

14 · Pain Management



CHAPTER CONTRIBUTORS

COMMITTEE MEMBERS

Gail Amalia B. Katz (CO-CHAIR)

Citizen

Amjad Riar, MD (CO-CHAIR)

Private Physician, Pain and Palliative Medicine

Mary Baluss, Esq.

The Pain Law Initiative

Michael Erdek, MD

Division of Pain Management, Johns Hopkins Hospital

Henry Farkas MD, MPH

Union Hospital of Cecil County, Hospice Network of Maryland

Jawad Hasnain, MD, MBA

University of Maryland Medical System

Karen Keiser

University of Maryland

David Maine, MD

Center for Interventional Pain Medicine, Mercy Medical Center

Suzanne Nesbit, PharmD, BCPS

The Sidney Kimmel Comprehensive Cancer Center
at Johns Hopkins

Bette O'Connor, RN, MSN, OCN

Harbor Hospital Center

Kathryn Walker, PharmD, BCPS

University of Maryland School of Pharmacy
Union Memorial Hospital

14

PAIN MANAGEMENT

Pain affects more people in the United States than diabetes, heart disease, and cancer combined.¹ It is the most frequent reason patients seek physician care in the United States. When including healthcare expenses, lost income, and lost productivity, the annual cost of chronic pain in the US is estimated at \$100 billion.² A major category of pain and contributor to pain costs is cancer-related pain.

ALTHOUGH THE INCIDENCE OF CANCER PAIN has been difficult to measure,³ some studies have shown that cancer pain is reported by about 50% of patients at all stages, and more than 70% of patients with advanced neoplasms.⁴ Pain is also an issue for children with cancer, and in more than 70% of cases the pain will be severe at some stage.⁵ Cancer pain can be managed effectively in up to 90% of Americans who have cancer or a history of cancer. Unfortunately, pain associated with cancer is frequently undertreated.⁶

Cancer is the second leading cause of death in Maryland, accounting for 24% of all deaths. More than 24,000 Marylanders were diagnosed with cancer in 2006.⁷ The fact that a large number of these patients will experience unrelieved pain constitutes a public health crisis. Additionally, as the population ages and people over the age of 65 become our fastest-growing demographic group, cancer pain issues will become even more prevalent.⁸

In a recent report card on the palliative care programs in the United States published by the Center to Advance Palliative Care and the National Palliative Care Research Center, Maryland earned a grade of “B” in regard

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15

to the percentage of hospitals (50+ beds) with a palliative care program that enable physicians to treat pain for patients with terminal illnesses such as cancer.⁹ According to the 2008 report card, 67% of Maryland hospitals have palliative care programs (Table 14.1). This is an increase in comparison to the findings in the 2002 Last Acts report, “Means to a Better End: A Report on Dying in America Today,” which found that only 25.8% provided palliative care programs. The Last Acts report also noted that 59.7% of Maryland hospitals offered pain management programs, 19.4% provided hospice programs, and referrals to hospice and length of stay in hospice were low.¹⁰

This chapter addresses the status of cancer pain assessment and management in Maryland, with a focus on both patient and clinician issues, and offers recommendations for addressing barriers within each group.

Patient Issues

PATIENTS WITH CANCER PAIN frequently report feeling out of control and vulnerable. As a result, they are often unable to advocate for themselves in the challenging healthcare arena. Empowering patients to form a partnership with their treating healthcare providers is an important step in making progress toward better cancer pain management in Maryland. To achieve this empowerment, patient education, access to pain management resources, and legislation and advocacy should be addressed.

Patient Education

EDUCATING PATIENTS ABOUT CANCER PAIN is an important piece of pain management. The following fundamental issues make up the syllabus for pain management and should be included in educational efforts directed to patients.

- Importance of pain control.
- Value and process of pain assessment.
- Types and purposes of various pain treatments.
- Effective methods of communication with medical professionals about pain.

TABLE 14.1

Percentage of Hospitals Reporting a Palliative Care Program

	REPORT CARD GRADE (based on midsize & large hospitals)	MIDSIZE & LARGE (50+ beds)	LARGE (300+ beds)	MIDSIZE (50-299 beds)	SMALL (< 50 beds)
MARYLAND	B	67%	80%	63%	0%
REGION (SOUTH)	C	41%	65%	32%	13%
UNITED STATES	C	53%	75%	45%	20%

Sources: Center to Advance Palliative Care and National Palliative Care Research Center, 2008.
 “America’s Care of Serious Illness: A State-by-State Report Card on Access to Palliative Care in Our Nation’s Hospitals.”

