



# National Pain Strategy

A Comprehensive Population  
Health-Level Strategy for Pain



## National Pain Strategy Implementation: A Listening Session May 11, 2017, Hubert Humphrey Building, Washington DC

On May 11, 2017 the Office of the Assistant Secretary for Health (OASH) and the National Institutes of Health (NIH) of the U.S. Department of Health and Human Services (HHS) hosted a webinar, "Implementation of the National Pain Strategy (NPS) Listening Session." The goals of the meeting were to share information about NPS implementation activities, to hear about external partner activities in implementing the NPS, and to discuss barriers, gaps, and new strategies for implementing the NPS. Speakers included federal officials and scientists as well as researchers and external partners involved in implementation of the NPS.

### Welcome and Opening Remarks

#### Thomas Novotny, M.D. - OASH, HHS

Dr. Novotny welcomed everyone to the meeting, and provided a brief introduction of HHS and regional offices. He noted that the current Secretary of HHS has recognized that improved pain management is an important part of managing the current opioid crisis.

The NPS was the government's first broad-ranging effort to improve how pain is perceived, assessed, and treated. Several projects that support objectives are underway, and this meeting will provide a time to update all stakeholders and the public on the progress made on implementing the recommendations of the NPS, and to have a discussion about what is being done in the community.

#### Alicia Richmond-Scott - OASH, HHS

Ms. Richmond Scott provided the charge of the meeting as follows:

- The purpose of the meeting is to report out what currently is being done to implement the NPS and to hear about other NPS activities that are being led by our external stakeholders.
- Each session had time built in for discussion to allow full participation by the audience. The participants were also encouraged to keep HHS informed of activities going forward.
- HHS envisions implementation of the NPS as an extensive collaboration with the public and private sector.

### Linda Porter, Ph.D. - National Institute of Neurological Disorder and Stroke, NIH

Dr. Porter recognized the co-chairs involved in writing the NPS report. She discussed the prevalence of pain and the fact that many people are being under-treated for their pain. It was noted that 27% of all adults with Low Back Pain, Joint Pain or headache use prescription analgesics, and 22% of adults with these conditions use over the counter analgesics.

The NPS aims to address many issues surrounding pain care. Many people don't have adequate access to pain care, and vulnerable populations are especially likely to be underserved. In addition, there is stigmatization associated with chronic pain that affects the quality of care and psychosocial health of sufferers. Medical students receive very limited education on pain management, and this lack of training carries over to their later medical practice. There is also a lack of information for patients and caregivers about the variety and effectiveness of non-opioid pain treatments. Patients need to be their own advocates, but they lack sufficient information to manage their own treatment.

How does the National Pain Strategy address these issues?

- HHS is collecting an inventory on NPS implementation activities that we hope will be useful to all partners:
  - o A description of the implementation strategy can be found at the following site:  
[https://iprcc.nih.gov/National\\_Pain\\_Strategy/NPS\\_Implementation.htm](https://iprcc.nih.gov/National_Pain_Strategy/NPS_Implementation.htm)
  - o A list of implementation actions can be found at the following site:  
[https://iprcc.nih.gov/National\\_Pain\\_Strategy/NPS\\_Objectives\\_Updates.htm](https://iprcc.nih.gov/National_Pain_Strategy/NPS_Objectives_Updates.htm)

**The Federal Pain Research Strategy** – when the NPS was developed, the IPRCC decided to develop the research component of the NPS through a separate effort. Given that the IPRCC itself had the expertise to oversee the development of a federal pain research strategy, it took on this task after completion of the NPS.

A draft of the Federal Pain Research Strategy was released for public comment on June 1, 2017.

<https://iprcc.nih.gov/docs/DraftFederalPainResearchStrategy.pdf>

### Population Research on Pain

#### Charles Helmick, M.D. – Centers for Disease Control and Prevention

Dr. Helmick discussed the NPS Population Research Workgroup's efforts, focused on Healthy People Objectives for the Nation for 2020 and 2030. A previous Assistant Secretary for Health, Dr. Howard Koh, charged the IPRCC with getting pain-related objectives into Healthy People 2020. As a result, the workgroup developed four objectives related to high impact chronic pain. The workgroup members also developed a case definition for high impact chronic pain (i.e., pain which interferes with work or activities) and questions to monitor progress on the objectives through the National Health Interview Survey (NHIS). These questions were cognitively tested by the National Center for Health Statistics and have been included in the NHIS for 2016-2017.

