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American Medical Women's Association

Comments on HHS Draft Report on Pain Management Best Practices: Updates, Gaps, Inconsistencies and Recommendations

The American Medical Women's Association (AWMA) appreciated the opportunity to provide comments to the HHS Pain Management Best Practices Interagency Task Force during their initial deliberations in September 2018, as well as now in response to their draft report: "Pain Management Best Practices: Updates, Gaps, Inconsistencies, and Recommendations". AMWA has been in existence for over a century to help address the health needs of women, including those that result from sex- or gender-based differences. In light of that, we appreciate the inclusion of a separate section in the Report that specifically addresses the needs of women.

Reflecting the information that we provided previously, we strongly support the Task Force in its listing of "individualized, patient-centered care" as a key concept. Women are more likely than men to suffer from chronic pain, due to a greater propensity for pain-generating conditions, possible differences in perception of pain or pain processing signaling. In addition, women respond differently to opioids and are more likely to become addicted more quickly and at lower doses of opioids. Addressing this requires that healthcare professionals understand the unique features of a patient's pain experience, including the impact of the patient's sex and gender. We agree with the Task Force's recommendation for increased development of and use of CPGs; however, this needs to be done within the context of individualized, patient-centered care. CPGs should take into account the impact of sex and gender on pain and the response to treatment.

We also support the Task Force's key concept of the use of a biopsychosocial model of care, given the impact in some female patients of prior trauma, depression, anxiety, and/or PTSD on the pain experience. Treating pain in women with these underlying conditions only using opioids does not treat the source of their pain and may increase their risk of becoming chronic opioid users and potentially becoming addicted to opioids. However, identifying these underlying conditions can be time consuming; healthcare professionals should be made aware of the multiple factors that can impact pain and allowed additional time (and compensated for this) with these extremely complex patients. As noted later in the document, allowing the time needed to address these complex patients could help to relieve some of the stress felt by healthcare providers.

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As the Task Force notes, a multidisciplinary approach to pain management is ideal. However, we would recommend in the discussion of this approach in the initial key concepts, that the focus of treatment should be to improve function, as mentioned in the Introduction. This change in focus should be given additional emphasis within the key concepts, as the goal of treatment should be to help patients achieve the function and quality of life that they strive for, rather than an emphasis on the level of pain or a pain score. In addition, we recommend that pain be removed as the "5th vital sign", as, unlike true vital signs, there is no objective way to measure pain or the response to intervention. Using pain scores as a vital sign has likely contributed to the increased use of opioids by healthcare professionals and the opinion of many members of the public that pain is an abnormal state and should be controlled at all costs.

We agree with the Task Force's additional key concept that more public and healthcare provider education is needed. However, we would recommend that this include discussion of sex and gender differences in pain generators, expression of pain, and response to opioids. In addition, we agree that more research is needed in the area of pain. However, again, we would recommend that this include study of sex and gender differences in pain and pain response, as well as response to opioids. The last should include research into additional options for pain management, including medication, that may improve pain and function among women. This research should also include ways to address neonatal abstinence (withdrawal) syndrome (NAS), such as the provision of contraception (including long-acting contraceptives), to women of childbearing age who access the healthcare system due to chronic opioid use. NAS has significant short- and long-term impact on the infants and their families and costs society over $500 million per year. We need to investigate options to address this preventable condition. In addition, risk of pregnancy or NAS needs to be a part of the risk-benefit analysis when deciding on prescribing opioids to women of childbearing age.

Women are more likely than men to be prescribed benzodiazepines, along with opioids. According to some studies, they are also more likely to seek care or prescriptions from more than one healthcare professional. Given that, prescription drug monitoring programs (PDMPs) are particularly useful in keeping track of prescriptions among women. Use of PDMPs is a necessary key concept. However, funding for these programs is tenuous. AMWA recommends that the Task Force also emphasize the need for maintaining the financial stability and interoperability of these programs.

In addition to the above comments regarding the Reports' key concepts, AMWA recommends that specific mention be made of the impact of sex and gender on pain and opioid use and the needs of women in several of the specific recommendations of the Task Force.

1. In the management of acute pain, AMWA recommends that Recommendation 2b state that the primary goal of acute pain management is improvement in function and that individualized treatment and consideration of "patient variability" specifically include the patient's sex, along with the other factors listed.
2. In section 2.2 Recommendation 1a, AMWA recommends that development of treatment algorithms include considering of the sex and gender of the patient, noting pain syndromes and

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conditions that have been found to have sex-based differences in incidence, etiology, presentations, or responses to treatment.

