

Evidence-Based Nonpharmacologic Strategies for Comprehensive Pain Care

The Consortium Pain Task Force White Paper

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DOI: <https://doi.org/10.1016/j.explore.2018.02.001>



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ABSTRACT

Medical pain management is in crisis; from the pervasiveness of pain to inadequate pain treatment, from the escalation of prescription opioids to an epidemic in addiction, diversion and overdose deaths. The rising costs of pain care and managing adverse effects of that care have prompted action from state and federal agencies including the DOD, VHA, NIH, FDA and CDC.

There is pressure for pain medicine to shift away from reliance on opioids, ineffective procedures and surgeries toward comprehensive pain management that includes evidence-based nonpharmacologic options. This White Paper details the historical context and magnitude of the current pain problem including individual, social and economic impacts as well as the challenges of pain management for patients and a healthcare workforce engaging prevalent strategies not entirely based in current evidence. Detailed here is the evidence-base for nonpharmacologic therapies effective in postsurgical pain with opioid sparing, acute non-surgical pain, cancer pain and chronic pain. Therapies reviewed include acupuncture therapy, massage therapy, osteopathic and chiropractic manipulation, meditative movement therapies Tai chi and yoga, mind body behavioral interventions, dietary components and self-care/self-efficacy strategies.

Transforming the system of pain care to a responsive comprehensive model necessitates that options for treatment and collaborative care must be evidence-based and include effective nonpharmacologic strategies that have the advantage of reduced risks of adverse events and addiction liability.

The evidence demands a call to action to increase awareness of effective nonpharmacologic treatments for pain, to train healthcare practitioners and administrators in the evidence base of effective nonpharmacologic practice, to advocate for policy initiatives that remedy system and reimbursement barriers to evidence-informed comprehensive pain care, and to promote ongoing research and dissemination of the role of effective nonpharmacologic treatments in pain, focused on the short- and long-term therapeutic and economic impact of comprehensive care practices.

Keywords:

[Non Surgical Pain Management](#), [Public Health](#), [Evidence-Based Practice in Health Care System](#), [Acute Pain](#)

[+](#) List of organizations and abbreviations.

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SECTION 1: The Problem Historical Context for a Call to Change

Pain care in America is in crisis. The prevalence of pain is high despite costly, well-intentioned medical responses, which rely mainly on pharmaceuticals and high-tech interventions. Pain and aspects of current pain management strategies are having enormous deleterious impacts on patients, the health system and society.^{1, 2} From the 1970s to the 1990s there was hope that new drugs, more liberal use of opioids, new technologies and a growing understanding about the mechanisms of pain would reduce the occurrence of uncontrolled pain. This was not the case. Growing rates and escalating costs of pain-related morbidity, mortality and disability have led to calls for culture change in pain medicine by The Office of the Army Surgeon General Pain Management Task Force (PMTF) Report,³ Institute of Medicine (IOM) (now the National Academy of Medicine, NAM),^{1, 2} Interagency Pain Research Coordinating Committee's National Pain Strategy⁴ and others. Government leaders have declared the opioid crisis a national emergency. The recommendations consistently promote a shift toward a more comprehensive, patient-centered and health-focused approach to pain patients. In this model, collaborative care is team-based, interdisciplinary, and involves both pharmacologic and nonpharmacologic approaches. The model affirms the essential role patients have in improving their own health and pain-related behaviors. There is a growing recognition that current conventional medical treatment may not be the best starting point and is often not sufficient. In addition to inadequately addressing pain there is increasing evidence that conventional treatment strategies are fueling the opioid crisis, according to a National Institute for Drug Abuse (NIDA) report citing one in three Americans used prescription opioids for pain in 2015.⁵ Moreover, evidence-based nonpharmacologic approaches may be the more appropriate initial treatment for acute and chronic pain management.

Currently, there is no clear roadmap for a comprehensive approach to pain management that includes evidence-based nonpharmacologic strategies. The goal of this white paper is to outline the role of evidence-based nonpharmacologic strategies for the management of pain and how they can best be integrated with conventional approaches. This integrative pain management approach is in alignment with the stated goals of the reports from the Office of the Army Surgeon General PMTF, NAM, National Academies of Science, and the NIH National Pain Strategy. How pain is assessed, managed and taught to health professionals must be updated. A shift is essential to address the immense deleterious impact that pain and the current system of pain care, including opioid reliance, have on patients, the health system and society.

Magnitude of the Pain Problem

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Societal impact

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The morbidity, disability and economic costs of pain in America are enormous. Recent estimates for the cost of pain care fall in the vicinity of \$560–635 billion annually.¹ This exceeds the annual expenditures for heart disease, cancer and diabetes combined, the nation's priority health conditions.⁶ The IOM report estimated over 100 million American adults suffer from chronic pain. This figure is likely an underestimate of America's overall pain burden, as it does not include children, nursing home residents, active military, or those in prison.^{1, 2} The prevalence of chronic pain conditions in the general adult US population is estimated to range from 11–47% in large surveys.^{1, 6, 7, 8, 9, 10, 11} Low back and neck pain, osteoarthritis (OA), and headache are the most common pain conditions in the US and are leading global causes of disability in 2015 in most countries.¹² Unfortunately, we can expect the chronic pain burden to escalate. A 2013 National Academy of Sciences report predicts pain prevalence will rise as chronic illnesses increase.¹³ For example, neuropathic pain currently affects over six million Americans and is expected to rise dramatically due to the increasing prevalence of diabetes. Obesity is also increasing and is associated with risk of diabetes, neuropathy and orthopedic problems.¹ Inadequate postsurgical pain management strategies for the increasing numbers of ambulatory and outpatient surgeries have resulted in chronic pain. As surgical, anesthetic and pharmaceutical interventions save lives in cases of catastrophic injury and life threatening illness there is another growing cohort of people who are living with chronic pain.¹

Although pediatric pain statistics are less well studied, a systematic review of the epidemiology of chronic pain in children and adolescents found that “persistent and recurrent chronic pain is overwhelmingly prevalent in children and adolescents and should be recognized as a major health concern in this population.”¹⁴ The most common pediatric chronic pain complaints include migraine, recurrent abdominal pain and general musculoskeletal pain, including limb pain and back pain.¹⁵ Depending upon the population surveyed and time frame of the survey, prevalence estimates for pediatric chronic pain range from 4–89%: headache (8–83%), abdominal pain (4–53%), back pain (12–24%), musculoskeletal pain (4–40%), and “other” or general pains that

included recurring earaches, throat pain.¹⁴

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Impact of pain: individual, workplace and employer health costs

The impact of pain is felt at many levels ranging from the effects on the individual, families, the healthcare system, employers and the community at large. Chronic pain is a high-impact disruptor of lives and economies. It is complex—physically, neurologically, psychologically, socially, spiritually, economically and symbolically.¹⁶ For the individual, there may be decreased physical functioning and increasing difficulties with simple daily and self-care activities.¹⁷ These changes can have an effect on psychological health, with an increase in sadness, worry, anger, depression, suicidal thoughts and a reduced sense of self-worth with changes in abilities.¹⁸ For children, there may be an impact on school performance, school attendance and interactions with peers.^{14, 19} For both adults and children, pain negatively effects social functioning and relationships. As a result of alterations in work capacity, people in pain have lower hourly wages and miss more time from work than those without pain.⁶ In some cases pain leads to the need for work modifications or disability claims. Pain is associated with impairment in physical and psychological functioning,^{12, 20} lost work productivity²¹ and lower socioeconomic status.²² In addition to the costs and time needed for seeking care, people with pain conditions have significantly higher direct healthcare expenditures.⁶

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Opioid abuse/dependence impact on health care costs



Among the distinctions of the current epidemic from earlier opioid abuse epidemics is that this crisis, having been based in medical prescribing, is disproportionately affecting white, middle-class people in nonurban settings, including those with private insurance.²³

- 2007–2014 opioid dependence rose by 3,203% among patients privately insured.²³
- 2011–2015 privately insured opioid abuse or dependence charges rose from \$72 million to \$722 million.²⁴
- Allowed amounts for opioid abuse/dependence healthcare services grew more than 13-fold during the same period, from \$32 million in 2011 to \$446 million in 2015.
- In 2015 the average annual per-patient charges and estimated allowed amounts by insurance were more than five times higher for patients with diagnoses of opioid abuse or dependence than for those with any diagnosis.
- In 2015 private insurers and employers providing self-funded plans paid nearly \$16,000 more per patient with a diagnosis of opioid abuse or dependence than for those with any diagnosis.²⁴
- 2006–2010 emergency department (ED) visits related to prescription opioid poisoning increased to 259,093: over half were hospitalized resulting in over \$4 billion in costs.²⁵
- ED visits for pediatric opioid poisoning between 2006 and 2012 numbered 21,928 with over \$81 million in total charges.²⁶
- From 2007–2014 pregnancy drug dependence diagnosis (including prescription opioid) rose 511%.²³
- From 2003–2012 neonate abstinence syndrome (NAS) admissions increased more than fourfold with annual costs growing from \$61 million to nearly \$316 million.²⁷
- Hospital stay is 3.5 times longer for NAS neonates compared to non-NAS neonates, with a threefold increase in cost.²⁷
- A sizable percentage of the driving public has detectable levels of opioids in their blood²⁸ with opioid impaired driving implicated in motor vehicle accidents.²⁹

These costs and risks are substantial and yet fail to measure the costs to the health and wellbeing of society: communities, families, friendships and individuals.

Economic impact of pain

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The US spent 17.8% of its GDP on healthcare in 2015,³⁰ expected to increase to 20% or higher by 2025.³¹ A significant portion of that is pain related since pain is the most common and compelling reason for seeking medical attention.^{32, 33} “The economic burden of prescription opioid overdose, abuse and dependency is estimated to be \$78.5 billion each year in the United States”.³⁴ Social Security Disability Insurance statistics suggest that worker disability from musculoskeletal and connective tissue disorders is rising, not falling. Work disability attributed to musculoskeletal and connective tissue disorders increased from 20.6% of beneficiaries in 1996 to 25.4% in 2005³⁵ to 31.7% in 2015.³⁶ In addition to worker disability there are direct and indirect workforce financial costs including both workplace absenteeism² and lost productivity from ill and injured workers while still working, called presenteeism.^{37, 38} There can be lost business opportunities and reduced customer goodwill due to work that goes undone and deadlines, meetings, appointments or engagements missed due to employee absence or reduced capacity. The Integrated Benefits Institute (IBI) conducted a landmark and ubiquitously cited survey in 2005: nearly all CFOs surveyed (343 senior finance executives) reported that they will focus on controlling health plan costs over the next two years because they believe that work time lost to employee illness including chronic pain is reaching critical levels and is affecting business performance.³⁹ A majority will seek to manage all health-related costs, including absenteeism and bottom-line

effects as key impacts of employee ill health. IBI also found, however, that CFOs are ill-informed about health-related lost work time. Nearly half of survey respondents never receive reports about “incidence of absence,” and less than a quarter receive reports on its financial impact. Far fewer know about presenteeism with nine in ten never receiving reports on the incidence or impact of presenteeism in the organization.

Cost savings from improving worker health requires new record keeping strategies. One of the most significant new research models is the extension of return on investment (ROI) analyses to include economic outcomes resulting from health interventions such as performance and productivity. For example, while very few newly approved pharmaceuticals actually save money, they can improve health at a reasonable cost. In pharmacy literature, net increases in spending that are up to \$50,000 may be deemed acceptable or cost-effective if these dollars will save at least one quality-adjusted year of life (QALY). However, this widely accepted methodology has rarely been used when considering the value of health improvement programs.⁴⁰ By contrast, the more demanding objective of realizing net savings has generally been required in evaluations of health and productivity management programs.⁴¹ Companies with successful wellness programs, with improved health-related and economic outcomes, encouraged wellness to improve employees’ lives not only to reduce costs.⁴² Furthermore, employers and payers need to realize that benefits of investments in health accrue over time, and there may be a lag between improvements in health and savings from improved productivity. Standard calculations of documenting ROI may need to become more sophisticated to capture net cost savings in the intermediate and long run.

The current workforce literature is inadequate to evaluate the specific role of pain as distinct from overall illness. The literature on work-related injuries such as back, neck and upper limb pain covers a subset of pain problems but does not capture data on such pain-related conditions as arthritis, autoimmune disorders, and diabetic and other neuropathies that are not work related. The current lack of clarity of clinical and especially cost implications remains to be resolved by future, more rigorous studies conducted at worksites over multiple years with adequate follow up times to determine both clinical and cost benefits.^{43, 44} Ongoing studies seek to develop best practice models for business analysis outcomes. Recent reviews confirm that companies that invest in worker health and well-being, including through health-promotion programs, have markedly improved stock price performance compared to the Standard and Poor’s 500 Index (S&P).^{45, 46} Similar savings have also been observed through health promotion programs among individuals who are retired and on Medicare.⁴⁷

Health disparities and pain: race/ethnicity, gender and age

Pain and pain care impact specific socioeconomic and demographic groups differently. Increased vulnerability to pain is associated with having English as a second language, race and ethnicity, lower income and education, sex and gender, age group, geographic location, military veterans, cognitive impairments, surgical patients, cancer patients and the end of life.¹ Many of these same groups are also vulnerable to pain treatment that is limited in access and scope.^{1, 2, 48} In addition to factors such as age, race/ethnicity, socioeconomic status, gender and geography, education and health literacy also influence access to kinds of care and to care outcomes. For example, while back pain is common across all primary care populations, low-income, racially diverse individuals are impacted differently. African Americans have a lower likelihood than whites of receiving comprehensive pain assessment and management.⁴⁸ African Americans may also receive less intensive diagnostic and treatment approaches compared to white patients.⁴⁸ For occupation-related back pain, whites are more likely to be diagnosed with disc herniations and have surgery than blacks; yet a nonspecific diagnosis and lack of surgery uniquely predicts lower treatment expenditure and disability ratings for African Americans.⁴⁹ Perversely, it is possible that this disparity in care provides an advantage to those African Americans who might ostensibly be considered “undertreated”: less treatment for back pain may be better treatment.³⁵