Dr. Helmick noted that the objectives included in Healthy People 2020 related to pain are:

- Decrease the prevalence of adults having high impact chronic pain,
- Increase public awareness/knowledge of high impact chronic pain,
- Increase self-management of high impact chronic pain,
- Reduce impact of high impact chronic pain on family/significant others.

The following questions were included in the 2016-2017 NHIS.

- In the past six months, how often did you have pain?
- Over the past six months, how often did pain limit your life or work activities?

Two additional questions were considered for later surveys.

- Over the past six months, how often did YOUR pain affect your family or significant others?
- To what extent are you able to manage your pain so that you can do the things you enjoy doing?

The data from the NHIS for 2016 are now being analyzed. The 2018 NHIS is being restructured as a shorter survey, but will include pain questions as core questions. The next steps include determining if any additional questions should be included in NHIS; one of the four objectives on high impact chronic pain will be included in Healthy People 2030.

#### **Michael Von Korff, Sc.D. - Group Health Research Institute**

Dr. Von Korff reported that the NPS Population Research Workgroup was very grounded in the World Health Organization's efforts on chronic pain management. He also asked the group whether patient reported data can be linked with Electronic Health Records (EHR) in order to monitor population trends through health systems. The group felt strongly that it was important to differentiate between chronic pain (CP) and high impact chronic pain (HICP). They also felt that it was important to ask about both pain in general and specific pain conditions in clinical settings, because condition-specific pain is not representative of the entire population. The questions (above) that resulted from the workgroup and were ultimately included in the NHIS were validated through a pilot study which showed that people in the HICP group are very different from people who have CP but are not severely impacted. In addition, many people report pain and chronic pain, but a much smaller percentage report HICP.

These NHIS data were compared with EHR data collected by Group Health in Washington State. The Washington State Department of Health provided opioid prescribing guidelines in 2007; thus, the EHR could be used to query how the guidelines are implemented. The ICD-9 and ICD-10 Codes for pain conditions were identified, and these were used to extract information about chronic pain conditions. Researchers found that people with chronic pain due to fibromyalgia are prescribed opioids even though opioids are not recommended as a treatment of choice for fibromyalgia. It was also found that there is a downward trend in opioid prescribing, but Medicaid patients are more likely to receive high dose opioids than patients in other insurance programs. They are also more likely to receive co-occurring prescriptions for sedatives.

The group discussed next steps for this type of research. A pilot study is now being conducted in collaboration with the Veterans Health Administration (VHA) and Kaiser Permanente using an on-line

survey to collect patient-reported data on pain-relevant measures; these self-reported data are then linked to EHR Data.

The group suggested that a national chronic pain research network is needed to expand such approaches and focusing on implementation research. Research networks for other conditions have helped advance the treatment of conditions such as diabetes, cardiovascular disease, and infectious diseases such as HIV/AIDS. It is becoming more common for physicians to collect pain information, and these data can be used to improve the population-based approach to pain care.

**Richard Nahin, Ph.D. – National Center for Complementary and Integrative Health, NIH**  
Dr. Nahin discussed the prevalence of pain in the U.S. population and described the NIH “All of Us” initiative on precision medicine. The NHIS has included questions about painful conditions, but only in 2010 did they start asking about people’s perception of pain. It was found that there is a large amount of heterogeneity in how people respond to pain, even if they have the same level of pain. For example, not everyone with very severe pain reports poor health. It was also found that pain intensity measures are closely tied to healthcare utilization. The prevalence of painful conditions was associated with the severity of pain, but not directly tied to the prevalence of self-reported pain. Therefore, to get a complete picture, it is important to collect data on both painful conditions and patient perception of pain.

