Federal Pain Research Strategy

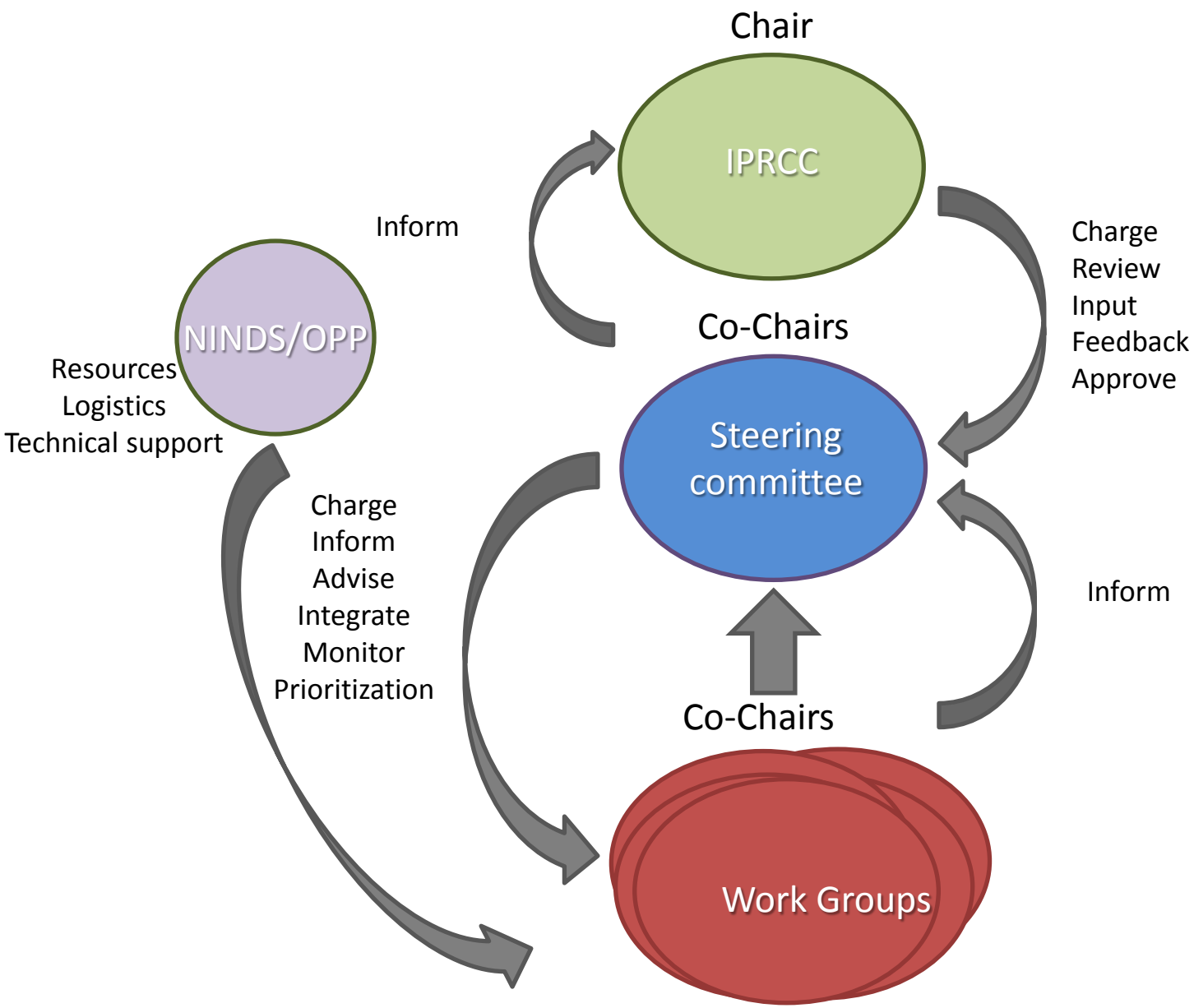
Planning Committee Proposal

Federal Pain Research Strategy

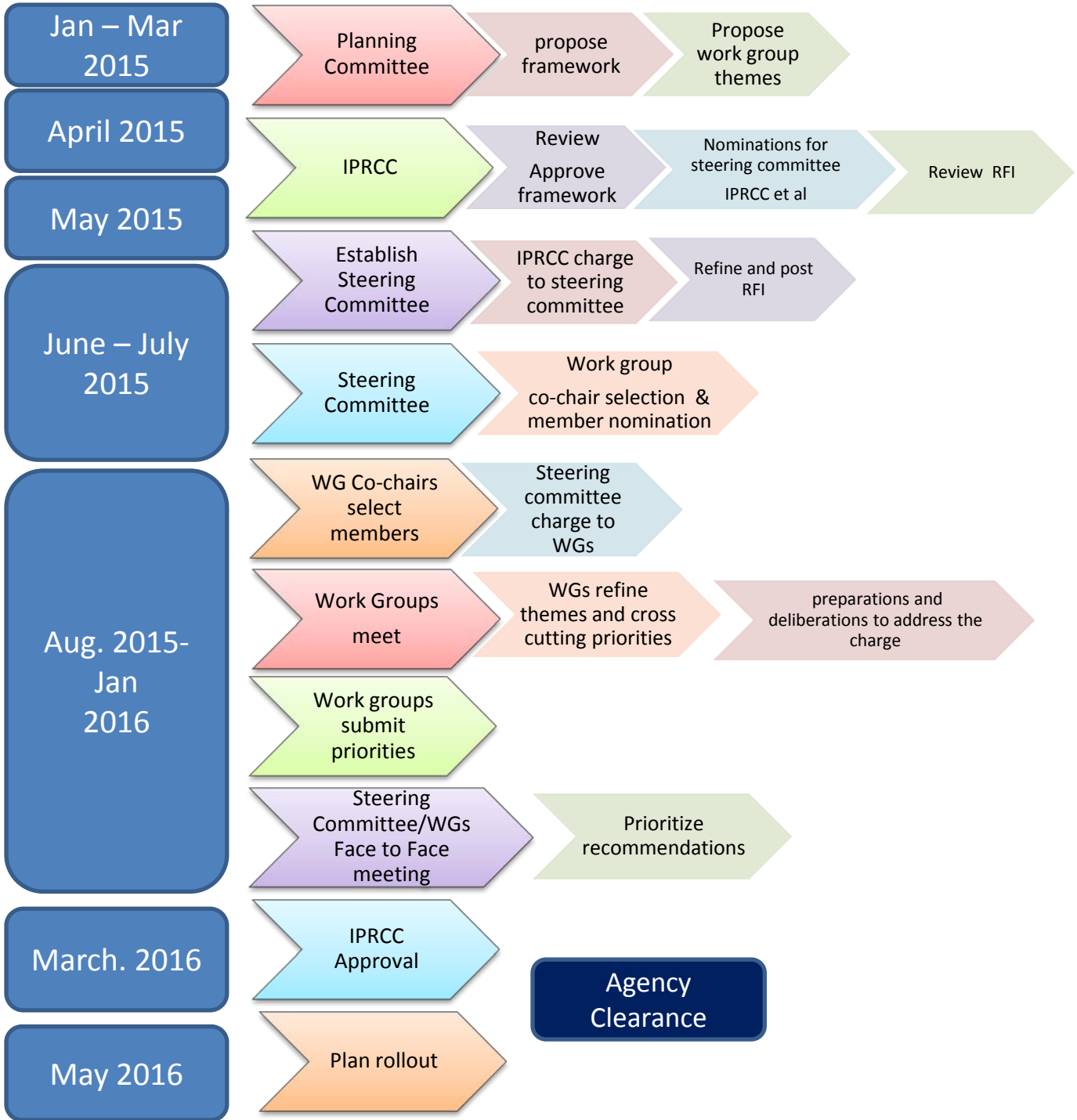
Planning Committee

- Allan Basbaum, IPRCC
- Chris Veasley, IPRCC
- Trip Buckenmaier, DoD, IPRCC
- Audrey Kusiak VA, IPRCCJ
- 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

