

Oregon Pain Management Commission

Advancing Pain Management in Oregon

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The Oregon Pain Management Commission (OPMC)

- Inadequate pain treatment is a serious public health problem. This curriculum is designed to provide an overview of the efforts of pain advocates in Oregon in advancing pain management and addressing the under-treatment of both acute and chronic pain throughout the State and increase awareness regarding some of the major challenges healthcare providers face in providing effective pain management.
- It is recognized that the issues surrounding the treatment of pain are complex, and cannot be adequately addressed in this one-hour introductory presentation. It is anticipated that relevant issues will be more extensively addressed in the 6-hour continuing education curriculum requirement.
- This introduction to the pain management domain in Oregon qualifies as a portion of your selected continuing education requirement in pain management.
- We thank you for your time and hope this information offers insight into the importance of pain management for all Oregonians.

The Oregon Pain Management Commission

"The management of pain is a cornerstone of the compassionate practice of medicine. The knowledge exists to ameliorate pain in most of our patients. We now require the will to do so."
Schechter, Berde, Yaster, 2003

- In 2001, the Oregon Legislature mandated the creation of a commission to focus on the issue of pain in Oregon. The OPMC is a 17 member commission within the Department of Human Services. Its members are a multidisciplinary group of physicians, pharmacists, nurses, psychologists, social workers, patient advocates, healthcare consumers, acupuncturists, naturopaths, researchers, and other involved parties.
- Among the tasks of this commission was to develop requirements for pain management education for Oregon physicians and other licensees of the regulatory boards.
- This commission has mandated a requirement of one hour of Oregon specific pain education, and six additional hours of continuing education on the issue of pain management or palliative care. This is a one-time requirement of the licensees of the regulatory boards, and must be completed prior to license renewal in 2009. In comparison, the state of California has a 12 hour requirement, with no specific required content.
- This presentation fulfills the requirement of the one hour of Oregon-specific pain education. At your next license renewal, you will be required to certify that you have viewed this presentation and received an additional six hours of pain medicine or palliative care-related medical education hours.

The Oregon Pain Management Commission's Vision

Attention and resources devoted to pain management in Oregon are as available, effective, and guided by current science as services for other common disease states of similar prevalence and health impact. Oregonians should be satisfied with the availability and quality of their pain management resources.

- Although there are many challenges to achieving adequate pain management for all Oregonians, the Oregon Pain Management Commission has a vision for pain care in Oregon.
- This vision is intended to reflect the desires and concerns of the people of Oregon, not simply the opinions of a commission. These desires are in-line with the right to pain management as declared by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and the belief that everyone deserves treatment of their pain, as well as the recommendations of authoritative bodies involved in this important issue.
- We feel that this vision for adequate pain management in Oregon can be realized over the next 3-5 years if there is sufficient collaboration and communication between regulatory agencies, healthcare providers, insurers, and patients.

OPMC Responsibilities

- **Improve/coordinate regulatory and legal communication for patients and providers**
- **Advance a pain management practice program**
- **Develop and disseminate recommendations for improving pain management in Oregon**
- **Represent concerns of patients**
- In 2003, the OPMC endorsed Senate Bill 436 which removed the requirement in the Oregon Intractable Pain Treatment Act that a patient seek a second opinion on an intractable pain diagnosis, and clarified that healthcare providers will not be subject to disciplinary action from regulatory agencies for prescribing medication with the goal of controlling a patient's pain for the duration of the pain. However, it should be noted that the OBME strongly recommends a second opinion.
- One of the primary responsibilities of the OPMC is to create a pain management practice program. This presentation is part of this practice program. The Commission also developed the requirement that clinicians perform 7 hours of continuing education specific to pain management by 2009.
- In addition the OPMC is studying ways to improve pain management services in Oregon through research, policy analysis, and model projects. Senate Bill 436, which amended the Intractable Pain Treatment Act, is reflective of such efforts.
- Finally, the OPMC strives to represent the concerns of patients in Oregon on issues of pain management to the Governor and Legislative Assembly.

Key Pain Concepts and Definitions

Identifying and defining some key concepts in pain management helps ensure that patients and providers understand these terms correctly and can communicate appropriately.

Pain -

“An unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage, or both.”