3. In section 2.2 Recommendation 4b, AMWA recommends that the Task Force consider the impact of providing coverage for contraception as part of buprenorphine treatment for women of childbearing age who are not currently pregnant, to attempt to decrease the incidence of neonatal abstinence syndrome.
4. AMWA agrees with the recommendations in section 2.2.1.1 that address issues of increasing interoperability and use of PDMPs, as this an important tool in addressing the opioid crisis. This tool is especially of importance in the treatment of women patients, as they are more likely to seek prescription opioids from more than one provider, likely due to the complexity of their pain and treatment in the healthcare system. However, funding for PDMPs is inconsistent, placing the viability of state PDMPs at risk. We recommend that the Task Force emphasize the need for secure funding for PDMPs.
5. In section 2.2.1.2, we agree with Recommendation 1a but recommend that this be expanded. Comprehensive evaluation of patients with chronic pain is time-consuming, as noted. However, women with chronic pain may also be victims of violence or human trafficking. This will take additional time and resources to address, and this work should be adequately supported and compensated.
6. AMWA agrees with the inclusion of vertebral augmentation among the interventional procedures to address pain. Vertebral compression fractures related to low bone mass are significant issues among women. While these techniques can lead to pain relief, we recommend that the Task Force note that some patients will have recurrent pain, frequently due to additional fractures. We recommend that the Task Force note the need for evaluation and treatment of low bone mass after vertebral compression fracture.
7. AMWA supports the recommendations in section 2.7.2, as a large proportion of older adults are women. However, we would recommend that while developing the pain management guidelines for this population, their function be taken into account. Many older adults, especially women, suffer from chronic pain from degenerative conditions, such as osteoarthritis. These conditions can impact the ability to perform daily self-care and to maintain their desired quality of life. Pain management guidelines should balance the patient's ability to care for themselves with risk factors related to treatment, with an emphasis on non-opioid pain management. In addition, education of health care professionals who care for this population should include becoming facile with measurements of daily function.
8. AMWA appreciates the inclusion of section 2.7.3, that addresses the issues faced by women. We agree with Recommendation 1a but would ask that this be expanded to include research into sex-based differences in response to opioids and increased risks of addiction. We also ask that Recommendation 1b be expanded to include raising awareness among members of the public and healthcare professions about sex-based differences in pain and response to opioids among all women, not only those in the postpartum period. In addition, while we agree with including ob/gyn providers in this education effort, we would recommend including all healthcare professionals who treat women of all ages. Women who are addicted to opioids

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have more issues in overcoming their addiction than do men. For women who are single mothers, especially if they work, these issues are compounded as it is difficult for them to access or fully participate in addiction recovery programs. We would ask that interventions be developed to address this specific population and research evaluate the impact that these interventions have on addiction and incidence of recidivism among women.

9. In section 2.7, AMWA would recommend expanding recommendation 1b to include counseling on the use of contraception, along with counseling on the risks of opioids, as part of the treatment for all women of childbearing age who are not pregnant when they access the healthcare system, whether for the treatment of chronic pain, after an overdose, or for treatment of addiction. We would also recommend research into the impact of provision of contraception on the incidence of neonatal abstinence syndrome and any related cost-savings.
10. In section 3.1, AMWA agrees with the recommendations to decrease the stigma associated with the disease of addiction. However, we think that this should include outreach to pregnant women, who frequently avoid prenatal care if they are addicted during pregnancy, compounding the impact of neonatal abstinence syndrome.
11. In Section 3.1, AMWA recommends that Recommendation 1d state that sex-based differences be assessed in any potential biomarkers that are identified.
12. In section 3.2.1, AMWA recommends that public awareness campaigns mention sex and gender based differences in pain. We would also recommend that public education campaigns emphasize the importance of function, rather than pain or pain scores.
13. In section 3.2.3, AMWA recommends that provider education include discussion of sex and gender differences in the pain experience, as well as response to treatment. We would also recommend de-emphasizing pain scores, in favor of measurement of function, and, ideally, removing pain as the "5th vital sign" and as a measurement of quality of care.
14. In section 3.3.4, we agree that there is a gap in knowledge regarding the impact of contributing factors that predispose some patients to addiction. We would recommend that these lifelong risk factors include the impact of intimate partner violence and human trafficking on the development of chronic pain syndromes and addiction.

AMWA applauds the HHS Pain Management Best Practices Interagency Task Force on the development of this Report and appreciates the opportunity to provide comments and recommendations. We are available to provide any additional input that is deemed necessary. This Report is a major step forward in highlighting the current gaps in research, education, and treatment of pain. We believe that including more specific mention of sex and gender differences and the needs of women in this area will help to address a significant women's health issue.

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