This does not, however, erase the sting of discriminatory care. Episodes of major lifetime racial discriminatory events are the strongest predictors of back pain reported in African Americans, with perceived day-to-day discrimination being the strongest predictor of back pain for African American women.⁵⁰ Racial discrimination as a predictor of pain is consistent with the impact of social context and its interrelationship with chronic pain.⁵¹ Older African Americans experience severe mismanagement of pain and potentially inappropriate or dangerous medication duplication or interactions, particularly those with comorbidity, multiple providers and limited access.⁵² Patients of lower socioeconomic status and lower healthcare literacy are less likely to be able pursue effective healthcare options not typically covered by insurance. There is ongoing research to assess how disparities in health care and outcomes operate along ethnic and socioeconomic lines. A recent review of long-term survey data indicate that racial/ethnic disparities in pain may be in part accounted for by socioeconomic status and education level—both factors that interact with race and ethnicity.¹¹

Hispanics are at higher risk for pain and pain undertreatment given the incidence of lower education, income levels, and lack of health insurance and/or access to care. These disadvantages are further compounded when there is limited English proficiency that impacts communication with healthcare providers.¹ American Indians and Alaska natives have markedly higher rates of pain symptoms compared to US general population,⁵³ with high rates of diseases and health conditions such as diabetes, arthritis and obesity that produce significant pain.¹ Despite this, American Indians report minimizing pain complaints and not readily asking for help, likely exacerbating disparities through underdiagnosis and undertreatment.⁵⁴ Asian Americans have overall lower pain prevalence than non-Hispanic whites. However, the variety of national origins, cultures, languages and

ethnicities lead to variations within this group. Lower reports may be due to a general reluctance to report pain (perceived as a sign of weakness) and a fear of side effects of pain medication combined with the potential liability of lower English proficiency and the experience of cultural bias by health professionals.¹

In every ethnic/racial category, women are more likely than men to report a wide range of chronic pain conditions^{1, 55, 56} while pain prevalence varies for women by age and race/ethnicity.⁵⁷ Women experience disparities in pain care with misdiagnoses, delays in correct diagnoses, improper and uneven treatment, gender bias, stigma and neglect, and dismissal and discrimination from the healthcare system.^{1, 58} Women report greater severity, longer-lasting and more frequent pain than men, and also experience multiple pain problems. Women are prescribed opioids and benzodiazepine sedatives at higher rates than men.^{59, 60} While men are more likely than women to die from prescription opioid painkillers, the percentage increase in deaths since 1999 is over fivefold greater among women.⁶¹ Between 1999 and 2010, about 18 women died every day in the US from a prescription opioid overdose. For every woman who died of an overdose, there were 30 who went to the emergency department for painkiller misuse or abuse.⁶¹

Chronic pain in children is often underrecognized¹ and even when recognized is still undertreated, with consequences that include behavioral changes and adverse effects on child development.⁶² While both boys and girls are more at risk of chronic pain as they get older, girls report chronic pain more often than boys.^{14, 63} Undertreated pain is also common among hospitalized children.⁶⁴ There are many levels at which children may receive disadvantaged care.⁶⁵ Many pain medicines have not undergone clinical trials or been approved for pediatric use and consequently providers are more reluctant to administer them.

The prevalence of chronic pain among independent living older adults ranges from 18% to 57%, depending on the definition of chronic pain. More severe pain and pain that interferes with activities increases with age.¹ Additionally, there may be difficulty assessing pain in older adults with cognitive impairment. Side effects of drug treatment may further adversely affect their cognitive function and overall health.^{66, 67, 68}

Easy access to opioids as the main pillar of pain care can be viewed as inadequate or “disadvantaged” care based on the lack of evidence for safety or effectiveness for chronic noncancer (CNCP) pain.^{69, 70} This is further reinforced by opioids’ abuse liability. The successful marketing of opioid dose-escalation for CNCP has adversely affected those traditionally considered disadvantaged as well as those who are not.

The perfect storm of circumstances, with opioids for CNCP promoted by physicians⁷¹ and pharma alike, opened the floodgates to single modality care with opioids creating an addiction crisis⁷² with a staggering impact on, for example, unemployed and disabled workers in economically devastated industrial communities.⁷³ White, middle-class people in non-urban settings are disproportionately affected by the current opioid crisis. Between 2007 and 2014, opioid dependence rose by 3,203% among patients privately insured in these communities.²³ Effective pain care is not assured by economic access to care, for example, through private insurers.¹³

While the 2016 Centers for Disease Control and Prevention (CDC) guidelines confirm non-opioid therapy is preferred for chronic pain outside of active cancer, palliative and end-of-life care,⁷⁴ for these populations pain is often the dominant symptom.¹ There is substantial evidence that nonpharmacologic therapies can play a significant role in cancer pain, palliative and end of life pain care as well.^{75, 76, 77}

Taking into account all health care disparities and the current US crisis in pain care, a case can be made that any patient no matter their ethnic or socioeconomic status, who is not informed or who is not offered effective nonpharmacologic options for pain is, in fact, inadequately served. One could argue that given the risks of standard care, failing to educate patients and recommend nonpharmacologic care should be considered unethical.

Complexity of pain categorization

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There is tremendous variability in the categorization of pain states that can obscure the magnitude of the problem of pain management. Pain is commonly categorized into acute and chronic, according to timeline and connection to tissue injury. Acute pain typically lasts less than 3 months but may persist longer and usually has a clear connection to a physically identifiable nociceptive (pain generating) pathology or tissue damage.⁷⁸ Acute pain is expected to resolve as the tissue damage heals. Chronic pain is present for longer than 3 months and may or may not have a clear and current connection to an identifiable tissue-based cause, structural injury or defect. Cancer pain can be acute, whether it is post-surgical or due to ongoing nociception, or can be chronic. The timeline of a pain condition is increasingly being recognized as an artificial metric, as the distinguishing features of the mechanisms of acute and chronic pain are recognized. For chronic pain, the search for causative physical sources can be frustrated by many factors, including the lack of sensitivity of available imaging technology to detect soft tissue and neuropathic causes, the complex structures that can be involved in the generation and modification of pain, and the limited training most doctors receive in the subtleties of physical examination for pain conditions.^{79, 80} Physicians report wanting more training and knowledge on evidence-based nonpharmacologic therapies and are not aware of evidence-based resources.⁸¹ “Any meaningful effort to improve pain management will require a basic culture shift in the nation’s approach to mandating pain-related education for all health professionals who provide care to people with pain.”⁸²

More recent discoveries about central and peripheral nervous system pain processing (central sensitization and peripheral sensitization) are being recognized as more actionable when classifying pain. Central sensitization involves neuronal and nonneuronal pathways (e.g., glial pathways) to and from the brain and spinal cord.⁸³ Peripheral sensitization involves peripheral structures such as muscle, nerve, fascia and others.^{84, 85} In both central and peripheral sensitization, decreased inhibitory signals meant to downregulate nociceptive transmission are themselves inhibited, leading to enhanced perception of pain. This presents clinically as hyperalgesia (experiencing a mildly painful stimulus as very painful) and allodynia (experiencing nonpainful stimuli as painful). The phenomena of peripheral sensitization are increasingly recognized in the medical community and well documented in basic science literature.^{84, 85} Another increasingly recognized neuroplastic process is the reorganization of the somatosensory cortex leading to altered and inefficient movement strategies, which can themselves cause fatigue and pain.^{86, 87} These changes in the nervous system currently inform our perceptions of chronic pain and are seen in many common chronic pain syndromes, including headache; back and neck pain; chronic abdominal pain; fibromyalgia and chronic fatigue; visceral pain; and the group of conditions called repetitive strain injuries such as cervical postural syndrome, most cases of thoracic outlet syndrome, carpal tunnel disorders, trigger fingers, and forearm and thumb tendonitis.

Pain can also be subcategorized according to anatomical sites where the pain is felt such as headache, neck and back pain. Pain can be named for the tissues involved such as musculoskeletal, visceral or neuropathic. It can be named for the pathological process such as cancer pain, osteoporotic pain, OA pain, repetitive strain injury or post-surgical pain. Many of these categories of pain can coexist and even overlap, making it important to understand the parameters and definitions used with studies evaluating pain statistics. Regardless of classification systems, the number of people in pain is high and increasing.^{1, 7, 8, 9, 10} Moreover, chronic pain states have the highest economic and societal adverse impacts.

Comorbidities associated with pain

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The definition of pain commonly used in hospice was proposed by Dame Cicely Saunders and includes the physical, psychological, social and spiritual domains.⁸⁸ This inclusive definition can be helpful in thinking about non-terminal cases involving pain since comorbidities spanning Saunders' domains are common in chronic pain patients and can complicate the evaluation and successful treatment of pain. There is a complex association between pain and psychiatric disorders. Adults with mental health disorders are significantly more likely to be prescribed opioids; 16% of Americans who have mental health disorders receive over half of all opioid prescriptions.⁸⁹ Patients with chronic pain are at increased risk of comorbid depression, anxiety and post-traumatic stress disorder.^{32, 90} Pain increases depression risk 3-5 fold.⁹¹ Pain, rather than chronic disease, is associated with the recurrence of depressive and anxiety disorders;²⁰ 50–80% of chronic pain patients report insomnia of a severity that warrants clinical attention.⁹² However, opioids generally exacerbate rather than improve these sleep and mental health comorbidities.⁹³

There are many interconnections between social rejection or exclusion and pain; for example, both are experienced in the same parts of the brain.⁵¹ Social isolation is a common condition among pain patients. Pain itself isolates the individuals since they may withdraw from family, work, school and social activities. Pain medications, however, can exacerbate rather than improve isolation by interfering with hormonal and neurotransmitter functions.⁹⁴ The endogenous opioid system is involved in the development and maintenance of human attachment. According to the brain opioid theory of social bonding,^{95, 96} beta endorphins attach to mu opioid receptors resulting in analgesia and feelings of well-being. These are closely related to the dopamine reward system and the oxytocin system affecting bonding, reinforcing the rewarding nature of close social interactions.^{97, 98, 99} The disruption of these interconnected functions—human social bonding, parent-infant bonding, the endogenous reward system, which includes sexual response—by exogenous opioids is currently being studied extensively. Hypogonadism as a result of long-term opioids has long been recognized.¹⁰⁰ The measure of the social dysfunction seen with opioid use is far reaching and has not been adequately addressed in most clinical practice settings.⁹⁹

As discussed above, substance use disorders (SUD) commonly occur and have increased as a result of the liberal use of prescription opioids. These may result from preexisting SUD or be iatrogenically induced dependence, tolerance and addiction to prescribed opioids. For a brief time, the term “pseudo addiction” was used to justify the prescribing of higher opioid doses while ignoring “red-flag” signs of addiction such as lost prescriptions, requests for early refills and nonadherence with prescribed doses.¹⁰¹

In studying the association of prolonged opioid use with psychiatric comorbidities, there is an “adverse selection” at play; people with serious psychiatric comorbidities are more likely to end up on high dose, long-term opioids.^{102, 103, 104, 105} This could be in part a result of the difficulty accessing behavioral health and addiction services as well as the need to present with physical symptoms to obtain care. Opioids are being used as a proxy treatment, a convenient but risky option for complex pathologies that are characterized and labeled as “pain” by patients and practitioners.¹⁰² The social services needed to fully assess and treat them are often unavailable.

Pain interacts with overall health. Other comorbidities such as diabetes, cardiovascular disease and obesity are at once the cause of certain types of pain and exacerbated by pain.¹ Illnesses that are comorbid with pain can, in turn, be exacerbated by the use of opioids that are ineffective for chronic pain, produce illness behavior and

carry a significant abuse liability.

Healthcare workforce considerations

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Many factors contribute to the current trends in pain management. The majority of medical/healthcare visits are initiated because of pain^{32, 33, 34, 35} and as a result, primary care practitioners (PCPs), family medicine, general internal medicine, general pediatrics, combined medicine-pediatrics, general obstetrics and gynecology, osteopathy, and general surgery assisted by nurses, nurse practitioners (APRN) and physicians' assistants (PAs) care for the largest proportion of those with pain and prescribe the largest proportion of pain medications including opioids.^{106, 107, 108} The current business model for most primary care settings encourages short appointments to increase the volume of patients seen. Pain patients, especially chronic pain patients, have complex medical histories and often have multiple overlapping causes of pain. These presentations place an intense time pressure on PCPs making it difficult for them to fully address the complexities of chronic pain and may encourage therapeutic choices that can be easily recommended within the time allotted, most commonly prescription drugs. In 2012 nearly 49% of all dispensed opioid prescriptions were accounted for by primary care specialists.²

Additionally, the education currently provided to PCPs is deficient in content related to pain in general and the full spectrum of evidence-based pain care approaches. Pain curricula in medical school education for both MDs and DOs in the US ranges from 1 to 31 hours during the 3–4 year curriculum, with a mean of 11.13 hours and a mode, or common length, of 4 hours.¹⁰⁹ Residency education is also insufficient to prepare primary care practitioners for competency in the treatment of common pain problems.^{1, 110} “A lack of knowledge and/or evidence of clinical effectiveness preclude the delivery of adequate care.”¹¹⁰ “Thus, the current training system has left primary care practitioners with inadequate tools with which to deal with some of their most frequent and challenging patients.”⁸⁰ “Any meaningful effort to improve pain management will require a basic culture shift in the nation's approach to mandating pain-related education for all health professionals who provide care to people with pain.”⁸²

Other medical specialists also treat pain that is within the purview of their specialty on a regular basis. Examples of this are urologists treating kidney stones and their painful sequelae or orthopedic surgeons treating post-operative pain. Generally, these specialists will treat pain for a short term and then return the patient to primary care or specialty pain care. Other specialties such as rheumatology, sports medicine, and physical medicine and rehabilitation (PM&R) sometimes have long-term engagement with pain care for their patients, mainly with interventional and pharmacologic options.

The medical pain specialty grew out of the work of John J. Bonica who directed the Department of Anesthesiology and Pain Medicine at the University of Washington in the 1960s. Many, if not most, pain clinics are still housed in anesthesiology clinics, but fellowship pain training can now be pursued not only by anesthesiologists but other specialists in neurology/psychiatry, PM&R, and internal and family medicine. Physicians who receive fellowship training in pain care learn interventional pain strategies that originated in regional anesthesia and acute pain care. Acute pain interventions are an essential part of pain care. But the expansion of these strategies, which are the mainstay of anesthesiology and acute pain practices, to chronic pain care have had more modest success and only in carefully selected patient groups.¹¹¹ Additionally, there are licensed practitioners from evidence-based disciplines, as in acupuncture therapy, massage therapy, osteopathic therapy, chiropractic and others, providing pain care but whose work may currently be less accessible within most formalized health systems.

