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Pain Health Policy Brief

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Summary Pain is a very common complaint from patients that physicians encounter in their office and hospital practice. Access to pain care is a problem in the United States. Chronic pain is a major health care concern and the cost of inadequate pain control is enormous. There are many barriers to appropriate pain care in the United States. The US House of Representatives passed H.R.756, which seeks to identify the problems with pain access and address the issues. The senate bill, S.660, which addresses these pain care barriers, is currently being debated on the Senate floor. The goal of S.660 is to standardize pain care access, quality, and treatment through research and a collaborative approach to pain care. Section 660 places an emphasis on medical education to get involved in teaching physicians to recognize and appropriately treat pain.

Access to pain care is a problem in the United States. Chronic pain is a major health care concern and the cost of inadequate pain control is enormous. Different pain requires different types of treatment (i.e., nociceptive vs. neuropathic pain).[1] The quality, cost, and access to pain care is not standardized throughout the United States. Different sectors of the population and different demographic groups face a shortage in pain care treatments and interventions. There are many obstacles to appropriate pain care that both the physician and the patient face. Pain is a subjective complaint with different qualities that are individualized for each patient. The recognition of pain care and its barriers are addressed in the House of Representative bill H.R.756 and the senate bill S.660. The goal of S.660 is to evaluate the way pain is recognized and treated among various Americans, and to identify groups that are inadequately treated and to help close the gap on access to pain care in the United States. The goal of S.660 is to standardize pain care access, quality, and treatment through research and a collaborative approach to pain care.

Twenty-five percent of Americans have chronic pain, and 60% of Americans older than 65 complain of pain daily.[1] Nearly half of all Americans have visited their primary care physician with the chief complaint of pain.[1,2] Pain medication is the third most common prescription written by primary care and emergency department physicians.[2] "Pain is a common and disabling condition in the workforce."[3] Pain is the second leading cause of work absenteeism, and approximately $61 million are lost in businesses annually as a result of pain's associative costs.[4] Approximately three fourths of the $61 million lost is attributed to poor performance at work because of pain-related issues.[4] Thirteen percent of the US workforce has reported taking off work because of some sort of pain (headache being the most common cause followed by back and arthritis pain).[3,4] More than 10% of the United States' population suffers from moderate to severe pain, and many of these patients feel their pain is inadequately treated.[8] Many studies have shown that the prevalence of pain increases with age.[8]

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Because pain is such a common complaint, there has been a push to recognize and improve access to pain care. The Joint Commission (formerly known as the Joint Commission on the Accreditation of Healthcare Organizations [JCAHO]) has passed a law that states pain should be documented as a fifth vital sign in all hospital admissions and triages.[9] This documentation can be done using a visual analog scale and linking it to faces representing pain amounts.[10]

The National Institutes of Health (NIH) is currently doing research on chronic and acute pain.[5] The NIH recruits patients who suffer from chronic pain caused by low back pain, headaches, regional pain syndromes, and neurological conditions (all common causes of pain).[6] Research has shown that individuals who have chronic pain may have lower levels of endorphins in their spinal fluid than individuals who do not have pain.[6] The NIH has conducted numerous studies on different treatment modalities for chronic pain such as pain medicines, acupuncture, nerve stimulation, and surgery.[6] The reason the NIH's research has not led to better pain care is because many of the studies being performed are for limited topics, and are duplicated between private and public research institutes.[5,6] Pain is a subjective symptom with very few objective tests.[7,8] There is a belief that people with chronic pain are often mislabeled by the media and there is not as much attention paid to pain care as there is to other diseases and illnesses. Pain patients argue that they feel health care providers are prejudiced against chronic pain patients, and think of them as malingerers.[8] There is a stereotype that pain patients seek attention and seek pain medication for recreational purposes.[8] The psychological, social, personal, and mental consequences of chronic pain are numerous.[8]

