



Foundation *for* **Opioid Response** **Efforts**

Program Advisory Meeting Summary
Improving Clinical Practice of Pain Management
August 23, 2019



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Program Advisory Meeting: Improving Clinical Practice of Pain Management

Note: This summary is not intended to be a consensus document, but instead represents the breadth of discussion and guidance provided to FORE during the meeting. The use of the term “participants” does not imply majority agreement.

Executive Summary

On August 23, 2019, the Foundation for Opioid Response Efforts (FORE) convened an advisory meeting in New York City to discuss pain management. Participants were asked to consider barriers to implementing or improving changing pain management practices and what would need to happen to encourage clinicians to do so. The objectives were to add to FORE’s understanding of current practices and challenges in acute and chronic pain management and to identify opportunities to support effective approaches within the context of more restricted use of opioids. Participants made recommendations and offered guidance on the role FORE could play through grantmaking, convening, and information dissemination. This report summarizes the discussion and recommendations.

Key discussion points include:

- Reframing pain management among both clinicians and patients;
- Educating health care providers, policymakers, and patients about the range of pain management options;
- Developing programs to help patients learn how to manage chronic pain, similar to diabetes education programs;
- Broadening the range of pain management options through insurance coverage;
- Developing new care models that draw on pharmacists, navigators, telehealth tools, and other supports;
- Focusing on pain management guidelines rather than opioid use guidelines; and
- Focusing on both pain and overall well-being.

I. CURRENT LANDSCAPE OF PAIN MANAGEMENT

The meeting started by highlighting discussions that have occurred over the past few years throughout the country around clinical guidelines for pain management. These discussions focused on how to prevent opioid use disorder (OUD) by educating clinicians, changing prescribing practices, reducing the volume of opioids in communities, and assessing the appropriateness of opioid prescribing. FORE staff noted that while these early guidelines met some of their goals, they also had unintended consequences that presented new challenges to the clinical culture and practice of pain management.

FORE staff highlighted the need for greater understanding and further reform of acute and chronic pain management practices. There is significant variation in the number of pills prescribed across specialties and procedures, including in perioperative pain management. They also noted the risks of long-term opioid therapy, including opioid abuse or dependence, limited evidence on the effectiveness of different dosing strategies, and limited evidence on methods for treating acute exacerbations. Yet opioid therapy for chronic pain remains common practice. Facilitators noted some of the reasons why this is the case, including limited insurance coverage for alternatives to opioids, providers' lack of pain management training, insufficient numbers of pain management specialists, and providers' time and financial constraints.

Facilitators noted that in 2019, the Centers for Disease Control and Prevention (CDC) reported that opioid prescribing rates had begun to decline, but less so in rural than urban areas. This decline was attributed to prescription drug monitoring programs (PDMPs), medication-assisted treatment (MAT), and opioid guidelines. Yet, fentanyl and heroin are replacing prescription opioids as the more frequent causes of opioid-related deaths. In light of these trends, participants were asked about promising pain management practices and what more can be done to adequately address pain without increasing risks. They also noted the need to recognize and address the link between pain and mental health.

A. Cultural Shift

Participants noted that the opioid epidemic is far worse in America than in any other country and addressing it will require a shift away from our country's "pill culture." Participants felt that patients' expectations, providers' practices, and the health system (with short visits/reimbursement structures) all played roles in "pill culture," whereas some Eastern and other cultures rely more frequently on nondrug treatments. Providers, too, may feel time and other pressures to prescribe. Pain is a universal experience, but is managed differently, with

different expectations, across cultures and countries.

Participants said the U.S. health care system needs a cultural shift to focus on pain management, not just pills. They noted that individuals with injuries are often discharged from care too soon and that people experiencing pain do not typically receive adequate disability benefits, time off from work, or physical therapy. Health care providers may prescribe opioids because pills may be less expensive, less time consuming, and may be perceived as allowing patients to return to work sooner than alternative approaches; some payers will cover opioids but not alternatives such as lidocaine patches or physical therapy.

Participant called for patient education, noting for example that patients should be informed that opioids may decrease the likelihood of recovery from an underlying injury or condition and the likelihood of going back to work. Participants also emphasized the need for adequate insurance coverage of alternative pain treatments. Many insurers require patients to go through “fail first” step therapy in which they try opioids first because pills are less expensive than other therapies.

B. Psychology of Pain and Concurrent Mental Health Conditions

Participants noted that pain has emotional and psychological components. For many patients, prescription opioids help to mollify the fear, anxiety, or other emotions that may accompany pain. And patients who prefer opioids may also enjoy the feeling of euphoria the drugs provide for some people. Health care providers need to talk to patients about their pain, expectations for relief and ability to tolerate pain, and the range of tools for managing their conditions. Otherwise, patients may feel that effective medications are inappropriately being withheld from them.

