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Alleviating Pain: From Policy to Practice

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Alleviating Pain: From Policy to Practice

Eliminating barriers to adequate pain control and decreasing disparities in the management of pain is increasingly on the international health policy radar. The World Health Organization's (WHO) published guidelines for physicians and pharmacists regarding administration of pain treatment have been adopted by professional provider associations world wide.¹ The WHO Collaborating Center for Policy and Communications in Cancer Care works internationally with governmental and nongovernmental organizations and individuals to decrease barriers to pain relief through active demonstrations, networking, and policy initiatives. In 2003, legislation was introduced (H.R.1863) to recognize pain as a priority health problem in the United States. The "National Pain Care Policy Act" calls for the establishment of a National Center for Pain and Palliative Care Research at the National Institutes of Health and the development of six regional pain research centers throughout the country. At the level of patient care, The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has clearly addressed the imperative for accredited hospitals and other healthcare settings to competently assess and manage pain.²

The Einstein Center for Urban Health Policy and Research and the Einstein Cancer Center in Philadelphia are collaborating on a project, funded by the Nathan Cummings Foundation, to address barriers to optimal pain control for low to moderate income patients with cancer pain.³ Patients with moderate to severe pain are identified from their self-rated pain scores. Consenting patients are interviewed in greater depth about their level of pain and their beliefs and attitudes towards pain. Eligibility for relevant pharmaceutical 'safety net' programs, which provide vouchers for the necessary medication, is also assessed at this time. A nurse program manager is available to provide education and counseling to participants when issues are identified during the assessment phase.

To date, 40 patients have been enrolled in the program. Primary patient attitudinal beliefs related in the under treatment of pain include: the well-documented fear of addiction; fear that pain is a sign of disease progression, which results in their not wanting to talk about it with their physician; troubling side effects such as constipation; and the desire to save medication for when they "really need it." Fifteen (38 %) participants reported not having the financial ability to pay for their medications. Co-payments were reported from a low of \$6.00 a prescription to a high of \$87.00 per prescription. For patients covered by Medicaid, there can be monthly caps on number of pills and refills, and prescriptions.⁴ Even other insurance plans can cause similar barriers to receiving appropriate pain treatment, including different coverage for pain medications with modest to substantial co-payments, and other limitations for non-hospitalized, community dwelling patients.

An important objective of the collaborative project is to facilitate enrollment for these patients into pharmaceutical safety net programs. Application processes for these programs often require extensive documentation that can challenge even the seasoned health professionals. We discovered that safety net programs offered by the pharmaceutical companies that produce the most commonly prescribed long acting opioids were available only to the uninsured, or had been discontinued because a generic form of the drug had become available. Because our low-income patients were covered by Medicaid or were Medicaid eligible, the pharmaceutical

safety net programs were not available to them. Our interim finding that safety net programs were not an option for our patients led us to explore the potential use of Methadone, a highly effective, low cost analgesic. Although Methadone has been used successfully in severe pain, close supervision and dosage adjustment is required and it is not clear that this is a viable option for our patient population at this time. The program continues to consider other options and works towards reducing the existing barriers to pain control for those with limited income. It is clear that Medicaid must reevaluate current caps and other limitations related to prescription pain medication. Other initiatives to allow patient access to needed pain medications are crucial to reaching pain management goals. Additionally, we find that counseling patients on attitudinal barriers is an important and often neglected component of the field of pain management.

Pain policies and guidelines emphasize pain as a profound human experience. The clinical application of pain policies requires continued efforts at multiple levels to ensure we meet our humanitarian obligation as health care providers to assess and manage pain optimally across all patient populations.

For more information about our program, contact phippst@einstein.edu.

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About the Author

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