creating tremendous inefficiency, and resulting in a loss of time and resources. This situation is problematic when patients change insurance coverage, requiring a new set of preauthorization rules to be followed and potentially leading to delays in critical, ongoing treatment.⁴⁶²

GAPS AND RECOMMENDATIONS

Gap 1: Time and resources are insufficient for complex and safe opioid management.

- **Recommendation 1a:** Reimburse complex opioid and non-opioid management consistent with the time and resources required for patient education; safe evaluation; risk assessment; reevaluation; and integration of alternative, non-opioid modalities.
- **Recommendation 1b:** CMS and private payers should investigate and implement innovative payment models that recognize and reimburse holistic, integrated, multimodal pain management, including behavioral health.

Gap 2: Many pain related payer guidelines are outdated with respect to current clinical practice guidelines.

- **Recommendation 2a:** CMS and private payers should align their reimbursement guidelines for acute and chronic multidisciplinary pain management with current CPGs.

Gap 3: Payers often do not reimburse for non-opioid pharmacologic therapies that are more expensive than opioids, such as long-acting local anesthetic injection/infusion and intravenous acetaminophen analgesia.

- **Recommendation 3a:** CMS and other payers should align their reimbursement guidelines for non-opioid pharmacological therapies with current CPGs.

Gap 4: Coordinated, individualized, multidisciplinary care for chronic pain management is a best practice, yet this model of care is difficult to achieve with current payment models.

- **Recommendation 4a:** Payers should reimburse pain management using a chronic disease management model. CMS and private payers should reimburse for integrative, multidisciplinary pain care by using a chronic disease management model similar to that currently used to reimburse for cardiac rehabilitation and diabetes chronic care management programs. In addition, reimburse care team leaders for time spent coordinating patient care. A CPT code should be developed for pain care coordination as well as team and group conferences to enable multidisciplinary care.
- **Recommendation 4b:** Payers should reimburse for pain management in a manner that facilitates access in underserved locations through telehealth or other technology-assisted delivery methods.

3.4.3 WORKFORCE

A 2011 IOM report highlighted the current shortage of pain management specialists, citing that for every physician who is board certified in pain care, there are more than 28,500 Americans living with chronic pain.⁵ As of August 2018, there were 2,300 American Board of Pain Medicine-certified pain specialists⁴⁶⁴ and 6,595 physicians certified in pain management by the American Board of Medical Specialties⁴⁶⁵; many of these physicians have both certifications. Pain management specialists possess expertise and are specially trained in the evaluation, diagnosis, and treatment of acute and chronic pain.⁴⁶⁶ Because of an inadequate number of specialized pain physicians, PCPs are tasked with managing the majority of patients with painful conditions, often without adequate time and resources.⁴⁶⁷ This indicates the need for an increase in the pain specialist

workforce to support PCPs while also ensuring that specialists and PCPs have adequate time, incentives, and resources to manage patients with painful conditions. Likewise, access to behavioral pain management is limited because financial incentives are lacking for psychologists and other providers to specialize in pain. Many insurance programs do not reimburse for behavioral pain treatments, or they reimburse at a much lower rate than for pharmacologic or interventional treatments. Because of the lack of incentives, not enough providers are trained in behavioral pain management.^{279,282} Taken together, the severe shortage of pain medicine specialists and under-resourced and insufficiently trained PCPs treating pain along with insufficient access to behavioral therapists, pharmacists, and other members of the pain management team has hindered the development of efficient, cost-effective health care delivery models to treat chronic pain.^{5,15,468}

GAPS AND RECOMMENDATIONS

Gap 1: There is a shortage of clinicians who specialize in pain. These clinicians include pain physicians, addiction psychiatrists, psychologists, pharmacists, nurses, nurse practitioners (NPs), physician assistants (PAs), physical therapists, and others who make up a multidisciplinary pain management team. Furthermore, there is a shortage of multidisciplinary pain management teams to care for patients with complex pain conditions and physical and psychological comorbidities.

- **Recommendation 1a:** Expand clinician training in acute, chronic, or end-of-life pain evaluation and treatment. Enhancements should be made in professional school curricula, postgraduate training programs, and continuing education courses.
- **Recommendation 1b:** Expand postgraduate (e.g., residency, fellowship) positions to train clinicians as pain specialists, especially positions that train clinicians to work in multidisciplinary pain management teams.
- **Recommendation 1c:** Expand the availability of clinician specialists, including physicians, nurse practitioners (NPs), physician assistants (PAs), nurses, physical and occupational therapists, psychologists, and behavioral health specialists.
- **Recommendation 1d:** Encourage and incentivize the creation of multidisciplinary pain management teams and programs as centers of excellence, where patients with diverse and complex pain conditions as well as physical and psychological comorbidities can be managed effectively and investigated for optimal outcomes.