Pain Care Bill of Rights

As a person with pain, you have the right to:

- Have your report of pain taken seriously and to be treated with dignity and respect by doctors, nurses, pharmacists, social workers, and other healthcare professionals.
- Have your pain thoroughly assessed and promptly treated.
- Participate actively in decisions about how to manage your pain.
- Be informed and know your options. Talk with your healthcare provider about your pain: possible cause(s), treatment options, and the benefits, risks, and costs of each choice.
- Have your pain reassessed regularly and your treatment adjusted if your pain has not been eased.
- Be referred to a pain specialist if your pain persists.
- Get clear and prompt answers to your questions, take time to make decisions, and refuse a particular type of treatment if you choose.

Although not always required by law, these are the rights you should expect for your pain care.

Source: American Pain Foundation (<http://www.painfoundation.org>).

- Patients’ Pain Bill of Rights as put forth by the American Pain Foundation. (See text box above, “Pain Care Bill of Rights”).
- Assurance that everyone has a right to pain control without regard to age, race, gender, culture, and/or history of substance abuse.

Providing education to patients is a key step in empowering them to help seek treatment and manage cancer pain. Educational efforts could include summits or conferences, educational videos to be shown in physician-office or

treatment-center waiting rooms, and media outreach such as public service announcements. Adequate funding is needed to support these efforts.

Access to Pain Management Resources

IN ADDITION to the need for patient education, accessing pain management resources continues to be a major problem. Pain management resources can include education, medication, support, comprehensive care, and specialists to treat pain. As a result of this lack of access to resources, there are many untreated cancer patients suffering in pain unnecessarily.

For example, one New York study found that only 25% of pharmacies in nonwhite neighborhoods had a sufficient supply of opioids required to treat severe pain, compared with 72% in predominately white neighborhoods.¹¹ This is a serious concern for those practitioners attempting to treat cancer patients adequately for pain who can be limited by the patients' access to receiving the prescribed medications. The availability of opioids in Maryland pharmacies is not currently known, but based on anecdotal reports it is perceived by the cancer pain community to be inadequate. For this reason, further research studies on opioid availability in Maryland should be conducted, especially in urban settings. Such studies can be used to inform future attempts at increasing access to this pain management resource.

Another barrier to accessing pain management resources is a lack of comprehensive insurance coverage for pain management.¹² Formularies developed by insurance companies and Medicaid, along with the use of "caps" on prescription drugs, can also limit access to pain management resources.¹³ Such barriers can seriously affect cancer patients seeking pain relief. According to a survey conducted by the Maryland State Medical Society (MedChi), Maryland physicians have voiced concern about these and other barriers including cost-containing measures such as prior authorization, pre-certification, step therapy, and therapeutic switching. The survey reported that nearly 95% of Maryland physicians believe that insurance carrier requirements that dictate how and what physicians can prescribe have a negative impact on their ability to treat

patients.¹⁴ To address some of these barriers, MedChi has petitioned the Maryland Insurance Administration for a formal review.¹⁵

Legislation and Advocacy

A 2008 PROGRESS REPORT CARD published by the University of Wisconsin Paul P. Carbone Comprehensive Cancer Center rates the quality of state policies affecting pain treatment. Maryland was given a "B" on the report card, scoring lower than 16 states.¹⁶ One strategy to improve Maryland's national standing related to pain is to focus on correcting the conflicting terminology used in Maryland controlled substance statutes and regulations related to pain (i.e., physical dependence, addiction, tolerance). A consensus document from the American Academy of Pain Medicine, the American Pain Society, and the American Society of Addiction Medicine points out that inconsistent use of this terminology often results in misunderstandings among regulators, healthcare providers, patients, and the general public regarding the use of medications for the treatment of pain.¹⁷ Correcting these commonly misused terms would contribute to improving

Definitions Related to the Use of Opioids for the Treatment of Pain

PHYSICAL DEPENDENCE Physical dependence is 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.

ADDICTION Addiction is a primary, chronic, neurobiologic disease, with genetic, psychosocial, and environmental factors influencing its development and manifestations. It is characterized by behaviors that include one or more of the following: impaired control over drug use, compulsive use, continued use despite harm, and craving.