To help the NIH deal with some of these barriers to research, H.R.756 was passed. In March 2009, H.R.756 established an interagency Pain Research Coordinating Committee to coordinate studies that relate to pain issues. This collaborative approach to pain research will limit the amount of duplication of research trials. Also, grants will be awarded to support and improve pain research. The senate bill S.660 is currently in debate and on March 19, 2009 the bill was referred to the Committee on Health, Education, Labor and Pensions.[11]

As many as 40% of chronic pain patients feel their pain is "out of control."[31] This statistic shows the suboptimal treatment of pain in America.[31] The patient and physician need to be honest and realistic with each other and the goals of pain management should be discussed at every visit.[31] Some chronic pain patients and physicians must acknowledge that complete pain relief may not be obtained.[31] For this reason, some physicians may have a hard time treating patients whose outcome may improve very little but may be able to obtain a better quality of life with pain medication and other modalities.

Another barrier to pain care is the adverse side effects of many pain medications. Nonsteroidal antiinflammatory drugs (NSAIDS) are commonly used pain medications, and are associated with morbidity related to many organ systems.[12] Pregnant women cannot be treated with NSAIDS, and many pain medication are teratogenic.[27] Research has shown that bone pain is treated more effectively with NSAIDS, steroids, or bisphosphonates than using narcotics.[15] Many pain medicines come with black box warnings, issued by the Food and Drug Administration (FDA), that warn of risks of overdose and possible death. In July 2009, the FDA issued a black box warning for pain medications containing propoxyphene because of an increased risk of death in patients taking this pain reliever.[13] Adverse side effects of some pain medications include dyspepsia, gastrointestinal bleeding, constipation, nephrotoxicity, hepatotoxicity, severe allergy, hallucinations, and sedation.[12,14] Many doctors will prescribe medication to alleviate the nausea that is a side effect of opioid pain medication.[15] Many doctors are afraid to prescribe appropriate doses of pain medication because the prevalence of adverse effects increases with increasing dosages.[12]

A disproportionate amount of pain care access is seen in the Midwest. These barriers may be caused by fear of abuse or drug diversion in the Midwest states. There is an uneven distribution of substance abuse in rural and urban areas of the country.[16] In rural areas, substance abuse "is a public health issue that has its most devastating effects on high risk sub populations such as rural youth ages 12-17 and young adults ages 18-25."[16] Rural youths use methamphetamine ("meth") and alcohol at a higher rate than age-related youths of other populations.[16] Physicians in the Midwest may be fearful of prescribing pain medications and this fear may be contributing to this epidemic. There are fewer pain management clinics in the Midwest as opposed to Eastern or Western states.

Physicians are afraid of patients developing addictions to pain medication. Addiction is multifactorial, and many factors influence what patient will become addicted to pain medication. These factors are neurobiological, genetic, psychosocial, and environmental.[17] Addiction occurs when there is impaired control over drug use, compulsive use, and continued use despite harm.[17] The term *abuse* as it relates to this subject is the use of a pain medication to modify mood or in a way that is harmful to one's self or others.[17] Pain medicine can also be misused or used in a manner that is illegal or not consistent with medical guidelines.[17] Patients treated with pain medicine over an extended period of time will develop tolerance to the drug. Tolerance occurs when an ever-increasing dose of pain medicine is needed to achieve pain control.[17] *Withdrawal* is symptoms that occur when the drug is quickly stopped after a long period of use.[17] Thus, some pain medication cannot be stopped abruptly.

The Drug Enforcement Agency (DEA) oversees all prescription pain medicine prescribed in the United States. One of every 1400 doctors in America are prosecuted for inappropriate use of pain medication.[18] Each year, the DEA investigates complaints of illegal pain prescription writing in the 788,000 practicing physicians in the United Sates.[19]

The DEA prosecuted 597 of the 620 physician cases they investigated in 2008.[18] The media has covered many cases of doctors who were illegally prescribing pain medication, and a much publicized case was that of Dr. Graves, who received a sentence of 63 years in federal prison for inappropriate use and monitoring of pain medication.[9] Many state medical boards independently seek legislation to regulate pain clinics.[28] The Texas Medical Board is seeking legislation that demands pain management clinics obtain a special license from the medical board.[28] The Texas Medical Board will not give the license to physicians who have been convicted of any drug-related felony or misdemeanor.[28] It seeks to standardize pain clinics in respect to billing, inspections, and quality of patient care.[28] Those opposed to the Texas Medical Board legislation feel it "places regulatory burden on pain doctors in Texas, who already suffer from a disproportionate number of disciplinary actions and investigations by the Medical Board."[28]