3.4.4 RESEARCH

Research is fundamental to advancing both the understanding and treatment of acute and chronic pain. The NIH Help to End Addiction Long-term (HEAL) initiative is a trans-NIH effort to improve prevention and treatment strategies for opioid misuse and addiction and to enhance pain management; resources include governance and guidance, and research and funding opportunities. NIH launched the Acute to Chronic Pain Signatures (A2CPS) program to investigate the biological characteristics underlying the transition from acute to chronic pain and to look at mechanisms that make some people susceptible and others resilient to the development of chronic pain. New knowledge development is needed in various areas of pain research, with emphasis placed on molecular and cellular mechanisms of pain, the genetics of pain, bio-behavioral pain, and preclinical models of pain.^{5,469} Supporting research initiatives throughout these fields across the basic science, translational, and clinical research arenas will aid in addressing current research gaps. This will lead to understanding the mechanisms of pain and SUD, translating promising advancements into effective therapies, and identifying best practices to implement in the management of acute and chronic pain. As novel and proven treatment options emerge to improve acute pain and specific chronic pain conditions, they should be rapidly incorporated.

GAPS AND RECOMMENDATIONS

Gap 1: Incentives for innovations in the treatment of chronic and acute pain are necessary for the advancement of treatment.

- **Recommendation 1a:** Support public private partnerships for improved funding to support and accelerate basic science, translational, and clinical research of pain and implementation research in health care systems. Allocate funding to develop innovative therapies and build research capabilities for better clinical outcomes tracking and evidence gathering.

Gap 2: Sex as a biological variable, as well as genetic, epigenetic and experiential factors in the progression of pain are not well understood.

- **Recommendation 2a:** Improve understanding of the specific interplay of sex as a biological variable, as well as genetic and experiential contributions to pain, including identification of biomarkers; factors that play a role in persistent pain and eventually chronic pain; the role of comorbid conditions; and predictive risk factors.

Gap 3: There is a lack of understanding of contributing factors that predispose certain patients to SUD and addiction.

- **Recommendation 3a:** Further evaluate the lifelong risk factors for the development of SUD rather than the isolated evaluation of prescription opioid use (e.g., adolescent substance use, early life trauma).
- **Recommendation 3b:** Conduct research to identify biomarkers, genetic predisposition, epigenetic mechanisms and other patient factors to assist in improved and accurate identification of those patients at risk for SUD.

Gap 4: There is a lack of research on and funding of potentially innovative modes of health care delivery and treatment.

- **Recommendation 4a:** Increase research into novel strategies that target the underlying mechanisms of chronic pain, including pharmacologic and biologic research and development, medical devices, medication delivery systems, neuromodulation, regenerative medicine, and complementary and integrative health approaches, including movement-based modalities.
- **Recommendation 4b:** Increase the level of research on accelerating the development and implementation of integrated pain care.

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4. REVIEW OF THE CDC GUIDELINE

In 2016, in response to growing concerns about overprescribing opioids for pain management and opioid-related overdose, CDC published a widely read guideline on opioid therapy for chronic pain.¹²⁶ Their recommendations focus on the use of opioids in treating chronic pain in patients 18 years or age or older. The *CDC Guideline for Prescribing Opioids for Chronic Pain* is not intended for patients who are in active cancer treatment, palliative care, or end-of-life care.

It is important to note that CDC reports that the recent acceleration in deaths due to opioid overdose is largely driven by illicit opioids as opposed to prescribed opioids.⁴⁷⁰ Illicit fentanyl has been found in a growing number of toxicology studies of overdose decedents. Furthermore, given the current state of the overdose crisis, further drastic reduction of clinician prescribing alone may not have a large effect on decreasing opioid overdose deaths in the short term.^{471,472}