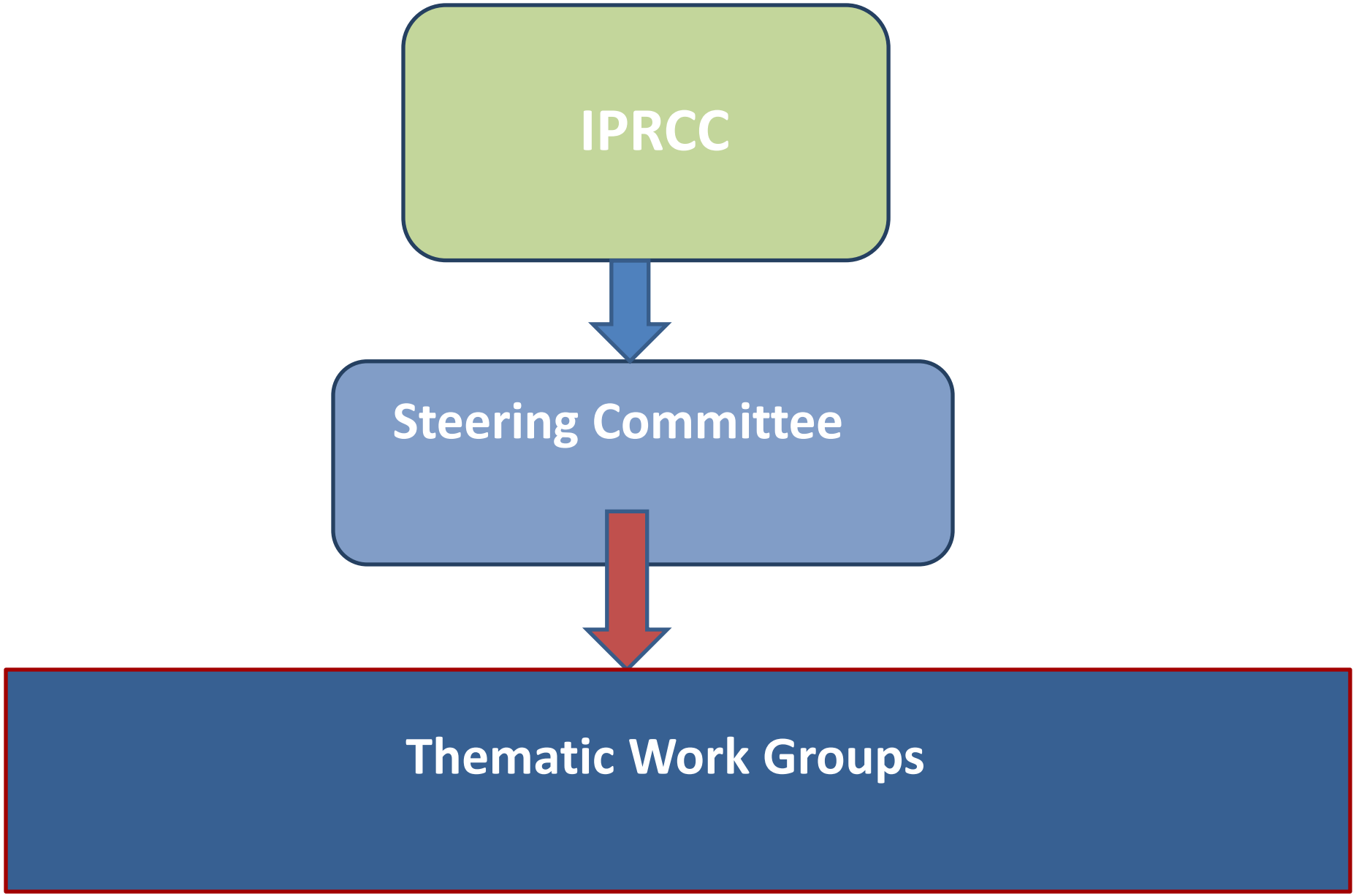
Proposed Operational Structure



Work Flow


Jan – Mar 2015
Planning Committee
propose framework
Propose work group themes
April 2015
IPRCC
Review
Approve framework
Nominations for steering committee
IPRCC et al
Review RFI
May 2015
Establish Steering Committee
IPRCC charge to steering committee
Refine and post RFI
June – July 2015
Steering Committee
Work group
co-chair selection & member nomination
Aug. 2015-Jan 2016
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
March. 2016
IPRCC Approval
Agency Clearance
May 2016
Plan rollout

Proposed Organizational Structure



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

IPRCC

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*)

IDENTIFYING APPROPRIATE THEMES

- 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)

