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ASSOCIATION

March 18, 2019

Office of the Assistant Secretary of Health
U.S. Department of Health and Human Services
200 Independence Avenue SW, Room 736E
Washington, DC 20201

Attn: Alicia Richmond Scott, Pain Management Task Force Designated Federal Officer

Dear Ms. Scott:

We are writing on behalf of the American Psychological Association (APA) and our Society for Health Psychology (Division 38) to convey our comments regarding the draft report issued by the Pain Management Best Practices Inter-Agency Task Force led by the U.S. Department of Health and Human Services (HHS), in coordination with the U.S. Department of Veterans Affairs (VA) and the U.S. Department of Defense (DoD). APA is the nation's largest nonprofit membership organization representing the profession of psychology, with more than 118,400 members and associates who are clinicians, researchers, educators, consultants, and students.

We greatly appreciate the work of the Task Force, and we strongly support the report's recognition of the biopsychosocial nature of pain, the importance of behavioral health approaches to pain management, and the need for work on several fronts to improve access to multidisciplinary pain management care that includes behavioral interventions. Psychologists are primary developers and providers of the behavioral interventions that are preferred alternatives to the use of opioids for treating chronic pain, including back pain, arthritis, fibromyalgia, migraine, and neuropathic pain. Early psychological interventions can provide an upstream preventative impact on long-term opioid use. Psychologists have been at the forefront of the shift away from responding to pain as a physiological condition and toward an understanding of pain as a biopsychosocial phenomenon. They have also been actively engaged in the development of interventions to manage pain in the service of maximizing patient functioning and quality of life.

We commend the inclusion of a section in the report devoted to behavioral approaches to pain management. We also applaud the report's recommendations for the provision of patient-centered and individualized care, and for addressing the needs of particularly disadvantaged and neglected populations, such as children, adolescents, and older adults. The report also

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recognizes that long-term opioid use is safe and effective for many patients suffering from chronic pain, and that restricting access to opioids can be dangerous for these patients.

Although the report as a whole endorses the biopsychosocial model of pain management, it includes language reflecting an outdated biomedical model of care and that suggests opioids are the first treatment option. As an example, the draft accurately states on page 5 that “[c]omprehensive pain management can be a challenge for various reasons,” but then discusses only the difficulties associated with the use of opioids, with no mention of the need for both an adequate multidisciplinary workforce of pain management providers and more appropriate financing and reimbursement of pain management services.

Similarly, two paragraphs later the report states that “[t]he Task Force recognizes that comprehensive pain management *often* [emphasis added] requires the work of various health care professionals, including physicians, dentists, nurses, pharmacists, physical therapists, occupational therapists, behavioral health specialists, psychologists, and integrative health practitioners.” Although we believe the biopsychosocial nature of pain merits prioritizing the role of psychologists within this list, we are more concerned that the Task Force would hold that comprehensive pain management does not include the work of a multidisciplinary team *as a rule*. The multi-faceted nature of pain, the correlations between pain and comorbid conditions, and the effect of pain on patient functioning and well-being all dictate that the clinical best practice for managing pain starts with the use of a multidisciplinary pain management team or approach, including a psychologist or other behavioral health care provider integrated within the treatment team or available through care coordination.

Before providing our recommendation for other sections of the report, we want to particularly highlight our strong endorsement of the report’s statements in two areas. First, we agree with the report’s statements regarding the need for a stronger health care provider workforce for pain management, as discussed primarily in Section 3.3.3 on pages 49 and 50. The realization of Recommendation 1c on expanding the availability of psychologists and other nonphysician providers, and Recommendation 1a on enhancing health care provider education and training on treating chronic pain in patients with psychological comorbidities, would go far to improve the quality of pain management services. We urge HHS and other federal agencies to increase federal funding to programs in this area.

Second, and perhaps more importantly, we believe it is imperative that the Centers for Medicare & Medicaid Services (CMS) and other health care payors improve reimbursement policies to more appropriately incentivize psychological and other nonpharmacological interventions for pain management, as referenced within the recommendations included on page 49 and 50 of the report. Our members’ experience is that psychologists and other behavioral health providers are particularly lacking financial support. As the report states:

... “[a]ccess to behavioral pain management is limited because of financial incentives for psychologists and other providers to specialize in pain. Many insurance programs do not reimburse for behavioral pain treatments, or they reimburse at a much lower rate than for pharmacologic or interventional treatments. Because of the lack of incentives, not enough providers are trained in behavioral pain management.” (p.49)

Although this statement is included in the report's section on workforce, it aligns with the Gap 4 statement regarding insurance coverage, on the same page, that "[c]oordinated, individualized, multidisciplinary care for chronic pain management...is nearly impossible to achieve with current payment models." We strongly encourage further work by HHS and other agencies to address financing and reimbursement barriers.