Participants also noted the need for care delivery models that address both pain and mental health. Some 60 million opioid prescriptions are written for individuals who also have co-occurring mental health conditions and 52 percent of individuals in pain clinics or inpatient pain programs experience concurrent pain and depression.¹ Mental health professionals often take leadership roles in recognizing the mental health issues related to pain and developing care

¹ Matthew A. Davis et al., “Prescription Opioid Use Among Adults with Mental Health Disorders in the United States,” *Journal of the American Board of Family Medicine*, July 2017, 30:407–17, <https://www.jabfm.org/content/jabfp/30/4/407.full.pdf>, and Matthew J. Bairet et al., “Depression and Pain Comorbidity: A Literature Review,” *Archives of Internal Medicine*, 2003, 163 (20):2433–445, <https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/216320>.

models to address both.

Participants stated that pain patients are often seen by their health care providers as angry, difficult, dissatisfied, and not satisfying to treat. And medical residents may be trained to focus on prescribing opioids and benzodiazepines for pain patients. Both practicing and trainee clinicians should receive training about a range of pain treatments and ways to identify and treat patients' underlying mental health conditions (e.g., sleep disorders, depression, anxiety, post-traumatic stress disorder, and trauma).

II. ACUTE PAIN MANAGEMENT

Participants started the discussion on acute pain, defined by the Cleveland Clinic as a transient pain that comes on suddenly caused by a specific event, by noting that while there has been a decline in opioid prescribing, more needs to be done to influence prescribing practices. Participants recommended that FORE focus on alternative models for pain management. A Gallup survey found that 78 percent of Americans would rather try nonpharmacological options than a prescription opioid for back or neck pain.² Furthermore, research has shown that opioids are no better than other medications for many common kinds of acute pain. Many nondrug pain management approaches, such as chiropractic services, yoga, and physical therapy, have high levels of patient satisfaction. And yet physicians are more likely to prescribe medications than offer such alternatives.³ Both patients and providers need education on pain management options as well as greater understanding of the emotional components of pain.

A. Patient Expectations

Participants noted that many practitioners are open to the idea of alternatives to opioids but have concerns about their patients' expectations. While research has shown that opioids may not be more effective than other medications for most common acute pain conditions, many patients are skeptical. And while patients may understand that heroin is dangerous, they may not understand prescription opioid analgesics also present risks. Additionally, some may expect that if opioids were prescribed to them in the past (e.g., when they had their wisdom teeth removed a decade ago), they will be prescribed in the future. Some patients may be dissatisfied with recommendations to try over-the-counter medications like ibuprofen and acetaminophen for pain management. And some patients may be looking for the euphoria as well as pain relief that

² See "Americans Prefer Drug-Free Pain Management Over Opioids," Gallup, 2017, <https://news.gallup.com/reports/217676/americans-prefer-drug-free-pain-management-opioids.aspx>.

³ <https://www.healthaffairs.org/doi/10.1377/hblog20161004.056935/full/>

comes with opioids.

Participants noted that because clinicians' compensation is often based in part on patients' satisfaction ratings, they may feel pressure to succumb to patients' demands. As such, participants noted the importance of initiatives to educate patients and their family members about the risks of opioids and the availability of other medications as well as nondrug treatments. Patients should understand that practitioners are not "cutting off" opioid treatment but making efforts to offer better and safer pain treatment.

B. Interventions in the Emergency Department

Participants noted that many people with pain present in the emergency department (ED). Up to 42 percent of all ED visits are related to pain.⁴ A 2015 study found that 17 percent of all patients discharged from the ED received opioid prescriptions.⁵ Participants recommended the development of pain management strategies to reduce that number. To achieve that goal, two participants recommended a model they had developed, the Alternatives to Opioids (ALTO) program, which has been described as a "a comprehensive plan for the management of acute and chronic pain as well as opioid addiction and abuse in the emergency department," that "aims to utilize evidence based multi-modal non-opioid approaches for the pain."⁶

Alternatives to Opioids in the ED: ALTO Program

Emergency department staff at St. Joseph's Regional Medical Center in New Jersey developed and implemented the Alternatives to Opioids (ALTO) program, which involves patient education by physicians and nurses, as well as community outreach. Nationally, 17 percent of patients presenting with pain in the ED are prescribed opioids. The ALTO program has reduced this number to 2 percent opioid prescribing in their ED.