International Association for the Study of Pain (2001)

- Nociceptive pain is pain from pain receptor stimulation. It may be somatic pain from activation of receptors in the musculoskeletal system or visceral pain which arises from receptors in the viscera.
- Neuropathic pain is due to changes in the peripheral or central nervous system.
- Idiopathic pain is pain without a known cause, and is not a diagnosis of psychogenic pain.
- Accurate assessment of the type of pain will allow more accurate selection of appropriate medications. Pain may be multifactorial and require multiple approaches to treatment.

Acute Pain -

- **A response to injury or illness**
- **Time limited**
- **Usually responsive to treatment**
- **Inadequate treatment delays recovery**

- The Federation of State Medical Boards (2004), a non-profit organization of 70 regulatory boards from across the country, defines acute pain as, "The normal, predicted psychological response to an adverse chemical, thermal, or mechanical stimulus..." It is generally time limited and is responsive to antiinflammatory and opioid medications as well as other approaches. Inadequate treatment may delay full recovery and increase healthcare costs.
- Acute pain may be due to trauma, or an acute medical or orthopedic problem. Postoperative pain, acute exacerbations of pain associated with chronic medical problems (e.g., cancer), and pain associated with medical procedures are also considered to be acute pain.
- The treatment of acute pain should be as effective as possible to prevent the formation of prolonged or unusually severe pain episodes that can have negative psychological and physical effects.

Impact of Acute Pain -

- **Prolonged hospital stays**
- **Delayed recovery**
- **Increased healthcare costs**

The importance of effectively treating acute pain and providing greater comfort with the use of new medications and techniques must be emphasized. This is especially true given the recent research which indicates that the failure to effectively treat acute pain can lead to prolonged hospital stays and delayed recovery, both of which ultimately drive up healthcare costs and adversely affect medical and social outcomes.

Chronic Pain -

"A state in which pain persists beyond the usual course of an acute disease or healing of an injury, or that may or may not be associated with an acute or chronic pathologic process that causes continuous or intermittent pain over months or years. "

The Federation of State Medical Boards (2004)

- It is estimated that approximately one third of the population suffers from chronic pain and up to 9% of adults suffer from moderate to severe non-cancer related chronic pain (American Pain Society [APS], 2002).
- In addition, chronic pain is estimated to affect 15% to 20% of children (Goodman & McGrath, 1991).
- The Wisconsin Task Force on Pain Management defines chronic pain as persistent pain, which can be either continuous or recurrent and of sufficient duration and intensity to adversely affect a patient's well being, level of function, and quality of life.

Intractable Pain -

"A pain state in which the cause of the pain cannot be removed or otherwise treated and for which, in the generally accepted course of medical practice, no relief or cure of the cause of the pain has been found after reasonable efforts, including but not limited to, evaluation by attending physicians."

Oregon Law (ORS § 667.470-677.485)

- Intractable pain can be treated with controlled substances, including opioids, that are FDA approved for the treatment of pain, if certain guidelines are met.
- These guidelines include complete record keeping of a diagnosis, plan of care, monitoring of care and record of prescriptions.
- A Material Risk Statement (a specific Procedures, Alternatives, and Risks statement, OAR 847-015-0030[2]) must be agreed to and signed by the patient and witnessed by the physician (See OBME-approved form at www.bme.state.or.us/forms).

Psychosocial Aspects of Chronic Pain

- **Loss of vocational, recreational, and familial activities alter self-image**
- **Depression, post-traumatic stress disorder, grief, and other complicating factors**
- **Need for psychological evaluations and support**

- Chronic pain is distinct from acute pain in that there are long-term changes in quality of life, occupational activities, and self-image that may predispose patients to depression, pathological grief over these losses, and substance abuse problems.
- Mental health providers, including psychologists, psychiatrists, medical social workers, and counselors can help provide ongoing evaluations and support during chronic pain treatment.
- Clear communication between mental health providers and other care providers improves patient advocacy efforts and attention to psychological aspects of chronic pain.

Impact of Chronic Pain

- **The economic and social impacts of chronic pain are thought to be greater than for any other single disease entity.**
- **Chronic pain is a major cause of healthcare consumption and disability. (Loeser, 1999)**

- Chronic pain is a major public health problem because it affects millions of individuals, their families, and the healthcare system.
- The economic impact of pain is significant. In 1986 back pain alone cost over 20 billion dollars in healthcare and related disability costs. It is estimated that U.S. business and industry loses about \$90 billion annually to sick time, reduced productivity, and direct medical and other benefit costs due to chronic pain among employees.
- Chronic pain and its related causes are the greatest single source of healthcare consumption and disability during an individual's working years.