The CDC guideline provides useful general guidance for prescribing opioids that is primarily intended for primary care providers. Various organizations, such as the American College of Physicians, supported the guideline when it was initially released, but clinicians, patients, professional organizations and other stakeholders have highlighted important limitations since publication of the guideline. A commentary by Busse et al.⁴⁷³ identified several limitations related to expert selection, evidence inclusion criteria, method of evidence quality grading, selective support of some recommendations with low-quality evidence, and instances of vague recommendations. CDC cited the lack of clinical trials with a duration of one year or longer as lack of evidence for sustained clinical effectiveness of opioids in chronic pain. The Task Force respectfully points out that there is little clinical trial evidence showing that opioids lack clinical efficacy for such patients. Furthermore, Tayeb et al.¹¹² found that lack of long term efficacy is true for all common medication and behavioral therapy studies. Long-term studies of therapies for chronic, moderate, or severe pain are difficult to conduct because of patient drop-out for ineffective treatment.⁴¹⁵ One long-term study from VA assessed patients on opioids versus non-opioid medications over a 12-month study evaluation period.¹¹¹ Both groups showed similar changes in pain severity and pain-related function over 12 months. The authors conclude that the results of this study do not support initiation of opioid therapy alone for moderate to severe chronic back pain or hip or knee osteoarthritis pain.¹¹¹ Noting that the CDC guideline focused primarily on patients initiating opioid treatment, Gordon and Connolly⁴⁷⁴ discussed application of the guideline to patients who are already receiving opioid maintenance therapy for chronic pain. Given that chronic pain is associated with many different underlying conditions, with great patient variability in analgesic drug metabolism, risk for abuse and underlying comorbid medical condition, further studies are needed to assess the value of long-term opioids alone and in combination with other therapies, coupled with risk assessment and periodic reevaluation (see Section 3.1 Risk Assessment).

The Task Force recognizes the utility of the 2016 CDC guideline for many aspects of pain management and its value in mitigating adverse outcomes of opioid exposure. Unfortunately, misinterpretation, in addition to gaps in the guideline, has led to unintended adverse consequences. Our report documented widespread misinterpretation of the CDC guideline, specifically the recommendation regarding the 90 mg morphine equivalent (MME) dose. In November 2018, the American Medical Association issued a statement advocating against the misapplication of the CDC guideline.⁴⁷⁵ Educating stakeholders about the intent and optimal application of this guideline and re-emphasis of its core beneficial aspects are essential. Instances have been reported where the CDC guideline was misapplied to the palliative care and cancer populations with pain and to providers who care for these populations of patients. It is important to recognize the need of an individualized approach to palliative care and cancer patients with pain, a population that typically requires higher doses of opioids for pain relief and function, often for long periods.^{304,353} The American Society of Clinical Oncology (ASCO), the American Society of Hematology (ASH) and the National Comprehensive Cancer Network (NCCN) recently received a key clarification letter from the CDC (February 2019) that the guideline was developed to provide recommendations for primary care clinicians who prescribe opioids for patients with chronic pain outside of active cancer treatment, palliative care and end-of-life care and the guideline is not intended to deny clinically-appropriate opioid therapy to any patients who suffer acute or chronic pain from conditions such as cancer and sickle cell disease.⁴⁷⁶

The 2016 CDC guideline, which provided a comprehensive synthesis of scientific evidence on opioid prescribing, was intended as a tool, primarily for PCPs to help inform their decisions about managing pain with opioids and to encourage dialogue and discussion of risks between providers and patients (shared decision making).¹ Although the CDC guideline was not intended to be model legislation, at least 28 states have gone beyond the guidelines and enacted legislation related to opioid prescription limits. As a result, such unintended consequences have led healthcare providers to limit or not provide pain treatment due in part to concerns and undue burdens of investigation and prosecution by drug enforcement.¹⁸ Furthermore, many states and organizations have implemented the guideline without recognizing that the intended audience was PCPs; have used legislation to override what should be medical decision making by healthcare professionals; and have applied them to all physicians, dentists, NPs, and PAs, including pain specialists.^{477–480} Some stakeholders have interpreted the guideline as intended to broadly reduce the amount of opioids prescribed for treating pain; some experts have noted that the guideline emphasizes the risk of opioids while minimizing the benefit of this medication class when properly managed.⁴⁸¹

A major problematic unintended consequence of the guideline is the forced tapering, medication discontinuation or abandonment that many patients with chronic pain on stable long-term doses of opioids have experienced.⁴⁸² The CDC recently authored a pivotal article in the *New England Journal of Medicine* (NEJM) on April 24, 2019, specifically re-iterating that the CDC Guideline has been, in some instances, misinterpreted or misapplied. The authors highlight that the guideline does not address or suggest discontinuation of opioids prescribed at higher dosages. They note “policies invoking the opioid-prescribing guideline that do not actually reflect its content and nuances can be used to justify actions contrary to the guideline’s intent”.¹ This conclusion is supported by the comments the Task Force has received indicating that many patients have experienced access issues related to provider fears and concerns with how the guideline would be interpreted and have caused some to consider obtaining opioids from illicit sources or suicide (see Section 3.2 Stigma). The FDA recently issued a safety announcement recognizing harm reported from sudden discontinuation of opioid pain medicines, including serious withdrawal symptoms, uncontrolled pain, psychological distress and suicide. They are requiring label changes to guide prescribers on gradual, individualized tapering.⁴⁸³ PCPs should be encouraged to refer to or seek input from pain specialists and (potentially) addiction specialists in complex or high-risk patient scenarios (see Section 2.5 Behavioral Health Approaches). In the expert opinion of the Task Force members, the CDC guideline does not sufficiently emphasize that optimal pain management begins with identification of the cause of the pain and the biopsychosocial mechanisms that contribute to its severity and associated disability (please also refer to other sections of this report for further discussion and information on various modalities for the treatment of pain, including Section 2.2 Medication, Section 2.3 Restorative Therapies, Section 2.4 Interventional Procedures, Section 2.5 Behavioral Health Approaches, and Section 2.6 Complementary and Integrative Health).⁴⁸⁴