Another way to categorize the practitioners in the pain field is through insurance reimbursement. Some practitioners are typically insurance reimbursable such as physical therapists, psychologists, psychiatrists, social workers and dentists, and under certain circumstances, pharmacists. Practitioners licensed in fields such as acupuncture, massage, chiropractic and naturopathy provide care that is 60–70% less likely to be reimbursed.¹¹² Even when health coverage is available it is generally limited, such that patients will still have substantial out-of-pocket costs.¹¹³ There are also studied approaches to pain care that are not regulated but are delivered by licensed practitioners “in place” such as nurses using guided imagery or progressive relaxation, for example. These services are generally not reimbursed.

The need for an informed strategy including all evidence-based comprehensive pain care is clearly demonstrated to be in patients' best interest, as reflected by their healthcare seeking and out-of-pocket expenditures for pain care. Reported in 1993 the number of visits to what were called “unconventional” providers exceeded visits to all US primary care physicians; 1990 expenditures were 13.7 billion, 10.3 billion of which was out of pocket.¹¹⁴ Analysis of the 2012 National Health Interview Survey estimated the out-of-pocket expenditure at \$30.2 billion.¹¹⁵ Out-of-pocket expenditures for back pain alone was \$8.7 billion.¹¹³

Coordination of care across disciplines and access to nonpharmacologic care have not been optimized in the current system in most states and territories. There are a few state Medicaid policy initiatives aimed at increasing access to effective nonpharmacologic therapies as a first line treatment for pain conditions. For example, the Oregon Health Plan (OHP—Oregon's Medicaid program) covers acupuncture therapy, chiropractic and osteopathic manipulation, physical therapy and cognitive behavioral therapy for all back conditions. In addition, yoga, intensive rehabilitation, massage and/or supervised exercise therapy are recommended to be

included in the comprehensive treatment plans and will be provided where available as determined by each of Oregon's Coordinated Care Organizations.¹¹⁶ Vermont's legislature is piloting a program where they will cover acupuncture therapy for back pain in a Medicaid population and monitor health outcomes and cost-effectiveness.¹¹⁷ Private coverage of every category of licensed provider is mandated in the State of Washington, where the number of people using insurance benefits for care by these providers was similar to data by the National Health Interview Survey (NHIS); hence coverage did not lead to runaway utilization.¹¹⁸ Musculoskeletal pain was the most common diagnosis for a visit. For insured patients with back pain, fibromyalgia and menopause symptoms, users of nonpharmacologic therapy providers had lower insurance expenditures than those who did not use them.¹¹⁹

Coverage for care is not current to the evidence-based detailed in Section 2 [Solutions to the Problem](#) below. Diversity of practice and engaging multiple evidence-based disciplines is enthusiastically embraced in pain medicine as a concept. Yet without a strategy on evidence-based pain care both in terms of effectiveness and cost-effectiveness, patients are not well guided in options and are often left to be the sole case managers for their own care as they navigate a system fragmented into silos.

Practitioners and patients are challenged by other barriers in access to nonpharmacologic options that are effective for pain. In addition to the socioeconomic, gender and racial/ethnic disparities already detailed, geographic disparities exist in the numbers and locations of practitioners using nonpharmacologic options leaving many regions and populations underserved.^{120, 121} As of the writing of this paper there are ongoing meetings regarding Medicare and Medicaid coverage for licensed practitioners working within their state-regulated scope of practice and utilizing therapies proven effective for pain. The Joint Commission (TJC), which has long recognized nonpharmacologic approaches to pain, has now mandated that it's accredited hospitals and facilities provide evidence-based nonpharmacologic options for pain, emphasizing the importance of options in comprehensive care. Strategies will be needed to facilitate both access and coverage to nonpharmacologic therapies.

Risk and lack of effectiveness of prevalent pain care strategies

Despite increased medical expenditures for pain and technological advances such as magnetic resonance imaging, new medications and surgical approaches, the prevalence and impact of chronic pain is worsening rather than improving. Many factors have contributed to the current situation. Both patients and medical practitioners labor under the mistaken idea that most pain problems can be fixed by the doctor or surgeon with a drug or procedure. Medical school and graduate courses still emphasize a search for appropriate dosing of opioid medications rather than considering other options. The business model of medicine, the cultural authority of projected and perceived certainty, and the disempowered position of patients in pain has promoted simplistic solutions—albeit well-intentioned—to complex problems. Patients are often regarded as passive participants with little emphasis placed on self-care, on pain prevention, or therapies that engage preventive and self-care strategies, despite demonstrated longitude of benefit.

The increasing need to respond to poorly addressed pain resulted in the numeric quantification of pain. As the notion of pain as the “fifth vital sign” took hold in the late 1990s, pain assessment became increasingly focused on a single dimension of patient status—the pain score on an 11-point, 0–10 rating scale; either a numeric rating scale with numbers marked on a 10cm line or the visual analogue scale like the Wong-Baker scale, usually a 10-cm line with faces expressing levels of pain and no numeric markings on it.¹²² By taking eyes off the more complex goals of quality of life and overall functional ability, the system inadvertently contributed to reduced functioning and increased suffering of pain patients.⁶⁹ The pressure to manage pain scores rather than to treat patients themselves has contributed to overprescribing opioids, widespread drug diversion, which is engaging illegal sources for prescription drugs, the resurgence of heroin addiction, increasing disability from pain, and deaths from overdose.^{1, 2, 35, 123, 124} Pain practitioners have long noted that pain scores do not deliver accurate information about the status of a patient. Scores vary inexplicably and alone do not inform tailored, comprehensive and effective solutions. Pain scores do not capture level of function or quality of life (QOL) intrinsic to an experience of well-being that can be present despite high pain scores. The reduction of a patient's pain experience to pain scores led to a narrowly defined goal of pain score reduction in response to interventions.¹²³

Opioids and other drugs

The US prescribes 50 times more opioids than the rest of the world combined.⁷² Between 1999 and 2010, opioid prescriptions in the US were enough to medicate every American adult with a standard pain treatment dose of 5 mg of hydrocodone every 4 hours for a month.¹²⁵ This indicates a public health crisis as prescription opioids contribute to substance use disorder (SUD) or addiction. Prescription opioids are now the most frequent gateway drug to heroin. Inadvertent overdose deaths associated with prescription opioids exceed overdose deaths from heroin and cocaine combined¹²⁵ and in many states now exceed deaths from motor vehicle accidents.^{126, 127} Societal and family disruption, violence and insufficient resources to treat SUD have resulted.

Complications attributable to the rapid rise of opioid use for chronic noncancer pain (CNCP) have led to an evidence-based re-evaluation of the practice of prescribing ever-increasing doses of opioids that have known

risks and unproven benefits.^{69, 128} This has finally propagated recommendations for a shift away from opioids and toward comprehensive, multi-modal evidence-based care. While the government has increased access to naloxone for the treatment of acute opioid toxicity (respiratory arrest), it is important to note that this is not a preventative strategy for the deepening opioid crisis.

Acute pain care can impact the development of chronic pain and disability and the development of opioid dependence, tolerance, addiction and diversion. Patients often receive long-term opioid therapy after an acute problem such as dental procedure, surgery or injury. Alarming numbers of patients then transition to chronic use after starting opioids for the short-term treatment of post-operative pain (27%) or injury-related pain (27%).¹²⁹ Pain relievers are the medications reported most often prescribed at hospital emergency and outpatient department visits.³³ Per the CDC, the economic burden of prescription opioid overdose, abuse and dependence is estimated to be \$78.5 billion each year in the US.^{34, 130} Moreover, misuse and abuse of prescription opioids costs the country an estimated \$42 billion a year in lost productivity.¹³¹ Workers' compensation data from Washington State indicates that injured workers who are on opioids for over three months are unlikely to return to work.¹²⁴

The probability of long-term opioid use increases after as little as five days of prescribed opioids as the initial treatment of pain; the probability of patients remaining on opioids for the long-term is the highest when treatment is initiated with long acting opioids,¹³² a strategy borrowed from cancer pain treatment⁷¹ and not well studied in noncancer pain. Tolerance (requiring higher doses to achieve the same analgesic effect), dependence (suffering withdrawal symptoms if a dose is missed) and opioid induced hyperalgesia¹³³ (a heightened sensitivity to pain) can develop quickly. There is no clear way to ascertain what baseline pain is present and what pain is in response to withdrawal from the last dose of opioid or induced by the opioid itself.

Acetaminophen (APAP) has been found to be only modestly helpful for mild pain; it is ineffective for acute low back pain,¹³⁴ and it is uncertain if it has any effect in chronic low back pain (cLBP).¹³⁵ Although there are fewer adverse events with acetaminophen than other medications,¹³⁴ there are dose limitations due to hepatotoxicity.⁶⁸ *Nonsteroidal anti-inflammatory (NSAID)* medications may be helpful in decreasing pain from a variety of causes such as arthritis, headache and back pain. More recent trials, however, report "that NSAIDs had smaller benefits for cLBP than previously observed".¹³⁴ The benefit of NSAIDs for spinal pain compared to placebo were not clinically important.¹³⁶ NSAIDs are now recognized to interfere with healing^{137, 138} and cause significant morbidity and mortality. They are a well-recognized cause of rebound headaches. Rebound pain, chronic medication use, and discontinuation syndromes in other conditions have not been as widely studied but exist.¹³⁹ Many patients have difficulty tolerating NSAID medicines due to gastrointestinal (GI) side effects such as nausea and abdominal pain.¹⁴⁰ The FDA has issued new warnings on NSAIDs,⁶⁶ adding stroke and cardiac risk to the list of already well-known risks, which include delayed healing, renal failure and acute and chronic GI bleeding.^{2, 68} There are 16,500 deaths annually from NSAID associated GI complications among RA and OA patients alone.^{67, 140}

Corticosteroid medications are considered potent anti-inflammatories often prescribed orally or by injection for refractory neurologic and autoimmune related pain as in discogenic pain, rheumatoid arthritis and intractable headache. Recent studies challenge the usefulness of steroids for many indications including chronic pain.^{134, 141} One in five American adults in a commercially insured plan were given prescriptions for short-term use of oral corticosteroids during the three-year period from 2012 through 2014.¹⁴² Even at relatively low doses, corticosteroids can be associated with insomnia, nervousness, behavioral changes, increased appetite, headache and joint pain.^{143, 144} There are increased risks of serious acute complications such as infection, venous thromboembolism, avascular necrosis and fracture. There are also risks of development and or exacerbation of chronic disease such as diabetes mellitus, hypertension, osteoporosis and other features of iatrogenic Cushing's syndrome.¹⁴² Corticosteroids are one of the most common reasons for admission to hospital for drug related adverse events.¹⁴² Yet corticosteroids do not appear to be effective for acute, radicular, or nonradicular low back pain.^{134, 141, 145} Epidural steroid injections are associated with less improvement in patients with lumbar spine stenosis,¹⁴⁶ increased risk of spinal fractures,¹⁴⁷ and increased risk of infection if followed within three months by spinal fusion surgery.¹⁴⁸

Skeletal muscle relaxants are prescribed for short-term pain relief in acute pain but are associated with central nervous system adverse effects, especially sedation.¹³⁴ Research is equivocal on significant benefit of some muscle relaxants for pain or muscle spasm.¹⁴⁹ Baclofen (oral, IV, or intrathecal) can be helpful for neurologically mediated spasticity as in multiple sclerosis, traumatic brain or spine injury but with risk of increase in mean fat body weight¹⁵⁰ and serious complications, even organ failure, with disruption in administration.¹⁵¹ Carisoprodol (Soma) should be avoided as it metabolizes to meprobamate, which has been withdrawn from the market in many jurisdictions due to toxicity and respiratory suppression when combined with opioids. Benzodiazepines may provide some relief for nonradicular low back pain and muscle spasm.¹³⁴ However, common adverse effects include anticholinergic symptoms such as dry mouth, blurred vision, constipation, drowsiness, sedation and confusion. Adverse effects and risk of dependence are important limiting factors especially since there is a high prevalence of concurrent benzodiazepine and opioid use in patients with chronic pain.¹⁵² Moreover, half of deaths from drug overdoses among veterans occurred when concurrently prescribed benzodiazepines and opioids.¹⁵³

Anticonvulsant (antiepileptic) medications gabapentin and pregabalin are often used in neuropathic and

neurological pain conditions such as diabetic neuropathy, postherpetic neuralgia and migraine and more recently in acute perioperative pain.² Topiramate and valproate/divalproex are commonly used for headache attenuation or prevention.^{154, 155} Though carbamazepine is commonly used in the treatment of trigeminal neuralgia, evidence for its effectiveness is not strong.^{155, 156} These medications provide mild to moderate benefit while being limited by neurological adverse effects including drowsiness and cognitive slowing.¹⁵⁷

Antidepressants of various classes including tricyclic, serotonin and norepinephrine modulators are commonly used in pain conditions including neuropathic, migraine, and amplified pain disorders such as fibromyalgia and complex regional pain syndrome.¹⁵⁸ There is also a growing recognition that mood disorders, anxiety and other psychiatric comorbidities increase the suffering associated with pain, which has resulted in an increase in the use of non-opioid drugs such as antidepressants. Certain antidepressants have propensity to anticholinergic effects, vasomotor symptoms, weight gain, sexual dysfunction, emotional blunting and suicidality, and need to be chosen carefully based on risk and comorbidities.¹⁵⁹

Breakthroughs in neuroscience regarding the roles of glial cells¹⁶⁰ and other pain modulating neuroplastic changes have led to the premature use of purported *modulators of glial function*, including ketamine, naltrexone, dextromethorphan, some tricyclics and other drugs, with variable results.^{161, 162} But an effective course of acupuncture applied to local points for carpal tunnel syndrome results in distinct neuroplastic changes^{87, 163} as do other nonpharmacologic interventions for chronic pain.¹⁶⁴ This trend to include the neuroplastic related aspects of chronic pain represents a significant contribution to pain care and is the focus of further research.