Nurses educate patients on such key concepts as treatment of pain as opposed to masking pain, the risk of addiction from opioids, and the availability of alternative treatments. St. Joseph's staff also conducted outreach with the community to highlight the opioid crisis in New Jersey and explain its new policy — making clear that while it was not banning opioids, the drugs would not be a first-line treatment, but rather would be prescribed on a case-by-case basis. The branding and framing of this project aided in its success.

⁴ Pinyao Rui and Susan M. Schappert, "Opioids Prescribed at Discharge or Given During Emergency Department Visits Among Adults in the United States, 2016," NCHS Data Brief No. 338, May 2019, <https://www.cdc.gov/nchs/products/databriefs/db338.htm>.

⁵ Joseph Guarisco and Adam Salup, "Reducing Opioid Prescribing Rates in Emergency Medicine," *The Oschner Journal*, Spring 2018 18(1):42–5, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5855421/>.

⁶ Alternatives to Opioids for Pain Management in the ED, *Urgent Matters*, George Washington School of Medicine and Health Sciences, <https://smhs.gwu.edu/urgentmatters/content/alternatives-opioids-pain-management-ed>.

As a result of its efforts, the ED saw greater numbers of vulnerable populations, including geriatric and pediatric patients, perhaps because those caring for children or aging parents felt more comfortable bringing their loved ones to St. Joseph's because they were less likely to receive opioids there.

Some patients who were seeking opioids were deterred from coming to the ED, but that was not intended. Instead, social workers sought to engage such patients by offering counseling and referring them to physical therapists, mental health clinicians, or other alternative pain treatment options.

C. Dentistry

Participants acknowledged that dental practices have contributed to the opioid epidemic. In 2009, 12 percent of all opioid prescriptions were written by dentists. For decades, patients received opioids when they had their wisdom teeth removed — a key point at which to introduce opioids to adolescents. Some patients may remember receiving opioid medication for this procedure and therefore ask for it when they have an oral procedure years later. Additionally, 40 million people fear going to the dentist, creating an emotionally stressful component for which opioids may provide comfort.⁷ Yet, nonsteroidal anti-inflammatory drugs (NSAIDs) are usually effective for pain associated with oral surgeries and procedures. Dental students are now being trained on appropriate opioid prescribing, including by checking PDMPs and encouraging opioid alternatives and state boards of dentistry are mandating CE courses of opioid prescribing for licensed dentists. The American Dental Association has issued clinical guidelines on pain management and, the American Dental Education Association (ADEA) is working with dental schools throughout the US to support faculty development for continuing dental education (CDE) courses on this topic. ADEA actively supports interprofessional education and believes that more could be done to manage dental patients' pain and anxiety through development of interdisciplinary team models.

D. Unintended Consequences of State Prescribing Restrictions

One participant noted that states have enacted laws that restrict opioid prescribing practices for acute pain. For example, Tennessee enacted such a law in 2018 that limited opioid prescriptions to three-day quantities unless several other requirements were met or the patient

⁷ What is Dental Anxiety and Phobia?, Colgate, <https://www.colgate.com/en-us/oral-health/basics/dental-visits/what-is-dental-anxiety-and-phobia>.

was part of an exempt group (e.g., chronic pain, sickle cell, or major trauma).⁸ The participant noted that the law had several unintended consequences. For example, many primary care providers who treated patients with opioids stopped prescribing and transferred their patients to pain specialists. Many patients were denied opioids altogether. Overdose rates increased because as the supply of prescription opioids decreased, patients with pain sought illicit substances instead. Practitioners who still prescribed opioids sought workarounds, such as providing patients with multiple three-day prescriptions at a time. Tennessee is now working to revise this law.

Participants felt policymakers need education so that they do not pass laws that are more harmful than helpful. The Tennessee law was passed without the opportunity for review and input from a range of primary care providers or pain specialists who might have provided insights that could have minimized unintended consequences. While many policymakers feel strongly about addressing the opioid epidemic, they may hear mixed messages on how to do so. Participants noted that while professional societies can be effective lobbyists, each medical specialty has its own interests that may or may not be aligned with those of patients. Participants also noted the importance of feedback loops so that legislators understand the impact of a new law or regulation. In particular, policymakers must understand that appropriate legislation involves more than just restricting the number of pills prescribed. Participants highlighted the need for a nimble group that is focused on the interest of patients and suggested that FORE could help educate policymakers on some of these key issues. In particular, there would be great value in bringing health care providers and policymakers together in an ongoing dialogue.

III. CHRONIC PAIN

Chronic pain is defined as persistent and recurring pain lasting longer than 3 months.⁹ Participants were asked to consider chronic pain, current treatment approaches, and how they might be improved. They were also asked to consider education and training activities used to manage chronic pain and whether there were policy initiatives which would support better care.