TOLERANCE 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.

Discussion: Most specialists in pain medicine and addiction medicine agree that patients treated with prolonged opioid therapy usually do develop physical dependence and sometimes develop tolerance, but do not usually develop addictive disorders.

Source: American Pain Society. Definitions Related to the Use of Opioids for the Treatment of Pain; 2001. Accessed August 26, 2010 from <http://www.ampainsoc.org/advocacy/opioids2.htm>.

Maryland's national standing on pain treatment policies. The American Pain Society has provided definitions of these terms, shown in the text box "Definitions Related to the Use of Opioids for the Treatment of Pain" on page 5.

Increased patient and healthcare provider participation in legislative events will be necessary to educate lawmakers on the importance of adequately treating pain. Together, patients and providers should work to move pain issues to the forefront of Maryland's legislative agenda. One way to do this would be to empower patients to advocate for themselves in the legislative arena. Teaching patients to effectively engage in advocacy will bring an important voice to the process of changing the face of pain in Maryland.

Lastly, to enhance the impact of pain advocacy, it is recommended that all committees, associations, and legislative activities related to pain include patient representation. Pain is a very multidimensional experience and even the most knowledgeable clinicians cannot fully understand the experience of living with cancer pain. This influence is vital to ensure that advocacy activities are targeted toward improving patients' quality of life.

Clinician Issues

THE APPROACH TO PAIN MANAGEMENT by clinicians can be influenced by many barriers, including the understanding of pain and pain management, the quality of pain assessments, and attitudes and legal issues regarding pain medications. Such barriers can be overcome by an emphasis on clinician education and training, an effort to involve pain specialists in the interdisciplinary management of pain, and the use of policy tools to move pain control forward. These factors must be addressed in order to optimize pain control and minimize the impact on quality of life for cancer patients.

Understanding Pain

One of the first steps in achieving effective pain control is an understanding that pain is not only a symptom but also a disease process in itself. There are many systemic effects and

consequences of unrelieved pain (Table 14.2). Pain is a disease state of the nervous system and deserves the same management attention given to any other disease states.¹⁸

The issue of prognosis and pain is often interrelated, particularly in the patient's mind. In some cases cancer pain may be an almost an existential threat to the patient, bringing up questions such as: *Does this pain mean that my cancer is worse? That my cancer has recurred? That I am going to die? That I am going to die sooner than expected?* Patients may handle their pain very poorly because it is an unfamiliar or new pain with undetermined and/or undiscussed prognostic

FAST FACT Pain is not only a symptom. It is also a disease process in itself.

TABLE 14.2 Consequences of Unrelieved Pain

CARDIOVASCULAR Increased heart rate, peripheral vascular resistance, arterial blood pressure, and myocardial contractility resulting in increased cardiac work, myocardial ischemia and infarction.

PULMONARY Respiratory and abdominal muscle spasm (splinting), diaphragmatic dysfunction, decreased vital capacity, impaired ventilation and ability to cough, atelectasis, increased ventilation/perfusion mismatch, hypoventilation, hypoxemia, hypercarbia, increased postoperative pulmonary infection.

GASTROINTESTINAL Increased gastrointestinal secretions and smooth muscle sphincter tone, reduced intestinal motility, ileus, nausea, and vomiting.

RENAL Oliguria, increased urinary sphincter tone, urinary retention.

COAGULATION Increased platelet aggregation, venostasis, increased deep vein thrombosis, thromboembolism.

IMMUNOLOGIC Impaired immune function, increased infection, tumor spread or recurrence.

MUSCULAR Muscle weakness, limitation of movement, muscle atrophy, fatigue.

PSYCHOLOGICAL Anxiety, fear, anger, depression, reduced patient satisfaction.

OVERALL RECOVERY Delayed recovery, increased need for hospitalization, delayed return to normal daily living, increased healthcare resource.

Source: Office of the Army Surgeon General. Pain Management Task Force Report: "Providing a Standardized DoD and VHA Vision and Approach to Pain Management to Optimize the Care for Warriors and their Families"; 2010.

significance. Adopting a strictly biomedical model of pain fails to address the full meaning of the pain in a cancer patient. The topic of prognostic implications should be addressed with patients at the earliest possible point. In some cases, support to the patient in the form of psychological counseling should be offered.

