Federal Pain Research Strategy

Planning Committee Proposal
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Planning Committee

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- Chris Veasley, IPRCC
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- Audrey Kusiak VA, IPRCC
- John Kusiak, NIDCR, NIH, IPRCC (Dr. Somerman)
- Chad Helmick, CDC, IPRCC
- Sharon Hertz, FDA, IPRCC
- Rick Ricciardi, AHRQ, IPRCC
- Linda Porter, OPP/ NINDS
- Wen Chen, NCCIH, NIH
- Partap Khalsa, NCCIH, NIH
- Sue Marden, NINR, NIH
- Ann O’Mara, NCI, NIH
- Wendy Smith, OD, NIH
- David Thomas, NIDA, NIH
Proposed Operational Structure

Chair

IPRCC

Co-Chairs

Steering committee

NINDS/OPP

Resources
Logistics
Technical support

Inform

Co-Chairs

Charge
Inform
Advise
Integrate
Monitor
Prioritization

Co-Chairs

Work Groups

Inform

Charge
Review
Input
Feedback
Approve

Inform
Planning Committee propose framework Propose work group themes

IPRCC Review Approve framework Nominations for steering committee IPRCC et al Review RFI

Establish Steering Committee IPRCC charge to steering committee Refine and post RFI

Steering Committee Work group co-chair selection & member nomination

WG Co-chairs select members Steering committee charge to WGs

Work Groups meet WGs refine themes and cross cutting priorities preparations and deliberations to address the charge

Work groups submit priorities

Steering Committee/WGs Face to Face meeting Prioritize recommendations

IPRCC Approval

Agency Clearance

Plan rollout

Jan – Mar 2015

April 2015

May 2015

June – July 2015

Aug. 2015-Jan 2016

March. 2016

May 2016
Proposed Organizational Structure

IPRCC

Steering Committee

Thematic Work Groups
Proposed Responsibilities

- Reviews and approves the organizational and operational structure for the strategy
- Provides input for an RFI to inform the work groups
- Sets charge to the steering committee
- Provides feedback throughout the process through the steering committee
- Final approval of the strategy
Proposed Organizational Structure

Steering Committee

- Co-chairs: 1 federal, 1 non-federal IPRCC scientist
- 8-12 members: most external
- Broad, balanced range of expertise
- Patient advocate, ethics, science: basic, translational, clinical, population, dissemination, implementation, non-pain
Proposed Responsibilities

Steering Committee

• Revises and completes the RFI
• Selects work group co-chairs
• Sets charge to the work groups with RFI feedback considered
• Co-chairs serves as liaison to the IPRCC and work groups
• Monitors work group progress through the work group co-chairs
• Coordinates and integrates work group discussions
• Oversees the prioritization of recommendations across the work groups (Delphi method*)
Currently there are nine themes around which the federal portfolio analysis is organized.

Themes are not sufficiently cross-cutting to develop a comprehensive and effective research strategy.

The Autism Interagency and Muscular Dystrophy Coordinating Committee themes are not good models as they address needs of a single condition.

Pain research must address its multidisciplinary nature and the continuum of pain from prevention to chronicity.
Thematic Work Groups
(Overarching principle)

A CONTINUUM OF PAIN (NPS)

- Pain is a temporal process
- Pain begins with an acute stage
- Acute pain may progress to a chronic state
- Mechanisms activated in acute pain setting influence chronic pain development
- Chronic pain has a variable onset and duration and may occur post injury or surgery
- Individual variation influences chronic pain susceptibility
Thematic Work Groups

PREVENTION
OF ACUTE &
CHRONIC PAIN

ACUTE PAIN &
ACUTE PAIN
MANAGEMENT

TRANSITION
FROM ACUTE TO
CHRONIC PAIN

CHRONIC PAIN
& CHRONIC PAIN
MANAGEMENT

DISPARITIES

QUESTIONS

WHAT HAPPENS AND
TO WHOM?

WHY AND HOW DOES
IT HAPPEN?

HOW TO MANAGE?

BASIC
SCIENCE

CLINICAL
SCIENCE

UNDERSTAND
MECHANISMS

TRANSLATE
MECHANISMS/
TREAT
How did we get to these themes?
Primary pain prevention
-- Focuses on efforts to reduce injuries or disease that may result in pain

Secondary pain prevention
-- Focuses on reducing the likelihood that acute pain transitions into chronic pain.