APA urges strengthening the report's language relating to the biopsychosocial nature of pain.

- Within the Acute Pain section, recommendation 2b suggests "accounting for patient variability with regard to factors such as comorbidities, severity of conditions, surgical variability, geographic considerations, and community/hospital resources." This list should include a reference to patient variability with respect to psychological factors, given the biopsychosocial nature of the experience of pain.
- We appreciate the summary of behavioral health approaches for managing pain included on page 27. Cognitive processes (e.g., attentional focus, hypervigilance, threat appraisal) contribute to pain production and are critical therapeutic targets. We suggest moving the reference to "pleasant activity scheduling" from the cognitive behavioral therapy (CBT) intervention paragraph to the behavioral therapy paragraph. We also ask that the CBT paragraph include a reference to its efficacy for chronic headache and irritable bowel syndrome, as studies have documented significant effect sizes for the use of CBT with these patient populations.
- The report includes recommendations for research to improve the understanding and treatment of acute and chronic pain, in section 3.3.4. Given the central role that psychological factors play in the experience of pain and the importance of behavioral interventions in preventing, minimizing, and responding to pain, these should be explicitly referenced in this section. Notably, Recommendation 4a on page 51 references increasing levels of research across an array of possible interventions, including pharmacologic and biologic research. Psychological and behavioral research should be included in this list, along with translational and implementation research. Similarly, the draft's initial list of key priority areas references, on page 2, the need for research into "innovative medical devices and medications." This language suggests that only biological interventions are worthy of research. Instead, the description should be broadened by explicitly including psychological factors and behavioral interventions as areas meriting greater research funding.
- Section 3.1 (Stigma) and 3.2 (Education) both speak to the need to increase patient, provider, and societal understanding of the nature of acute and chronic pain. Within section 3.1, we believe that Gap 1 and Recommendation 1a, on pages 41 and 42, should explicitly reference education regarding the biopsychosocial nature of pain. We are also concerned that Gap 1 and Recommendation 1d reference identifying biomarkers for chronic pain, which reflects a biological, not biopsychosocial, model of understanding and responding to pain. Gap 1 in Section 3.2.2 focuses on the lack of patient education relating to both acute and chronic pain. For addressing this gap, we encourage inclusion of a recommendation that education on the biopsychosocial model of pain and self-management techniques be integrated into primary, secondary, and tertiary levels of pain treatment. Given the importance of minimizing pain catastrophizing, we strongly

support Recommendation 2a on page 44, on the need to emphasize discussions about pain control including education about non-pharmacological interventions after surgery during the preoperative visit.

- Gap 2 within Section 3.2.3, regarding provider education, describes pain as a “category of disease.” We are concerned that this terminology supports the biomedical model of pain, in which pain is an aberrant phenomenon that is to be treated and cured, rather than a part of life that might not be completely eradicated and avoided. We suggest replacing the term “category of disease” with the term “condition” for both the gap statement and the ensuing recommendations.

APA recommends changes to more strongly prioritize and support psychological and other non-pharmacological pain management interventions.

- As mentioned, we applaud the inclusion of Section 2.5.1 regarding access to psychological interventions for pain management. While we endorse all three recommendations included in this section on page 29, we believe that ready access to psychological interventions should be standard operating procedure for pain patients throughout health care systems, not provided primarily through alternative treatment delivery methods as referenced in Recommendation 1a.
- Psychological and behavioral health interventions merit increased support both as part of integrated, multidisciplinary, and multimodal treatment approaches, as described in Recommendation 1c on page 29, and as standalone services added to existing treatment programs and policies. Consequently, we recommend the inclusion of a new recommendation in this section to “Increase access to evidence-based psychological interventions by improving health insurance coverage and reimbursement policies across health care delivery systems.”
- We strongly agree with the report’s first gap and recommendations section within the section on Acute Pain (2.1.1), regarding the underutilization of psychological and other nonmedical interventions in the perioperative setting. In many cases, such interventions can completely obviate the patient’s need for opioids. It is imperative that HHS develop appropriate reimbursement and authorization policies to support the use of psychological and other multimodal therapies in the perioperative setting, as described in Recommendation 1c, on page 9.
- Gap 1 within Section 2.2 (Medication) calls for the establishment of guidelines for medication use for specific populations of chronic pain patients, differentiated by age, gender, medical condition, and comorbidities. Effective patient-centered pain management requires addressing the patient’s psychological and social history and context. Two individuals sharing the same gender, age group, and medical condition will likely have divergent pain experiences and responses to treatment because of prior trauma, abuse, and social context. Consequently, we believe the current gap statement should be reworded to call for the development of “guidelines for the use of nonpharmaceutical and pharmaceutical-based interventions” for specific populations of patients.