Effective pain management is possible for patients with cancer or a history of cancer and will improve the patient’s quality of life throughout all stages of the disease. However, it is important for clinicians to have an understanding of the pain and remain flexible in its management. As patients differ in diagnosis, stage of disease, and responses to pain and treatments, this management must be individualized.¹⁹

Comprehensive Pain Assessments

COMPREHENSIVE PAIN ASSESSMENT is critical to provide healthcare providers with information for cancer pain management. Providers cite the lack of systematic assessment as one of the biggest obstacles to providing effective pain management.²⁰ Routine screening using pain measurement tools can help healthcare providers determine when a patient is experiencing pain and thus respond to changes in pain. However, simple pain screenings do not assess how pain affects that patient’s life, the quality of the pain, when it occurs, or how much or what kind of medication(s) or other therapies will help reduce a particular patient’s pain.

Delivery of quality cancer care includes providing pain and symptom management, alongside disease-directed treatment, which requires frequent and comprehensive pain assessment. As improvements continue in cancer management that extend life expectancy for patients, it will be increasingly important to also control cancer-related pain during the active treatment course to reduce the likelihood that cancer survivors will have to endure chronic pain later on. However, mounting evidence indicates that inadequate assessment and treatment of cancer pain continues to be a significant public health problem that requires immediate and concerted action.^{21,22,23,24}

FAST FACT Effective pain management is possible for patients with cancer or a history of cancer and will improve quality of life throughout all stages of the disease.

Pain Medication: Attitudes and Legal Issues

MEDICATIONS ARE AN IMPORTANT TOOL in pain management. However, one of the major barriers to managing pain are the words associated with pain management medications: “narcotics,” “addiction,” “painkillers.” These words can be strong, scary, and stigmatizing, thus discouraging patients from taking the medicines they need.²⁵ In addition, patients, families, and healthcare professionals often have misconceptions and confusion about addiction, physical dependence, and tolerance, which contribute to patient and family fears about using pain medications and to practitioners’ reluctance to prescribe them.^{26,27,28,29,30,31} As noted in the Patient Issues section, the misuse of terminology in Maryland policies also contributes to this problem.

Pain management is affected by legal and legislative barriers developed in response to concerns about drug abuse. Laws concerning controlled substances vary. In states with pain coalitions, efforts are being made to revise legislation to remove barriers to the use of opioids, such as removing dosage restrictions. However, 16 states’ controlled-substance or professional-practice laws, including Maryland’s, would still incorrectly define any patient who is physically dependent on an opioid medication as an “addict.”³² An up-to-date interpretation differentiates clearly between dependence and addiction. A balanced approach to the dispensation of pain medication is needed so the effort to prevent drug abuse does not impede access to controlled substances to pain sufferers.^{33,34}

Overcoming Barriers

CLINICIAN EDUCATION AND TRAINING

EDUCATION AND TRAINING for future and current healthcare providers is necessary for improving pain management for cancer patients. Knowledge gaps, inadequate assessment skills, and negative attitudes toward opioids are all barriers to effective cancer pain management that can be addressed through education and training.

The low priority traditionally given to pain treatment in professional training^{35,36,37,38,39} and educational texts⁴⁰ has contributed to the barriers of pain management. Senior medical students were found, in one study, to be reluctant to prescribe opioid therapy for pain.⁴¹ Another study found them to be deficient in their understanding of multiple available options for relieving suffering in cancer patients.⁴² In addition, a recent study found pain management to be lacking among pharmacy school curricula.⁴³

The Office of the Army Surgeon General recently released a “Pain Management Task Force Report” that includes the education of clinicians about pain treatment as a best practice for adopting an integrative and interdisciplinary approach to managing pain.⁴⁴ Maryland educational institutions provide opportunities for education in pain and symptom management as part of some curricula, residency programs, and fellowship programs for physicians, nurses, and pharmacists. However, this has been a recent addition and most clinicians practicing in Maryland did not complete their training in the state in recent years. Therefore, many clinicians in Maryland may not have been exposed to adequate pain management training during their basic or advanced training. Postgraduate training for practicing healthcare providers may address this gap and increase the use of effective methods of pain assessment and treatment.^{45,46} Pain management education for Maryland’s healthcare professionals could be further facilitated by completion of additional training in this area through required continuing education programs.