The NIH “All of Us” program is an initiative to collect data from a broad cohort for healthcare research and development of precision medicine approaches to diverse populations. The program will include one million or more participants, reflecting the broad diversity of the U.S. and will provide data on an ongoing, longitudinal basis. Data will be collected on lifestyle, genomics, and the environment. This program is not a study on any one disease, but is rather a huge data resource to inform many research studies on a wide variety of health conditions. The initial launch will include the pain-related question, “In the past 7 days, how would you rate your pain on average: 0 (no pain) to 10 (worst pain imaginable).”

### **Discussion of Implementation of Population Health Research on Pain Session**

Questions were asked both by participants in the room and by those participating by webinar.

A question was asked about the tension in the research community between looking at heterogeneous populations with pain versus looking at homogeneous populations with specific conditions.

- This is noted to be a problem, because to understand a specific condition, researchers need to evaluate homogeneous populations. However, in many cases, those who suffer from the most pain have multiple conditions. It was also noted that researchers are moving towards the understanding that it is important to study pain in general. It is not possible to fully understand a person’s pain without understanding the context of his or her pain and the setting in which it is being addressed.

A question was asked regarding the relationship between adverse childhood experiences and pain.

- Evidence suggests that early adverse experiences put people at a higher risk for some painful conditions such as fibromyalgia, arthritis, back pain, and headache. There may be an

association between childhood experiences and other types of pain, but these assessments are very difficult to conduct.

It was asked if there are data about Medicare beneficiaries and those that are dually eligible for Medicare and Medicaid.

- Some work has been done, but it has only been recently that CMS has made datasets available for such analyses.

The concern was raised that in shifting the focus to HICP that we must be careful not to minimize the impact of chronic pain in general.

- Stopping people from transitioning from acute to chronic pain is a primary concern in pain research; hopefully, the “All of Us” cohort will give some insight into the population of people in pain to aid this research. It was also noted that the NHIS survey questions were designed to address low impact chronic pain as well as HICP.
- The large percentage of people reporting chronic pain is challenging. If a problem is perceived as very big, such data may help with public attention and congressional funding; however, it is a barrier to for health care systems to commit to the problem.

A question was asked if there were a consensus for the actual number of people with HICP.

- Different studies report different numbers, but these are probably correct for what is measured in each specific study (which is inconsistent from one study to another). It is hoped the NPS will help the community develop a standard set of questions to be used in research and monitoring so that we can get a consistent picture of the prevalence of pain and progress over time.

## Prevention and Care

### Richard Ricciardi, R.N, Ph.D. - Agency for Healthcare Research and Quality

Dr. Ricciardi discussed that as a primary care nurse, he has tried to bring the perspective of pain patients and those who care for them to the policy-makers and researchers. He introduced the speakers of the session and moderated discussion.

### Robert Kerns, Ph.D. -Yale University

#### **Stepped Care Model for Pain Management**

Dr. Kerns discussed the VA/DoD Step Care Model (SCM) of patient care. The SCM suggests that increasingly complex, intense, and/or frequent care to patients should be determined by the complexity of their condition. Most pain care takes place in the home and primary care settings, so it is important that pain care in these settings is well developed. Therefore, the VA has worked to implement this model across the United States, and Dr. Kerns described that there has been significant progress and that implementation efforts are continuing.

#### **The Step Care Model**

Step 1 – Patient-aligned care team in primary care

- Most pain is cared for in the home
  - Patient/family education / interactions between patients and their family/community and the PACT at the VA.
- Step 2 – Secondary care (integrated patient care)
- Multidisciplinary pain medicine specialty team
    - o Rehabilitation/ behavioral pain management/ mental health
- Step 3 – Advanced pain medical diagnostics and interventions

**Chester “Trip” Buckenmaier, M.D., Department of Defense**

**Integrated Pain Care Efforts in the DoD**

Dr. Buckenmaier described the pain management system and SCM being implemented in the DoD. He noted that less than few wounded soldiers die in conflict, but many are non-functioning thereafter because of debilitating conditions including chronic pain. To address this problem, the DoD Pain Task Force released a report (prior to the well-known [Institute of Medicine Report](#) in 2011).

