Summary:
Dr. Vanila Singh explains the work of the Pain Management Best Practices Inter-Agency Task Force.

On May 30, the Pain Management Best Practices Inter-Agency Task Force released its final recommendations, which emphasize the importance of providing balanced, individualized, patient-centered pain management to ensure better clinical outcomes for pain that improve quality of life and functionality for patients. The group recommended a broad framework of approaches for treating acute and chronic pain. Following is an interview with Dr. Vanila Singh on the Task Force's work.

Q: Dr. Singh, the Pain Management Best Practices Inter-Agency Task Force, a federal advisory committee that you chaired, just voted on final recommendations for pain management best practices. What was the Task Force's charge?
A: We were charged by section 101 of the Comprehensive Addiction and Recovery Act of 2016 (CARA) - PDF to propose updates to best practices and issue recommendations that address gaps or inconsistencies for managing chronic and acute pain.

Q: What were some of your key recommendations?
A: We recommended the importance of diagnosis, key patient-clinician therapeutic alliance, a multimodal approach for patients who experience acute injury and perioperative pain, as well as a multidisciplinary approach, when clinically indicated, for patients with chronic painful conditions to improve clinical outcomes while ensuring safer patient care. . The Task Force report emphasizes safe opioid stewardship through risk assessment tools, education, addressing stigma and improving access to care. It also highlights various treatment modalities for pain management: medications (non-opioid as well as opioid,)interventional approaches, restorative therapies, behavioral health interventions and complementary and integrative health approaches.

In addition, the Task Force report emphasizes telemedicine/telehealth, innovative research to improve pain treatment options, and using existing resources to mitigate unnecessary opioid exposure such as National Prescription Drug Take Back Days and the American Association of Poison Control Centers..

Q: What kinds of gaps did the Task Force identify?
A: We identified a number of gaps and inconsistencies that need to be addressed in order to improve pain management. We highlight the need for access to various treatment modalities and for multidisciplinary approaches for pain care that focuses on the patient's medical condition, co-morbidities and other various aspects of care. The treatment modalities include: medications, restorative movement therapies, interventional procedures, complementary and integrative health services, and behavioral health approaches. The Task Force highlights the workforce shortage gap for pain specialists as well as behavioral specialists. The Task Force highlights the need for pre-operative consultation and reimbursement for a comprehensive plan for the perioperative period so that multimodal approaches can be included so that each individual patient can get the care that is most appropriate and allows for the best possible health outcomes.

In our recommendations, the Task Force underscores the need to address stigma, risk assessment, access to care and education for all stakeholders. Addressing these needs and gaps will help clinicians manage acute and chronic pain in an individualized patient-centered way. The Task Force also identified special populations and certain population-specific circumstances that need to be considered during diagnosis and the development of treatment options.

Q: What is needed to deliver patient-centered care?

A: A very important principle of the Task Force final report is individualized patient-centered care when diagnosing and treating acute and chronic pain. Each person has their own set of medical, genetic, environmental, and sociocultural factors that affect their medical conditions and lives. A biopsychosocial approach is absolutely needed to address the unique challenges for each individual and to achieve the best possible clinical outcomes. Clinicians treating patients with painful conditions on the frontlines need the time and resources to perform a thorough history, physical exam, and **risk assessment** when determining a diagnosis and a treatment plan, especially when considering medications such as opioids. Taking the time for each of these steps is essential for clinicians to form a therapeutic alliance with their patients because the goal of treatment is to improve clinical outcomes. Chronic pain is a general term for dozens and dozens of various underlying painful conditions. Such conditions include common pain issues related to back and neck pain or more rare painful conditions such as lupus, multiple sclerosis, phantom limb pain and others. Many different possible medical conditions contribute to significant challenges in obtaining adequate care for chronic pain, resulting in profound physical, emotional, and societal costs. In the end, there is no one size that fits all.

Q: Which patient safety measures are covered in the report?

A: Our report emphasizes **safe opioid stewardship**, through important risk assessment with a clear discussion of risks and benefits between patients and their clinicians and consideration of non-opioid alternatives, screening tools, including prescription drug monitoring program (PDMP) checks and labs, and **clear measureable goals that include improved functionality, quality of life, and activities of daily livin**g. The report emphasizes that when opioids are clinically indicated and prescribed as part of a treatment plan, the shortest duration of the lowest effective dose is prescribed along with periodic reassessment. The Task Force report notes that opioid management should be viewed as complex management in medical care and should be provided time and resources through appropriate payment and reimbursement for clinicians to ensure they are able to provide the safest and most effective care.

Q: What barriers to adequate pain care are addressed by the Task Force?

Several factors act as barriers to adequate pain care, including stigmatization of patients with pain, insufficient insurance coverage for pain management services, complex opioid management, workforce shortages of medical and behavioral pain management specialists, provider disincentives to treat pain, clinicians' underestimation of patients' reports of pain, medication and biological product shortages, and **the need for more research on innovative** and effective pain management approaches. Pain and substance use disorder 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 substance use disorders.