The CDC guideline recommends that opioids prescribed for acute pain be limited to three or fewer days and that more than a seven-day supply is rarely necessary.¹²⁶ Various health insurance plans, retail pharmacies, and local and state governments are implementing the CDC guideline as policy, limiting the number of days a patient can receive prescription opioids even when the seriousness of the injury or surgery may require opioids for adequate pain management for a longer period. A more even-handed approach would balance addressing opioid overuse with the need to protect the patient-provider relationship by preserving access to medically necessary drug regimens, and reducing the potential for unintended consequences.⁴⁸⁵ The vast majority of medical organizations in response to the 90-day public comment period to the Task Force draft report supported this balanced approach. Policies should help ensure safe prescribing practices, minimize workflow disruption, and ensure that beneficiaries have access to their medications in a timely manner, without additional, cumbersome documentation requirements.⁴⁸⁵ In essence, clinicians should be able to use their clinical judgement to determine opioid duration for their patients while considering risk assessment recommendations as discussed in Section 3.1 Risk Assessment. Safe opioid stewardship involves a proper history and examination, periodic reevaluation and risk assessment, with a focus on measurable outcomes, including function, QOL and ADLs.

Recommendations noted in this section are organized into two groups:

- **Update:** Requires updated scientific evidence since the release of the CDC guideline in March 2016
- **Emphasize or Expand:** Refers to content already in the CDC guideline or areas to expand on

UPDATE

1: There is an absence of high-quality data on the duration of opioid effectiveness for chronic pain, which has been interpreted as a lack of benefit.

- **Recommendation 1a:** Support studies to determine the long-term efficacy of opioids in the treatment of chronic pain syndromes (primary and secondary) in different populations as determined by clinical context, clinical conditions, and comorbidities.
- **Recommendation 1b:** Conduct clinical trials on specific disease entities, with a focus on patient variability and response to tissue injury and on the effectiveness of opioid analgesics. Design trials to be applicable in real-world settings (e.g., patients receiving trialed opioid medications while maintaining the usual multimodal therapy).

2: There is an absence of criteria for identifying the sub-population of patients for whom opioids may contribute significantly to improve their pain management and therefore their QOL and functionality.

- **Recommendation 2:** Conduct clinical studies or complete systematic reviews to identify which chronic pain conditions and patient characteristics are appropriate for long-term opioid treatment in conjunction with the various non-opioid modalities.

EMPHASIZE OR EXPAND

3: There is wide variation in patient and disease factors that determine the dose of opioids that is optimal for pain relief and minimizes risk.

- **Recommendation 3a:** Consider patient variables that may affect opioid dose in patients prior to initiation of opioid therapy, including respiratory compromise, individual patient metabolic variables, or differences between opioid medications that could affect plasma opioid concentrations.
- **Recommendation 3b:** Perform comprehensive initial assessments for patient management, with an understanding of the need for periodic comprehensive reevaluation to adjust the medication dose.
- **Recommendation 3c:** Careful consideration should be given to patients on an opioid pain regimen who have additional risk factors for OUD (see Section 31. Risk Assessment)
- **Recommendation 3d:** The CDC guideline, meant for primary care clinicians, should explicitly re-emphasize that the 90 MME/day maximum dose recommendation is not mandatory but is a target that may be exceeded if clinically appropriate when benefits outweigh risks

4: Specific guidelines addressing opioid tapering and escalation need further elucidation

- **Recommendation 4a:** Undertake opioid tapering or escalation only after a thorough assessment of the risk-benefit ratio. This should be done in collaboration with the patient.
- **Recommendation 4b:** Develop guidelines for tapering and dose escalation for the sub-populations of patients who have chronic pain conditions that includes consideration of their comorbidities.
- **Recommendation 4c:** Consider maintaining therapy for patients who are stable on long-term opioid therapy and for whom the benefits outweigh the risks.