INTEGRATING PAIN SPECIALISTS TO INTERDISCIPLINARY PAIN MANAGEMENT

CANCER PAIN IS TYPICALLY MANAGED by an interdisciplinary approach including a broad team of health professionals. In a “Pain Management Task Force Report” released by the Office of the Army Surgeon General, one best practice identified was that healthcare organizations and professionals must be accountable to their patients for the attentive treatment of pain.⁴⁷ One way to achieve this is with the integration of pain specialists into the interdisciplinary pain management team.

However, the number of pain specialists may be inadequate to meet these needs. According to

a recent report jointly produced by the Center to Advance Palliative Care and National Palliative Care Research Center, there is a lack of palliative medicine physicians certified by the American Board of Hospice and Palliative Medicine (ABHPM), as well as advanced practice nurses (APN) and registered nurses (RN) certified by the National Board for Certification of Hospice and Palliative Nurses (NBCHPN). For example in 2007, 2,651 United States physicians held board certification in the practice of palliative medicine (1 physician per 560 Medicare deaths). In comparison, there are 16,800 cardiologists in the US (or 1 per 71 heart attack victims). In 2007 in Maryland, there were only 56 physicians with board certification in the practice of palliative medicine (1 physician per 487 Medicare deaths).⁴⁸

To achieve the optimal interdisciplinary approach to pain management utilizing pain specialists, this deficiency will have to be addressed by increasing the number of clinicians with the ability to provide specialized consultations on pain.

POLICY TOOLS

ONE OF THE BEST PRACTICES identified in the “Pain Management Task Force Report” released by the Office of the Army Surgeon General includes the need for policies on reimbursement for health professionals, medications, and other palliative treatments (e.g., counseling, cognitive treatment for symptoms, and other supportive care), as well as controlled substance regulations designed so that they do not create barriers to symptom treatment. The task force report also calls for the establishment of:

- Pain management requirements to standardize patient care services.
- Interdisciplinary pain management services to oversee optimum pain care.
- An effective pain management advisory board.
- A state-level pain management education plan that addresses the full spectrum of stakeholders and issues.⁴⁹

In addition, the National Pain Care Policy Act of 2009 highlights the continued need to increase awareness of pain assessment and management and its barriers, expand pain research, and improve the education and training of health

professionals on a national scale.⁵⁰ Language to this effect is also included in the recently passed federal healthcare reform legislation, the Affordable Care Act.⁵¹

By utilizing identified best practices and recommendations as well as national and state policy models, many of the barriers to effective pain management could be addressed with a statewide Maryland Pain and Palliative Care Act. A statewide act could improve pain management by establishing a statewide advisory council on palliative care and pain management, creating and enhancing undergraduate and graduate training programs, establishing Centers for Excellence, and certifying one or more resource centers to assist physicians in the treatment of patients in pain.

Summary of Recommendations

THE PERVASIVENESS OF PAIN as a problem to the many cancer pain patients and survivors in Maryland is not in question: the issue is what should be done to alleviate their pain. Both clinicians and the patients themselves have responsibilities in this realm. It is hoped that the outcome of this chapter will facilitate the lessening of chronic, acute, and breakthrough pain and afford caregivers with more tools to accomplish this outcome.

Specifically, pain patients as well as their families and other caregivers must be empowered to manage and advocate for their own needs regarding pain and the quality of their lives. Pain education, including the importance of pain control, the variety of pain treatments, a Patients' Pain Care Bill of Rights, and effective means of communication with providers must be offered. It is also essential that barriers to accessing quality

pain management resources, specifically medications, be removed.

It is also necessary to develop clinicians' skills to optimize their ability to manage patients' pain, either personally or through referrals, so that the quality of life of oncology patients, survivors, and their families is elevated. Clinicians should be encouraged to use the services of accredited pain management practitioners and facilities, which will require addressing the deficit of pain specialists that currently exists. To facilitate these actions, a plan to insure that all oncology patients' pain is professionally assessed and treated within the first 24 to 48 hours after diagnosis or admission to a hospital should be developed by a group of pain and palliative care specialists.

Legislative issues cut across both the patient and clinician domains. Enacting a Pain and Palliative Care Act in Maryland would provide a useful policy tool to help move pain control forward, including the creation of training programs for students and clinicians, the establishment of a statewide advisory council as well as a Center for Palliative Care Excellence, and the provision of palliative care resources at all hospitals with oncology centers. In addition, if Maryland enacts any legislation related to Prescription Drug Monitoring Programs, electronic medical records, or electronic prescribing, it should not hinder a patient's access to adequate pain control. These same considerations must be paramount every time the Medicaid formulary is reevaluated.