The VA and DoD pain collaboration is working to shift the culture around pain management, and to do so, many integrative pain management techniques are being utilized. The Defense and Veterans Pain Rating Scale includes both a pain rating scale and supplemental questions about how pain interferes with activity, sleep, mood, and stress. The goal is to recalibrate standardized pain assessments so that the focus is no longer on getting pain to zero, but on improving a person’s ability to function. In addition, Dr. Buckenmaier noted that in the DoD, opioid misuse is being treated as a symptom of the pain management problem. Like the VA, the DoD also uses the SCM and is working to fully implement it.

The DoD has published many pain education videos available at the following website.

<http://www.dvcipm.org/clinical-resources/joint-pain-education-project-jpep-1/educational-videos>

**Elisabeth Kato, M.D., Agency for Healthcare Research and Quality (AHRQ)**

**Noninvasive, Nonpharmacological Treatment for Chronic Pain: Planning a review of the evidence**

Dr. Kato reported that AHRQ is tasked with improving the quality and safety of healthcare by creating evidence based tools that other agencies can use. With regard to the NPS, AHRQ is addressing the objective to *incorporate the most effective and cost-efficient treatments into practice guidelines and other best practices efforts.*

Dr. Kato described a systematic review of the literature led by AHRQ with support from the CDC and the Assistant Secretary for Planning and Evaluation (ASPE). It will review current published evidence for effectiveness of non-pharmacological treatments for five highly prevalent pain conditions. The questions to be addressed in the review were developed by AHRQ based on scientific reports, published for public comment, and then posted on the AHRQ website. The focus of the review is on back pain, neck pain, osteoarthritis, fibromyalgia, and tension headache because these are the five conditions with the highest opioid use, according to the Kaiser Permanente data. The goal is to establish an evidence base for alternatives to opioid treatments that can help reduce the use of opioids for these conditions. The review will consider evidence for effectiveness of reduction in pain and improvement of function as well as any adverse secondary effects. The Protocol is now available at:

<https://effectivehealthcare.ahrq.gov/ehc/products/661/2470/nonpharma-treatment-pain-protocol->

[170426.pdf](#) The timeline is for the draft Report to be posted for comment is September 2017 and for the Final Report to be released is December 2017.

## Discussion of Prevention and Care

A question was asked about consistency of care across the VA system.

- The VA is in some ways a centralized system, but with 141 core facilities and several thousand points of access, there is considerable variability across the system. The VA overall performs well in pain management, but there are gaps of care within the system. It can be support innovation, when something is developed in one center, it can spread quickly across the system, but individual centers are often inadvertently missed/excluded. As with everything, there is competition for resources, so unless something is mandated, implementation can vary from center to center.

The question was asked if yoga is being used in integrative care in the DoD system.

- There is varied use of yoga among centers. Since it is not mandated and isn't covered, it can't be prescribed.

A comment was made that were recent publications in Scientific American Mind and in an Associated Press report about non-pharmacological treatments for pain. It is important to note that these treatments are available.

## Service Delivery and Payment

### Christopher M. Jones, PharmD, MPH - ASPE, HHS

Dr. Jones described a pilot study funded by ASPE and CDC to examine what pharmacological and non-pharmacological treatments are covered for low back pain through three different coverage plans: a large state Medicaid plan (Medi-Cal), a large private insurer (Anthem), and a large pharmacy benefit manager (CVS Caremark).

In all three plans, most standard pharmacological treatments are covered, but there is variation in the specifics of what is covered. For example, private insurers may cover a wider variety of medications. For non-pharmacological interventions, there were more limits and greater variation. Many non-pharmacologic treatments with an established evidence base are not covered.

The limits of the study were that the sample size was very small and that the publicly available records didn't provide as much information as hoped. Despite these limitations, some conclusions can be drawn. Variation in coverage parameters across programs is evident. Some evidence-based non-pharmacological interventions such as cognitive behavioral therapy and biofeedback were not covered. Certain policies for non-pharmacological therapies such as determinations of medical necessity could be barriers to using these treatments. The final report will be available in 2017. The next step is an expansion of the study to a nationwide analysis, supported by NIH and ASPE.