The Task Force recommends more effective **education** about acute and chronic pain at all levels of clinician training with the use of proven innovations, such as the Extension for Community Healthcare Outcomes (**Project ECHO)** telehealth model. Research is also fundamental to advancing both the understanding and treatment of acute and chronic pain. New knowledge development is needed in various areas of pain research, including molecular and cellular mechanisms of pain, the genetics of pain, bio-behavioral pain, and preclinical models of pain. Supporting research initiatives, such as the NIH Acute to Chronic Pain Signatures program, will aid in addressing current research gaps. As novel and proven treatment options emerge to improve acute pain and specific chronic pain conditions, they should be rapidly incorporated.

Q: Which special populations are highlighted by the Task Force report?

A: 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 the following:

- Active duty service members and Veterans,
- Pediatric/youth,
- Older adults,
- Women,
- Pregnant women,
- Sickle cell disease,
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- Chronic relapsing pain conditions
- ,Alaska Natives, American Indians, African-Americans, and Hispanic/Latino Americans
- Cancer and those in palliative/hospice care

The special populations section in this report was included to highlight special considerations for pain management. The populations highlighted in the report are not 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.

Q: What did the Task Force say about the CDC Guideline for Prescribing Opioids for Chronic Pain?
A: The Task Force emphasizes individualized patient-centered care when considering pain care. The Task Force recognizes that, in some cases, the CDC Guideline has been misinterpreted and misapplied. Unfortunately, unintended consequences such as forced tapering and patient abandonment contribute to adverse patient outcomes and provider disincentives in treating patients with complex acute and chronic pain.

These findings are consistent with the FDA safety announcement in April 2019 on opioid tapering and the patient harm due to forced tapering. Also in April 2019, CDC Guideline authors published a perspective piece in the New England Journal of Medicine, indicating that some policies and practices that cite the Guideline are not consistent with its recommendations, or go beyond its recommendations, potentially putting patients at risk. Issues include application of the Guideline to populations beyond the Guideline's intended audience, abrupt tapering or sudden discontinuation of opioids, and misapplication of the dosage recommendation to medication-assisted treatment (MAT) for opioid use disorder. I encourage everyone to read this article.

Q: How does the Task Force address the opioid crisis?
A: The Task Force was created in the midst of a national opioid epidemic, but also at a time when an estimated 50 million adults in the U.S. experience chronic daily pain. It is important to strike a balance between mitigating opioid exposure while ensuring that adequate pain treatments are available for patients to have the best quality of life possible.

Q: Is there a place for opioids in pain treatment?
A: Opioids are an important and necessary component in treating certain pain conditions in certain patients. The decision to prescribe an opioid depends on the patient's condition and the provider's ability to do a proper risk assessment with periodic re-evaluation and thoughtful consideration of the risks associated with opioids. It is important to ensure that the patient is educated on risks and alternatives. The patient's history and medical condition are critical components of this assessment.

The Task Force does not recommend the indiscriminate removal or forced tapering of opioids as a treatment option. We acknowledge that opioids have the potential to lead to physical dependence and possible opioid use disorder, particularly in certain at-risk populations. Risk assessment and periodic re-evaluation and monitoring is required and should be a part of the treatment plan.

The Task Force acknowledges that there is a certain subpopulation of patients whose health outcomes do not improve with non-opioid treatments. Initiation of opioid therapy, when the benefits are deemed by the patient and the clinician to outweigh the risks, should be administered for the shortest duration and at the lowest dose of medication required to optimally control the pain and/or improve function and quality of life. We addressed this at length in our recommendations.

Q: How did you decide which types of members to put on the Task Force?
A: The law that created the Task Force specified the membership composition of the Task Force as well as the expertise that members needed to possess. I urge anyone who is interested in this to read section 101(c) of CARA - PDF, which pertains to membership.

The Task Force has 29 members, representing federal and non-federal entities with diverse disciplines and views. Members have significant public- and private-sector experience across the disciplines of pain management, patient advocacy, substance use disorders, mental health, veteran health and minority health, as well as other areas of expertise.

Q: Do you expect organized medicine and the federal government to adopt all of the Task Force's recommendations?
A: We are a federal advisory committee, which means our job is to offer advice – in this case, to the Secretary of Health and Human Services, relevant federal agencies, and, ultimately, the American public. We have no rulemaking authority. It was our job to study the situation and to propose updates to best practices and issue recommendations that address gaps or inconsistencies for managing chronic and acute pain.

Q: Dr. Singh, what was your experience like, serving as chair of this task force?
A: It was the honor of a lifetime. I have devoted my career to caring for patients with complex pain issues. Before I agreed to serve as Chief Medical Officer for the Office of the Assistant Secretary of Health, I spent 13 years as a clinical associate professor of anesthesiology, perioperative and pain medicine at Stanford University School of Medicine. I'm board-certified in both anesthesia and pain medicine. So this issue goes to the heart and soul of who I am as a physician and as a person. I have always been committed to the notion of individualized, patient-centered care. And I believe our final report and recommendations value and highlight this important vital principle.