5: There are multiple potential causes of worsening pain that are often not recognized or considered. Non-tolerance-related factors include iatrogenic causes such as surgery, flares of the underlying disease or injury, and increased ergonomic demands or emotional distress.

- **Recommendation 5a:** When a stable dose has been established for at least two months, avoid increases in the dose until the patient is reevaluated for the underlying causes of elevated pain or possible OUD risk.
- **Recommendation 5b:** Considerations to avoid dose escalation should include opioid rotation, non-opioid medications, interventional strategies, cognitive behavioral strategies, complementary and integrative health approaches, and PT.

6: Although the risk of overdose by benzodiazepine co-prescription with opioids is well established, this combination may still have clinical value in patients who have chronic pain and comorbid anxiety, which commonly accompanies pain, and in patients who have chronic pain and spasticity. However initiating regular long-term use of benzodiazepines with opioids should be done with caution, since SSRIs, SNRIs and psychotherapies are preferred treatments for anxiety disorders (see Section 2.2 Medication for further discussion about anxiolytics, as well as treatment of anxiety and chronic pain).

- **Recommendation 6a:** If clinically indicated, co-prescription should be managed and coordinated by physicians, providers, and clinician specialists who have knowledge, training, and experience in co-prescribing benzodiazepines with opioids. For those patients who have anxiety disorders or SUD who have been prescribed benzodiazepines, collaboration with experts in mental health and the use of psychological modalities should be considered.
- **Recommendation 6b:** Develop CPGs that focus on tapering for co-prescription of benzodiazepines and opioids.

7: The variability in effectiveness and safety (respiratory depression and abuse liability) at any given dose of an opioid is not clearly defined and may vary between different opioids and different patients. Consequently, the risk-benefit balance for opioid management of pain may vary for individual patients. Similarly, the balance of benefit and risk for doses above 90 Morphine Milligram Equivalents (MME)/day may be acceptable in some patients. Failure to closely monitor patients when opioid dose is adjusted puts them at risk for either inadequate pain control or overdose toxicity.

- **Recommendation 7a:** Use the lowest effective opioid dose and shortest duration appropriate for the pain condition that balances benefits, risks, and adverse reactions. Clinicians should individualize dose based on a carefully monitored medication trial. With each dose adjustment patients should be assessed at expected peak drug concentration for analgesic effectiveness and adverse effects, such as respiratory compromise and sedation.
- **Recommendation 7b:** Additional factors influence risk and benefit that should be considered; therefore, guidance regarding dose should not be applied as strict limits. Providers should use established and measurable goals such as functionality, ADL, and QOL measures.

8: The duration of pain following an acute, severely painful event such as trauma, surgery, or burn is widely variable.

- **Recommendation 8a:** Appropriate duration of therapy is best considered within guidelines, and then ultimately determined by the treating clinician. The CDC recommendation for duration of treatment should be emphasized as guidance only for a general approach, with individualized patient care as the primary goal and the clinician then considering all modalities for best outcomes.
- **Recommendation 8b:** Develop and/or update acute pain management guidelines for common surgical procedures and trauma management, as noted in Section 2.1.1 Acute and Chronic Pain, Recommendation 2a.
- **Recommendation 8c:** To address this variability and provide an easy solution to the challenges of medication duration, consideration should be given to a partial refill system.

FEDERAL RESOURCES CENTER

FOR PATIENTS AND FAMILIES

Pain Management Fact Sheet

Information about past, present, and future of pain management.

[https://report.nih.gov/NIHfactsheets/Pdfs/PainManagement\(NINR\).pdf](https://report.nih.gov/NIHfactsheets/Pdfs/PainManagement(NINR).pdf)

VHA Pain Management Website

Information for Veterans and the public, including an online course.

https://www.va.gov/PAINMANAGEMENT/Veteran_Public/index.asp

Behavioral Health Treatment Services Locator

A confidential and anonymous source of information for those seeking treatment facilities in the United States or U.S. territories for substance abuse/addiction or mental health conditions.

<https://findtreatment.samhsa.gov/>

Medicare Coverage

Medicare offers medically necessary benefits, including transitional care management, chronic care management and complex chronic care management, behavioral health integration and collaborative care management, physical and occupational therapy, in- and outpatient pain rehabilitation, and electrical nerve stimulation. Local coverage may include additional options.

<https://www.medicare.gov/what-medicare-covers>

CDC Information for Patients

Resources for patients, including responses to frequently asked questions about opioids for chronic pain and other helpful materials.