Tertiary pain prevention
-- Attempts to limit the development of disabilities and other complications of chronic pain.
Basis of Theme 2 (NPS)

◆ Acute Pain
  -- is time limited
  -- is an expected physiologic consequence of trauma, disease, surgery or illness
  -- may progress to a chronic pathological state

◆ Acute Pain
  -- may be treated through self-management, pharmacological or nonpharmacological approaches
**THEME 3: TRANSITION FROM ACUTE TO CHRONIC PAIN**

Basis of Theme 3 (NPS)

◆ **Contributors to the transition**
  -- nature of the initial insult
  -- mechanisms activated in the acute pain setting
  -- patient-related risk factors

◆ **Chronic Pain**
  -- may start early after injury or surgery
  -- mechanisms that underlie the transition are complex and unclear
Basis of Theme 4 (NPS)

**Chronic Pain**

-- a complex biopsychosocial condition with distinct pathology -- has biological, psychological, and cognitive correlates

-- may interfere with many aspects of a person’s life
  -- (high impact chronic pain)

-- may require a biopsychosocial approach to multidisciplinary, multimodal and integrated care
**Thematic Work Groups**

**Basis of Theme 5 (NPS)**

- Health disparities affect vulnerable populations:
  -- in occurrence of care
  -- in assessment of pain
  -- in access and quality of care
  -- in outcomes of care

- Increased risk for disparities are associated with:
  -- race or ethnicity, religion, sex, gender, age, mental health, cognitive factors, mental health
  -- other factors linked to discrimination or exclusion
Proposed Organizational Structure

Cross-Cutting Issues
Cross-Cutting Issues

PREVENTION OF ACUTE & CHRONIC PAIN MANAGEMENT

ACUTE PAIN & ACUTE PAIN MANAGEMENT

TRANSITION FROM ACUTE TO CHRONIC PAIN MANAGEMENT

CHRONIC PAIN & CHRONIC PAIN MANAGEMENT

DISPARITIES

What happens and to whom?

Epidemiology (prevalence, onset, course, impact, cost, access, categorization by condition, etc.)

Diagnosis & Assessment (patient-centered assessment, phenotyping, genotyping)

Why and how does it happen?

Susceptibility & Resilience (underlying environmental & biopsychosocial mechanisms)

Mechanisms (disease mechanisms, treatment response)

How is it managed?

Lifespan (disease progression, age relevance, palliative care, unique populations)

Treatment (biopsychosocial approach – pharmacological, non-pharmacological, self-management)

Dissemination & Implementation (individualized, patient-centered, integrated treatment)

Tools/Infrastructure for Basic & Clinical Research

Translation (bench-to-bedside & reverse)
Primary prevention focuses on reducing injuries or diseases that might result in pain. Secondary prevention focuses on reducing the likelihood that acute pain transitions into chronic pain. Tertiary prevention interventions attempt to limit the development of disabilities and other complications of chronic pain. (NPS)
Acute pain is a time limited and expected physiologic effect of trauma, disease, surgery or illness that may progress to a chronic pathological state. It may be treated through self-management, pharmacological or non-pharmacological approaches. (NPS)

* Suggested after planning committee met
Acute pain may progress into a persistent painful condition with the nature of the initial insult and various patient-related risk factors as contributing factors. Chronic pain may start early after injury, surgery, or other precipitating factors through mechanisms activated in the acute setting. The cause of this transition is often unclear and the mechanisms by which it occurs are complex. (NPS)
Chronic pain is a complex biopsychosocial condition that has a distinct pathology with biological, psychological, and cognitive correlates, that may interfere with many aspects of a person’s life (high impact chronic pain). Chronic pain may require a biopsychosocial approach to multidisciplinary, multimodal and integrated care. (NPS)
Health disparities in pain occurrence, assessment, access, quality, and outcomes of care adversely affect vulnerable populations. Increased risk for disparities is associated with race or ethnicity, religion, socioeconomic status, sex, gender, age, mental health, cognitive, disability, and other characteristics linked to discrimination or exclusion. (NPS)