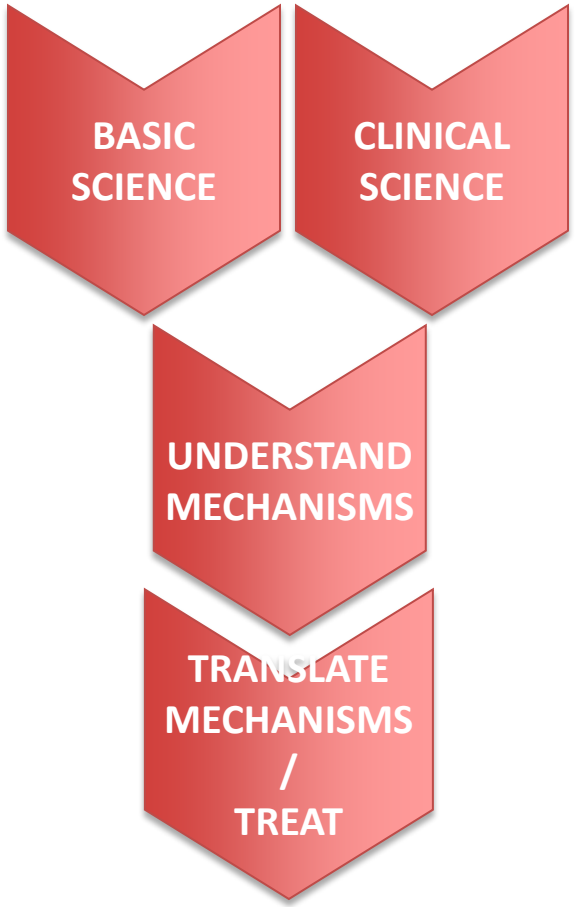
- *Pain is a temporal process*
- *Pain begins with an acute stage*
- *Acute pain may progress to a chronic state*
- *Mechanisms activated in acute pain setting influence chronic pain development*
- *Chronic pain has a variable onset and duration and may occur post injury or surgery*
- *Individual variation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



How did we get to these themes?

THEME 1: PREVENTION OF ACUTE & CHRONIC PAIN

Basis of Theme 1 (NPS)

- *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.*

THEME 2: ACUTE PAIN & ACUTE PAIN MANAGEMENT

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*

THEME 4: CHRONIC PAIN & CHRONIC PAIN MANAGEMENT

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

THEME 5: DISPARITIES

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

ACUTE PAIN & ACUTE PAIN MANAGEMENT

TRANSITION FROM ACUTE TO CHRONIC

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)*

PREVENTION OF ACUTE & CHRONIC PAIN

ACUTE PAIN & ACUTE PAIN MANAGEMENT

TRANSITION FROM ACUTE TO CHRONIC

CHRONIC PAIN & CHRONIC PAIN MANAGEMENT

DISPARITIES

- Epidemiology
- Diagnosis and assessment
- Susceptibility and resilience
- Mechanisms
- Lifespan
- Treatment
- Dissemination and implementation

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)*

PREVENTION OF ACUTE & CHRONIC PAIN | **ACUTE PAIN & ACUTE PAIN MANAGEMENT** | TRANSITION FROM ACUTE TO CHRONIC | CHRONIC PAIN & CHRONIC PAIN MANAGEMENT | DISPARITIES

- Epidemiology *
- Diagnosis and assessment
- Susceptibility and resilience
- Mechanisms
- Lifespan
- Treatment
- Dissemination and implementation

*** 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)

- Epidemiology
- Diagnosis and assessment
- Susceptibility and resilience
- Mechanisms
- Lifespan
- Treatment
- Dissemination and implementation

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)*

PREVENTION OF ACUTE & CHRONIC PAIN

ACUTE PAIN & ACUTE PAIN MANAGEMENT

TRANSITION FROM ACUTE TO CHRONIC

CHRONIC PAIN & CHRONIC PAIN MANAGEMENT

DISPARITIES

- **Epidemiology**
- **Diagnosis and assessment**
- **Susceptibility and resilience ***
- **Mechanisms**
- **Lifespan**
- **Treatment**
- **Dissemination and implementation**

*** Suggested after planning committee met**

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)*

PREVENTION OF ACUTE & CHRONIC PAIN

ACUTE PAIN & ACUTE PAIN MANAGEMENT

TRANSITION FROM ACUTE TO CHRONIC

CHRONIC PAIN & CHRONIC PAIN MANAGEMENT

DISPARITIES

- **Epidemiology**
- Diagnosis and assessment
- Susceptibility and resilience
- **Mechanisms**
- Lifespan
- **Treatment**
- **Dissemination and implementation**