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POLICY FORUM

Addressing Obstacles to Evidence-Informed Pain Care

AMA Pain Care Task Force

Abstract

Pain is a universal human experience and the most common reason patients seek health care. This article describes barriers to effective, high-quality, evidence-informed pain care. Based on the clinical literature and pain specialists' survey results, the AMA Pain Care Task Force suggests strategies that clinicians can use to offer good pain care to patients. The task force also canvasses key policy-level concerns that situate clinicians in micro- and macro-level complexities related to payers, workforce and training demands, legal and regulatory questions, research, stigma, and patients' beliefs and expectations.

Framing the Issue

The costs of pain-related health care utilization and lost productivity are estimated to be \$560 to \$635 billion per year in the United States.^{1,2} Personal costs to patients with persistent pain are almost incalculable due to their significant impact on patients' emotional, functional, and financial health and social life. Everyone, at some point in their life, looks to their physician for relief from pain. From Hippocrates³ to the American Medical Association (AMA) *Code of Medical Ethics*,⁴ physicians have been charged to care for patients in pain, even if they have an incurable disease. Treatment of pain has been described as a "moral imperative" for the medical and scientific communities.⁵

A mandate in the Patient Protection and Affordable Care Act of 2010, together with widespread recognition that there was a need for better understanding of the science and complexity of pain, led to development of a series of government reports and action plans, including a 2011 report by the Institute of Medicine (IOM; now the National Academy of Medicine), *Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education, and Research*, as well as a follow-up action plan in 2016 by the US Department of Health and Human Services (HHS), "The National Pain Strategy" (NPS).^{5,6} NPS recommendations called for reducing barriers to all modalities for treating pain and for reducing pain stigma.⁶ The action plan also noted that existing chronic pain prevention and treatment knowledge could be used more effectively.⁶ In 2019, the HHS Pain Management Best Practices Inter-Agency Task Force report was released.⁷ The HHS task force performed a comprehensive and up-to-date review of a wide range of pharmacological and nonpharmacological therapies and, on this basis,

identified gaps in knowledge and made recommendations for research and policy on pain treatment to help create a national approach to pain management.⁷

Experts recommend that policymakers at all levels proceed with caution, balance, and deep understanding of the complexity of pain management in the formulation of effective policy.⁸ Many complex and compounding barriers exist that directly and indirectly affect the practice and delivery of pain care. Payer coverage and administrative practices, physician training and education issues, research and evidence utilization, and stigma are among the barriers identified. Additionally, patient expectations concerning pain management, disparities in pain care, and confusion about opioids and opioid-related laws and regulations have created significant barriers to physicians' provision of optimal pain care.

Payer Administrative and Reimbursement Barriers

Administrative practices and payment structures put in place by payers create some of the most significant barriers for physicians seeking to provide pain care. Prior authorization requirements by payers are particularly burdensome for physicians and their staff. In fact, 92% of pain specialists surveyed in 2019 by the American Board of Pain Medicine reported that they were required to submit a prior authorization for nonopioid pain care, which delayed patient treatment, and 66% hired additional staff to process the additional workload.⁹ Treatments shown to provide benefit for chronic pain but commonly subject to prior authorization include manual manipulation (ie, occupational or physical therapy), nonopioid prescription pain medications or treatments, and pain creams and patches.⁹ Another barrier is "fail first," whereby payers cover the least costly medication or treatment first instead of what was recommended by the patient's clinician. Variation in benefit plans means that pain services and medications are covered for some but not others.¹⁰

Payer coverage models vary widely and increase the complexity of prescribing treatment and the difficulty of accessing care. For example, there is clear evidence that integrated, multidisciplinary, and multimodal care results in better overall outcomes for chronic pain and is more cost-effective in the long-term than opioid therapy alone.^{8,11,12} Nevertheless, coverage of and payment for this type of pain care is inadequate.⁸ Benefit plans that don't support multidisciplinary, multimodal, and collaborative care for pain are out of step with many clinical practices, current and emerging evidence, and the needs of patients with complex pain. The AMA endorses the HSS Pain Management Best Practices Inter-Agency Task Force recommendations that payers remove barriers of inadequate coverage and inadequate reimbursement of treatments for chronic pain.¹³

Physician Workforce and Training

According to the IOM Report, in 2011 there were "strong indications that pain receives insufficient attention in virtually all phases of medical education,"⁵ and many physicians were still unprepared to provide high-quality pain care.¹⁰ A study published in 2011 showed that almost 80% of US medical schools required courses on pain but that the curriculum was "limited, variable and fragmentary."¹⁴ In 2013, an interprofessional committee developed core competencies for pain, which recognized that pain care goes beyond knowledge of anatomy to integration of knowledge with skills in preventing, assessing, and treating pain, sometimes as part of a multimodal team.¹⁵ Enhancing the pain management curriculum in medical education is increasingly being seen as a priority.^{15,16,17}

