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NASW
National Association of Social Workers

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Pain Management Best Practices Inter-Agency Task Force
Office of the Assistant Secretary for Health
U.S. Department of Health and Human Services
5600 Fishers Lane
Rockville, MD 20857

Submitted electronically: *https://www.regulations.gov*

Re: HHS-OS-2018-0027- Pain Management Best Practices Inter-Agency Task Force Draft Report on Pain Management Best Practices

The National Association of Social Workers (NASW), representing 120,000 social workers, submits comments on Pain Management Best Practices Inter-Agency Task Force Draft Report on Pain Management Best Practices (HHS-OS-2018-0027).

NASW is the largest professional social work organization in the United States with 55 Chapters. Social workers provide psychosocial support to patients and families and work as practitioners in a variety of health care settings. Social workers serve vulnerable populations with chronic mental and physical conditions, and individuals living with pain. They help individuals reach their optimal level of functioning and personal goals while living with illness. Clinical social workers provide diagnosis and treatment for mental health conditions.

NASW strongly advocates for individuals with pain to have access to appropriate care and appreciates the integrative, patient-centered models advanced by this draft report. NASW has collaborated with organizations through the Academy of Integrative Pain Management and strongly endorses the coalition's consensus definition of comprehensive integrative pain management (CIPM):

> *Comprehensive integrative pain management (CIPM) includes biomedical, psychosocial, complementary health, and spiritual care. It is person-centered and focuses on maximizing function and wellness. Care plans are developed through a shared decision-making model that reflects the available evidence regarding optimal clinical practice and the person's goals and values.*

In this Task Force report, many different terms are used to describe CIPM including multidisciplinary, integrated, integrative, multimodal, holistic, and comprehensive. NASW suggests that for consistency and clarity, these various terms be replaced with "Comprehensive integrative pain management (CIPM)." NASW supports many sections of the report that encourage access to CIPM early and consistently, including behavioral health, psychological and non-pharmacological interventions.

2. Clinical Best Practices

2.1.1. Acute Pain. NASW agrees that psychological and integrative therapies to mitigate opioid exposure, and enhance emotional well-being, are underutilized in the perioperative period. Behavioral health screening and monitoring are particularly useful for individuals with comorbidities and/or an identified mental health or substance use disorder diagnosis (Gap 1, Recommendations 1 a, b & c).

2.2 Medication. NASW supports efforts to enhance CIPM and multidisciplinary treatment approaches that are shared between health care and community providers (Gap 1, Recommendations 1 a,b,c&d). Assessment, care coordination and follow up are particularly important for individuals with comorbidities and/or high social needs that create barriers to care. Social workers, who may visit the home and interact with all family members, can facilitate care coordination and enhance safe medication storage and disposal practices (Gap 5, Recommendation 1a).

2.2.1 Risk Assessment. NASW encourages the inclusion of social workers as behavioral health providers in care teams. Social workers provide comprehensive screening and assessment to help determine risk of opioid use disorder and need for further support for addiction (Gap 1 Recommendation 1a,b).

2.5 Behavioral Health Approaches. Clinical social workers in health settings provide expertise in delivering many of the behavioral health interventions outlined.

2.5.1 Access to Psychological Interventions. As described, there are many barriers to accessing behavioral health care. NASW encourages adoption of integrated care models which include behavioral health providers in care teams on site and provide seamless transitions to support. Otherwise, hospitals and clinics must establish strong relationships with community providers for referrals. Telehealth advancements are promising, though challenges to the delivery of telehealth services continue to exist, including state-based licensing for many health care professionals.

2.5.2 Chronic Pain Patients with Mental Health and Substance Use Comorbidities. Early referral to behavioral health specialists is important and often lacking.

2.6 Complementary and Integrative Health. NASW supports efforts to include complementary and integrative health approaches in the treatment of acute and chronic pain, when indicated, including acupuncture, mindfulness meditation, movement therapy, art therapy, massage therapy, manipulative therapy, spirituality, yoga, tai chi, and other non-pharmacological approaches such as physical therapy and occupational therapy.

2.7 Special Populations. For children, older adults and other populations with particular needs, NASW encourages support for the identified patient, family caregivers.

2.7.2 Older Adults. NASW affirms the task force's identification of older adults as a special population dealing with chronic pain. As the draft report notes, chronic pain in older adults is quite common and is often challenging to address. Yet, NASW is concerned about the task force's statement that "chronic pain in older adults usually results from a physical or psychological pathology, especially those conditions such as cancer and arthritis that may increase in frequency with age" (2.7.2, para 1). The most common causes of pain in older adults are physical, such as arthritis, cancer, neuropathy, cardiovascular disease, degenerative bone disease, and pain associated with various chronic illnesses—and pain tends to be under diagnosed and under treated in older adults.[1,2,3,4,5,6] Although psychological factors can exacerbate pain in older adults, older adults are no more prone to many of these factors—such as depression, for example—than are younger people.[7] As noted in many of the previously cited sources, however, older adults often experience exacerbations in psychological challenges as a *result* of pain rooted in a physical cause; this dynamic is not unique to older adults, however, and is addressed in 2.5.2, Chronic Pain Patients With Mental Health and Substance Use Comorbidities. Thus, NASW is concerned that language attributing chronic pain in older adults to psychological causes could exacerbate underdiagnosis and undertreatment of such pain. The association recommends that the task force to delete language in Section 2.7.2 about