Topical medications from various categories including local and general anesthetics (e.g., lidocaine and ketamine), muscle relaxants (e.g., baclofen), capsaicin, anti-inflammatory drugs (e.g., ketoprofen and diclofenac) and antidepressants (e.g., amitriptyline) are used singularly or in combination for local pain management. Anti-inflammatories and capsaicin have been most studied and have the strongest evidence for benefit in musculoskeletal and neuropathic pain, respectively.^{165, 166} Local anesthetics have been used topically and as intralesional injections. More recently intravenous infusions have been used for neuropathic pain or generalized pain.¹⁶⁷

Inhaled and topical medications containing *cannabinoids*, most commonly tetrahydrocannabinol (THC) and the less psychotropic cannabidiol (CBD), interact with cannabinoid receptors primarily in the brain to provide a broad range of effects.¹⁶⁸ In addition to reduction of nausea, recent evidence demonstrates that cannabinoids exhibit comparable effectiveness to opioids in models of acute pain and significant effectiveness in chronic neuropathic pain.^{169, 170} In a systematic review of RCTs of medical marijuana for CNCP, no serious adverse events were noted but “neurocognitive adverse effects related to learning, memory and psychomotor deficits were common even with low-dose, short-term use of medical marijuana though they appear well tolerated”.¹⁷¹ Headaches, sedation, dysphoria and poor concentration were also noted. Long-term consequences of medical marijuana remain unknown and research is ongoing for benefit in non-neuropathic chronic pain.

Several classes of condition-based medications like *triptans* are prescribed for acute migraine¹⁷² and “disease modifying agents” in autoimmune conditions have benefit in reducing pain related to these conditions, as in rheumatoid arthritis.¹⁷³ Cardiovascular and immunosuppressive adverse effects limit their use.

Imaging, procedures and surgery

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In medical systems where a team approach to care is absent, a variety of specialists end up delivering a menu of very similar services, primarily medication, along with costly, invasive procedures and surgeries. A sometimes-premature response to or over-interpretation of imaging technology can result in higher rates of procedures and surgeries.

In the first decade of the 21st century, the use of high-cost imaging for spine and joint pain rose dramatically.¹⁷⁴ However, studies suggest that MRI findings do not correlate well with pain intensity or functional impairment, nor is advanced imaging associated with better outcomes.¹⁷⁵ Surgery rates are highest in areas of the country where imaging rates are highest,¹⁷⁶ yet imaging is not associated with an advantage in subsequent pain, function, quality of life or overall improvement.³⁵ While the process of imaging is not related to a high incidence of adverse events, part of the risk of imaging is the prompting of interventions that may result in increased risk with little gain. Moreover, common age-related, nonspecific MRI findings such as degenerative disc disease or anomalies of the spine may unnecessarily contribute to patient alarm and distress³⁵ that leads to reduced physical and work activity and a vicious cycle of disuse, distress and greater disability. The focus on imaging encourages patients to identify with their anatomical pathology often with little understanding of how that contributed to their pain or functional state.

Procedures for pain include injections of various kinds, nerve blocks, epidurals, tissue ablations, spinal cord stimulators and pain pumps. These procedures can significantly reduce suffering and allow salvage of damaged limbs and tissues in the case of acute tissue injury. Timely use of these techniques can reduce the development of post-traumatic stress disorder (PTSD).¹⁷⁷ In chronic pain these interventions can also be very helpful in carefully selected patients.^{178, 179} Unfortunately, for many procedures there are no practice guidelines that are universally followed. Expensive interventional procedures for chronic pain, such as epidural and joint steroid

injections increased by 228% from 2000 to 2011,¹⁸⁰ and surgical center utilization increased by 300%.¹⁸¹ The overuse of these strategies raises risk for patients and costs to the system. Moreover, their lack of effectiveness can be demoralizing for patients.^{182, 183}

As the long-term outcomes of surgical procedures are assessed, it is more evident that surgery performed to alleviate pain often does not achieve its goal. In geographic regions, the best spinal surgery outcomes occurred where surgery rates were the lowest; the worst results occurred in areas where rates were the highest.³⁵ Structural pathology of the knee, rated during meniscal surgery, for example, does not correlate with patient reported pain and function.¹⁸⁴ There is equivocal evidence for many common surgeries intended to remedy chronic pain; knee arthroscopies¹⁸⁵ and meniscectomies, for example.^{186, 187, 188} Surgery is found effective in the short but not in the long term for most patients with cervical radiculopathy and facet arthropathy neck pain.¹⁸⁹ When long-term follow-up for lumbar spine stenosis surgery is done, non-operative groups fare as well as the operative groups,¹⁹⁰ except the operative groups experience an increased rate of side effects.

The cost of a laminectomy can range from \$50,000 to \$90,000 without insurance and up to \$2000 in copayments with insurance coverage. A spinal fusion can cost between \$80,000–\$150,000.¹⁹¹ “Despite no specific concurrent reports of clarified indications or improved efficacy, there was a 220% increase in the rate of lumbar spine fusion surgery from 1990 to 2001 in the US”.³⁵ Yet there are no clear benefits observed with surgical vs. non-surgical treatment.¹⁹⁰ Conservative treatment including physical therapy has been associated with positive long-term outcome and a reduced likelihood of cross-over to surgery after one year.¹⁹²

Increased costs and lack of evidence of efficacy is not to condemn surgery as an option, but to question practice that engages surgery before or instead of more conservative, evidence-based therapeutic care. Decisions are complicated by a business model of medicine that continues to value costly interventions not necessarily supported by evidence, particularly in the case of chronic pain and despite the fact that many patients who submit to surgery do not have resolution of their chronic pain.

While more research is needed to understand the progression from acute to chronic pain, it is clear that the limited, siloed strategies of the prevalent pain management system have not addressed the scope of pain in America. The NIH National Pain Strategy,⁴ NAM,⁸² the CDC opioid guidelines,¹⁹³ the updated pain mandate from The Joint Commission,¹⁹⁴ the FDA,¹⁹⁵ and the American College of Physicians (ACP) Clinical Practice Guideline¹⁴¹ recommend evidence-informed, comprehensive pain care while conceding that past strategies generally, and the use of opioid medications specifically, have not remedied but rather exacerbated chronic pain, abuse, addiction, illness behavior and disability. Rapidly emerging science continues to inform our understanding of pain states and potential responses. Emerging science about the impact on pain states by the microbiome,^{196, 197, 198} mitochondria,¹⁹⁹ fascia,^{200, 201, 202} glia¹⁶⁰ and neuroplasticity,^{87, 163} and movement disorders secondary to pain⁸⁶ will likely inform future pain treatments.

The national pain strategies are shifting from a model of pain care, well-intentioned but delivered in specialty silos, favoring expensive solutions that have equivocal evidence of benefit to multimodal evidence-informed options, fitted to a patient’s whole experience of pain and therapeutic goals.

Evidence-informed practice is based in evaluation and dissemination of current research including biological, medical and behavioral science. Thirty seven US State Attorneys General have submitted a letter to America’s Health Insurance Plans (AHIP) asking them to include and incentivize evidence-based non-opioid treatments for pain.²⁰³ Nonpharmacologic therapies for pain are now recommended by the American College of Physicians (ACP) for acute, subacute and chronic... and chronic low back pain. As of January 1, 2018, the largest hospital accreditation organization, the Joint Commission, will require hospitals provide nonpharmacologic modalities for pain.²⁰³ The current evidence for nonpharmacologic therapies for acute and chronic pain is detailed next.

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SECTION 2: Solutions To The Problem Evidence-Based Nonpharmacologic Pain Care (NPPC)

Nonpharmacologic therapies are best considered within the context of all evidence-based medical treatment. The terms “complementary and alternative” stratify care by considerations other than evidence of effectiveness and risk. Evidence-based nonpharmacologic therapies are safe and effective components in comprehensive pain care that can also be opioid sparing, that is, reduce the need for opioids to manage severe, acute pain and consequently reduce the need for chronic opioids. Nonpharmacologic therapies can be stand-alone interventions or work in combination with medicine, procedures or surgery. An often underrecognized feature of nonpharmacologic therapies is their ability to confer additional benefits: a treatment to reduce pain can also reduce anxiety and depression, nausea and vomiting; facilitate restful sleep; and increase a patient’s sense of well-being and desire to participate in their own recovery.

Policy decisions for strategies on pain care must be informed by research and evidence for all practices in medicine. The assumption that conventional care is proven care has been challenged by reviews: the US Office of Technology Assessment in 1978 estimated that only 10–20% of all procedures then used in medical practice were shown to be efficacious by controlled trial.²⁰⁴ Estimates reported in the early 1990s determined 10–15% of

medical interventions were based on results from randomized controlled trials; by 2003 that figure improved: approximately 50% of conventional care was found to be evidence-based.²⁰⁵ Comprehensive, research-informed care should follow the evidence and include all evidence-based disciplines in a multimodal approach to pain care, particularly therapies that have evidence not only in the short term but have been evaluated for impact longitudinally, that is, care that registers improvement months and years following a course of treatment.^{206, 207}

There are effective nonpharmacologic therapies available from licensed and regulated professionals such as acupuncture therapy, massage therapy, osteopathic manual medicine, chiropractic, physical therapy and psychology. There are instructors trained in evidence-based, directed or self-engaged movement and meditative movement therapies as in yoga and Tai chi. Lifestyle or behavioral approaches, such as stress management, cognitive behavioral therapy, meditation/mindfulness and meditative movement therapies are also recommended as nonpharmacologic strategies. Other lifestyle approaches including diet and sleep hygiene have been shown to benefit health. These are low risk, low cost, well accepted by patients and many have been used successfully for thousands of years.

There is an additional benefit to many of NPPC strategies; unlike drugs and surgery, they involve patient participation and a commitment to self-care. Increased self-efficacy in managing pain often accompanies NPPC and correlates with improved mood and predicts improved outcomes in many chronic conditions, including pain.²⁰⁸ For example, the military has studied “active self-care therapies” as a category of pain management that may be of value in an integrated, multimodal approach.²⁰⁹

Evidence-Based Nonpharmacologic Therapies for Acute Pain

Over 50% of chronic opioid use begins in the acute care setting, after surgery, or for treatment of acute injury related pain.¹²⁹ Nonpharmacologic therapies have demonstrated benefit for acute pain with opioid sparing in hospital settings for inpatient post-operative pain and for acute pain not related to surgery. The largest hospital accreditation organization in the US, The Joint Commission (TJC), has revised its pain mandate, originally introduced in 2000. Effective January 1, 2018, TJC will require that its accredited hospitals and facilities provide nonpharmacologic therapies for pain as a scorable element of performance.¹⁹⁴ Per TJC clarification statement of 2015, these include but are not limited to, physical modalities such as acupuncture therapy, chiropractic therapy, osteopathic manipulative treatment, massage therapy, physical therapy (PT), relaxation therapy and cognitive behavioral therapy (CBT).²¹⁰ While CBT, PT, exercise² and electrical stimulation (E-Stim) have shown benefit for chronic pain,^{211, 212} they are not covered in detail in this evidence review as they are currently recognized and part of covered conventional care options, albeit underutilized in some systems. CBT, PT, exercise and E-Stim are effective nonpharmacologic therapies for pain and are included in our recommendations.

Nonpharmacologic Therapies for Acute Inpatient Pain with Opioid Sparing

Acupuncture therapy post-operative pain

Acupuncture is understood as the insertion and manipulation of fine solid core needles at specified points or combination of points on the body. “Acupuncture therapy” derives from the traditional East Asian paradigm recognizing the interrelationship of organs and body points and channels as well as associated symptoms, disease and dysfunction. Depending on a state’s scope of practice, acupuncture often includes treating by means of mechanical, thermal or electrical stimulation; by insertion of needles, or by application of heat, pressure or other forms of stimulation. In practice, acupuncture needling is often done in combination with other therapies such as palpation, Tui na, Gua sha, cupping, moxibustion, E-Stim, auricular treatment, herbal medicine and recommendations on diet, exercise, self-reflection and meditative movement like Tai chi. Acupuncture therapy, therefore includes acupuncture needling, accompanying therapies and recommendations that engage a patient in self-care, particularly in the treatment of chronic pain.

In multiple systematic reviews with meta-analyses, acupuncture was effective in reducing post-surgical pain compared to sham acupuncture, controls and usual care with reduction in opioid need (21% opioid reduction at 8 hours, 23% at 24 hours and 29% at 72 hours post-surgery) with lowered incidence of opioid-related side effects such as nausea, dizziness, sedation, pruritus and urinary retention.^{213, 214, 215} A systematic review with meta-analysis found acupuncture after total knee arthroplasty reduced pain and was associated with delayed opioid use.²¹⁶ In a systematic review and meta-analysis, peri-operative auricular acupuncture reduced postoperative pain and need for analgesic use compared to sham or standard-of-care controls.²¹⁷ Pain benefit at 48 hours was equivalent to analgesics with fewer side effects. These findings have potential for reduction of hospital readmission due to uncontrolled pain.²¹⁸

Intraoperative electrical stimulation of acupuncture points reduced intraoperative opioid requirements, post-operative pain and duration of stay in the post-anesthesia care unit.²¹⁹ Acupuncture was effective, safe and well tolerated for post-tonsillectomy pain in children with no significant side effects.²²⁰ The American Pain Society’s guidelines on post-operative pain management neither “recommend nor discourage” acupuncture therapy as

part of recommended multimodal post-operative pain based on the literature available at the time of it's guideline writing.²²¹ A subsequent systematic review with meta-analysis cited above supports the use of acupuncture as adjuvant therapy in treating post-operative pain and reducing opioid use.²¹⁴

Acupuncture therapy acute non-surgical pain

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For acute and subacute low back pain, a systematic review with meta-analysis²²² led the American College of Physicians (ACP) to recommend acupuncture as a first-line treatment.¹⁴¹ Acupuncture is also effective for acute migraine.²²³ In an RCT enrolling 300 patients with acute pain presenting to an emergency department, acupuncture was superior to parenteral morphine for pain relief and onset of action with fewer adverse effects.²²⁴ A retrospective study of emergency department acute pain patients found acupuncture decreased pain comparable to analgesics with additional benefit of reduction in anxiety.²²⁵ A trial of 1,964 patients found acupuncture benefit comparable to pharmacotherapy for emergency department patients presenting with acute low back pain and ankle sprain.²²⁶ A systematic review with meta-analysis of acupuncture analgesia in the emergency setting found acupuncture “provided statistically significant, clinically meaningful, and improved levels of patient satisfaction with respect to pain relief in the emergency setting”.²²⁷ The authors found evidence of lower cost and low adverse effects profile. In an observational study of 1,008 patients including children, acupuncture given as first aid immediately after, optimally within 48 hours, of a burn injury reduced pain, reddening, pigmentation, scarring and PTSD that commonly follows traumatic burns.²²⁸