<https://www.cdc.gov/drugoverdose/patients/index.html>

Tribal Consultation Services

The Health Resources & Services Administration's (HRSA's) Office of Regional Operations regularly attends, presents, and provides consultation as needed or requested to help tribes and nations use HRSA programs to address SUD/OD in their communities.

<https://www.hrsa.gov/about/organization/bureaus/ohe/populations/aian.html>

VA/DoD Clinical Practice Guideline for Opioid Therapy for Chronic Pain

This CPG's patient summary provides an overview of chronic pain, treatment, and questions patients may have about opioid medications.

<https://www.healthquality.va.gov/guidelines/Pain/cot/VADoDOTCPGPatientSummary022717.pdf>

ClinicalTrials.gov

This site is a database of privately and publicly funded clinical studies conducted around the world.

<https://clinicaltrials.gov/>

What to Ask Your Doctor Before Taking Opioids

The FDA provides this list of questions patients can ask their HCP before getting a prescription for an opioid medication.

<https://www.fda.gov/ForConsumers/ConsumerUpdates/ucm529517.htm>

Prescription Opioids What You Need to Know

This CDC factsheet describes the risks and side effects associated with opioid use.

<https://www.cdc.gov/drugoverdose/pdf/aha-patient-opioid-factsheet-a.pdf>

Safe and Responsible Use of Opioids for Chronic Pain: A Patient Information Guide

This VA-issued patient guide provides information about opioid safety and alternatives to opioid therapy.

https://www.va.gov/PAINMANAGEMENT/Opioid_Safety/OSI_docs/10-791-Safe_and_Responsible_Use_508.pdf

DEA National Prescription Drug Take Back Day

DEA's biannual event at multiple national locations provides a safe, convenient, and anonymous means of disposing of prescription drugs. Federal Drug Take Back Day is held at federal buildings typically on Wednesdays prior to public Drug Take Back Day events.

<https://takebackday.dea.gov/>

National Prescription Drug Take Back Day

Google-based resource include take-back facility locator, fact sheets, and frequently asked questions.

<https://get.google.com/rxtakeback/>

Opioid Treatment Program Directory

SAMHSA's online directory of opioid treatment programs is cataloged by state.

<https://dpt2.samhsa.gov/treatment/directory.aspx>

Buprenorphine Practitioner Locator

SAMHSA maintains an online list of practitioners authorized to treat opioid dependency with buprenorphine, cataloged by state.

<https://www.samhsa.gov/medication-assisted-treatment/practitioner-program-data/treatment-practitioner-locator>

National Suicide Prevention Lifeline

This site provides 24/7, free, confidential support for people in distress as well as prevention and crisis resources.

<https://suicidepreventionlifeline.org/>

Poison Help

Nationwide poison centers provide educational services to prevent poisonings as well as help during poison emergencies to people who need it.

<https://poisonhelp.hrsa.gov/>

Poison Help telephone number: 1-800-222-1222

Disposal of Unused Medicines: What You Should Know

The FDA maintains a list of medicines that can be disposed of by flushing when take-back options are not readily available.

<https://www.fda.gov/drugs/resourcesforyou/consumers/buyingusingmedicinesafely/ensuringsafeuseofmedicine/safedisposalofmedicines/ucm186187.htm>

Help, Resources and Information: National Opioids Crisis

HHS maintains an online catalog of resources categorized by prevention, treatment, recovery, and general information about the opioid crisis.

<https://www.hhs.gov/opioids/>

National Helpline: 1-800-662-4357

Opioid Overdose Prevention Toolkit

SAMHSA's "Opioid Overdose Prevention Toolkit" provides strategies to help prevent opioid-related overdoses and deaths.

<https://store.samhsa.gov/product/Opioid-Overdose-Prevention-Toolkit/SMA18-4742>

National Capital Region Pain Initiative

The National Capital Region Pain Initiative improves access to care for Tricare beneficiaries with pain, TBI, and PTSD across the National Capital Region. A key component is education; including staff, providers, patients, and families. These enhancements to our existing pain programs ensure a coordinated effort across the National Capital Region

<https://www.capmed.mil/CapMedServices/NCRPI/SitePages/Home.aspx>

Nursing Home Compare

CMS monitors the quality of care in the nation's long-term care facilities (nursing homes), requiring that residents receive necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, including recognition and management of pain.

<https://www.medicare.gov/nursinghomecompare/search.html>

FOR PROVIDERS**Implementation Guide. Factors to Consider in Managing Chronic Pain: A Pain Management Summary**

This resource for integrating with an EHR system helps HCPs see all EHR data before making decisions about pain management in one screen to support individualized treatment.