Successful implementation of these recommendations will help to improve pain management for cancer patients and their families in ways that all of society can appreciate.

GOALS - OBJECTIVES - STRATEGIES

GOAL 1

Empower cancer patients to take an active role in partnering with healthcare providers in managing pain and minimizing impact on quality of life.

OBJECTIVE 1

By 2015, increase the proportion of Maryland cancer patients exposed to pain education.

STRATEGIES

- 1 **PROVIDE ADEQUATE FUNDING** to support events to educate cancer patients about important pain topics.
- 2 **ORGANIZE A PATIENT EDUCATION SUMMIT** in partnership with interested organizations on topics such as:
 - Importance of pain control.
 - Value and process of pain assessment.
 - Types and purposes of various pain treatments.
 - Effective methods of communication with medical professionals about pain.
 - Patients' Pain Bill of Rights as put forth by the American Pain Foundation.
- 3 **PRODUCE AN EDUCATIONAL VIDEO** to be shown in cancer office waiting rooms and other venues where patients can learn about cancer pain principles. Include in this video all of the rest of the strategies with an emphasis on the assurance that all patients have a right to quality pain control without regard to age, race, gender, culture, and/or history of substance abuse.
- 4 **DEVELOP AND IMPLEMENT A SURVEY** of accredited cancer centers in Maryland to measure the proportion of cancer patients exposed to pain education.

OBJECTIVE 2

By 2015, decrease barriers to accessing quality pain management resources (specifically pain medications) for all Marylanders regardless of age, race, culture, and history of substance abuse as outlined in the strategies below.

STRATEGIES

- 1 **COLLABORATE WITH PHARMACIES** to ensure that pain medication is adequately stocked in all communities and explore legislation that would require pharmacies to stock pain medication.
- 2 **CONDUCT A STUDY** to measure availability of opioids in Maryland pharmacies, especially in urban settings. Set targets and measure changes over time.
- 3 **TEACH PATIENTS** how to navigate third-party challenges to decrease insurance barriers.
- 4 **CONDUCT AN INVESTIGATION** of insurance practices regarding adequate and fair coverage for patients in pain and create a report card that would allow patients to make informed decisions when selecting a health plan.

OBJECTIVE 3

By 2015, assure that legislation in areas such as **Prescription Drug Monitoring Plans, electronic medical records, electronic prescribing, and Medicaid formulary does not hinder a patient's access to adequate pain control.**

STRATEGIES

- 1 **INCREASE INVOLVEMENT** in legislative events to move pain issues to the forefront of Maryland's agenda.
- 2 **SPONSOR AN EVENT** for patient empowerment to teach patients how to engage in the legislative aspect of pain advocacy.
- 3 **CORRECT THE TERMINOLOGY** in the state report card to improve the pain report care grade (i.e., definition of addiction, dependency, etc.).
- 4 **INCLUDE PATIENT REPRESENTATION** in committee meetings, associations, and legislative activities related to pain.

GOALS - OBJECTIVES - STRATEGIES

GOAL 2

Educate and involve clinicians to optimize cancer pain control and take an active role in partnering with other healthcare providers and patients in managing pain and minimizing impact on quality of life.

OBJECTIVE 1

By 2015, increase clinician education and awareness by providing seminars, grand rounds, and/or other opportunities for pain management education at 50% of accredited cancer centers in Maryland.

STRATEGIES

- 1 PROVIDE SUPPORT** through academic institutions and training programs to develop education tools that emphasize the importance of quality of life and optimum symptom management and pain control.
- 2 PROVIDE A MECHANISM** for the education to be available at cancer centers.
- 3 DEVELOP A TRACKING MECHANISM** to measure the utilization of this program by cancer centers.

OBJECTIVE 2

By 2015, increase the proportion of Maryland physicians utilizing pain consult from practitioners in the area of pain and palliative care.

STRATEGIES

- 1 UTILIZE EXISTING STRUCTURES** to implement and make programs available to clinicians with the focus on pain control by partnering with state agencies such as the Maryland Board of Physicians to require CME in pain for renewal of medical licenses.
- 2 DEVELOP METHODS** to measure the proportion of physicians utilizing pain consult from pain and palliative care practitioners in order to establish a baseline and monitor progress.