Acupuncture therapy safety

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Acupuncture has a low risk of adverse events. The NIH Consensus Statement on Acupuncture published in 1998 found that “the incidence of adverse effects is substantially lower than that of many drugs or other accepted procedures for the same conditions”.²²⁹ Systematic reviews and surveys have clarified that acupuncture is safe when performed by appropriately trained practitioners^{230, 231, 232, 233, 234, 235, 236, 237} with infrequent minor side effects such as feeling relaxed, elated, tired or having sensation or itching at point of insertion.²³⁴ Rare serious complications such as infection or pneumothorax are directly related to insufficient training.^{235, 236, 238} Safe use of acupuncture has also been established in pediatrics^{230, 239, 240, 241} and for women who are pregnant.^{242, 243, 244}

Massage therapy post-operative pain

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Massage therapy involves manipulation of soft tissue structures of the body to prevent or alleviate pain, spasm, tension or stress and to promote health and wellness. A systematic review with meta-analysis of 10 trials showed a single dose of massage therapy provided significant improvement in post-operative pain.²⁴⁵ In a systematic review of 16 trials, massage therapy was effective for treating pain and anxiety compared to active comparators in surgical pain populations.²⁴⁶ In a randomized trial of veterans undergoing major surgery, massage was effective and a safe adjuvant therapy for the relief of acute post-operative pain.²⁴⁷ Massage is effective for pain reduction in post-cesarean section patients,²⁴⁸ cardiac²⁴⁹ and thoracic surgery patients.²⁵⁰

Massage therapy safety

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Therapeutic massage is considered safe. Studies in adults and children with cancer^{251, 252, 253} and in the post-operative period²⁴⁷ have found rare serious adverse events^{254, 255, 256} and low rates of minor complaints such as muscle soreness.¹⁴¹

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Mind body¹ directed therapies post-operative and acute pain Music therapy post-operative acute pain

A systematic review with meta-analysis of research found music therapy reduced pain in burn patients²⁵⁷ and in pediatric post-operative pain.²⁵⁸ A meta-analysis of 97 studies evaluating music therapies for pain from a variety of causes (acute and procedural pain, and cancer/chronic pain) demonstrated statistically significant decreases in pain intensity, emotional distress and analgesic use, both opioid and non-opioid intake.²⁵⁹ A trial of music therapy for post-cesarean section pain found decreased pain in the 24 hours following surgery and decreased analgesic consumption in the first four hours.²⁶⁰

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Suggestive techniques and guided imagery post-operative and acute pain

A meta-analysis of trials found suggestive techniques such as hypnosis may be useful tools to alleviate post-operative pain, especially in minor surgeries.²⁶¹ A systematic review and meta-analysis of the efficacy of audio recorded therapeutic suggestions given while under general anesthesia found no effect on pain and small but significant effects on medication use and recovery.²⁶² Listening to a guided imagery CD 2 weeks before and 3 weeks after total knee replacement resulted in reduced pain that persisted at 3 weeks.²⁶³

Virtual reality assisted distraction

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Virtual reality (VR) technology enables people to become immersed in a computer-simulated, three-dimensional environment as a distraction to pain.²⁶⁴ Coupled with standard analgesia, VR has been found beneficial in

reduction of burn-induced pain and burn wound care in adults and children.^{264, 265} VR assisted burn and nonburn wound care reduced opioid need by 39% compared to no VR, while levels of pain and anxiety were similar.²⁶⁶ VR has shown potential in inpatient cancer procedure-related pain.²⁶⁷

Mind body directed therapies safety

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Music therapy, suggestive techniques and guided imagery are not associated with significant adverse effects and are safe options to improve post-operative recovery.^{260, 261, 262} VR has potential risk of nausea and increased potential for collisions with objects in the real world.²⁶⁸ The latter is controlled by creating “safe areas” to use VR and with in-person “spotting” supervision. Debriefing post-VR experience may benefit especially young children and those vulnerable to effects of immersive reality experience.

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Multimodal Approach to Acute Pain Care

Multimodal pain care is now recognized as the optimal inclusive and responsive approach to patients experiencing pain: inclusive of all evidence-based therapies including effective nonpharmacologic options and responsive to patients’ diverse and evolving needs. Evidence-based nonpharmacologic therapies are recommended in comprehensive pediatric and adult pain care.^{82, 194, 269} Multimodal pain care is recommended by the American Pain Society in it's guidelines to post-operative pain management.²²¹ Effective nonpharmacologic options are recommended by the ACP in it's guidelines for acute low back pain.¹⁴¹

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Frequency, Dosage and Timing of Nonpharmacologic Interventions for Inpatient and Acute Pain Care

Therapies that are delivered by a single licensed independent practitioner, such as an acupuncturist, massage therapist or therapist providing an engaged or guided mind body intervention, are generally given as daily treatment for the term of the inpatient stay with referral for outpatient care follow-up. Care such as music therapy or virtual guided imagery are not single practitioner dependent. Access can be continuous or timed if provided by recordings that can be self-administered by patients. A session of inpatient acupuncture or massage therapy care can last from 20-45 minutes. There is evidence-based data on dosage and frequency of nonpharmacologic therapies, but more research is needed to determine the optimal frequency, dosage and timing of interventions: length of a session, or for the case of acupuncture therapy, what constitutes an optimal intervention in terms of session time, number of points palpated, needled, point retention time, and with what additional hands-on therapies.

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Evidence-Based Nonpharmacologic Therapies for Cancer Pain

Acupuncture therapy cancer pain

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The American Society of Clinical Oncology Clinical Practice Guidelines found acupuncture was effective in improving pain. The reviewers categorized these findings as “evidence-based, benefits outweigh harms, evidence quality: low, and strength of recommendation: weak”.²⁷⁰ A more recent systematic review with meta-analysis of 29 RCTs found acupuncture effective for cancer-related pain, particularly malignancy-related and surgery-induced pain.⁷⁵ Acupuncture alleviates side effects of radiation treatment, including pain associated dysphagia,²⁷¹ as was found in a systematic review of acupuncture treatment for dysphagia following stroke.²⁷² Cancer patients receiving inpatient acupuncture at a major cancer center experienced significant improvement in pain, sleep disturbance, anxiety, drowsiness, nausea and fatigue.²⁷³ In a systematic review with meta-analysis acupuncture relieved joint pain associated with breast cancer treatment induced menopause.²⁷⁴ A review on the management of peripheral neuropathy induced by chemotherapy found acupuncture to be among therapies that may be useful.²⁷⁵

Massage therapy cancer pain

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Massage therapy was found in systematic reviews with meta-analyses to be effective for pain in cancer patients compared to active comparators²⁷⁶ or usual care.⁷⁶ Massage therapy was also effective for metastatic bone pain,²⁷⁷ for pain in children with cancer²⁷⁸ and those undergoing stem cell transplantation.^{278, 279}

Mind body directed therapy cancer pain

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Mindfulness-based courses including web-based mindfulness interventions (eHealth)²⁸⁰ are supportive for cancer patients’ symptom burden. In systematic reviews with meta-analyses mindfulness-based stress reduction (MBSR) had a beneficial psychological impact for breast cancer patients,^{281, 282} and on quality of life, mood and distress in cancer patients.²⁸³ A recent trial of MBSR for metastatic breast cancer patients demonstrated a positive impact on distress with a mild effect of improving average pain.²⁸⁴

In a large systematic review with meta-analysis, music therapy showed statistically significant improvements in cancer pain, emotional distress from pain and a small but significant effect on anesthetic use, opioid and non-opioid intake.²⁵⁹ Music therapy in a palliative care setting produced significant improvement in pain, anxiety,

depression, shortness of breath and mood.⁷⁷

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Evidence-Based Nonpharmacologic Therapies for Chronic Pain

Nonpharmacologic therapies are well studied and effective for chronic pain. A Clinical Practice Guideline from the American College of Physicians (ACP) states nonpharmacologic interventions should be considered as first-line options in chronic low back pain, noting that fewer harms are associated with these effective therapies than with pharmacologic options. The ACP emphasizes therapies be administered by practitioners with appropriate training.¹⁴¹

Acupuncture therapy chronic pain

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Acupuncture has accrued extremely strong evidence in the treatment of chronic pain. An individual patient data meta-analysis of 29 randomized trials involving 17,922 patients using acupuncture therapy for chronic musculoskeletal pain related to the neck and low back, knee OA, headache and migraine found acupuncture was significantly better than both sham acupuncture and usual care for all conditions.^{285, 286} In a systematic review with meta-analysis, acupuncture was associated with greater immediate relief of chronic pain compared to sham acupuncture or analgesic injection.²⁸⁷ In a meta-analysis on long-term impact, the effects of a course of acupuncture treatment for patients with chronic pain persisted significantly following care; 90% of acupuncture benefit persisted at 12 months in trials using wait list or usual care controls. Trials comparing acupuncture to sham found 50% persistence of benefit at 12 months for the verum groups.²⁰⁷

An updated individual patient meta-analysis of acupuncture for chronic nonspecific back pain, neck pain, shoulder pain, chronic headache or osteoarthritis included an additional 7 years of trials evaluating 39 trials (20,827 patients).²⁸⁸ Acupuncture was superior to both sham and no acupuncture controls for each pain condition. The effects of acupuncture were found to persist over time with only a small decrease, approximately 15%, in treatment effect at one year after randomization or 9–10 months after the completion of treatment. A new finding was additional confirmation of benefit for acupuncture over sham on upper body musculoskeletal pain, neck and shoulder pain.

In a systematic review with meta-analysis, acupuncture showed benefit over controls in the treatment of peripheral neuropathy related to diabetes, HIV, Bell's palsy and carpal tunnel syndrome.²⁸⁹ Simple pressure sustained by seeds or small magnets taped to ear points, a form of auricular treatment, showed benefit in acute and chronic pain in systematic reviews with meta-analyses.^{217, 290}

In a large multicenter trial of 14,161 patients with chronic neck pain, acupuncture (15 sessions over 3 months) added to routine care was associated with improvements in neck pain and disability maintained through six months compared to routine care alone.²⁹¹ Although acupuncture care increased cost of treatment, the health benefits lasted well beyond the three-month study duration; per international cost-effectiveness threshold values, acupuncture was determined to be a cost-effective treatment strategy.²⁹² In a cost-effectiveness review of nonpharmacologic interventions for low back pain (LBP), acupuncture was found to be a cost-effective option.²¹¹ Meta-analyses demonstrate acupuncture is effective and cost-effective for knee OA.^{293, 294} A systematic review and meta-analysis of manual acupuncture for myofascial pain syndrome found treatment of myofascial trigger points reduced pain and improved pain threshold in studies using a single treatment or a course of eight treatments.²⁹⁵ Further research is needed to clarify the longitudinal impact of myofascial trigger point treatments as single or multiple sessions. A network meta-analysis demonstrated that acupuncture needling alone and combined with Gua sha, moxibustion, or e-stim are effective in decreasing pain and in improving physical function in myofascial pain syndrome.²⁹⁶

In systematic reviews^{297, 298} and meta-analyses,²⁹⁹ acupuncture was found effective for frequent episodic or chronic tension headaches and for episodic migraine. Acupuncture has also been shown to be effective for chronic shoulder pain,^{285, 300} pain related to OA of the hip,³⁰¹ and temporomandibular disorder myofascial pain.^{302, 303} In a military population, acupuncture treatment given at least four times within a year was associated with improved symptoms, ability to function and sense of wellbeing as well as reductions in opioid prescriptions (45%) muscle relaxants (34%), NSAIDs (42%) and benzodiazepines (14%).³⁰⁴

In a systematic review and meta-analysis, acupuncture therapies with prokinetics were more effective than prokinetics alone for functional dyspepsia.³⁰⁵ Acupuncture therapy is recommended for functional dyspepsia in patients contraindicated for prokinetics.

A systematic review and meta-analysis of trials comparing acupoint stimulation to NSAIDs for primary dysmenorrhea found advantages in acupoint stimulation in alleviation of dysmenorrhea symptoms with fewer side effects and potential use for patients with NSAID contraindication.³⁰⁶

Based on a systematic review, the American College of Physicians (ACP) Clinical Practice Guideline recommends acupuncture for acute, subacute and chronic low back pain (cLBP).^{141, 222} The US Department of Health and Human Services Agency for Healthcare Research and Quality (AHRQ) concluded that acupuncture therapy is effective for cLBP compared to placebo, sham, no treatment, usual care or wait list controls.¹⁴⁵ The NIH also recommends acupuncture for low back pain and for knee OA.³⁰⁷ The *FDA Education Blueprint For*

Health Care Providers Involved In The Management or Support of Patients with Pain suggests acupuncture among a range of available therapies as part of a multidisciplinary approach to pain management.¹⁹⁵

As stated above, acupuncture therapy has a low risk of adverse events when provided by qualified trained practitioners.

Massage therapy chronic pain

Based on it's systematic review, the ACP Clinical Practice Guideline recommends massage for acute, subacute and chronic low back pain (cLBP).^{141, 222} AHRQ found massage effective for cLBP compared to placebo, sham, no treatment, usual care, or wait list controls.¹⁴⁵ The NIH also recommends massage for neck pain.³⁰⁷

Sixty high quality and seven low quality studies included in a systematic review with meta-analysis on pain and function across all pain populations found massage therapy effectively treats pain compared to sham, no treatment and active comparators.³⁰⁸ A systematic review for upper and lower extremity conditions found soft tissue therapy effective for the management of heel pain and lateral epicondylitis.³⁰⁹ A trial of massage therapy for knee OA found the optimal dose at 8 weekly one-hour sessions with benefits persisting for at least 8 weeks beyond treatment.³¹⁰ A systematic review with meta-analysis found manual therapy including massage was effective for pain, stiffness and physical function in knee OA with a call for more study with extended follow-up.³¹¹ Stiffness and physical function showed significant improvement with treatment duration of more than 4 weeks.

As indicated above, massage therapy has a low risk of adverse events when provided by a trained practitioner.