Inadequate Pain Treatment Can Lead To:

- **Lost productivity**
- **Excessive healthcare expenditures**
- **Needless suffering**
- **Domestic and occupational problems**
- **Increased thoughts and risk of suicide**

- These factors have driven estimates of the economic burden of chronic pain as high as \$100 billion annually. (American Pain Society, 2001; National Conference of State Legislatures, 1999)

Impact of Pain at End-Of-Life

- **Pain in terminally ill individuals should always be adequately relieved.**
- **Opioid dependency is not a relevant issue in end-of-life pain management.**

- Pain management in terminally ill individuals involves different concerns; keeping the patient comfortable and the family satisfied with pain control measures are primary goals. Withholding pain medications because of fears of overuse, physical dependency, or disciplinary concerns are inappropriate in this setting.
- The Oregon Board of Medical Examiners, DEA and other oversight organizations understand that pain medication parameters are more liberal when dealing with end-of-life issues, and that a dying patient should not be denied reasonable pain relief.
- As long as the intention for prescribing analgesics is the relief of pain, the possibility that they may hasten death is not a reason to withhold these medications from a dying patient.

Pain Management Goals

- **Pain reduction**
- **Improved functioning**
- **Improved quality of life**

- Treatment goals should be SMART (Specific, Measurable, Achievable, Realistic, Time based).
- Appropriate consultations, referrals, diagnostic tests, accurate record keeping, and timely follow-up are the cornerstones of good pain management practices.
- If treatment goals are not easily achieved or the primary healthcare provider does not have adequate time to devote to pain management, consultation from, or referral to, a pain management specialist is in the patient's best interest. A multidisciplinary approach is recommended and may be required for optimal treatment. The primary healthcare provider may then continue to give the best continuity of overall care for the patient.

Pain Management Team

Each member of the pain treatment team understands the anatomical and physiological basis of pain perception, the psychological factors that modify the pain experience, and the basic principles of pain management.

- Effective management of severe and/or chronic pain usually involves more than one healthcare provider over the course of treatment, and clear communication between these providers is extremely important.
- All team members need to be advised of any changes or developments by the involved specialists and other providers.
- Family members may be part of the pain management team in the administration of medication and other aspects of pain care. Strict adherence to HIPAA privacy policies and other ethical boundaries and risks, including the risks of medication diversion, should be kept in mind when involving family members.

Primary Care and Pain Management

- **Primary care providers are often the most appropriate leader of the pain treatment team**
- **Gatekeepers need to be involved and notified of treatment/condition changes**

- The primary care provider is a key part of any pain treatment team. Much of the treatment of chronic pain can and should, with adequate resources, occur in the primary care setting.
- Primary care providers are often held accountable financially and otherwise for referrals, pharmacy costs, specialty care and other aspects in the continuum of care, and as such, need to be advised of any changes or developments by the involved specialists and ancillary care providers as much as possible.

Pain Management Specialists

Specialize in the diagnosis and treatment of the entire range of painful disorders. Because of the vast scope of the field, pain management is a multidisciplinary subspecialty. The expertise of several disciplines is brought together in an effort to provide the maximum benefit to each patient.

- While healthcare providers from a wide variety of specialties may be called upon to treat acute or chronic pain, appropriate pain management is such an involved science that it is often considered a subspecialty.
- Pain management specialists provide a consultation and referral resource for all healthcare providers who are having difficulty achieving the desired pain control or who need advice on a particular patient.

Key Concepts - Pain Management

- Considered routine part of medical practice
- Most care at primary care level

- There are several key concepts regarding pain management that the OPMC believes are important. First, pain management should be considered a routine part of medical practice and be given the same attention and resources as other medical conditions.
- The OPMC believes that the majority of pain care should occur at the community level in the primary care setting utilizing the spectrum of other disciplines as indicated. Specialty evaluation and treatment should follow the same patterns established for other medical conditions.

Key Concepts - Pain Management (cont.)