Another reason that some doctors are afraid to prescribe pain medication is because of drug diversion. Diversion is obtaining a controlled substance by an illegal method or redirecting its supply.[17] Physicians accused of drug diversion also risk persecution by the DEA.[9] There are many states that require pharmacies to prevent drug diversion and are starting a computerized version of pain medication prescriptions. These databases will allow the physician to see what drugs the patient has been prescribed and what have been filled.

Time constraint is another obstacle faced by physicians writing pain prescriptions. Many pain medications are covered by Medicaid but some require prior authorization that must be done through the physician's office. Prior authorization requires the physician or assistant to call the insurance company and state what the need is for that specific medication. The need must be approved, then a number is given and the pharmacy must get the number to fill the prescription. The process is time-intensive. Some insurance companies refuse to cover pain medications.

The elderly are frequently not assessed properly and are inadequately recognized as suffering from pain. However, there are a substantial number of elderly patient who misuse pain medication, or who turn to substance abuse because of inadequate control of pain. The reason for this is multifactorial; one in four elderly Americans suffers from a mental disorder.[32] Because older adults often use a larger number of prescription medication, they are at a greater risk for using the medications inappropriately.[32] The elderly population also has a higher rate of medical comorbidities, therefore making them more prone to substance abuse.[32] There is inadequate assessment of pain in the elderly population and many elderly patients are not questioned about substance abuse at doctor visits. More than 4 million Americans age 50 and older use illicit drugs or prescription drugs inappropriately.[33] There is an initiative known as BRITE (Brief Intervention and Treatment for Elders) that seeks to screen elders for substance abuse problems.[33]

There are many groups that this bill will help if passed by the senate. Two major stakeholders that publically support the bill are Medtronic and the American Pain Foundation.[20,21] Medtronic is the global leader in medical technology and its goal is to research, design, and manufacture instruments that alleviate pain and restore health.[22] Medtronic is the company that supplies a majority of the patient-controlled analgesia devices to most hospitals in the United States, so they have a financial interest in this bill being passed. They agree that pain care should be addressed more aggressively and that more education and research should be done on advances in pain care.[22] The American Pain Foundation, a nonprofit organization that serves people with pain through information, advocacy, and support, also publically supports S.660.[20,23] Their mission is to promote pain education and to remove the barriers to appropriate pain care in the United States.[23] They have a large member base and have a division devoted to the members of the United States Military who live with chronic pain.[23] They acknowledge the barriers to pain care and lobby for more research, reimbursement, and acknowledgement of pain as a problem that is not adequately addressed.[23]

Other stakeholders for amending the Public Service Act with regards to pain care include the NIH. In H.R.756 and S.660, the NIH would be responsible for arranging and organizing the research on methods of pain control; therefore, their research consortium would go through one committee and there would be one Institutional Review Board combining the similar studies on pain control.[11] H.R.756 establishes an Interagency Pain Research Coordinating Committee, which "coordinates all efforts within the Department of Health and Human Services (HHS) and other Federal agencies that relate to pain research."[11] They would also expand their research committee through the pain consortium. Pain management doctors would also find the bill beneficial because there would be more physician education on when to request a pain management consultation. H.R.756 and S.660 acknowledge the role of "credentialed pain management specialists and subspecialists" in the treatment of pain.[11] The pain management services would be used more effectively because of the renewed interest in pain care and its importance in meeting the goals of pain care. Residency programs would also benefit from S.660 because the bill recommends that residency programs teach residents more on pain medication and the risks and benefits to pain care.[11] Medical education departments and residency consortiums would be advised to include training programs dedicated to pain care, which would teach the training physician the barriers to pain care and appropriate ways to acknowledge and provide pain care. H.R.756 provides for "award grants (approximately $5,000,000), cooperative agreements, and contracts to health professional schools, hospices, and other public and private entities for the development and implementation of programs to provide education and training to health care professionals in pain care."[11] Physicians would be able to participate in the pain consortium conference to further educate themselves on pain management. Residencies need to stress the impor-