Spinal manipulation therapy and manipulative therapy chronic pain

Spinal manipulative therapy (SMT) involves treatment of the spine and pelvic related joints; manipulative therapy (MT) refers to the treatment of other joints in the body including upper and lower extremities. SMT and MT are often associated with high velocity, low amplitude (HVLA) thrust techniques, as well as low velocity, low amplitude (LVLA) or joint mobilization techniques. SMT, MT, HVLA and LVLA are techniques commonly used to improve pain and function, primarily by osteopathic physicians and chiropractors.

A systematic review with meta-analysis showed SMT improves low back pain with benefits maintained for up to six weeks.³¹² SMT was also shown to be cost-effective for low back pain.²¹¹ Based on it's systematic review, the ACP Clinical Practice Guideline recommends spinal manipulation for acute, subacute and chronic low back pain (cLBP).^{141, 222} AHRQ found SMT as effective as other active interventions for cLBP.¹⁴⁵ Systematic reviews found SMT beneficial for neck pain,³¹³ cervicogenic headache,³¹⁴ and prophylaxis of migraine.³¹⁵

Systematic reviews and a meta-analyses found manual therapy beneficial for knee OA^{311, 316} as well as OA of the hip, patellofemoral syndrome, ankle inversion sprain, plantar fasciitis,³¹⁷ and common shoulder disorders.³¹⁸ A systematic review also found evidence that MT is effective when combined with exercise and/or multimodal therapy for lateral epicondylitis, carpal tunnel syndrome and temporomandibular disorders.³¹⁹ A systematic review found for adults with “whiplash-associated disorders” and “neck pain associated disorders,” nonpharmacologic therapies including manual therapy are cost-effective.³²⁰ For improving low back and shoulder pain, MT may be more cost-effective than usual care that included exercise, stabilization and/or advice about activity.³²¹

Manipulation therapy safety

Adverse events associated with spinal manipulation include muscle soreness or transient increases in pain.¹⁴¹ Rare serious adverse events include cervical artery dissection, stroke and neck injury.³²² The most recent review of systematic reviews found that though rare, there is some risk of significant adverse events with spinal manipulation.³²³

Mind body directed therapies for chronic pain Mindfulness, meditation and relaxation therapies chronic pain

Mindfulness and meditation-based therapies focus training on moment to moment awareness of breathing and attention without judgment to transform perception and relationships to pain and the larger environment.

Mindfulness-based stress reduction (MBSR) is a training that has had considerable study for chronic pain. A systematic review and meta-analysis found MBSR for low back pain was associated with short-term improvements in pain intensity and physical functioning compared to usual care.³²⁴ In a trial for patients with chronic low back pain, comparing MBSR to CBT or usual care found both MBSR and CBT to be cost-effective and MBSR to be cost-saving.²¹² CBT is recognized as a moderately effective approach to chronic pain, for example, low back pain;¹⁴¹ however, we do not include an in-depth review of CBT as it is currently part of covered conventional care options, albeit underutilized. Based on it's systematic review, the American College of Physicians (ACP) Clinical Practice Guideline recommends both CBT and MBSR for chronic low back pain.^{141, 222}

Mindfulness and relaxation-based eHealth interventions have evidence of positive effects on health outcomes for patients with chronic pain including headache, fibromyalgia and irritable bowel syndrome.²⁸⁰ Internet-delivered pain-coping skills training (PCST) with physiotherapist-prescribed home exercise for persons with chronic knee pain provided clinically meaningful improvements in pain and function that are sustained for at least six months.³²⁵ PCST is an approach based on CBT principles that target psychological factors such as low self-efficacy, poor pain coping, and pain catastrophizing, common in persons with chronic pain. PCST has been shown to be effective for osteoarthritis or rheumatoid arthritis pain³²⁶ and specifically knee OA.³²⁷

MBSR has also shown benefit in pain in adolescents^{328, 329} and in adult patients with chronic headache.^{330, 331} A review of patients with arthritis, chronic back or neck pain, or two or more comorbid pain conditions experienced the largest average improvement from a mindfulness program in pain severity and functional limitations.³³² Greater home meditation practice was significantly associated with greater improvements in psychological distress and self-rated general health. Benefit for pain and high continued compliance have been consistently associated with MBSR from its earliest study.³³³

Relaxation therapies use physiologic techniques (e.g., slow diaphragmatic breathing or progressive muscle relaxation) to regulate the sympathetic/parasympathetic balance and reduce symptoms of sympathetic arousal often seen in chronic pain including situational stress, muscle tension and shallow breathing. They also include other directed therapies like guided imagery (use of words depicting calming images and music to evoke positive imaginative scenarios), hypnosis and suggestion (induction of a relaxed but focused state of consciousness receptive to positive suggestion), acceptance and commitment therapy (strategies of mindful awareness and acceptance) and music therapy.

In a large meta-analysis, music therapy showed a reduction of chronic pain, emotional distress due to pain and a small but statistically significant reduction in opioid and non-opioid intake.²⁵⁹ Based on its systematic review, the ACP Clinical Practice Guideline recommends progressive relaxation for chronic low back pain.^{141, 222} The NIH also recommends relaxation, “autonomic regulatory” approaches for fibromyalgia.³⁰⁷

In a meta-analysis of trials, acceptance and commitment therapy (ACT) and mindfulness-based interventions were shown to be comparable to cognitive behavioral therapy (CBT) in managing chronic pain.³³⁴ ACT was comparable to CBT but with higher patient satisfaction in one trial on chronic pain;³³⁵ older adults with chronic pain were more likely to respond to ACT in another RCT.³³⁶

Systematic reviews of guided imagery were found encouraging but inconclusive for musculoskeletal and non-musculoskeletal pain.^{337, 338} A more recent systematic review of guided imagery in fibromyalgia, arthritis and rheumatologic disorders found statistically significant improvement in pain and function, with several trials demonstrating reduction in medication use.³³⁹

Mindfulness, meditation and relaxation therapy safety

The body of research evidence has shown mindfulness-based practices, hypnosis, suggestive therapies, guided imagery, CBT, ACT and progressive relaxation techniques are utilized across diverse patient populations. These approaches are safe, with rare adverse reactions in psychiatric patients, people with epilepsy or those who have suffered abuse or trauma where relaxation may trigger a rare paradoxical reaction.^{141, 324, 339, 340}

Biofeedback chronic pain

Biofeedback utilizes techniques in which a signal generated by a device trains the patient to manipulate an aspect of their physiology not typically directed (e.g., heart rate variability and muscle tension) and provides a self-care tool for physiologic modulation. A meta-analysis of biofeedback for chronic low back pain (cLBP) found pain reduction, reduced depression, disability, and muscle tension and improved coping.³⁴¹ Based on another systematic review, the ACP Clinical Practice Guideline recommends electromyography biofeedback for cLBP.^{141, 222}

A meta-analysis of trials also found biofeedback effective for tension headache with stable benefit over an average follow-up phase of 15 months. Biofeedback with relaxation therapy was most effective for children and adolescents with headache.³⁴² A meta-analysis of biofeedback for fibromyalgia found significant reduction of pain,³⁴³ with less effect established in another systematic review due to variability of measures across trials.³⁴⁴

Biofeedback safety

In a systematic review of trials for fatigue and cognition, neurofeedback (EEG biofeedback) and biofeedback were shown to be well-tolerated without major adverse effects.³⁴⁵ Biofeedback has low risk of harms with rare side effects of headache, fatigue or sleep problems.³⁴³ No adverse events are reported in a meta-analysis of biofeedback for chronic back pain.³⁴¹

Movement therapies for chronic pain Yoga chronic pain

Therapeutic yoga is the use of yoga to help people with health problems manage their health conditions and

reduce their symptoms. Yoga originated in ancient India and has been adapted in the West. Yoga practice combines attention and meditation (dhyana), breathing (pranayama) and physical postures (asanas).

A Cochrane review of yoga for chronic nonspecific back pain found moderate supporting evidence that yoga compared to non-exercise controls resulted in small-to-moderate improvements in back-related function at three and six months and was comparable to exercise for chronic low back pain (cLBP).³⁴⁶ Early intervention with “medical yoga”—group sessions of guided Kundalini yoga individualized to each medically screened patient with low back pain—was found to be cost-effective.^{211, 347} Based on its systematic review, the American College of Physicians (ACP) Clinical Practice Guideline recommends yoga for cLBP.^{141, 222} AHRQ found yoga effective for cLBP compared to placebo, sham, no treatment, usual care or wait list.¹⁴⁵ NIH recommends yoga (hatha, Iyengar and viniyoga) for cLBP.³⁰⁷

In a systematic review and summary of reviews,^{348, 349} yoga was found to have beneficial effects in patients with pain. In addition to low back pain, systematic reviews with meta-analyses found yoga beneficial for osteoarthritis, rheumatoid arthritis, kyphosis and fibromyalgia.³⁵⁰ Additional systematic reviews found yoga to have positive effects on pain and function in patients with knee OA³⁵¹ and neck pain.³⁵² A meta-analysis found yoga, even as a short-term intervention, could be effective for pain and associated disability.³⁵³ A large systematic review (306 trials) identified 52 different yoga styles and techniques with the most common being hatha, Iyengar, Pranayama and integrated approaches to yoga therapy. There was no advantage to a particular style of yoga. The reviewers recommended the choice of yoga style be based on personal preference and availability.³⁵⁴ In a systematic review with meta-analysis on efficacy and safety of meditative movement therapies (Qi gong, Tai chi and yoga) for fibromyalgia syndrome, yoga yielded significant effects on pain, fatigue, sleep, depression and health-related quality of life at final treatment, while Tai chi showed benefit for sleep.³⁵⁵ In an access-to-care innovation for veterans, a clinical yoga program via telehealth real-time interactive video conferencing, provided comparable satisfaction and health improvements to in-person yoga, including benefit for pain.³⁵⁶

Yoga therapy safety

Reported harms associated with yoga for cLBP were mild to moderate;^{141, 357} self-limiting joint and back pain comparable to physical therapy (PT).³⁵⁸ A systematic review and meta-analysis of RCTs found yoga to be as safe as usual care and exercise.³⁵⁹ No association between yoga practice and joint problems was found in a large survey of women aged 62–67.³⁶⁰ A review of published adverse event cases associated with yoga recommends patients with medical preconditions such as glaucoma or compromised bone health work with their physician and a qualified yoga teacher to adapt postures.³⁶¹

Tai chi chronic pain

Tai chi is a low-impact, mind body exercise originating in China that has become increasingly popular in the West as an effective exercise for rehabilitation related to multiple medical conditions. Tai chi consists of slow prescribed movements with attention to breathing and meditative concentration.

In systematic reviews with meta-analyses, Tai chi was effective for chronic pain associated with OA.^{362, 363} An evidence map of 107 systematic reviews on health outcomes confirmed its potential benefit for chronic pain syndromes and OA.³⁶⁴ Based on its systematic review, the American College of Physicians (ACP) Clinical Practice Guideline recommends Tai chi for chronic low back pain (cLBP).^{141, 222} The US Department of Health and Human Services AHRQ found Tai chi effective for cLBP compared to placebo, sham, no treatment, usual care or wait list controls.¹⁴⁵ The NIH also recommends Tai chi for knee OA and fibromyalgia.³⁰⁷ In a RCT of 12 weeks of Tai chi with heart failure patients, decreased pain was among the physical benefits reported.³⁶⁵

Tai chi safety

In a review of 153 trials, adverse events related to Tai chi were not regularly monitored or reported. When reported, Tai chi did not result in any serious adverse events but was associated with minor musculoskeletal aches and pains not unlike other forms of therapeutic movement.³⁶⁶

Other movement therapies chronic pain: Alexander technique, Pilates and Feldenkrais

Alexander technique (AT), Pilates and Feldenkrais are therapies developed by Frederick Alexander, Joseph Pilates and Moshe Feldenkrais, respectively. They share features of touch, directed exercise, strengthening, and awareness of posture and muscle utilization in the treatment of pain and postural problems. While there are fewer studies and reviews of these therapies, there is preliminary evidence of benefit for chronic pain.

A systematic review supported the effectiveness of AT lessons in chronic back pain.³⁶⁷ A large three-arm randomized trial compared usual care, usual care plus acupuncture therapy (10 sessions), and usual care plus AT (14 sessions) for chronic neck pain (median duration 6 years). The acupuncture and AT groups both led to significant reductions in pain and associated disability compared with usual care, with benefit persisting at 12 months following the intervention period.³⁶⁸

In systematic reviews of Pilates for chronic nonspecific low back pain, significant improvement in pain relief and

functional enhancement was demonstrated.³⁶⁹ Pilates exercise offered greater improvements in pain and functional ability compared to usual care and physical activity in the short term and improvements equivalent to massage therapy and other forms of exercise for chronic low back pain (cLBP) in the short or long term.³⁷⁰ A trial of post-menopausal women with cLBP compared six weeks of Pilates plus physiotherapy to physiotherapy alone and found improvement in pain management and functional status with benefits persisting after one year.³⁷¹

Feldenkrais has demonstrated benefit in chronic pain trials for neck and scapular pain in people who are visually impaired.³⁷²

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Alexander technique, Pilates and Feldenkrais safety

Adverse events related to movement therapies are low with minor events of transient pain and muscle soreness.^{368, 373, 374, 375}

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Frequency, Dosage and Timing of Nonpharmacologic Interventions for Chronic Pain

A recommended course of acupuncture treatment for chronic pain will depend on the patient and the term and severity of the condition. In a large meta-analysis of RCTs of acupuncture for chronic pain of the head, neck, shoulder, low back and knee, where benefit persisted significantly (12 months) following a course of treatment, patients received on average 8–15 treatments over 10–12 weeks.²⁰⁷ In the Cochrane reviews recommending acupuncture for tension headache²⁹⁷ and migraine,²⁹⁸ a minimum of six sessions was required for review. Weekly treatment was common; no trials gave acupuncture more than twice per week.³⁷⁶

In a large meta-analysis that identified characteristics of acupuncture treatment associated with outcome, where average session time was recorded in a trial, the length of session averaged 16–45 min.³⁷⁶ Average needle insertion sites were 6–20. Increased number of needle sites treated and more sessions were associated with better outcomes.³⁷⁶ Therefore, referral for acupuncture therapy is recommended for at least 8 sessions, and preferably 8–15 weekly sessions of care. For a severe or acute ambulatory pain event, initial treatment frequency may be more than once per week.