- Multidisciplinary approach
- Vulnerable populations

- Often a multidisciplinary team approach is best, utilizing the expertise of physicians, nurses, physical therapists, chiropractors, acupuncturists, surgeons, naturopaths, psychologists, researchers, and pain centers as indicated by the clinical situation.
- Thus the OPMC advocates for a team approach using a combination of appropriate evidence-based practices that include pharmacologic, non-pharmacologic (such as cognitive behavioral therapy), surgical/procedural approaches, and physical therapy. Complimentary and alternative approaches like acupuncture, chiropractic/osteopathic treatment, nutritional therapy and naturopathy have their place in the management of acute and chronic pain, depending on the needs and responses of the patient.
- The OPMC recognizes the potential for inadequate pain management in vulnerable populations such as children, the elderly, the cognitively impaired, and ethnic minorities and emphasizes the need to protect such individuals by educating providers on proper pain assessment and treatment options.

Key Concepts - Pain Management (cont.)

- Regulatory agencies, care providers, and patient advocates need to understand each other's concerns in order to work together efficiently and appropriately towards the best interests of pain patients.
- Policy clarification and education will foster improved pain management.

- The OPMC acknowledges the challenges faced by regulatory agencies in protecting the public from abuse of controlled substances while simultaneously ensuring these same medications are available for appropriate use in treating pain.
- The OPMC recognizes that it will take concerted action from all stakeholders in order to accomplish the goals set forth in the Vision. The OPMC views each stakeholder as being part of the final solution. To facilitate positive progress however, there needs to be ongoing cooperation between regulatory agencies, such as state licensing boards, and pain advocate entities like the OPMC.
- There is an urgent and basic need to provide ongoing education for healthcare providers on the policies that govern pain management and clarify the OBME's philosophy and intent on the use of opioids in treating pain. Effective provider education should help reduce or eliminate fears of regulatory scrutiny as a primary barrier to appropriate pain medication prescribing practices.

Pharmacologic Options in Pain Management

- Anti-inflammatory analgesics
- Opioid analgesics
- Antidepressant therapy
- Muscle relaxants
- Pain perception modifiers (e.g. anticonvulsants)

- There are several pharmacologic options available for the prescribing physician when treating acute and chronic pain.
- Ongoing medication evaluations to judge response, adjust dosages, and explore other options are key to effective pain management.

Tolerance, Physical Dependence, Addiction

- Distinct definitions
- Physical dependence vs. addiction
- Fear of causing addiction
- Low opioid addiction rates in pain treatment

- The confusion and misconceptions of tolerance, physical dependence, and addiction contribute to the problem of poor pain management. The American Pain Society and American Academy of Pain Medicine have defined these terms and advocated for their use so that providers understand the distinctions between the terms.
- Most experts agree that patients who are in pain and undergo prolonged opioid therapy usually develop physical dependence but rarely develop addictive behaviors.
- Fear of causing addiction to opioids is a major barrier to appropriate pain management. Research has shown that there was a "low and stable" abuse of opioids between 1990 and 1996 despite significant increases in opioids prescribed (Joranson DE, Ryan KM, Gilson AM, Dahl JL. JAMA 2000;283:1710-1714). Drug exposure is only one etiologic factor in development of addiction; other factors include genetics, social influences, and psychological characteristics.
- Thus, it is important to define these terms and highlight the distinctions between them for both the public and physicians in order to improve pain management and appropriate prescribing patterns.

Tolerance -

"...is a state of adaptation in which exposure to a drug induces changes that result in a diminution of one or more of the drug's effects over time."

American Academy of Pain Medicine, American Pain Society,
American Society of Addiction Medicine, 2001

- The American Academy of Pain Medicine (AAPM), the American Pain Society (APS), and the American Society of Addiction Medicine (ASAM) define tolerance as "a loss of drug effectiveness due to physical adaptation over a period of use."
- Significant tolerance to opioids can develop rapidly during sustained or prolonged analgesic treatment and should be accounted for in the dosing and prescribing process.

Physical Dependence -

"...a state of adaptation that is manifested by a drug class specific withdrawal syndrome that can be produced by abrupt cessation, rapid dose reduction, decreasing blood level of the drug and/or administration of an antagonist. "

American Academy of Pain Medicine, American Pain Society,
American Society of Addiction Medicine, 2001

- Physical dependence is not addiction. A withdrawal syndrome is to be expected after prolonged opioid therapy if there is sudden severe dose reduction or treatment cessation. The presence of a physical withdrawal syndrome does not in itself establish the diagnosis of addiction.