Catherine Underwood – American Pain Society (APS)

**APS – Pfizer: Independent Grants for Learning & Change: Implementing the National Pain Strategy**

Ms. Underwood commented that many members of the APS worked on the IOM Report on pain and the NPS. The APS's interest in moving the NPS forward led them to include the NPS as part of their strategic plan. She reported that Pfizer provided unrestricted funds to the APS for research. The APS dedicated these funds to support projects related to implementation of the NPS. The APS received many proposals through their RFA and selected, with no input from Pfizer, three proposals for funding. The three funded projects are:

**1. Web-based Self-management of Adolescent Chronic Pain: National Implementation Project -**

Tonya Palermo, PhD, Seattle Children's Hospital

Addresses the NPS objectives:

Objective 2: Prevention and Care

- To develop nationwide pain self-management programs

Objective 4: Disparities

- To improve access to high-quality pain services for vulnerable populations

**2. Development of an Electronic Prescription Bundle of non-Pharmacological Strategies for Chronic Musculoskeletal Pain -** Kathleen Sluka, PT, PhD, FAPTA and Barbara Rakel RN, PhD,

FAAN, University of Iowa – Colleges of Medicine & Nursing

Addresses the NPS objectives:

- Objective 1: Service Delivery & Payment

- To develop strategies to address the ...existence of more effective models, and the steps that can be taken toward achieving high quality care and outcomes.

**3. A Personalized Self-Management Program for Older Adults with Chronic Pain & Negative Emotions -** M. Cary Reid MD, PhD and Dimitris Kiosses PhD, Weill Cornell Medicine (WCM) at the NY Presbyterian Hospital Wright Center on Aging

Addresses the NPS objectives:

Objective 2: Prevention and Care

- Providing patients and their caregivers with an approach to gain the requisite skills, education & resources to play an active role in managing their pain

Objective 1: Service Delivery & Payment

- To conduct rigorous evaluations of models through independent evaluators, ...especially those using... the biopsychosocial model, team-based care, pain self-management approaches

### Discussion of Service Delivery and Payment Session

A comment was made that the public/private partnerships are important to improve pain care. It is great to see these partnerships, such as with the APS, in action.

Dr. Jones was asked if there will be a cost-benefit analysis included in the report.

- There will not be a cost-benefit analysis in this report, as the goal of this pilot is to provide a baseline for what is covered and what is not. This is an important aspect to study eventually, because some therapies are expensive.

Ms. Underwood was asked if the APS is open to partnering with other organizations.

- The APS is open to collaborations and this program has given a good model to work with funding agencies to manage proposals. APS currently partners with several non-profits including the Mayday fund.
- APS discussed of where we should be going for these types of partnerships, and that you need to go to organizations that have money. Importantly, the Pfizer partnership has no corporate strings attached. Pfizer was aware that they funded projects that could address either pharmacological or non-pharmacological interventions.
- The issue was raised about who would pay for implementation of the findings from these types of studies. For example, the tobacco settlement covered much of the implementation of state tobacco control programs as well as research institutions.
- Sometimes interventions don't pay for themselves and they require reallocation of resources.
- Many physicians are interested in these types of studies because they have a lot of patients who would benefit from non-pharmacologic approaches to pain management.

Ms. Underwood was asked if there are sustainability components to the program.

- She answered that there will be a need for more money depending on the project to cover sustainability components of the program.

It was noted that one of the things that we need to focus more on is not effectiveness of treatment, but dosing. It is really hard to do cost-benefit analysis of non-pharmacological treatments without sufficient evidence on dose-response and intensity of treatment.

- Some studies are taking steps to develop algorithms for dosing of non-pharmacologic treatments.
- This is an important topic of discussion at the NIH. It is necessary to find ways of better addressing who will benefit from a given pain treatment. If patients who would benefit from opioids were the only people who received them, then the opioid problem would be much smaller.

## Professional Education and Training

Scott Fishman, M.D. -University of California, Davis

### **Implementation of NPS Professional Education and Training**

Dr. Fishman discussed the lack of pain management education in medical schools. Both the IOM report and the NPS focused on pain education. The NPS, in-particular, focused on core competencies. A panel of experts were convened and agreed on the following core competencies to improve pain management.