tance of recognizing and treating pain appropriately. The Joint Commission now requires that hospitals recognize and treat pain appropriately.[9] Families of chronic pain patients will be stakeholders of S.660 because it will help educate physicians on how to include family members in discussions on pain care.[11]

The American Pharmacists Association also publically supports the passage of S.660.[24] Pharmacists fill pain medication prescriptions, and a unified approach to pain control will help patients receive the right combination of medications they need. The bill would also provide grants to train health care professionals to assess and appropriately treat patients' pain.[24]

The US Surgeon General (Dr. Regina M. Benjamin) would also be a stakeholder in S.660 because it would improve access to pain care for the US population. Section 249 of H.R.756 specifically states that "an official in the HHS would oversee the public awareness campaign and ensure the involvement of the Surgeon General, CDC and other representatives of offices and agencies that the secretary of the HHS determines appropriate."[11] H.R.756 and S.660 take into account the barriers to pain care for different geographic, racial/ethnic, and gender issues and seek to "provide resources that will reduce the disparities in access to appropriate diagnosis, assessment and treatment."[11]

The American Academy of Pain Management, the American Academy of Pain Medicine, the American Academy of Physical Medicine and Rehabilitation, and the American Society of Anesthesiologists all urge the passage of S.660.[24] The Accreditation Council for Graduate Medical Education (ACGME) and the American Osteopathic Association (AOA) have tried to create a single fellowship in pain management that would reflect a multidisciplinary approach, involving many specialties.[25] A collaborative approach to pain care has shown improvements in pain control.[26] A recent study compared chronic pain patients who were placed in a multidisciplinary group approach with those who were treated with pain medication alone.[26] The multifaceted approach led to a significant improvement in pain control.[26] This collaborative approach included pain education classes; pain management consult (if indicated); physical, recreational, and occupational therapy; and mental health services.[26] The outcomes of patients' pain were collected by electronic methods and the patients subjectively rated their pain using a pain scale.[26] Improvement in pain-related disability also led to decreased health care costs associated with pain.[26]

Mental health services would also be stakeholders because many studies have shown the association between chronic pain and mental health problems. The bill acknowledges the need for interdisciplinary groups to help deal with pain in a coordinated fashion. If pain control was addressed properly, mental health professionals would be able to focus on the goals of providing the appropriate mental health treatment needed. Mental health professionals would also be in favor of educating the family members and loved ones of patients with chronic pain because they are a support system. The members of the American Medical Association and AOA would be stakeholders in the S.660 bill because it will help doctors expand their knowledge of pain care. The AOA 2010 goal includes the healthy people act, which sets to remove barriers to appropriate medical treatments for all communities.[29] The AOA has announced that chronic pain should be treated as a "distinct disease."[29]

Pharmaceutical companies would be stakeholders because the amendment seeks to encourage insurance companies to reimburse for many of the pain medications and to increase the amount of pain medications that are covered.[11] Pharmaceutical companies can also apply for research grants that would be established for pain research. The pharmaceutical companies would also benefit from researching the best pain modalities. Military personal also make up a large part of the American Pain Foundation and many of the patients in the Veterans Administration Hospital System throughout the United States have chronic pain and would benefit from the removal of certain barriers to appropriate pain treatment.[23]

A problem with S.660 is the amount of money needed to fulfill its ideals. The cost of S.249 of H.R.756 (the national education outreach and awareness campaign) is estimated to be $2,000,000 for the fiscal year 2010 and $4,000,000 for each of years 2011 and 2012. Approximately $500,000 would be budgeted for the National Convention on Pain.[11] The bill seeks approximately $5,000,000 for grants to promote appropriate pain management.[11]