Pseudoaddiction -

- The iatrogenic syndrome resulting from the misinterpretation of relief seeking behaviors as though they are drug-seeking behaviors that are commonly seen with addiction.
- The relief seeking behaviors resolve upon institution of effective analgesic therapy.

Federation of State Medical Boards (2004)

Addiction -

Addiction is characterized by at least one of the following behaviors:

- Impaired control over drug use
- Compulsive use
- Continued use despite harm
- Craving

American Academy of Pain Medicine, American Pain Society,
American Society of Addiction Medicine, 2001

- Addiction has several components and can be defined as a primary, chronic, neurobiologic disease, with genetic, psychosocial, and environmental factors influencing its development and manifestations. (American Academy of Pain Medicine, American Pain Society, American Society of Addiction Medicine, 2001)
- Addiction also includes one or more of the following hallmark behaviors: loss of control over drug use, compulsive use, continued use despite harm to self and/or others, and physical and psychological craving.
- The risk of addiction is low if appropriate medication levels are attained. An Addiction Medicine evaluation should be obtained if fear of addiction is causing physician apprehension and undertreatment.

Interventional Pain Management Options

- TENS units
 - Nerve blocks
 - Implanted nerve stimulators
 - Intraspinial delivery systems
 - Neuroablative procedures
- Healthcare providers may utilize a number of non-pharmacologic interventions to reduce pain, including transcutaneous nerve stimulators, nerve ablations or blocks, and other procedures designed to interrupt or reduce the pain signals.
 - Interventional treatments can be utilized with pharmacologic and other treatments and may help reduce medication use and side effects.

Non-Pharmacologic Pain Treatment Options

- Physical therapy, massage, body/energy work
 - Acupuncture
 - Chiropractic, naturopathic care
 - Behavioral medicine, mental health treatment, biofeedback
- Ancillary or adjuvant treatment options for chronic pain can generally be used concomitantly with other medical therapy.
 - Nurses and case managers may also be an integral and important part of an effective acute or chronic pain treatment team.

Physical Therapy and Other Body Work

- **PT and OT are widely available/reimbursable**
- **Massage therapy can help relax muscles and reduce pain perception**
- **Energy healing and other body work techniques, including Pilates, yoga, etc. may be helpful**

- Physical therapists are widely used and available for addressing pain with hands-on-techniques and for instructing patients in establishing a home exercise program (HEP).
- Occupational therapy can help address vocational issues, keeping patients employed or guiding job changes that maintain self-esteem.
- Licensed massage practitioners are trained in soft-tissue manipulation for muscle/fascial release. Myofascial trigger point and other techniques have been shown to be effective for pain reduction in certain conditions.
- Energy healing and instructions in self-disciplines such as Pilates and yoga can improve general sense of well being and induce needed relaxation responses in chronic pain patients.

Acupuncture -

- **Acupuncture has been demonstrated in clinical trials to be effective in treating acute and chronic pain with wide ranges of etiology**
- **Treats a wide variety of pain types with low incidence of adverse effects, as well as treating the causes of pain**
- **May be used in conjunction with pain medications and other treatments**

Pain, vol 83 (1999), Pain, vol 99 (2002), British Medical Journal, vol 328 (2004)

- The National Institutes of Health has stated that acupuncture is effective in treating pain (NIH Consensus Statement, Vol. 15, #5, 1997).
- Acupuncture treatments are widely used in Oregon, and Licensed Acupuncturists have strict licensing requirements and board oversight on quality of care. Many hospitals now have Licensed Acupuncturists on staff.
- Many insurance providers cover acupuncture for pain treatment. Oregon law makes acupuncture treatment the right of any insured individual who has been in a motor vehicle accident.

Chiropractic and Naturopathic Care

- **Chiropractor adjustments may aid in musculoskeletal mobilization to reduce pain and improve function**
- **Naturopathic physicians address pain with holistic approach that includes botanicals, nutrition, and nutraceutical supplements**

- Chiropractic and naturopathic physicians have their own licensing boards, requirements and regulatory oversight.
- Chiropractic manipulation may be helpful in addressing chronic or acute postural or other musculoskeletal problems.
- Naturopathic medicine utilizes a variety of nutritional and botanical approaches to improve overall patient health and treat the source of pain.

