Patient-Centered Care Is Key to Best Practices in Pain Management

May 10, 2019 | *By: Vanila M. Singh, MD, MACM, Chief Medical Officer, HHS Office of the Assistant Secretary of Health, and Chairperson, Pain Management Inter-agency Task Force*

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

On May 10, the Pain Management Best Practices Inter-Agency Task Force voted on its final recommendations, which emphasize the importance of providing balanced, individualized, patient-centered pain management to ensure better clinical outcomes for pain that improve quality of life and functionality for patients. The group recommended a broad framework of approaches for treating acute and chronic pain. Following is an interview with Dr. Vanila Singh on the task force's work.

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

Q: What were some of your key recommendations?
A: We recommended a multimodal approach for patients who experience acute injury and perioperative pain, as well as a multidisciplinary approach for patients with chronic pain and various underlying pain conditions. Our report emphasizes safe opioid stewardship, recommending approaches that mitigate opioid exposure. These multidisciplinary approaches may include medications (non-opioid as well as opioid, depending on the individual patient's situation), interventional approaches, restorative therapies, behavioral health interventions and other approaches.

Q: What kinds of gaps did the Task Force identify?
A: We identified a number of gaps that need to be addressed in order to improve pain management. We highlight the need for multidisciplinary approaches to chronic pain that focus on the patient's medical condition, co-morbidities and various aspects of care including: medications, restorative movement therapies, interventional procedures, complementary and integrative health services, and behavioral health and psychological interventions. Each multidisciplinary approach would depend on clinical indication and patient specific needs.

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

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

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

Q: How does the Task Force address the opioid crisis?
A: The Task Force was created in the midst of a national opioid epidemic, but also at a time when an estimated 50 million adults in the U.S. experience chronic daily pain. It is important to strike a balance

between mitigating opioid exposure while ensuring that adequate pain treatments are available for patients to have the best quality of life possible.

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

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

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

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

In a nutshell, the Task Force has 28 members, representing federal and non-federal entities with diverse disciplines and views. Members have significant public- and private-sector experience across the disciplines of pain management, patient advocacy, substance use disorders, mental health, veteran health and minority health, as well as other areas of expertise.

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

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

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