A. Appropriate Use of Opioids in Chronic Pain Management

Participants again highlighted the importance of treating the individual person and underlying condition rather than the symptoms. They noted that even for individuals who have

⁸ Factsheet: Tennessee's Oversight of Opioid Prescribing and Monitoring of Opioid Use, https://oig.hhs.gov/oas/reports/region4/41800124_Factsheet.pdf.

⁹ Treede RD, Rief W, Barke A, et al. A classification of chronic pain for ICD-11. *Pain*. 2015;156(6):1003-1007. doi:10.1097/j.pain.000000000000160

conditions for which opioids may be appropriate, it is important to carefully consider and periodically revisit their diagnosis, treatment plan, and options. Health coaches can offer patients help in managing their conditions. If providers created patient-specific pain management plans in interoperable electronic health records and/or PDMPs, they could be shared among clinicians to inform clinical decision-making and deter practitioners from stigmatizing patients who need opioids. Such plans could include information on treatments that proved to be ineffective, anticipated needs or problems, as well as information on any previous overdoses a patient may have experienced. Participants noted that while the technology to support this approach exists, it is expensive and would need to be adopted nationwide to be effective.

Another participant pointed to diabetes programs that help patients manage their condition as a model for chronic pain management. Such programs, which involve nurses as diabetes educators and take into account co-occurring depression, could be used as a model for pain management programs. Tools could be developed so that nurses who serve as diabetes educators could be trained to help with pain management.

B. Chronic Pain Treatment Options and Barriers to Implementation

Participants identified several treatment options for chronic pain as well as barriers that prevent patients from receiving them. In particular, they noted that some insurance policies make it hard for providers to do the right thing. For example, they might want to prescribe buprenorphine to treat patients with physical dependence due to opioid therapy for chronic pain. While an opioid, buprenorphine has pharmacological effects that make it less prone to cause respiratory sedation and overdose. One participant noted that the Washington State Medicaid program has removed the requirement that patients must be diagnosed with OUD to receive a buprenorphine prescription.¹⁰ But many other states require an OUD diagnosis to prescribe buprenorphine, which can dissuade patients with chronic pain from taking it because they do not have - and do not want to be labeled- as having an OUD.

As with acute pain, chronic pain treatment should be multi-modal. Participants said that patients with chronic pain may need multiple nondrug approaches such as exercise therapy, acupuncture, yoga, tai chi, and massage therapy. Patients also may need to modify their diet, nutrition, and exercise routine; take hot baths; or otherwise augment their therapy to get relief. Participants felt there is often a need for specialists or multidisciplinary programs who can help patients determine which therapy or strategy is most suited for them. However, nondrug pain treatments are often not covered by insurance and will therefore be out of reach for most

¹⁰ <https://www.hca.wa.gov/assets/billers-and-providers/opioid-policy.pdf>

patients.

Participants said that patients should begin with the least invasive, most appropriate treatment. Ensuring that patients receive the right treatment initially can reduce pain later in life. For example, knee replacement surgery may be highly effective for an individual with severe osteoarthritis, but it may not be effective if it is conducted too early. Participants discussed an initiative in which individuals with back pain who call primary care clinics are referred to chiropractors or physical therapy as a first line of care. They noted that a Scandinavian study showed that this model is less costly and more effective than the current standard U.S. model of starting with a specialist and procedure.¹¹ It may be harder to address chronic pain after several years of surgeries, revisions, opioid therapy, and other treatments. In some cases, it may be appropriate to focus on patient self-management and coping rather than medical treatments — which may be hard for some providers and patients to accept. It is important for providers to realize that even if they are not offering medication, they can still provide therapeutic support.

C. Understanding Pain and Providing Compassionate Care

Participants noted that chronic pain can be hard to understand. Someone can be in extreme pain without manifesting any measurable signs. Patients who request opioids are often treated by health care professionals with suspicion.

While most people have felt acute pain and can therefore empathize with sufferers, many people have not experienced chronic pain and therefore fail to understand it. Participants felt that the stigma among health care professionals against chronic pain has gotten significantly worse in recent years as the opioid epidemic has grown. Medical students, residents, nurses, and other health care professionals may become exhausted by chronic pain sufferers' complaints and find them hard to address. When patients with chronic pain present in the ED, it is typically because they have "acute-on-chronic" pain, or a flareup of an underlying condition. The acute pain is expected to subside, but their co-occurring conditions may make them more difficult to treat.

Participants recommended that all health professions students be taught communication skills so that they can have difficult conversations about chronic pain with patients.