Behavioral Medicine

- **Addresses the psychological aspects of pain**
- **Helps recognize and reduce psychological and behavioral complications to pain**
- **Assists in identifying behaviors or underlying disorders that contribute to pain and undermine treatment**

- Psychologists, psychiatrists, MSWs, and other mental health therapists may be effective and often indispensable parts of the pain treatment team.
- Behavioral medicine providers can assist in identifying and treating aspects of the patient's condition that may be difficult to detect without extensive one-on-one interviews and interaction, such as depression or unresolved grief.
- Psychiatric and personality disorders and addictions, which can complicate the evaluation and treatment of pain, can be properly identified and addressed by mental health specialists.

Pain Management Challenges and Deficiencies

- **Failure to properly assess pain**
- **Difficulties in assessing pain**
- **Lack of pain relief standards**

(McCaffery & Pasero, 1999; JCAHO, 2001)

- It has been reported that a common cause of unrelieved and unnecessary suffering stems from the failure of providers to fully or accurately assess pain, to accept a patient's subjective report of pain, and to perform actions to relieve the pain.
- It is recognized that pain assessment can be challenging in special populations such as neonates, children, and the cognitively or physically impaired.

Pain Management Challenges and Deficiencies (cont.)

- **Lack of provider accountability for effective pain relief**
- **Poor reimbursement for pain care**

(McCaffery & Pasero, 1999; JCAHO, 2001)

- Another barrier within organizations is the lack of healthcare provider accountability for effective pain relief. To ensure optimal pain management, organizations need to implement measures to hold individual providers responsible for appropriate pain assessment and treatment.
- Poor or inconsistent reimbursement of pain treatment can also serve as a barrier to providing pain care.
- The additive effects of these pain treatment challenges have resulted in undertreatment and inappropriate treatment of a significant portion of patients suffering from acute or chronic pain .

Healthcare Professional Pain Management Issues

- Negative attitudes and erroneous beliefs
- Lack of knowledge and proper training
- Misconceptions and fears

Turk, DC et al, Pain 1994 59:201-208

- Negative attitudes, beliefs, and behaviors of clinicians towards patients with pain and pain management in general can contribute to the undertreatment or mistreatment of pain.
- Another barrier to pain management is the lack of sufficient healthcare provider knowledge and training.
- Although most formal decisions regarding the treatment of chronic pain management with opioids are made by physicians, there is almost no formal pain management curriculum in most medical schools. Only 3% of medical schools have a separate required course on pain management (APS, 2003).
- Many provider-related issues that contribute to poor pain management involve the prescribing of opioids and other pharmacologic aspects of treatment: worry about patients becoming tolerant or addicted to analgesics; fear of drug diversion; and fears of overdoses or hastening death in a terminal patient. Fears of regulatory scrutiny for prescribing controlled substances is another major concern for providers.

Psychosocial Barriers

- Poor clinician-patient communication
- Reluctance to report pain
- Financial barriers
- Lack of insurance
- Cost of medications

(JCAHO, 2001)

- Patient characteristics, such as age, gender, language, cognitive abilities, ethnicity, coexisting physical or psychological illness, and cultural traditions, can all serve as potential barriers to effective pain management.
- Patients may be reluctant to report pain to their provider because of low expectations of obtaining relief, stoicism, fears, or concerns about what the pain may mean (such as worsening illness), side effects, or addiction.
- Other factors contributing to the undertreatment of pain are a lack of health insurance coverage and the high costs of medications. Both of these may result in the patient not reporting pain or not complying with a treatment plan.
- All of these factors can negatively impact the provision of pain management by making provider-patient communication problematic and by limiting the reporting of pain and/or utilization of appropriate services.