OBJECTIVE 3

By 2015, enact a statewide Maryland Pain and Palliative Care Act modeled after the New York Palliative Care Education and Training Act of 2007, which improves palliative care and pain management by:

- Establishing a statewide advisory council on palliative care and pain management.
- Creating undergraduate and graduate training programs.
- Establishing Centers for Palliative Care Excellence.
- Certifying one or more palliative care resource centers to assist physicians in the treatment of patients in pain.

STRATEGIES

- 1 INVOLVE ADVOCATES** such as the Maryland Department of Health and Mental Hygiene, MedChi, and physician specialty groups in developing a legislative strategy to pursue this objective.

OBJECTIVE 4

By 2015, develop a plan that ensures that patients' pain is assessed and promptly treated in 80% of cancer patients.

STRATEGIES

- 1 CONVENE A GROUP** of pain and palliative care specialists to develop the plan.

REFERENCES

- 1 American Pain Foundation. Pain facts and figures [Internet]. Baltimore (MD): American Pain Foundation; 2010 Jul 8 [cited 2010 Aug 11]. Available from: <http://www.painfoundation.org/newsroom/reporter-resources/pain-facts-figures.html>
- 2 Office of the Army Surgeon General (US). Pain management task force report: providing a standardized DoD and VHA vision and approach to pain management to optimize the care for warriors and their families [Internet]. Washington (DC): Office of the Army Surgeon General (US); 2010 [cited 2010 Aug 11]. Available from: http://www.armymedicine.army.mil/reports/Pain_Management_Task_Force.pdf
- 3 National Institutes of Health (US). Symptom management in cancer: pain, depression and fatigue [Internet]. Kensington (MD): National Institutes of Health State-of-the-Science Conference Statement; 2002 Jul 15-17 [cited 2010 Aug 26]. Available from: <http://consensus.nih.gov/2002/2002CancerPainDepressionFatigues022html.htm>
- 4 Portenoy, RK. Cancer pain. *Cancer*. 1989;63:2298-2307.
- 5 World Health Organization (Switzerland). Palliative care for children [Internet]. Geneva (Switzerland): World Health Organization; 2003 [cited 2010 Aug 24]. Available from: <http://www.who.int/cancer/palliative/palliativecarechildren/en/>
- 6 National Cancer Institute (US). Pain PDQ [Internet]. Bethesda (MD): National Cancer Institute (US); 2010 Apr 20 [cited 2010 Aug 17]. Available from: <http://www.cancer.gov/cancertopics/pdq/supportivecare/pain/patient/allpages>
- 7 Maryland Department of Health and Mental Hygiene (US). Cancer report 2009 [Internet]. Baltimore (MD): Maryland Department of Health and Mental Hygiene (US); 2009 [cited 2010 Aug 3]. Available from: http://fha.maryland.gov/pdf/cancer/2009_CRF_Cancer_Report.pdf
- 8 Maxwell T. Cancer pain management in the elderly. *Geriatr Nurs*. 2000;May-Jun;21(3):158-63.
- 9 Center to Advance Palliative Care and National Palliative Care Research Center (US). America's care of serious illness: a state-by-state report card on access to palliative care in our nation's hospitals [Internet]. New York (NY): Center to Advance Palliative Care and National Palliative Care Research Center (US); 2008 [cited 2010 Aug 11]. Available from: <http://www.capc.org/reportcard/state-by-state-report-card.pdf>
- 10 Robert Wood Johnson Foundation (US). Last acts. Means to a better end: a report on dying in America today [Internet]. Princeton (NJ): Robert Wood Johnson Foundation (US); 2002 [cited 2010 Aug 11]. Available from: <http://www.rwjf.org/files/publications/other/meansbetterend.pdf>
- 11 Morrison RS, Wallenstein S, Natale DK, Senzel RS, Huang LL. "We don't carry that"—Failure of pharmacies in predominantly nonwhite neighborhoods to stock opioid analgesics. *N Engl J Med*. 2000;342:1023-1026.
- 12 Miaskowski C, Cleary J, Burney R, Coyne P, Finley R, Foster R, Grossman S, Janjan N, Ray J, Syrjala K, et al. Guideline for the management of cancer pain in adults and children. *APS Clinical Practice Guidelines Series, No. 3*. Glenview (IL): American Pain Society; 2005.