D. Educating Clinicians on Chronic Pain Management

Participants noted that medical and other students of the health professions do not receive

¹¹ <https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0203029>

adequate training in the physiology of pain or how to determine who does and does not need opioid medications for chronic pain management.

Given that sophisticated clinical judgement is required to assess and manage chronic pain, participants called for expanded clinical education and training on pain management as well as assessment of practitioners. Such training should include shared decision making, understanding bias, and communication skills.

Participants expressed concern that medical school curricula often do not include pain management. They mentioned that there are several new medical schools, many of which are looking for ways to distinguish themselves and suggested some could emphasize the practice of pain medicine. Participants noted that the University of Washington offers a one-year clinical pain fellowship, which is accredited by the Accreditation Council for Graduate Medical Education (ACGME). The program touches upon various specialties, including anesthesia, rehabilitation, psychiatry, and neurology. Participants also noted that there is very little education on pain in emergency medicine. Another participant felt that all physicians should be educated on pain, not just those who intend to specialize in treating it. Licensing renewal processes can be an opportunity to require continuing medical education on pain management.

One participant noted that clinical pharmacists could have an important role in managing patients with chronic pain. The participant noted that the Veterans Administration (VA) embeds clinical pharmacists in primary care as part of the Patient Aligned Care Team (PACT), which “involves each Veteran working together with health care professionals to plan for the whole-person care and life-long health and wellness.”¹² At some VA facilities, clinical pharmacists have a scope of practice that includes prescribing of non-opioid medications, opioid tapering support, and motivational interviewing. Participants recommended developing incentives to support interdisciplinary training and collaboration among physicians and pharmacists.

E. Educating Patients

Participants also called for educating patients about chronic pain and treatment options that are preferred to opioids. They noted that many patients with chronic pain who receive opioid therapy were started on opioids a decade ago, when there was insufficient awareness of the potential risks. They also noted that today most patients are aware of the risks and don't want opioids if other options exist.

¹² Patient Aligned Care Team, [U.S. Department of Veterans Affairs, https://www.patientcare.va.gov/primarycare/PACT.asp](https://www.patientcare.va.gov/primarycare/PACT.asp).

Additionally, participants noted that patients who ask for opioids may feel their physicians do not believe they are in pain if their requests are denied. As such, it is important to educate patients that the goal of treatment is to improve functioning and well-being as much as possible rather than to completely eliminate pain at all costs. One participant recommended asking patients about their goals and how they might change if their level of pain were reduced. The treatment plan could then focus on how to achieve patients' objectives.

Participants identified the need to educate people about the ways of managing pain, and the risks of opioids. Even elementary school children can be taught what pain is, how to respond to it, and how to manage it, similar to how they are taught to manage their emotions.

F. Opioid-Dependent Patients and Tapering

Participants cautioned that opioid-dependent patients (i.e., those who have been prescribed long-term opioids for chronic pain but do not have OUD) face significant stigma among health care professionals. Participants also noted there is no standard of care to wean dependent individuals off opioids. Many practitioners who prescribe opioids for acute pain assume patients will stop using opioids when they no longer need them, but that is often not the case.

Some opioid-dependent patients are being abandoned by their prescribers. These individuals may then end up at the ED, where they may be labeled as drug seekers and unable to access their medication. Given that it can be harmful to abruptly discontinue opioid use due to the physical dependence, patients should be given support as they transition away from opioids over time.

Participants noted that the CDC's opioid prescribing guidelines, and in particular their morphine milligram equivalents (MME) limits, contribute to the problem. Participants noted that physicians have closed their practices due to federal investigations of those who prescribe over 90 MME. Such investigations may cause patients to lose their prescribers.

Participants noted that helping patients with chronic pain can be rewarding. They recommended creating standards for chronic pain patients which could include appropriate guidelines for tapering opioids over time. Participants noted that the federal Patient-Centered Outcomes Research Institute is funding a project on tapering opioids and finding other ways to manage pain. Participants also mentioned pharmacy telecare pain management programs, in which patients participate in "phone visits" with pharmacists. The model has been effective in

helping patients manage pain and could help opioid-dependent patients as well. They also noted that while insurers typically do not cover these services, FORE could provide funding to pilot such programs.

IV. FUTURE OF PAIN MANAGEMENT

A. New Treatment Models

Participants noted that because pain may have multiple causes and can be a complex experience, managing it requires multidisciplinary approaches. However, most pain management is siloed in different medical specialties and focused on pain rather than on patients. Practitioners should work together to educate patients and develop customized treatment plans that consider alternative approaches such as acupuncture, music therapy, and chiropractic services.