1. What is pain?
2. How is pain recognized?

3. How is pain relieved?
4. How does context influence pain management?

The U.S. Medical Licensing Examination (USMLE) program allowed a panel of experts to review the USMLE for representation of pain management. The results of this review are currently under embargo for publication. Broadly speaking, the panel found that pain issues were represented in the examination but that most of the questions focused on recognition of pain and not on understanding the context of the pain or adequate management.

Dr. Fishman also described the UC Davis ECHO tele-mentoring program. It was initially developed with grant funding, but is now funded primarily by subscriptions from insurance companies. ECHO is a peer-to-peer mentoring program consisting of weekly video conference sessions that include didactic presentations, demonstrations, and case discussions, to reach currently practicing physicians and to improve pain competency in primary care settings.

He also noted that it is not possible to train everyone in proper pain management, but the UC Davis has implemented a Training New Trainers (TNT) fellowship that will train physicians to lead and perpetuate pain education in their primary care communities. Even if we can improve pain care education in medical schools, the majority of the healthcare workforce is untrained and will not benefit from the shift in medical school training. We need to work with professional groups and federal and state organizations to broaden our network of trainers.

#### Sharon Hertz, M.D.- Food and Drug Administration (FDA)

#### **Update on Opioid Analgesic REMS: Professional Education and Blueprint**

Dr. Hertz discussed the FDA's risk evaluation and mitigation strategies (REMS). The FDA has the authority to require a REMS for applicable drugs. It is a risk-management plan that utilizes risk mitigation strategies beyond FDA-approved labeling, that is developed and, after approval by the FDA, implemented by drug manufacturers.

In 2012 the FDA approved a REMS program for extended release/long acting (ER/LA) opioid analgesics to reduce serious adverse outcomes resulting from inappropriate prescribing, misuse, and abuse of ER/LA opioid analgesics, while maintaining patient access to pain medications. Adverse outcomes of concern include addiction, unintentional overdose, and death. The primary components of REMS are manufacturer-funded grants to provide prescriber education offered by an accredited continuing education provider. The training is voluntary, and to date 400,000 health care providers have taken the training.

An advisory committee met to analyze the results of the opioid REMS program to date and recommended the following modifications.

- Extend REMS requirements to the immediate release (IR) opioid analgesics.
- Broaden education to include pain management.
- Extend the training to other HCPs involved in the management of patients with pain.
- Integrate the REMS education with mandatory education provisions.

On May 9, 2017 the FDA held a public workshop to discuss improvements to provider education on the safe use of opioids. A draft of the FDA blueprint was available for Public comment from May 9 – July 10, 2017. The blueprint revision focuses more on pain management.

### **David Thomas, Ph.D. - National Institute on Drug Abuse, NIH**

Dr. Thomas noted that we currently are dealing with the largest drug abuse epidemic in our history, in addition to a crisis for people in pain. Part of the problem is that we have poor clinician training in pain management and inadequate reimbursement for non-pharmacological pain management.

The Centers of Excellence in Pain Education (CoEPE) is a program funded by the NIH to address the Professional Education and Training objectives of the National Pain Strategy. There are nine NIH-funded CoEPEs and four case-based modules are currently available on the website:

[https://painconsortium.nih.gov/nih\\_pain\\_programs/coepes.html](https://painconsortium.nih.gov/nih_pain_programs/coepes.html)

In addition, there is a naloxone module on the website, and we hope to include the CoEPEs as part of central portal for pain education information. It is also important to bring attention to the lack of adequate pain education.

Dr. Thomas discussed that the CoEPEs program needs a coordination center and additional staff. With the right partnership and funding, the CoEPEs program could be expanded. The CDC opioid prescribing guidelines are important, and these will be more effective when linked to the NPS. It is not possible to adequately address the opioid problem without effectively treating the people who currently need opioids for pain management.

### **Discussion of Service Delivery and Payment**

A question was asked about abuse deterrent formulations of opioids and whether they need unique prescriber education.