Acupuncture therapy delivered in a group setting is being studied as an option for underserved populations,³⁷⁷ in line with research on group medical visits.³⁷⁸ Costs are reduced for patients and session times approximate individual practitioner-patient encounters. Patients' arrivals are staggered with care overlapping in a shared treatment space.

In a systematic review and meta-analysis of massage therapy for pain, treatment dosage ranged from a single session of 1.5 minutes to daily 40–60 minutes sessions for 20 weeks.³⁰⁸ In chronic ambulatory pain conditions, massage is usually given once per week, more frequently for a severe or acute ambulatory event. Sessions are typically 45–60 minutes, longer if elected. Number of sessions recommended is not established in the literature.

Chiropractic and osteopathic spinal manipulation reviews evaluate varied session frequency including single sessions trials, trials of 4-7 sessions over 2 weeks to 5 months, and up to 12 sessions or more a month with or without subsequent maintenance.¹⁴⁵ Once a week sessions for 4-6 weeks was slightly superior to back school or physical therapy for chronic low back pain.³⁷⁹

The most studied mindfulness intervention is MBSR, which is structured as eight weekly group sessions.^{222, 324, 380}

Movement therapies like Tai chi and yoga are typically given in group sessions, and have been studied in a term of intervention from 1-5 sessions per week for 6 weeks to a year for Tai chi^{362, 366} and as 12 weekly sessions of 75 minutes for yoga.³⁵⁸

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Lifestyle Behaviors and Self-Efficacy Chronic Pain

Self-efficacy is a psychological construct based on social cognitive theory, which describes the interaction between behavioral, personal and environmental factors in health and chronic disease. The theory proposes that patients' confidence in their ability to perform specific health behaviors influences their engagement in and actual performance of those behaviors, which in turn influences health outcomes.³⁶⁵

The evidence for the impact of healthy lifestyle choices—what we eat, drink, think, feel and do—on our health outcomes has become a major focus of current research. We are all born with a genome, a set of genes we inherit from our parents. Epigenetic changes happen when genes within our genome are turned on and off by environmental factors before and after conception. Epigenetic changes have been shown to be passed from generation to generation. Altered gene expression rather than genetic code accounts for the majority of risks to health outcomes. The NIH cites the following environmental factors as causes of epigenetic changes: exercise,

diet, nicotine, alcohol, chemical exposures, medications and stress.³⁸¹ Though pain specific studies are scarce,³⁸² there are many studies that document the relationship of healthy behaviors to improved overall health and a reduction of diseases such as diabetes, atherosclerosis and obesity,³⁸³ which are associated with pain conditions.^{384, 385} The relationships are complex, multifactorial and have reciprocal influence on each other. For example, obesity is associated with inflammation³⁸⁶ and musculoskeletal disorders involving connective tissue structures, including bones, joints and soft tissues of the musculoskeletal system.^{387, 388} At the same time, persistent or severe pain impedes weight loss in patients enrolled in weight management programs compared to none-to-moderate pain.³⁸⁹ Poor blood sugar control in type II diabetes leads to delayed healing, neuropathic pain and vascular complications all of which increase the difficulties that patients have with exercise that can benefit diabetic control. Optimal lifestyle choices can improve health and pain and are tantamount to healthy outcomes.

Studies have shown that healthy life choices, such as dietary changes, self-engaged stress management, smoking cessation, exercise, and supportive relationships with others can impact depression, hypertension, heart disease, cholesterol, obesity, diabetes and prediabetes, and cancer.^{390, 391} Success with healthy lifestyle choices improves patient self-efficacy and is also found to improve the length of leukocyte telomeres³⁹² associated with healthy aging and longevity.^{393, 394}

A large scale multiyear study, *The European Prospective Investigation into Cancer and Nutrition–Potsdam Study* (EPIC), studied 23,000 people for 7.8 years to evaluate the impact of four lifestyle factors on health—never smoking, a BMI under 30, physical activity for at least 3.5 hours a week, and eating a healthy diet that includes vegetables, fruit, whole grain bread and low meat consumption.³⁹⁵ Subjects with all four factors at baseline had reduced their risk of diabetes by 93%, myocardial infarction by 81%, strokes by 50%, and cancer by 36%, and had a 78% lower overall risk of developing a chronic disease. All of these diseases impact pain and healing. Lifestyle behaviors can affect biology as well as self-efficacy and therefore can be viewed as a key factor impacting pain.

Nutrition and pain



Nutrition science is not new and though it has long been recognized that nutritional status can either promote or reduce body-wide inflammation^{396, 397} and can promote healing or inhibit it, most medical encounters for pain do not address diet in a meaningful way. As there is a growing awareness of the impact of nutritional status on overall health, there are more studies of nutrition and pain.^{398, 399, 400}

An anti-inflammatory diet is one that is high in non-starchy vegetables, fruits, legumes, nuts and seeds, healthy oils and whole grains with low levels of animal protein consumption. This type of diet balances tissue pH levels for optimal mitochondrial enzyme functioning and has been shown to have health benefits.⁴⁰¹ Mitochondrial dysfunction in turn is being recognized as a root cause of many illnesses including pain related conditions.^{402, 403, 404} Dietary antioxidants are essential for optimal mitochondrial health⁴⁰⁵ and the basic science literature has thousands of articles on “targeting antioxidants to mitochondria” within the last 10 years alone.⁴⁰⁶

Turmeric, its derivative curcumin, and ginger, a related tuber, are extensively studied in both food and supplement form for pain patients. Turmeric is used for a wide variety of painful and inflammatory conditions including peri-operative pain⁴⁰⁷ with opioid and NSAID sparing; joint pain^{408, 409, 410} and musculoskeletal pain,⁴¹¹ and inflammatory bowel disease.^{412, 413} Ginger is studied for its effect on nausea^{414, 415} but also for pain,^{416, 417, 418} including joint pain⁴¹⁹ and primary dysmenorrhea.⁴²⁰ Though ginger and turmeric combine the actions of plant-based antioxidants and COX inhibition they are very well tolerated. Whereas pharmaceutical nonsteroidal anti-inflammatories (NSAIDs) cause very significant morbidity^{421, 422} and mortality,⁶⁷ ginger and turmeric do not show the same side effects profile.^{408, 418, 423} This is likely, at least in part, because NSAIDs have been shown to inhibit the initial step in healing which is an inflammatory one.⁴²⁴ A recent systematic review of curcuminoids for musculoskeletal pain found that in the studies comparing curcuminoids to nonspecific NSAIDs, the evidence was moderate to high for noninferiority of the curcuminoid intervention.⁴¹¹ Curcuminoids were equal to NSAIDs in terms of pain improvement without the long-term risks related to the morbidity and mortality of NSAIDs, situating curcuminoids as a viable oral pain medication option.

Micronutrient deficiency is prevalent in the United States,⁴²⁵ associated with the extensive consumption of highly processed foods. Although consumption of meals from fast food restaurants is decreasing, there has been a compensatory increase in retail purchase of highly processed foods.⁴²⁶ Symptoms associated with deficiencies, especially when sub-clinical, are nonspecific and include fatigue, irritability, aches and pains, decreased immune function and heart palpitations.⁴²⁵ Supplementation of deficient nutrients helps overall health and is being studied for its effects on pain. The following is by no means a comprehensive listing but touches on some of the most prevalent deficiencies.

Vitamin D is one of the best studied micronutrient deficiencies associated with pain and delayed healing. Skin pigmentation, obesity, northern latitudes and other yet unidentified factors lead to Vitamin D deficiencies. Deficiency of Vitamin D is often found in chronic pain sufferers, and is correlated with muscle fatigue risk factors.⁴²⁷ While no definitive mechanism for how Vitamin D influences chronic pain development is known, supplementation of Vitamin D may benefit chronic pain.⁴²⁸ It poses a low health risk, is well accepted, inexpensive and offers numerous health benefits.⁴²⁹ A rapid dose of Vitamin D₃ attenuates inflammation,

epidermal structure damage, and redness from acute sunburn.⁴³⁰

Magnesium is also seen as a common micronutrient deficiency, which is being studied for its relationship to muscle spasm, systemic inflammation, insulin resistance and diabetes, hypertension and neuropathic pain. There have been positive trials using magnesium infusions for migraine and many emergency rooms employ this intervention.^{431, 432} Magnesium has also been studied as an NMDA (N-methyl-D-aspartate) receptor blocker in the treatment of neuropathic pain.^{433, 434} A review of the concomitant use of magnesium with opioids in animals suggests that magnesium may potentiate opioid analgesia while also mitigating some of the adverse effects of opioids including the development of hyperalgesia, improving outcomes in neuropathic pain.⁴³⁵

Fish oils high in omega-3 fatty acids, also called polyunsaturated fatty acids (PUFAs), are associated with reduced pro-inflammatory prostaglandins.⁴³⁶ A 2012 meta-analysis concluded that PUFAs at doses over 2.7 g/day for over three months reduced NSAID consumption in rheumatoid arthritis patients.⁴³⁷ The North American diet is high in omega-6 fatty acids which are proinflammatory.

Vitamin B12 (cobalamin) deficiency has long been recognized as a cause of neurological disorders including pain. At present, we are only able to measure serum B12 which may or may not reflect B12 levels in the tissues where it is active. There are over 20 recognized genetic abnormalities affecting the cobalamin transport proteins required for intracellular delivery of B12 to tissue targets including mitochondria. Some are severe, leading to early failure to thrive and death and others are states where B12 is insufficient for cellular function despite normal serum levels.⁴³⁸

Other lifestyle factors

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Many medications have an adverse effect on micronutrient levels and the health of the microbiome, the mass of microorganisms mainly housed in the gut. Elie Metchnikoff, Nobel Laureate in 1908 for the discovery of cellular immunity, also identified the microbiome as a major determinant of health. Its role in protecting optimal intestinal permeability, modulation of body-wide inflammation, nutrient absorption, and abdominal pain in inflammatory bowel diseases is being widely studied.¹⁹⁶ Poor nutrition and many drugs can adversely affect the microbiome. Proton pump inhibitors (PPIs) deserve special mention in this regard since they are widely used for prolonged periods and their negative effects on nutritional status has long been unrecognized. The FDA has issued warnings of profound deficiencies in magnesium and calcium, B12 and protein absorption with the use of PPIs. PPIs also disrupt the microbiome and increase the risk of pathologic dysbiosis and enteric infection such as food poisoning and *Clostridium difficile*.⁴³⁹ Long-term use of PPI medication increases risk of death.⁴⁴⁰

Important behavioral factors such as physical activity level, sleep and stress management can have direct and indirect impact on the experience of pain. Physical activity can be practitioner or instructor directed as in physical therapy, acupuncture therapy, chiropractic, osteopathy, yoga, Tai chi, or other movement systems, or it can be and often is self-directed. Physical activity has been shown to increase strength, balance and coordination, reduce pain and improve motor function and mood for patients with hip and knee OA.^{441, 442, 443} Sleep disorders are commonly seen in pain patients. The disorders may follow or precede the onset of pain.⁴⁴⁴ Sleeplessness has been shown experimentally to induce a generalized state of hyperalgesia, a “fibromyalgia-like syndrome”.⁴⁴⁵ Both pain and pain medications can cause sleep disorders. Sleep apnea is a risk factor for many conditions such as diabetes and hypertension and can be aggravated by medications that are often prescribed for pain patients. Improved sleep leads to improved resilience for pain. Stress has long been reported by patients to be an aggravator of pain.



In the year 2000, the number of deaths related to poor diet and physical inactivity were 15–16% of total deaths in the United States, while continuing to increase.⁴⁴⁶

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Economic Benefits of Nonpharmacologic Therapies in the Treatment of Pain

Full economic evaluations, reported as cost-effectiveness analyses (CEA), cost-utility analyses (CUA), and cost-benefit analyses (CBA), often compare costs and health effects between two or more therapies.⁴⁴⁷ Low back pain, knee OA and headache are among the most common and costly chronic pain conditions responsible for a significant economic burden on the healthcare system.

There have been extensive economic evaluations of acupuncture therapies for pain conditions. Acupuncture has been shown to be cost-effective in the treatment of chronic, persistent low back pain.^{28, 206, 211, 448, 449, 450} A cost-effectiveness analysis of nonpharmacologic treatments for knee OA found acupuncture to be one of the more clinically and cost-effective therapies using the UK National Institute for Health and Care Excellence (NICE) QALY (quality adjusted life years) thresholds²⁹⁴ when done alone or together with exercise-based PT.⁴⁵¹ In a large trial, acupuncture was not only effective in the treatment of neck pain but benefits lasted beyond the three-month study duration, per international cost-effectiveness threshold values, showing acupuncture to be a cost-effective treatment strategy.²⁹² And while using acupuncture (12 treatments over three months) for migraine and chronic headache increased cost to the UK NHS health service, there was improved health-related

quality of life over the year that patients were followed that was favorably cost-effective compared to other NHS provided therapies.⁴⁵²

Similarly, the longevity of benefit for acupuncture in chronic pain was evaluated in a meta-analysis of 20 trials and over 6,000 patients and showed that clinical benefits of acupuncture were sustained at 12 months after a single course of treatment. Improvements in pain were 90% sustained at 12 months in trials compared to usual care and 50% sustained in trials that compared to sham,²⁸⁶ with implications for reduction in health care utilization over that period. An update to that meta-analysis of 7 additional years of trials (39 trials and 20,827 patients) confirmed previous findings.²⁸⁸

A curious and compelling finding in a large trial performing a one to one propensity score match (a statistical matching technique that attempts to estimate the effects of a treatment by accounting for the covariates that predict receiving the treatment) of 58,899 patients who received acupuncture for fibromyalgia to 58,899 who did not have acupuncture found the cumulative incidence of coronary heart disease (CHD) was significantly lower in the acupuncture cohort independent of age, sex, comorbidities or statins used.⁴⁵³

Systematic reviews have shown manual therapy is a cost-effective treatment for adults with whiplash-associated and neck pain-associated disorders³²⁰ and is also more cost-effective for improving low back and shoulder pain than general practice care that included exercise, stabilization and/or advice.³²¹

An inclusive review of effective nonpharmacologic therapies for chronic low back pain (33 studies) found cost-effectiveness for combined physical and psychological treatments, medical yoga, information and education programs, acupuncture therapy and spinal manipulation.²¹¹ An earlier review of 26 studies found cost-effectiveness for treatments consistent with the ACP guideline of interdisciplinary rehabilitation, exercise, acupuncture therapy, spinal manipulation and cognitive behavioral therapy for sub-acute and chronic LBP.⁴⁵⁴ Group acceptance and commitment therapy (ACT) was found cost-effective for fibromyalgia when compared to medication in a six month RCT.⁴⁵⁵

There may be a common perception that nonpharmacologic therapies are an “add on” expense; however, an analysis of the scope of economic benefits changes this perception. There is evidence of cost-effectiveness and cost savings through avoided high tech conventional care, lower future healthcare utilization, and reduction of productive loss for employers.⁴⁴⁷ A study by the State of Washington found that even with a substantial number of people using insurance benefits for nonpharmacologic therapies, the effect on insurance expenditures was modest.¹¹⁸ In a follow-up study of Washington state insured patients with back pain, fibromyalgia and menopause symptoms, users of nonpharmacologic therapy providers had lower insurance expenditures than those who did not use them.¹¹⁹

Finally, a cost-analysis of an interdisciplinary pediatric pain clinic found interdisciplinary treatment that included acupuncture, biofeedback, psychotherapy and massage with medication management reduced inpatient and emergency department visits and resulted in hospital cost savings of \$36,228/patient/year and in insurance cost savings of \$11,482/patient/year.⁴⁵⁶ The findings of the current cost analysis support that over the course of just one year, participation in an outpatient individually tailored interdisciplinary pain clinic can significantly reduce costs by more than the cost of the intervention itself.