One participant noted that a pain management treatment model could be based on the successful model used to provide care to children with cleft palates. Children with cleft palates receive treatment from a pediatrician, surgeon, social worker, and orthodontist all working together at the same hospital. Likewise, a pain management team could include a social worker, the ED staff, a primary care provider, and other practitioners who work together as a team in a hospital or outpatient setting. In such a model, it is important to designate someone to serve as a navigator to coordinate care. The U.S. Department of Defense and the U.S. Department of Veterans Affairs have taken leading roles in testing new models of pain management.

Participants noted that introducing some care models may be difficult in rural areas, which often lack adequate pain management and mental health services. Many rural primary care providers are unable to find specialists for their patients. Participants also said that it can be challenging to integrate services from specialist into such rural areas. One participant recommended using telehealth tools to extend services underserved areas.

Participants said that FORE has an opportunity to bring clinicians from different fields together so that each can learn from each other about what has been done to improve pain treatment models. Patients, too, need education on pain treatment options. Participants suggested reaching out to the public through libraries, places of worship, community centers, and schools and customizing communications for different groups. For example, one participant noted that it is important to communicate with millennials via their mobile devices whereas older populations may prefer to communicate in person.

B. Pain Assessment Tools

Participants noted that the zero to 10 numeric rating scale (NRS) is not an effective measurement for pain. Patients may interpret pain differently based on past experiences and social and cultural factors. Additionally, the NRS implies that the goal of treatment is to reduce pain intensity to zero, which may not be possible or appropriate and may only mask rather than address the underlying problem.

Participants recommended that the NRS be replaced with a functional assessment to ensure patients have adequate pain relief. Assessments should be patient-centered, rather than pain-centered, because factors beyond a pain score matter to patients. For example, patients should be asked to explain how their pain is affecting their lives (e.g., it makes them unable to work or enjoy time with their families). Patients who are hospitalized might be asked whether pain relief enables them to get out of bed, for example.

Participants pointed to the Pain, Enjoyment, and General Activity (PEG) scale as an alternative to the NRS. The PEG scale asks patients to assess their pain over the past week based on the average level, how significantly it interfered with their enjoyment of life, and how significantly it interfered with their general activities.¹³ This approach takes into account the fact that pain is experienced differently by different people, and offers practitioners a way to talk to patients about the impact of their pain including its emotional aspects. Similarly, participants identified the whole health initiative, in which practitioners conduct an inventory of the patient's values, goals, and life domains.

Participants also said that patients taking opioids should be asked whether they are experiencing feelings of euphoria, which would provide insight into potential risk factors for dependency. Practitioners also should take note if patients have a history of mental illness or family member with substance use disorder, both of which might place them at increased risk of developing OUD. However, one participant felt attempting to stratify patients by their risks is ineffective without offering follow-up treatment and noted that the practice could stigmatize patients. He argued that patients understand the purpose of risk stratification questions and will not answer those questions. Additionally, such questions may create a false reassurance in which prescribers believe it is appropriate to prescribe opioids simply because the patient has no heightened risks. Instead, practitioners should convey that opioids are not appropriate for most medical conditions.

¹³ The PEG is available at <http://briefmeasures.org/index.html>

V. CLINICAL GUIDELINES

Participants were asked to discuss ongoing guideline development for both acute and chronic pain and opportunities to support or enhance current guidelines. Participants noted the helpfulness of guidelines and the importance of incorporating them into continuing medical education curricula and board specialty certification. Participants also urged a move from guidelines to protocols and called for guidelines related to pain management, not just opioid prescribing.

A. Guidelines by Specialty

Participants noted that various medical specialty associations have created their own guidelines on pain management, including the American College of Emergency Physicians (ACEP),¹⁴ American College of Physicians (ACP),¹⁵ and the Federation of State Medical Boards (FSMB).¹⁶ The American College of Rheumatology is developing guidance on osteoarthritis.¹⁷ One participant noted that surgeons and OB-GYNs have developed appropriate perioperative and postoperative pain management procedures. Pain management standards are also being developed in orthopedic and pediatric medicine. One participant felt that these guidelines are siloed based on practice area or specialty, and it is unclear whether they have covered certain aspects of chronic pain. These standards could be replicated and made universal. National standards would help to reduce variation in opioid prescribing. Another participant pointed out that it is important to have treatment approaches for the underlying condition that take pain into account.

B. Guidelines for Chronic Pain

Participants discussed guidelines for chronic pain management. They felt that it may not be appropriate to have separate guidelines solely on opioids for chronic pain. Instead, participants recommended guidelines that focus on the whole patient and the underlying condition. It is important for the public to understand that pain guidelines are about more than just opioids. Such guidelines should also include other wellness factors that might have an impact on pain.