- They are currently treated the same way with respect to prescriber education. Some formulations require additional instructions.
- Some people have problems with some of the additives or the size of the abuse deterrent formulations, but people have similar problems with all pharmaceuticals.

It was asked if the FDA safe opioid use blueprint could be used as a skeleton for developing pain management curriculums.

- All medical schools view a curriculum in a different way, and it is therefore more useful to provide guidelines and agreed upon goals and metrics for curriculum development and evaluation.

A comment was made that it is important not to conflate the prescription drug abuse problem and pain management, and that it is very important to keep groups like this focused on pain management. It is important to have compassion for prescribers. It also is important to keep focus on the patient.

A question was asked about whether the FDA is able to act on new information regarding the long-term effectiveness of opioids for chronic pain. It was noted that there is not enough data to say that long-term opioid therapy is effective for chronic pain and there is some evidence to suggest that it may be harmful.

- The FDA is always open to new information and adjusting the labeling of regulated products accordingly. However, it is difficult to do long-term, controlled analgesic trials. There is no doubt that some people do better without long-term opioid therapy, but there is no conclusive evidence that there are not people who do better with opioid therapy. The FDA is willing to look at the labeling of opioids if there is conclusive evidence either way.

## Discussion Session

In the discussion session, six external stakeholders gave brief presentations concerning their activities relevant to implementation of the National Pain Strategy. Dr. Porter also led a general discussion of the session.

### **Sean Mackey, M.D., Ph.D. – Stanford University**

Dr. Mackey discussed the Stanford University Collaborative Health Outcomes Information Registry (CHOIR). He noted that the IOM report and NPS both called for better quality data and the CHOIR group has attempted to develop a system for collecting high-quality data and making it actionable. CHOIR was rolled out in 2012 as an open-source, free platform to collect data. It is freely available to anyone as long as they do not build a company around it or to distribute it without permission. Since the rollout, CHOIR has collected detailed assessments on over 50 thousand people and has expanded nationally and internationally. The group currently is building an adaptive randomization for pragmatic clinical trials to provide a simple design for large trials.

### **Stephani Sutherland Ph.D. – Neuroscience Writer**

Dr. Sutherland relayed her background as a pain physiologist who has been a science communicator for the past 15 years, and for the past five years has been writing for the pain research forum. She noted that translation to patients and between researchers is a big barrier. While the comment about not conflating pain and opioids is appreciated, it is important to get the word out that chronic pain is a big driver of the opioid epidemic. Dr Sutherland has published in different science journals and is open to collaboration from the pain community. She is available to do whatever she can to promote the goals of the NPS. How we treat chronic pain is a big problem, and available complimentary and integrative treatments should not be dismissed.

### **Steven Stanos, M.D. – Swedish Medical Center, Seattle Washington**

Dr. Stanos, is the current president of the AAPM. He described the functional restoration program that was started at the Swedish Medical Center. It is an interdisciplinary program where the treatment team is together and includes a rehabilitation program. It is a unique program because it is covered by Medicaid, whereas many functional restoration programs are available for injured workers and are paid by workers compensation. The program has 15 patients who are seen three half days a week for four weeks. They use different measures beyond pain intensity. From the clinical perspective, the biggest

outcomes are in patient catastrophizing and feelings of helplessness, and the best feedback from the patients is that they have learned to understand their bodies. The current problem facing the program is sustainability. Since most health care is paid as a fee-for-service, the program is not sustainable, and many patients are not able to participate because the out-of-pocket costs are too great.

- This started a discussion about the possibility of CMS or insurance companies paying centers of this kind a per diem for bundled services. It was discussed that patients in centers of this kind are high users of health services. It is difficult to do cost-effectiveness analysis of bundled services, but this is the type of innovation that is necessary to improve pain care.