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Course of treatment and cost for inpatient acute care

Inpatient acute pain care using nonpharmacologic pain modalities can engage a course of as little as one to several treatments, or daily treatment over the course of a hospital stay. Inpatient acupuncture sessions can be given at a patient's bedside and sessions can last from 20 to 45 minutes or longer and is recommended in the 24 hours before surgery, after surgery, and daily as requested by inpatients or their caregivers. An integrative medicine approach using yoga therapy, holistic nursing techniques and a “healing environment” used in inpatient oncology had an immediate term cost benefit from reduced use of antiemetic, anxiolytic and hypnotic medication costs in the amount of \$156/day/patient. If extrapolated to the number of patients, beds and days of operation for the unit studied this would result in a savings of nearly one million dollars a year.⁴⁵⁷

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Course of treatment and costs for outpatient chronic pain

Projections of costs for a course of treatment of an evidence-based nonpharmacologic therapy will vary depending on the geographic area, health system, and access to care options. First, a course of care recommendation would be based on studies as well as systematic reviews and meta-analyses of effectiveness trials. Second, a recommended course of treatment for chronic pain will depend on the patient and the term and severity of the condition.

In a large meta-analysis of RCTs of acupuncture for chronic pain of the head, neck, shoulder, low back and knee, where benefit persisted significantly (12 months) following a course of treatment, patients received on average 8–15 treatments over 10–12 weeks.²⁰⁷ In the Cochrane Reviews recommending acupuncture for tension headache²⁹⁷ and migraine,²⁹⁸ a minimum of six sessions was required for inclusions in the review. Weekly treatment was common; no trials gave acupuncture more than twice per week.³⁷⁶ Based on these

studies, referral for acupuncture therapy is recommended for at least 8 sessions, and preferably 8–15 weekly sessions of care. For a severe or acute ambulatory pain event, initial treatment frequency may be more than once per week. Acupuncture therapy cost per session varies from \$60–120⁴⁵⁸ or more, with the initial session longer and higher in cost. A course of ambulatory care of 10 sessions then can range from \$700.00 to \$1300 or more.

Acupuncture therapy delivered in a group setting is being studied as an option for underserved populations,³⁷⁷ in line with research on group medical visits,³⁷⁸ and group-style self-management interventions.⁴⁵⁹ Costs are reduced, with care overlapping in a shared treatment space. Group sessions can be less than half the cost of an individual session.

Chiropractic and osteopathic manipulation sessions are structured as individual care with additional costs of techniques like ultrasound that may be applied by an assistant. Sessions can be more than once a week to once a week for maintenance. Costs of sessions vary from \$35 to \$106⁴⁶⁰ or more for 30 minutes with averages \$65–\$70 depending on the region of the country. Charges may increase with a-la-carte fees for interventions in addition to manipulations, such as applications of heat or cold, for example.

Massage therapy is generally offered in weekly sessions with costs varying from \$60 to \$90 or more for a 60-minute session, less for shorter sessions, more for longer sessions. Fees also depend on the site, whether a clinic, gym, spa, hotel or practitioner’s office.

Movement therapies like Tai chi and yoga are typically given in group sessions, and have been studied in a term of intervention from 1-5 sessions per week for 6 weeks to a year for Tai chi^{362, 366} and as 12 weekly sessions of 75 minutes for yoga.³⁵⁸ Session fees can range from \$10–\$20, with prices reduced with purchases of multiple sessions or more if private or semi-private sessions. Similarly, sessions for Pilates, Feldenkrais or Alexander technique are paid as individual sessions or reduced if bought as a package for multiple sessions. Pilates costs anywhere from \$15–\$55 for 45-minute group mat classes, \$35–\$85 for group classes using equipment, and private sessions costing upwards of \$50–\$150 per one-hour session.⁴⁶¹ Feldenkrais is offered as private, semi-private or group sessions with costs varying from \$50–\$90 for private and \$10–\$25 for classes.⁴⁶² Alexander technique sessions vary in cost depending on country or region but are generally on par with massage therapy costs if given in private sessions, less if given in a group setting.

MBSR has been shown to be cost-effective and cost-saving for patients with low back pain.²¹² An eight-week course of MBSR ranges from \$500–\$600 or more depending on the area of the country.

In general, the costs of evidence-based nonpharmacologic options are nominal compared to medical costs of treating chronic pain with risk mitigation and greater potential for engaging patients in ongoing self-care.

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Recommendations Education, Treatment, and Research

Many in medicine and policy decision-making acknowledge the crisis in pain and pain care detailed in this paper and seek evidence-based solutions for successful comprehensive pain management. Currently, most of the nonpharmacologic strategies reviewed here are underutilized due to lack of evidence dissemination, education and reimbursement. It is time for civilian medicine to join the call to action of military medicine outlined by Schoomaker and Buckenmaier in “If not now, when? If not you, who?” urging the immediate incorporation of effective nonpharmacologic modalities and active self-care because of their safety, effectiveness and acceptance by patients.⁴⁶³ The goal in these recommendations and the call to action that follows is to increase awareness, access and utilization of safe, effective nonpharmacologic treatments through education of practitioners and patients; dissemination of and reimbursement for evidence-based treatment options; and to promote ongoing research focused on the therapeutic and economic impact, in the short and long term, of comprehensive care practices.

Education

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The training of physicians and healthcare providers must include current pain mechanisms and all evidence-based treatment options for pain including effective nonpharmacologic options as stand-alone first line of care and as part of individualized comprehensive pain care. This includes individualized pain care that is patient-centered and evidence-informed, and which assumes the following:

- (1) Patient-centered care focuses on each person’s unique healthcare needs and experiences by asking
 - a. How do you manage pain now and in the past?
 - b. What nonpharmacologic strategies have you used?
 - c. What are you interested in exploring?
- (2) Practitioners should become familiar with nonpharmacologic modalities and licensed independent practitioners in their system and or area of practice.

Treatment: nonpharmacologic therapy frequency, dosage and timing

While physicians are familiar with dosage of medications, evidence-informed frequency, “dosage” and timing of nonpharmacologic therapies is less well disseminated. For inpatient care daily care is recommended, or every other day when staggered with another available nonpharmacologic intervention. In acute extreme pain that is not well managed, a second same or different treatment may be needed in a single day.

Evidence-based nonpharmacologic options for inpatient acute pain care include:

- (1) Acupuncture therapy, massage therapy, mind body interventions and transcutaneous electric nerve stimulation (TENS).
- (2) Daily inpatient access to effective nonpharmacologic care is recommended.

Evidence-based nonpharmacologic options for chronic pain include:

- (1) Acupuncture therapy, chiropractic and osteopathic care, massage therapy, physical therapy, mind body and movement therapies and cognitive behavioral therapy.
- (2) Referral to a course of effective nonpharmacologic care is recommended.

Recommendations and referral must take into account a patient’s unique presentation and circumstances in terms of access and coverage. Even when not covered by insurance, a course of nonpharmacologic treatment may have a longitude of benefit that exceeds short-term benefit of medications that are accompanied by adverse events and addiction liability.

Research

The call for research includes further study on the timing, dosage, frequency, longitude and combinations of care in the development of a comprehensive pain care model for both the inpatient and outpatient setting.

SECTION 3: Call to Action

As detailed in this paper, documented in the literature and accepted by health professionals and researchers, the crisis in pain care and aspects of current pain management strategies are having enormous detrimental impacts on patients, the health system and society.^{1, 2} In response to the grim statistics about pain care and the opioid epidemic, health care professionals, policy makers, researchers and multiple major health organizations and government agencies are moving in the right direction. The IOM,¹ NAM,² NIH,⁴ the CDC,¹⁹³ The Joint Commission,¹⁹⁴ the military,⁴⁶³ the FDA,¹⁹⁵ the ACP,¹⁴¹ and the former US Surgeon General⁴⁶⁴ concede that past strategies and the use of opioid medications have not remedied but rather exacerbated chronic pain, abuse, addiction, illness behavior and disability and call for evidence-based, comprehensive pain care, to include nonpharmacologic therapies.

While there is consensus that pain care must drastically improve and prioritize evidence-based nonpharmacologic treatments, there is a need for an informed strategy that includes all evidence-based and comprehensive pain care. Currently, most of the nonpharmacologic strategies outlined in the preceding review are underutilized due to inadequate dissemination of evidence, professional and public education and inadequate reimbursement.

The Consortium Pain Task Force Goals in a Call to Action Are To.

increase awareness of effective nonpharmacologic treatments for pain

train healthcare practitioners and administrators in the evidence base of effective nonpharmacologic practice

advocate for policy initiatives that remedy system and reimbursement barriers to evidence-informed comprehensive pain care and

promote ongoing research and dissemination of the role of effective nonpharmacologic treatments in pain, focused on the short and long term therapeutic and economic impact of comprehensive care practices.

[View Table in HTML](#)

This paper is a call to action for policy makers, hospitals and health systems, insurers, primary care providers and other licensed health practitioners and health care educators to lead in effecting this change.

POLICY: Federal and State policy should increase access to and reimbursement for evidence-based nonpharmacologic therapies

Based on the literature, stakeholders must petition and support evidence-based policy guidelines to increase access to and coverage for nonpharmacologic options as an essential part of comprehensive pain care.

Federal policy

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Currently, there is evidence of effectiveness, cost-effectiveness, cost-savings and risk mitigation for evidence-based nonpharmacologic options. Nonpharmacologic therapies for pain are now recommended by the NIH, FDA, TJC, CDC and ACP. Federal reimbursement policy needs to be based on current evidence of effectiveness, cost-effectiveness and risk mitigation, and include nonpharmacologic care.

State policy

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States need to adopt policies of coverage and plans for access to pain care based on current evidence of effectiveness, cost-effectiveness, cost-savings and risk mitigation that includes effective nonpharmacologic therapies. Policy should require private insurers to cover evidence-based nonpharmacologic therapies for acute and chronic pain.

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BEST PRACTICES: Identify and develop clinical models that integrate evidence-based nonpharmacologic therapies for pain

Develop, optimize, incentivize and coordinate care across disciplines with nondiscriminatory access to evidence-based nonpharmacologic therapies, as stand-alone first line of care and as essential part of comprehensive care.

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EDUCATION: Deliver evidence-based training to learners and graduates of the healthcare system in all disciplines on pain and effective nonpharmacologic treatments for pain

As recommended by the National Academy of Medicine (NAM), pain-related education for all health professionals who provide care to people with pain must become a national mandate.⁸² Academic healthcare education should train students and health practitioners on the evolving understanding of pain and its complexities, including physical and psychiatric comorbidities and substance use disorder (SUD) as well as evidence-based frequency, “dosage” and timing of effective nonpharmacologic therapies. Healthcare practitioners require education and practical changes in practice models to enable them to be responsible to inform and educate patients on evidence-based comprehensive models of pain care including self-efficacy, patient responsibility, self-care and lifestyle choices.

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RESEARCH: Identify and fund research to evaluate health outcomes and economic impact of comprehensive pain care that includes effective nonpharmacologic therapies

The call for research includes studies on the timing, dosage, frequency, longitude of benefit, and combinations of care in the development of a comprehensive pain care model for both the inpatient and outpatient setting. NIH, NCCIH, AHRQ, CMS, and other agencies and foundations should seek to fund investigation of comprehensive models of pain care and their impact on health outcomes, potential opioid sparing and reduction of opioid liability overuse and dependency.

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DISSEMINATION: Stakeholder groups need to engage the media and foster public awareness of comprehensive pain care options that include evidence-based nonpharmacologic therapies

Academic organizations, pain societies, medical societies, patient advocacy groups, insurance carriers and the media have important roles in the dissemination and education of their members and the public regarding the benefits of nonpharmacologic options of pain care. Dissemination facilitates general and individual patient–practitioner conversations on options for personal comprehensive pain care.

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Appendix A. Supplementary material

[Supplementary material](#)

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The authors would like to express their gratitude for the support and/or review of this document to Jane Ballantyne, MD; Margaret Chesney, PhD; Roni Evans, DC, PhD; Seth Gilbert, BA; Marsha J. Handel, MLS; John Loeser, MD; Robert B. Saper, MD; Rebecca Schultz, MS, ARNP; Rosanne Sheinberg MD; and Leonard A. Wisneski, MD.

The Academic Consortium for Integrative Medicine & Health (the Consortium) is an institutional member organization of 72 North American academic medical centers and health systems whose mission is to advance evidence-based integrative medicine and health in research, curricula, and sustainable models of clinical care.

¹ The term “mind body” represents an attempt to accommodate the bidirectional or circular impact that interventions have on symptoms typically categorized as either mental/psychological/spiritual or “discretely physical.” However, this is an artificial bifurcation since all body systems use identical communication molecules and mechanisms and since there is never a physical condition that does not register a psychological component. We use the term here as it has been utilized in the current literature but acknowledge a certain limitation shared by terms such as “behavioral” or “relaxation” therapies.

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