¹⁴ <http://www.asep.com/courses/asep-090/pdf/chpt3.pdf>

¹⁵ <https://www.acponline.org/acp-newsroom/american-college-of-physicians-issues-guideline-for-treating-nonradicular-low-back-pain>

¹⁶ https://www.fsmb.org/siteassets/advocacy/policies/opioid_guidelines_as_adopted_april-2017_final.pdf

¹⁷ <https://www.rheumatology.org/Portals/0/Files/Osteoarthritis-Guideline-Early-View-2019.pdf>

Participants also recommended creating a separate guideline for individuals who are opioid dependent, which would include tapering strategies. They noted that the majority of primary care providers do not know how to taper patients off opioids or even how to broach a conversation about doing so.

C. Opioid Avoidance Protocols

Participants noted that the current focus on reducing opioids does not equate with good pain management guidance. One noted that many states have implemented opioid avoidance guidelines. For example, New Jersey uses Opioid Reduction Options (ORO). Through the ORO program, hospitals can apply for state funding to be a gold-, silver-, or bronze-tier hospital based on its approach for managing pain and prescribing opioids in the ED. There are guidelines for each of the three tiers, which include recommendations for decreasing opioid use and using buprenorphine in the ED.

At New Jersey's St. Joseph's Medical Center, the ALTO program for promoting alternatives to opioids in the ED was adopted by the surgery, orthopedics, and internal medicine departments. Staff in each department created their own protocols to appropriately reduce reliance on opioids while still managing patients' pain, using opioids as a last resort. The ALTO program provided a toolbox of non-opioid pain management options that could be customized for each patient.

D. Assessing Risk for OUD

One participant suggested that FORE support the creation of a new model for measuring a patient's risk of developing OUD and risk-assessment educational materials. For example, providers could use a matrix: one side would include an age continuum and the other side would include special populations (e.g., those with diabetes, sickle cell, or cancer). Younger adults face particular risks, such as being prescribed opioids to treat sports injuries or after having their wisdom teeth removed. Older adults may incur risks related to trauma, childbirth, chronic medical conditions, or surgery. The objective is to keep people healthy throughout their life using an overarching health and wellness approach and by giving them tools to manage their decisions about opioids.

E. Key Organizations

Participants were asked to identify key organizations that could be instrumental in

developing guidelines. They identified the medical specialty societies, the National Academies of Medicine, U.S. Department of Health and Human Services, the American Medical Association, the American Dental Education Association, and organizations which have developed promising practices, such as St. Joseph's Hospital (New Jersey).

VI. OPPORTUNITIES

At the end of the meeting, FORE asked participants to each suggest one or two projects that the foundation could support or undertake to address the issues discussed in the meeting. Participants identified the following:

A. White Papers/Analytic Activities, and Other Materials

Participants suggested developing white papers and other materials that would:

- Aggregate and assess the existing models used to decrease the prescribing of opioids;
- Create a repository of state projects to address pain management and limit opioid prescribing and assess the success and failures of such programs;
- Develop a repository for best practices for opioid prescribing in emergency medicine; and
- Compare the opioid prescribing and pain management guidelines set forth by major specialties; determine where they align and where discord exists; and develop a resource for clinicians, advocates, and policymakers to determine which guidelines or strategies have been successful based on metrics of treatment effectiveness and returns on investment (e.g., decreased hospital readmissions and other cost savings).

B. Meetings or Conferences

The participants recommended that FORE hold meetings and conferences to:

- Convene medical specialty groups and experts on the topic of pain management so they can learn from each other;
- Conduct a congressional briefing for policymakers so they can hear from health care practitioners who treat patients with pain and learn about their needs; and

C. Funding Opportunities

The participants suggested that FORE consider funding the following programs and services:

- Offer recognition through an award program for innovative pain management models;
- A telehealth program in which pharmacists could provide consults to assist patients as they taper off opioids;
- Support to national societies to develop pain management and opioid prescribing guidelines and standards, and help promote public health awareness once the guidelines and standards are developed;
- Projects that build pain management capacity in rural areas, including in community hospitals, targeting physicians, nurses, patients, families, and community leaders; these projects could include mobile outreach and webinars;
- A project to incorporate pain management navigators on care teams; fund pilots that test navigator models that include comprehensive plans for each patient;
- Development of a chronic care model for treating people with opioid dependence;
- Projects to assist primary care providers as they implement chronic pain guidelines;
- Offer concentrated, high-quality professional development focused on pain treatment for health professions students and practitioners;
- A chronic pain fellowship program; and
- A project that would allow for coordinated care for patients with chronic pain, including through navigation and care management.