[1] National Institutes of Health, NIH Pain Consortium. (n.d.). *Chronic pain in older adults.* Retrieved from https://painconsortium.nih.gov/sites/default/files/aging_and_chronic_pain_infographic_508.pdf

[2] Periyakoil, V. S. (2018). *Pain management* [Geriatrics Review Syllabus]. Retrieved from https://geriatricscareonline.org/FullText/B023/B023_VOL001_PART001_SEC002_CH016

[3] Carrington Reid, M. (2015). Management of chronic pain in older adults. *BMJ, 350*(h532). Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4707527/

[4] Byrd, L. (2013). Managing chronic pain in older adults: A long-term care perspective. *Annals of Long-Term Care: Clinical Care and Aging, 21*(12). Retrieved from https://www.managedhealthcareconnect.com/article/managing-chronic-pain-older-adult-long-term-care

[5] Robeck, I. (2012). Chronic pain in the elderly: Special challenges. *Practical Pain Management, 12*(2). Retrieved from https://www.practicalpainmanagement.com/pain/chronic-pain-elderly-special-challenges

[6] Peterson, K., & Moddeman, G. (2010). Managing chronic pain in the elderly. *American Nurse Today, 5*(9). Retrieved from https://www.americannursetoday.com/managing-chronic-pain-in-the-elderly/

[7] Administration for Community Living. (2019). *Behavioral health.* Retrieved from https://acl.gov/programs/health-wellness/behavioral-health

psychological etiology of pain in older adults, addressing instead the various physical factors that contribute to the high occurrence of pain in older adults.

NASW affirms Recommendations 1a and 1c in this section. Tools such as the Choosing Wisely® campaign of the American Board of Internal Medicine Foundation (http://www.choosingwisely.org/) and the American Geriatrics Society's *Geriatrics Review Syllabus*[8] can be useful in informing decision making and protocol development regarding pain care (1a) and educating health care providers (1c) about such intervention for older adults. NASW also strongly supports the use of a multidisciplinary approach and nonpharmacological interventions for treating chronic pain in older adults (1b), as well as for younger populations. At the same time, NASW recognizes that medication is an integral component—and, sometimes, the only effective component—of chronic pain care for older adults, and the association is concerned that the wording of 1b will discourage providers from prescribing any type of pain medication for older adults. Consequently, NASW suggests the following revisions to Recommendation 1b: "Use a multidisciplinary approach **that includes** nonpharmacologic **interventions** for pain **to decrease** risk of medication side effects."

2.7.7 Health Disparities in Racial and Ethnic Populations, Including African-Americans, Latinos, American Indians, and Alaska Natives. To reduce health disparities, both psychosocial and health needs must be addressed in a continuum of care that facilitates communication between patients and providers. Intervention programs should provide culturally and linguistically appropriate services that are developed for the specific consumer population. Mechanisms for regular consumer feedback and community input should also be established.

2.7.8 Military Personnel and Veterans. NASW supports the Veterans Health Administration's integrated models of care that include social workers. NASW also strongly supports all Recommendations under Gaps 1, 2 & 3. Care coordination across the spectrum of services, both within and outside of the VA, is critically important for service members, veterans and their families to receive timely and effective treatment.

3. Cross-Cutting Clinical and Policy Best Practices

3.1 Stigma. NASW supports efforts to reduce stigma around chronic pain and treatment of mental health and substance use disorders. In CIPM, when all team members are involved in care, barriers to access can be reduced and the quality of care is improved.

3.2 Education. NASW supports enhancing provider education to better understand pain, biopsychosocial factors and the components of pain treatment in CIPM. Similarly, patients and

[8] Periyakoil, V. S. (2018). *Pain management* [Geriatrics Review Syllabus]. Retrieved from https://geriatricscareonline.org/FullText/B023/B023_VOL001_PART001_SEC002_CH016

the public would benefit from education on the range of services and supports that should be included in CIPM. NASW supports national public education regarding acute and chronic pain.

3.3 Access to Pain Care. As the Task Force describes, there are many barriers to accessing pain care and pain care specialists. Very few medical institutions provide CIPM in one location; often patients and/or caregivers coordinate care themselves and have access to limited array of providers due to insurance coverage, provider shortages and geographic location.

3.3.2 Insurance Coverage for Complex Management Situations. NASW encourages CMS and private payors to investigate and implement innovative payment models that recognize and reimburse CIPM, including complementary and behavioral health approaches (Gap 1, Recommendation 1b). NASW also supports further exploration of reimbursement models that account for provider time that is spent on care coordination (Gap 4, Recommendation 4a).

3.3.3 Workforce. NASW supports expanding nonphysician, behavioral health specialists in pain care, particularly clinical social workers who have the skills and expertise to treat pain from a holistic approach. (Gap 1, Recommendation 1c).

4. Review of the CDC Guideline

NASW appreciates the Task Force review of the *CDC Guidelines for Prescribing Opioids for Chronic Pain* and clarification of the intended purpose of the Guidelines, noting that they were intended for primary care settings and not for patients in cancer treatment, palliative or end-of-life care. The association strongly supports comprehensive initial assessment and periodic reevaluation to guide decision making regarding prescription opioid use (Recommendation 3b). Such assessment should be multidisciplinary and, ideally, should include psychosocial assessment by a social worker.