Legal and Societal Issues

- Fear of regulatory scrutiny/sanctions
- Societal stigmatization
- Misconceptions about tolerance, addiction, physical dependence

(Joranson, Cleland, Weissman, & Gilson, 1992; JCAHO, 2001)

- One barrier to the provision of appropriate pain management is the fear of regulatory scrutiny that encompasses the use of opioids in treating pain. It has been reported that physicians reduce prescription amounts or prescribe fewer controlled drugs to avoid regulatory scrutiny, especially when prescribing for chronic pain. Much of this results from the confusion about the appropriate role of opioids in pain treatment.
- Additional issues include: vigorous enforcement efforts against prescribers who have been found to be in violation of the Medical Practice Act; regulations to increase restrictions on prescriptions; and federal proposals to monitor physicians' prescriptions.
- There are also several more systemic societal barriers that impact pain management. In some instances, drug abuse programs may serve as a barrier to the provision of pain management. In other instances, exaggerated reports of over-prescribing and the dangers of opioids in the media may impede appropriate pain management.
- Physicians describe both legal and ethical concerns regarding the prescribing of opioid analgesics. These concerns include providing adequate pain relief, fear of losing their licenses or other regulatory consequences, causing addiction in patients, and hastening the death of patients (Joranson, et al. 2002).

Supportive Policies and Guidelines – Federal, State, Organization Levels

- Although pain continues to be widely undertreated in many areas, there are laws and policies that emphasize the importance of treating pain and support adequate treatment of acute and chronic pain.
- In addition, several specifically address the use of opioid analgesics for treating pain.
- Although guidelines are not legally binding, they often outline the parameters of accepted standards of practice for those regulated by the agency.
- For example, the Oregon Board of Medical Examiners has issued guidelines regarding the medical use of opioids that define the conduct that the board considers to be within the professional practice of medicine.

Federal - Controlled Substance Act

- USC § 801(1) and USC § 130.04(a)
- Outlines essential and legitimate medical purpose of controlled substances
- Does not delineate selection or quantity prescribed
- Does not address provider's medical judgment

(Good, 1998)

- The Controlled Substance Act outlines the essential and legitimate medical purpose of controlled substances and their role in maintaining the health and general welfare of the public.
- The CSA does not address medical treatment issues such as the specific selection of controlled substances, the quantity prescribed, or the appropriateness of the provider's medical judgment.

Oregon's Pain Management Acts and Policies

- 1995 : OBME's Statement of Philosophy
- 1995 : Intractable Pain Treatment Act

- In 1995, the OBME released a statement of philosophy on pain management in acute conditions as well as terminal illness: Use effective pain control for all patients... the standard of care allows neither undertreatment nor overtreatment. (OBME, 1995).
- 1995 - ORS 677.470-485, Intractable Pain Treatment Act: Protects patients from inappropriate prescribing. Protects physicians from disciplinary actions if good medical care is given and the law is carefully followed.