<https://cds.ahrq.gov/sites/default/files/cds/artifact/476/ImplementationGuidePainManagementSummary50810012018.pdf>

CDC Interactive Training Series

These online training modules help HCPs apply CDC's recommendations in the clinical setting through patient scenarios, videos, knowledge checks, tips, and resources.

<https://www.cdc.gov/drugoverdose/training/online-training.html>.

Six Building Blocks

This Web-based training guide for clinicians, healthcare staff, quality improvement personnel, practice coaches, and clinic administrators focuses on improving patient care through chronic opioid therapy.

<https://www.ahrq.gov/professionals/prevention-chronic-care/improve/six-building-blocks.html>

Management of Suspected Opioid Overdose with Naloxone by Emergency Medical Services Personnel

This systematic review supports the development of an evidence-based guideline for naloxone use.

<https://effectivehealthcare.ahrq.gov/topics/emt-naloxon/systematic-review>

Technology Transfer Centers Program

SAMHSA's organization of technology transfer centers (TTCs) focuses on helping HCPs and organizations incorporate effective practices into SUD treatment, mental health treatment, and recovery services. The TTC program includes Addiction TTCs, Mental Health TTCs, and Prevention TTCs.

<https://www.samhsa.gov/technology-transfer-centers-ttc>

Evidence-Based Practices Resource Center

This collection of EBP resources includes Treatment Improvement Protocols, toolkits, resource guides, CPGs, and other science-based resources focused on improving prevention, treatment, and recovery support services for mental health conditions and SUD.

<https://www.samhsa.gov/ebp-resource-center>

Providers Clinical Support System

SAMHSA created this online curriculum to train HCPs on evidence-based approaches to opioid abuse and other SUDs in screening, assessment, treatment recovery services, and related public health issues.

<https://pcssnow.org/>

Opioid Analgesic Risk Evaluation and Mitigation Strategy

Education blueprint for health care providers involved in the treatment and monitoring of patients with pain.

https://www.accessdata.fda.gov/drugsatfda_docs/remis/Opioid_analgesic_2018_09_18_FDA_Blueprint.pdf

HRSA Bureau of Health Workforce Website

HRSA's Bureau of Health Workforce supports pain management training for postdoctoral students, nurse anesthetist trainees, and medical residents.

<https://www.hrsa.gov/about/organization/bureaus/bhw/index.html>

SAMSHA SAFE-T Risk Card

The downloadable Suicide Assessment Five-step Evaluation and Triage for Mental Health Professionals (SAFE-T) card describes a five-step evaluation and triage process for suicide assessment.

https://www.integration.samhsa.gov/images/res/SAFE_T.pdf

VA/DoD Clinical Practice Guideline Suicide Prevention Pocket Guide

This pocket guide provides a summary of clinical practice algorithms and tables from the VA/DoD Clinical Practice Assessment and Management of Patients at Risk for Suicide.

<https://www.healthquality.va.gov/guidelines/MH/srb/VASuicidePreventionPocketGuidePRINT508FINAL.pdf>

VA/DoD Clinical Practice Guidelines: Management of Opioid Therapy for Chronic Pain

This VA/DoD CPG providing evidence-based recommendations for the management of opioid therapy for chronic pain conditions.

<https://www.healthquality.va.gov/guidelines/Pain/cot/>

National Institute on Drug Abuse: Medications to Treat Opioid Use Disorder

This report provides research-informed responses to questions concerning the treatment of OUD.

<https://www.drugabuse.gov/publications/research-reports/medications-to-treat-opioid-addiction/overview>

HRSA Opioid Crisis Webpage

This resource page provides information about technical assistance and training for the prevention and treatment of OUD.

<https://www.hrsa.gov/opioids>

CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016

CDC provides comprehensive recommendations for PCPs prescribing opioids for chronic pain.

<https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm>

Additional HHS Resources

CDC provides a list of HHS resources, with links to HHS reports and tools.

<https://www.cdc.gov/drugoverdose/resources/hhs.html>

SAMHSA Treatment Improvement Protocol 63: Medications for Opioid Use Disorder

This site discusses the use of methadone, naltrexone, and buprenorphine to treat OUD as well as other strategies and services necessary to support recovery for individuals with OUD.

<https://store.samhsa.gov/product/TIP-63-Medications-for-Opioid-Use-Disorder-Full-Document-Including-Executive-Summary-and-Parts-1-5-/SMA18-5063FULLDOC>

MATx Mobile App to Support Medication-Assisted Treatment of Opioid Use Disorder

SAMHSA's mobile app supports clinicians who provide medication-assisted treatment for OUD.