Enhancing education for practicing physicians about pain and related areas is also increasingly a priority. As of 2018, efforts by the AMA and state and specialty societies have dramatically increased opportunities for health care professionals to complete continuing medical education and to access other resources related to pain care, opioid prescribing, substance use disorders, and other topics on pain management and the nation's opioid epidemic.¹⁸

Allied health care clinicians such as physician assistants and advanced practice nurses are often involved in a patient's treatment program, and these practitioners play an increasing role in pain care (eg, assessment, prescribing, follow-up). However, these clinicians frequently lack specific training in pain management. There are few formalized training programs on pain for nonphysician clinicians, and many such clinicians only have on-the-job training in pain management.¹⁹

Research and Utilization of Evidence

Pain is a challenging topic to investigate. Although evidence of effective treatment for pain currently exists, pain cannot always be objectively measured.²⁰ Additionally, to address the social, emotional, and functional factors involved in pain, researchers need to use different theoretical models, such as the biopsychosocial model, in studying pain assessment and treatment.⁶ Furthermore, clinicians need evidence of the safety, cost, usability, and effectiveness of a treatment when developing an individualized care plan.⁶ For example, out-of-pocket costs and travel required for treatments may not be feasible for some patients.

Physicians', payers', and policymakers' acceptance of existing evidence on the efficacy of integrative and complementary therapies is essential to providing high-quality care.⁶ Therapies such as acupuncture, bodywork, meditation, biofeedback, and guided imagery have been shown to help some chronic pain patients reduce their need for medications and experience significant decreases in pain but are rarely covered by payers.²¹ The HHS pain report states: "As novel and proven treatment options emerge to improve acute pain and specific chronic pain conditions, they should be rapidly incorporated,"⁷ but this uptake is impossible when payers don't acknowledge the growing evidence base and clinical efficacy of these treatments.^{6,22}

Stigma

Patients reporting pain have sometimes been disbelieved, dismissed, or seen as "drug seeking" for wanting to continue opioid analgesic therapy that has provided relief and maintained or improved function.⁵ Acknowledgement of the presence and impact of this stigma on patient care for chronic pain is crucial.²³ Patients seeking care should be treated with compassion and dignity without dismissing the need for careful management of opioid therapy.

Stigmatizing of medications used for opioid use disorder has resulted in barriers for pain and opioid management. Co-prescribing naloxone with opioid medication is an accepted and encouraged practice for risk mitigation and can provide lifesaving overdose reversal. However, it is not always in stock in pharmacies²⁴ and misperceptions about naloxone are common.²⁵ Pharmacists in one study described being reticent to offer naloxone out of fear they would be viewed as accusing the patient of being a drug "abuser" and out of discomfort with how to discretely dispense it.²⁶ Prescribing buprenorphine for pain, which does not require a federal waiver, is not commonplace and in some states is prohibited.²⁷ These restrictions make this useful medication

difficult to appropriately prescribe. For some patients, buprenorphine is an effective option for pain that provides less risk for respiratory depression than full agonist opioids,²⁸ but insurance companies may not cover it or may approve it only if prescribed for treatment of opioid use disorder.²⁹ General association of these medications with opioid use disorder is most likely creating stigma-related barriers to their widespread use.

We also must acknowledge health disparities in pain care, as in all aspects of health care, as a form of stigma. Racial and other biases, language differences, gender, economic disparities, and other factors create real barriers to care. Evidence has shown that minorities, those with lower income, and non-native English speakers with chronic pain are less likely than others to receive analgesic medications. Research also shows that African Americans are likely to have their pain intensity underestimated by primary care clinicians, and pharmacies located in minority areas are less likely to carry adequate stocks of analgesic medications.^{30,31,32}

Opioid Prescribing and the Centers for Disease Control and Prevention Guidelines

Unfortunately, one effort to decrease opioid-related harms has had the unintended consequence of encouraging rigid limits on opioid prescribing and of some patients' opioids being involuntarily discontinued or reduced inappropriately. In 2016, the Centers for Disease Control and Prevention (CDC) published a Guideline for Prescribing Opioids for Chronic Pain with the intent of providing voluntary prescribing guidelines to primary care physicians.³³ Among the recommendations were limiting opioid prescribing by day and dose thresholds. Even prior to the guideline release, the AMA raised concerns about possible unintended consequences of the CDC recommendations on chronic pain patients who had been effectively managed on long-term opioids that exceeded the voluntary dosage threshold.³⁴