	<p>Oregon's Pain Management Acts and Policies (cont.)</p> <ul style="list-style-type: none"> • 1997 : SB 1071 • 1999 : OBME Revised Statement of Philosophy <ul style="list-style-type: none"> ■ In 1997, Oregon Senate Bill 1071 established the Pain and Symptom Management Task Force. The Task Force studied the problem and made recommendations focused on: <ul style="list-style-type: none"> ■ the problems Oregonians faced in obtaining relief from pain ■ the nature of pain and symptom management practices, and ■ resources and remedies available for pain and symptom management ■ In 1999 the OBME urged the use of effective pain control for all patients, good medical record keeping, legitimate prescribing and dispensing (no false prescriptions), as well as recommending a Material Risk Notice (pain management contract between physician and patient) and a narcotics agreement (patient agrees to use one doctor and one pharmacy). ■ 2003 – OBME eliminated the requirement for evaluation by a specialist prior to treatment with opioids, but still recommends a second opinion as part of good medical practice. It also requires certain records and notices on OBME forms.
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	<p>National Organizations Positions and Purposes</p> <ul style="list-style-type: none"> • Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) • American Pain Society • American Academy of Pain Medicine (Good, 1998) <ul style="list-style-type: none"> ■ At the organizational level, the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) states that patients may experience pain and unrelieved pain has adverse physical and psychological effects. ■ JCAHO also supports the right of patients to pain management. By doing so, the JCAHO mandates that accredited organizations must ensure that pain is recognized and addressed appropriately by assessing for pain, educate all relevant providers about assessing and managing pain, and educate patients and families, when appropriate, about their roles in managing pain and the potential limitations and side effects of pain treatments. ■ The American Pain Society's stated goals are to advance the treatment of people in pain by ensuring access to treatment, removing regulatory barriers, and educating practitioners and policy makers in all settings about advances and economics of effective pain treatment. (http://www.ampainsoc.org/advocacy/) ■ The American Academy of Pain Medicine (AAPM) is a medical society representing physicians practicing in the field of Pain Medicine. The Academy is involved in education, training, advocacy, and research in the specialty of Pain Medicine. (http://www.painmed.org/)
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	<p>Conclusion and Recommendations</p> <ul style="list-style-type: none"> • Disseminate Federation of State Medical Board Guidelines • Create pain education guidelines and get endorsed by regulatory agencies • Analysis of regulatory and reimbursement policies <ul style="list-style-type: none"> ■ In order to advance pain management in Oregon, the identified barriers need to be appropriately addressed. The OPMC has the following recommendations that, if adopted, will hopefully lead to better pain management: <ul style="list-style-type: none"> ■ An initial step should be to disseminate the Federation of State Medical Board's the "Model Guidelines for Use of Controlled Substances for Treatment of Pain." These guidelines are widely endorsed by American Academy of Pain Medicine, DEA, American Pain Society, and National Association of State Controlled Substances Authorities. Dissemination of these guidelines standardizes and educates providers on pain policies. ■ Education specifically addressing pain management, regulatory requirements, medical board policies, and concerns about regulatory scrutiny should be implemented statewide to help remove these barriers. It is important that such guidelines are endorsed by state licensing boards for consistency. ■ It is also recommended that there be continued work with state agencies in evaluating current regulations and guidelines for effectiveness of advancing pain management in Oregon. For example, the amendment made to Intractable Pain Treatment Act. ■ Reimbursement policies of insurers regarding pain management services should be analyzed to enable further understanding of those promoting the most cost effective pain management.
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	<p>Further OPMC Recommendations</p> <ul style="list-style-type: none"> • Discussions on opioid analgesics • Mobilization of all stakeholders • Prioritization of pain management • Formal pain curriculum <ul style="list-style-type: none"> ■ Encourage discussions/forums on the use of opioid analgesics in treating pain. In addition, continued efforts to address misuse, abuse and diversion of controlled substances without interfering with appropriate medical use should be supported. The advocacy of the judicious use of opioid analgesics in treating pain must be consistent with the state of clinical experience, scientific knowledge and professional consensus. ■ It is important to mobilize all stakeholders involved in pain management. This includes the providers, the patients, the regulatory agencies, and the policymakers. Without mobilization of all concerned parties, pain management advocacy efforts will be limited. ■ There should be a prioritization of pain management within each healthcare discipline. Each licensing board should address pain management as an important issue and in doing so collaborate with the OPMC in designing education guidelines for all providers throughout Oregon. ■ Advocacy efforts should continue to strive for obtaining a pain specific curriculum in medical schools and other provider training programs.
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	<p>OPMC – Looking Forward</p> <ul style="list-style-type: none"> • Improved pain care in Oregon • Licensing board pain guidelines • Increased knowledge <ul style="list-style-type: none"> ■ The implications and impact of the OPMC have yet to be seen as it is in its early phases. If approached correctly through inclusion of other state agencies, the level of pain management in Oregon will only improve. ■ Continued evaluations through methods such as demonstration projects and research may help encourage state regulatory and licensing boards to develop guidelines for pain and symptom management and provider practices (See OBME Statement of Philosophy on Pain Management, www.bme.state.or.us/topics.htm). ■ Finally, attention to public, patient, and provider education and the addressing of barriers to appropriate pain management will help create momentum towards an improved healthcare climate for patients suffering from pain and the healthcare workers who attend them. When combined with the potential of formal pain curriculum in medical school and other practitioner programs this will provide an environment conducive to advancing pain management, resulting in better pain care for all Oregonians.
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	<p>Thank you!</p> <p>Thank you for your time in learning more about pain management in Oregon, the barriers to providing care, and what is needed to ensure that all Oregonians have access to the best possible pain treatment available to them.</p>
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Important Links

- Oregon Pain Management Commission:
<http://www.dhs.state.or.us/pain>
- OPMC 1 Hour Presentation Site:
<http://www.oregonpain.org/>
- Oregon Board of Medical Examiners:
<http://www.bme.state.or.us/>
- Oregon Psychological Association:
<http://www.opa.org/>
- Oregon State Board of Nursing:
<http://www.osbn.state.or.us/>
- Oregon Board of Chiropractic Examiners:
<http://www.obce.state.or.us/>
- Oregon Board of Naturopathic Examiners:
<http://www.obne.state.or.us/>