<https://store.samhsa.gov/apps/mat>

Integration of Buprenorphine into HIV Primary Care Settings

Training and implementation tools assist in the treatment of SUD in primary care settings.

<https://targethiv.org/ihip/buprenorphine>

CMS Roadmap: Fighting the Opioid Crisis

This road map describes the key areas of focus and the way forward for addressing the opioid crisis.

<https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Opioid-epidemic-roadmap.pdf>

CMS Regional Offices

CMS' regional offices play a leading role in HCP education, including through the chief medical officer's staff.

<https://www.cms.gov/about-cms/agency-information/regionaloffices/index.html>

FOR RESEARCHERS***NIH Helping to End Addiction Long-term (HEAL) Initiative***

Part of a trans-NIH effort to improve prevention and treatment strategies for opioid misuse and addiction and to enhance pain management, this site's resources include governance and guidance as well as funding opportunities.

<https://www.nih.gov/research-training/medical-research-initiatives/heal-initiative>

HHS 5-Point Strategy to Combat the Opioid Crisis

This site outlines HHS' comprehensive five-point strategy to address the national opioid crisis.

<https://www.hhs.gov/opioids/about-the-epidemic/hhs-response/index.html>

CMS Opioid Prescribing Mapping Tool

This interactive mapping tool shows geographic comparisons of deidentified prescriptions filled in the United States.

<https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Provider-Charge-Data/OpioidMap.html>

HEAL Partnership Committee

This committee subgroup of the HEAL Multi-Disciplinary Working Group formed to help guide HEAL program efforts to address pain and addiction.

<http://www.nih.gov/heal-initiative/heal-partnership-committee>

ACRONYMS

ACT	Acceptance and Commitment Therapy
ADF	Abuse-Deterrent Formulation
ADL	Activities of Daily Living
AHRQ	Agency for Healthcare Research and Quality
BT	Behavioral Therapy
CARA	Comprehensive Addiction and Recovery Act
CBP	Clinical Best Practice
CBT	Cognitive Behavioral Therapy
CDC	Centers for Disease Control and Prevention
CME	Continuing Medical Education
CMS	Centers for Medicare & Medicaid Services
COX	Cyclooxygenase
CPG	Clinical Practice Guideline
CPT	Current Procedural Terminology
CRPS	Complex Regional Pain Syndrome
DEA	U.S Drug Enforcement Administration
DoD	U.S. Department of Defense
EAET	Emotional Awareness and Expression Therapy
EBP	Evidence-Based Practice
ECHO	Extension for Community Healthcare Outcomes
ED	Emergency Department
EHR	Electronic Health Record
ERAS	Enhanced Recovery After Surgery
ESI	Epidural Steroid Injection
FDA	U.S. Food and Drug Administration
GI	Gastrointestinal
HEAL	Helping to End Addiction Long-term
HHS	U.S. Department of Health & Human Services
HRSA	Health Resources & Services Administration
IHS	Indian Health Service
IOM	Institute of Medicine
MBSR	Mindfulness-based Stress Reduction
MHS	Military Health System
MME	Morphine Milligram Equivalent
MS	Multiple Sclerosis
NCD	National Coverage Determination
NIH	National Institutes of Health
NP	Nurse Practitioner
NSAID	Nonsteroidal Anti-inflammatory Drug
NVDRS	National Violent Death Reporting System
OB-GYN	Obstetrician and Gynecologist
ONDCP	Office of National Drug Control Policy
OT	Occupational Therapy

OUD	Opioid Use Disorder
PA	Physician Assistant
PBM	Pharmacy Benefit Manager
PCP	Primary Care Physician
PDMP	Prescription Drug Monitoring Program
PNB	Peripheral Nerve Block
PRF	Pulse Radio-Frequency Lesioning
PSH	Perioperative Surgical Home
PT	Physical Therapy
PTSD	Post-traumatic Stress Disorder
QOL	Quality of Life
RCT	Randomized Controlled Trial
RF	Radio Frequency
SAMHSA	Substance Abuse and Mental Health Services Administration
SCD	Sickle Cell Disease
SNB	Sympathetic Nerve Block
SNRI	Serotonin-Norepinephrine Reuptake Inhibitor
SSRI	Selective Serotonin Reuptake Inhibitor
SUD	Substance Use Disorder
TBI	Traumatic Brain Injury
TCA	Tricyclic Antidepressant
TENS	Transcutaneous Electrical Nerve Stimulation
TTC	Technology Transfer Center
TU	Therapeutic Ultrasound
UDT	Urine Drug Test
VA	U.S. Department of Veterans Affairs
VHA	Veterans Health Administration

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