Following release of the CDC guideline, states, federal agencies, pharmacies, pharmacy benefit managers, and payers implemented regulations and restrictions on opioid prescribing and dispensing, and the voluntary dosage guidelines soon became rigid limitations in many areas of policy, practice, and regulation.³⁵ Although the CDC may have intended its guideline to be instructional, voluntary, and mainly applied to primary care practices, patients who have benefited from high-dose opioid therapy have been harmed due to some physicians assuming they must decrease opioid therapy for patients across the board to fit within the guideline's 90 MME daily threshold limit.³³ Unintended consequences, such as limiting access to opioid therapy for cancer, surgery,³⁵ and hospice patients, have been reported as a result of dispensing and coverage limits put in place by pharmacies and payers after the 2016 CDC guideline was released. Some patients have been forced to suddenly taper to lower doses or discontinue therapy, causing withdrawal and other physical problems.^{35,36} While the CDC guideline is commonly seen as one of the factors leading to the nation's 22% decrease in opioid prescribing between 2013 and 2017,³⁷ there seems to be no indication that patients' access to nonopioid pain care has increased or that pain care outcomes have improved.

In 2019, the CDC acknowledged these concerns and clarified that the intent of the guideline was not to support sudden tapering or "cutting off" opioids for patients who are simply physically dependent on high-dose or long-term opioids when doing so would result in severe withdrawal symptoms or psychological distress.³⁸ In welcoming the clarification, then AMA President-elect Patrice Harris, MD, stated: "The guidelines have

been treated as hard and fast rules, leaving physicians unable to offer the best care for their patients.”³⁷

Legal Issues and Opioid Prescribing

Although decisions concerning opioid treatment and any other form of pain therapy should be made between physician and patient, physicians’ fear of liability when prescribing opioids for pain has increased.³⁹ Because many state regulations have set hard limits on dosage and duration of opioid analgesic therapy,³⁵ some physicians have reported fears of sanction from state medical boards, increased scrutiny from the Drug Enforcement Administration (DEA), or being labeled a “high prescriber” by insurance companies or pharmacies when prescribing either long-term opioid therapy or, in some instances, any opioids for a patient with pain.³⁹ Being labeled a “high prescriber” is deeply concerning for palliative care and pain specialists, who generally prescribe higher levels of opioids for longer durations. DEA raids and possible criminal charges, being known as a high-prescriber on lists compiled by pharmacy chains, warning notifications from the US Attorney’s office, and medical board sanctions are some of the consequences that a physician can encounter.⁴⁰ These efforts can successfully target seriously unethical and excessive prescribers, but these prescribers are relatively few in number. A family physician in a small community who supplies most of the community’s pain care could be labeled a “high prescriber” and suffer consequences inappropriately. The AMA advocates that physicians should not be subject to professional discipline, loss of board certification or clinical privileges, criminal or civil liability, or other penalties solely for prescribing opioids at a quantitative level above voluntary thresholds when indicated.^{40,41}

Patient Expectations

Managing expectations for pain treatment and the resulting pain relief can be challenging for physicians and patients. Paramount for successful treatment is applying a collaborative approach with shared decision making and realistic goal setting. The idea of “acceptable” pain in some chronic pain situations has also been shown to be a realistic alternative to the idea of complete pain extinction.⁴² The focus can be on maximizing the safety and effectiveness of treatment as well as on progress on functional goals and quality-of-life improvements.⁴³

Conclusion

The IOM report on pain asserts that cultural transformation is necessary to better prevent, assess, and treat pain of all types.⁵ The barriers described are significant and, when compounded, make patient care complex and difficult. Acknowledgment of systemic barriers in the delivery of evidence-informed pain care in the United States is needed, and actions to remove those barriers is urged. Payer coverage, reimbursement, and administrative practices that interfere with accessing a variety of effective treatment options need to be removed. Expanding their knowledge and skills in addressing pain should continue to be a high priority for physicians. Pain assessment and treatment that applies the best available evidence and accepted standards of care should be individualized and physician driven. Dismantling pain-related stigma is essential. When indicated, physicians should prescribe opioids safely and in the best interests of patients. Policymakers must work with the medical community to remove arbitrary prescribing limits that have caused uncertainty and fear for patients and physicians. Until barriers to effective pain care are removed, the transformation necessary to provide effective and evidence-informed pain care will not be realized.

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AMA Pain Care Task Force (PCTF) was convened in 2018 and is made up of representatives from 20 federation member associations. This broad-based group of clinicians and experts is working collaboratively to improve pain care for patients by identifying actionable opportunities to improve medical education related to pain care, highlighting barriers to providing evidence-based pain care, and offering principles of pain care for physicians, payers, and policymakers. Dr S. Bobby Mukkamala is the current chair-elect of the AMA Board of Trustees as well as the chair of the PCTF.

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