Methadone maintenance clinics may be stakeholders against S.660 because of the fear of more competition for patients. Because training would be increased and standardized throughout the nation, doctors will be more comfortable prescribing pain medication and may not feel they need to send their substance abuse patients to methadone maintenance clinics. The bill specifically states that "credentialed pain management specialist and subspecialists" would be consulted and the question arises about what the word "credentialed" means.[11] Many physical medicine and rehabilitation doctors practice pain management without being fellowship trained; in fact there is no "single fellowship for pain medicine that represents all stakeholders."[25] Insurance companies may also oppose the bill because they would be expected to cover more pain medication, and some are quite expensive.

There needs to be a multidisciplinary approach to pain care and, as research has shown, pain treatment must be a collaborative approach.[26] There is a need for the standardization of pain care and greater research and education must be provided for teaching families and health care professionals how to deal effectively with chronic pain.[29] The AOA has noted that there are many obstacles to appropriate pain management, and there needs to be treatment standards.[29] The Joint Commission has demanded that pain be documented on hospital admission charts because there is a need for pain to be addressed and properly treated.[9] Pain is not adequately addressed among all demographics and population groups in the United States. As shown in the BRITE

project, every American, regardless of age, should be screened for pain and medication use. Millions of dollars are lost on productivity in the American workforce because of pain.[3] Chronic pain patients often need physical, mental, and occupational therapy to experience some breakthrough pain relief.[26] Pain patients should be reevaluated frequently, and the goals of realistic pain relief with treatment should be discussed.[31] Pain relief is a multimillion dollar business and there is a need for a collaborative research board to recognize the most effective ways to treat patients and their families.[6] Appropriate pain management and teaching should include the subjects of abuse, addiction, and diversion to help ensure they are appropriately addressed with pain patients and their support system.

Pain is a subjective complaint, and it is often difficult for patients to put their feelings into words.[7] The Mexican painter Frida Kahlo spent most of her life in pain after sustaining a trolley accident as a teenager.[7] At age 18, the bus she was riding was hit by a trolley and she broke her spinal column, pelvis, ribs, and right leg.[34] Frida was not expected to survive, and she was encased in a full body cast for months.[34] Although in her cast, she depicted her pain in many of her paintings.[7] She suffered from chronic pain and was hospitalized many times for debilitating pain.[34] As many chronic pain sufferers do, Frida self-medicated with illicit drugs, alcohol, and cigarettes.[34] She would often paint self-portraits of her pain on a daily basis.[7] *The Broken Column* was her most famous self portrait of the debilitating pain she felt.[35] At age 47, she had her right leg amputated and fell into a deep state of depression.[34] Frida committed suicide shortly after the amputation and the last words she wrote were "I hope the leaving is joyful and I hope never to return."[34] Frida Kahlo left a legacy through her paintings and she serves as a reminder that chronic pain patients *can* achieve accomplishments.

As shown by the biography of Frida Kahlo, chronic pain sufferers are often inadequately treated, and they turn to substance abuse to mask the pain. Many people who suffer chronic pain feel judged by society. Many feel as though doctors have failed them and many suffer depression and other mental illnesses because of their constant pain.[8] There needs to be organized support groups that educate patients and their families on pain and its management.[26] Patients should be told realistically about the pain relief expected from different modalities.[31] Pain care should be treated in a way that has been proved by research to provide relief. More emphasis must be placed on pain care research, to ensure proper treatment of pain patients.

The goal of H.R.756 and senate bill S.660 is to recognize pain as a public health problem and to evaluate and identify the barriers that are present to manage appropriate pain care in the United States. For many years, congress has tried to pass National Pain Care Policy Acts, but the bills have never been passed. Bills such as the National Pain Care Policy Act of 2003 (H.R.1863), National Pain Care Policy Act of 2005 (H.R.1020), and National Pain Care Policy Act of 2008 (H.R.2994, S.3387) all tried to amend the Public Health Service Act with respect to pain care.[30] The National Pain Care Policy Act of 2009 takes an important step for pain care reform in the United States.

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