D. Educational Efforts

The participants recommended that FORE offer or fund the following educational efforts:

- Community-based education and outreach on managing expectations for pain therapy, moving away from pill culture, and alternatives to pain management;
 - Such efforts should be carefully crafted for specific populations, including elementary school children, medical students, and the geriatric population
 - Potential partners could include organizations that address OUD and sports organizations
 - These efforts could be conducted at health fairs, school nurses, and libraries
- Train practitioners to serve as mentors to other practitioners, including pharmacists and nurses, on the treatment of pain, tapering off opioids, and pain management;

- Work with state hospital associations to reach rural areas using mobile technology; including by developing email or text communications that are customized for different languages or different populations;
- Engage in efforts to jointly address patients’ psychiatric issues, opioid use, and pain management; and create awareness of how these issues intersect in other practice areas;
 - Potential partners include the American Pharmacists Association and College of Psychiatric and Neurologic Pharmacists
- Work with the American Board of Specialists to develop a continuous certification program for pain so that every specialty with prescriptive capability can learn about pain management;
- Partner with payers to ensure coverage for best practices for pain management;
- Develop a campaign to address stigma, especially among individuals with chronic pain who are dependent on opioids;
- Engage the media to help educate patients and families on pain management; promote a segment on talk or news show; and create a public service announcement campaign similar to “The More You Know”;
- Disseminate and encourage implementation of the ACP Guideline for Low Back Pain and similar guideless that promote effective pain management through nonopioid approaches in concert with efforts to decrease access to opioids and provide effective addiction treatment;
- Bolster existing projects funded by the National Institutes of Health, PCORI, and the Agency for Healthcare Research and Quality to develop educational materials for clinicians and patients on non-pharmacological treatments for pain; and
- Educate dental students and practitioners on proper opioid prescribing for acute pain.

VII. ATTENDEES

The following individuals attended the advisory board meeting. FORE is grateful for their time and contributions. Their participation in the meeting does not constitute their endorsement of this document.

Chair:

- Carolyn Clancy, M.D., Deputy Under Secretary for Discovery, Education and Affiliate Networks, Veterans Health Administration

Attendees:

- Tyler W. Barrett, M.D., M.S.C.I., Associate Professor, Medical Director, Department of Emergency Medicine, Vanderbilt University Medical Center
- Christine Goertz, Ph.D., Vice Chairperson, PCORI Board of Governors; Chief Executive Officer of the Spine Institute for Quality; President, Christine Goertz LLC; Adjunct Associate, Department of Orthopedic Surgery, Duke University Medical Center
- Joshana K. Goga, Pharm.D., Interim Director of Clinical Services, Department of Pharmacy, Sheppard Pratt Health System; Clinical Associate Professor, University of Maryland School of Pharmacy
- Joanna G. Katzman, M.D., M.S.P.H., Senior Associate Director, ECHO Institute; Associate Professor, Department of Neurosurgery, University of New Mexico
- Erin E. Krebs, M.D., M.P.H., Chief of General Internal Medicine, Minneapolis VA Health Care System; Core Investigator, Minneapolis VA Center for Care Delivery and Outcomes Research; Professor of Medicine, University of Minnesota
- Alexis M. LaPietra, D.O., Founder, Alternatives to Opioids (ALTO SM) program; Medical Director, Emergency Medicine Pain Management Program, Fellowship Director, Emergency Medicine Pain Management Fellowship and Emergency Medicine Mental Health and Addiction Medicine Fellowship, St. Joseph's Health; Chair, ACEP Pain and Addiction Medicine Section
- Linda Niessen, D.M.D., M.P.H., M.P.P., Professor, Nova Southeastern University College of Dental Medicine; representing American Dental Education Association
- Mark Rosenberg, D.O., M.B.A., Chairman, Emergency Medicine, Associate Professor, Emergency Medicine, St. Joseph's Health; President Elect, ACEP, Secretary/Treasurer, ACEP
- Mark Sullivan, M.D., Ph.D., Psychiatrist, University of Washington Medical Center for Pain Relief and Regional Heart Center; Professor of Psychiatry and Behavior Science, Adjunct Professor of Anesthesiology and Pain Medicine, Adjunct Professor of Bioethics and Humanities, University of Washington

FORE Staff and Consultant:

- Karen Scott, M.D., M.P.H., President of FORE
- Shibani Gambhir, M.P.A., Chief Operation Officer at FORE
- Ken Shatzkes, Ph.D., Senior Program Officer at FORE
- Lydia Tschoe, M.H.A., Program Assistant at FORE
- Stacey Worthy, Esq., Partner with DCBA Law & Policy LLP