- We applaud the recommendations for Gap 2 within section 2.2 (Medication) to prioritize the use of nonpharmacologic treatments and nonopioid medications. We suggest that Recommendation 2a be revised to refer to “nonpharmacological interventions and treatments,” in order to encompass the full range of pain education, management, and prevention services described throughout the report.
- Section 2.7.2 of the report (page 35) appropriately identifies older adults as a special population in need of more effective pain management care. Although psychological factors are as much a factor for this population as in others, the only gap identified for this section is a lack of opioid prescribing guidelines for the aging population. Elsewhere the report states that “[d]espite widespread understanding of the importance of psychological interventions in the management of pain, many patients with pain receive inadequate care.” Consequently, we believe the gap statement in the Older Adults section should be amended to speak more generally about this population’s lack of access to the full spectrum of multimodal pain management services, and the need to prioritize nonopioid treatments when possible.

APA urges shifting away from physician-centric language to more effectively promote multidisciplinary pain management teams as best practice.

- The report frequently uses the term “physician” or “doctor” when the more broadly encompassing term “health care provider” or “specialist”, or the phrase “physician or other health care provider” should be used instead. As an example, on page 19 Section 2.2.1.2 (Screening and Monitoring) states that “[a]t follow-up, *doctors* should assess benefits in function, pain control, and QoL [quality of life]...asking patients about progress toward functional goals that have meaning for them.” In many cases it will be a psychologist, social worker, physical therapist, or other non-M.D./D.O. provider providing such follow-up for the patient.
- Section 3.2.2 discusses patient education, and Gap 2 includes recommendations for addressing patient expectations regarding pain management in the perioperative settings. Recommendation 2c is that CMS and other payors appropriately value and reimburse for time spent educating and managing patients’ expectations and compensate the delivery of such services “according to physician-patient time spent.” Since psychologists are frequently the providers engaged in this work, the wording should be changed to “according to provider-patient time spent.”
- We applaud the report’s recognition in Section 2.7.1 of the importance of applying the biopsychosocial model to pediatric pain care, and the contributions that psychological conditions have to long-term pain. However, the language in Gap 3 and Recommendation 3a focuses solely on attracting, training, and credentialing physicians in pediatric pain management. Instead, these references should be changed to explicitly include psychologists and other health care providers.
- Within Section 2.7.8 of the report (Military Personnel and Veterans), Gap 2 and Recommendation 2a both refer to “primary care, mental health and pain specialty physicians, and other health care providers.” Several non-M.D./D.O. providers—

including clinical psychologists, nurse practitioners, physical therapists, clinical nurse specialists, registered nurses, social workers, and others—provide primary care, mental health, and pain services. We urge the Task Force to change these references to “primary care, pain specialty, and behavioral health care providers” in order to more accurately describe the multidisciplinary nature the health care system.

- As mentioned previously, we strongly agree with the Task Force on the need to substantially improve health care providers’ education regarding pain and pain management, as discussed in Section 3.2.3 beginning on page 44. However, the recommendations for addressing this gap are focused almost exclusively on physicians. Although primary care providers are often involved in pain treatment, we believe Recommendation 1a would be greatly improved by also explicitly referencing psychologists, nurses, pharmacists, physical therapists, dentists, occupational therapists, behavioral health specialists, and integrative health practitioners. Recommendation 1c calls for exploring intensive continuing pain education for primary care providers; once again, the need for continuing pain education extends to the full range of health care providers. We suggest either amending this recommendation or adding a similar recommendation focusing on non-physician providers.

Thank you for the opportunity to provide comments on the Task Force’s draft report. We are encouraged by the breadth and depth of the Task Force’s recommendations, and we are committed to continuing to work with the Department of Health and Human Services and other federal agencies to significantly improve access to high-quality comprehensive pain management services.

Sincerely,



Arthur C. Evans, Jr., PhD
Chief Executive Officer



Nancy B. Ruddy, PhD
President, Society for Health Psychology