### **Myra Christopher – Pain Action Alliance to Implement a National Strategy**

Ms. Christopher noted that both the IOM report and NPS can be summarized by saying that what we really need is a cultural transformation. PAINS reached out to Touchstone Consulting to identify effective public health campaigns. All successful campaigns had a core message. The PAINS core message is “Comprehensive chronic pain care will improve the lives of millions of Americans, save billions of dollars and reduce the abuse of opioids.” She noted that we have to begin to change the perception of the public about those who live with pain and those who care for them because they have been stigmatized. The “No Longer Silent” campaign is a public engagement and awareness campaign. Ms. Christopher commented that research indicates that the public doesn’t know what it’s like for chronic pain patients and they don’t care. However, the public does care about stories of people who overcome adversity. The campaign is at the early stages of implementation and excited to collaborate with everyone.

Information about PAINS and the “No Longer Silent” campaign can be found at the PAINS website:

<http://painsproject.org/>

- There was a comment that before opioids were commonly prescribed people with chronic pain were highly stigmatized because it doesn’t fit with our medical model. People with mental illness have become much less stigmatized because as physicians learned about mental illness, they believed their patients.
- It also was mentioned that many pain patients are currently seen as opioid equivalents because physicians want to do something, and writing a prescription is what they know.

### **Clydette Powell MD, MPH, FAAP – Office of Disease Prevention and Health Promotion**

Dr. Powell described the Pathways to Safer Opioid Use training module. It was developed to promote safe and effective pain management and opioid use. It is an interactive module where you can take the role of the people involved in pain management. It was developed with the adult learning principle in that adults learn best with self-directed learning. The module allows participants to make mistakes in a safe environment. To date, almost 800 people have completed the module for CME and there have been over 7000 page views. We know that it needs to be utilized more often. To evaluate success, we are looking at changes in behavior and practice. A question was asked about the possibility for follow-up education if more funding was available.

- The ODPHP is working with the American Public Health Association and are in the early stages to develop follow-up education.

## Bruce Schoneboom Ph.D., CRNA, FAAN – American Association of Nurse Anesthetists

Dr. Schoneboom noted that the AANA has the unique ability to touch its membership through professional guidelines. The AANA offers workshops for acute pain management to stay current with practices in analgesia, and partner with accredited programs to develop curricula related to optimizing patients prior to surgery. The AANA also offers workshops related to chronic pain management as well as basic and advanced interventional pain. The AANA has partnered with academia and has provided educational webinars to address safe prescribing of opioids. The AANA's workforce is poised and ready to be a part of the solution, and look forward to the opportunity to work.

## General Questions

A question was asked about population research and whether there is a noted difference among different minority groups about how they define and report pain.

- There is a disparities group that did not present at this meeting. In addition, the FPRS has a disparities group that has put together excellent recommendations for future research into the disparities of pain sensation and pain management.

The question was asked if it time to think about high-utilization as a negative measure.

- We currently don't have a healthcare system, instead we have a disease maintenance system.
- It is time to ask primary care doctors what they need for effective pain management. This has been done in some instances and has been very popular.
- We need a cultural shift from where it's not okay to know how to treat pain, and it's possible that this shift is happening. The NPS is a big movement in this direction.

The comment was made that the listening session has been heartening. However, we need to deal with a substance abuse disorder at the same time because people with pain are never going to get the treatment they need until substance abuse disorder patients get the treatment they need.

- This can be accomplished from an educational standpoint by requiring competency of graduate students.
- It also was noted in the FDA workshop that it is probably necessary to have mandatory training, but this is very difficult to implement.

The comment was made that from the outset the NPS steering committee talked about public education as important. A few years ago, Research America asked people if they knew anyone with pain – more than 60% said yes – less than 20% though it was a public health issue. It's about helping people realize that it's a big problem.

## Closing Remarks

Dr. Novotny closed the meeting with a thank you to participants. He noted that many good things have been done, and that one of the biggest themes of the meeting was the cultural change that needs to happen. It is necessary to point out that pain is a public health problem, and it is necessary to change the expectations of patients who currently expect to go to a doctor and get a prescription. We need cost-effectiveness data. Policy can change if pain treatment is considered an essential service.

He also noted that we should look at successful public education campaigns as models for moving forward. For example, the tobacco control community has developed some important advocacy tools early on, but now we have so many more with social media and other channels. Another example is the research network that has grown up around the study of cardiovascular disease.

Dr. Novotny also noted pain management as part of the opioid strategy is an extremely important, positive step.