- 13 Joranson DE. Are health-care reimbursement policies a barrier to acute and cancer pain management? *J Pain Symptom Manage*. 1994 May;9(4):244-53.
- 14 The Maryland State Medical Society (US). Impact of patient health insurance protocols on the Maryland physician's ability to provide care [Internet]. Baltimore (MD): The Maryland State Medical Society (US); 2010 [cited 2010 Aug 9]. Available from: <http://www.medchi.org/sites/default/files/Impact%20on%20Public%20Health%20Survey.pdf>
- 15 Maryland Pain Initiative (US). Call to action! [Internet]. Baltimore (MD): Maryland Pain Initiative (US); 2010 Aug 16 [cited 2010 Aug 24]. Available from: <http://www.marylandpaininitiative.org/>
- 16 University of Wisconsin Paul P. Carbone Comprehensive Cancer Center (US). Achieving balance in state pain policy: a progress report card. 4th ed. Madison (WI): University of Wisconsin Paul P. Carbone Comprehensive Cancer Center (US); 2008 [cited 2010 Aug 19]. Available from: http://www.painpolicy.wisc.edu/Achieving_Balance/PRC2008.pdf
- 17 American Pain Society. Definitions related to the use of opioids for the treatment of pain [Internet]. Glenview (IL): American Pain Society; 2001 [cited 2010 Aug 26]. Available from: <http://www.painsoc.org/advocacy/opioids2.htm>
- 18 See note 2
- 19 See note 6
- 20 See note 2
- 21 Sun V, Borneman T, Ferrell B, et al. Overcoming barriers to cancer pain management: an institutional change model. *J Pain Symptom Manage*. 2007;34:359-369.
- 22 Simone CB, Vapiwala N, Hampshire MK, Metz JM. Internet based survey evaluating use of pain medications and attitudes of radiation oncology patients toward pain intervention. *Int J Radiat Oncol Biol Phys*. 2008;72:127-33.
- 23 Carr DB, Goudas LC, Balk EM, Bloch R, Ioannidis JPA, Lau J. Evidence report on the treatment of pain in cancer patients. *J Natl Cancer Inst Monogr*. 2004;32:23-31.
- 24 Brawley OW, Smith DE, Kirsh RA. Taking action to ease suffering: advancing cancer pain control as a health care priority. *CA Cancer J Clin*. 2009;59:285-289; originally published online Aug 14, 2009.
- 25 Mangione M, Crowley-Matoka M. Improving pain management communication: how patients understand the terms "opioid" and "narcotic". *J Gen Intern Med*. 2008;23(9):1336-1338.
- 26 See note 21
- 27 Agency for Health Care Policy and Research (US). Management of cancer pain: clinical guideline number 9. Rockville (MD): Agency for Health Care Policy and Research (US); 1994.
- 28 Von Roenn JH, Cleeland CS, Gonin R, Hatfield AK, Pandya KJ. Physician attitudes and practice in cancer pain management: a survey from the Eastern Cooperative Oncology Group. *Ann Intern Med*. 1993;119:121-126.
- 29 See note 22
- 30 Joranson DE, Gilson MS. Controlled substances, medical practice, and the law. In: Schwartz HI, ed. *Psychiatric practice under fire: the influence of government, the media and special interests on somatic therapies*. Washington (DC): American Psychiatric Press; 1994:173-194.
- 31 Joranson DE, Ryan KM, Gilson AM, Dahl JL. Trends in medical use and abuse of opioid analgesics. *JAMA*. 2000;283:1710-1714.
- 32 See note 16
- 33 Joranson DE, Gilson AM, Ryan KM, Maurer MA, Nischik JA, Nelson JM. Achieving balance in state pain policy: a guide to evaluation. Madison (WI): The Pain & Policy Studies Group, University of Wisconsin Comprehensive Cancer Center; 2000.
- 34 American Pain Society. Promoting pain relief and preventing abuse of pain medications: a critical balancing act. A joint statement between 21 health organizations and the Drug Enforcement Administration [Internet]. Glenview (IL): American Pain Society; 2001 Oct [cited 2010 Aug 26]. Available from: <http://www.medsch.wisc.edu/painpolicy/Consensus2.pdf>
- 35 Mullan PB, DE, Ambuel B, von Gunten C. End-of life care education in internal medicine residency programs: an inter-institutional study. *J Palliat Med*. 2002;5:487-96.
- 36 Singh, RM and Wyant SL. Pain management content in curriculum of US schools of pharmacy. *J Am Pharm Assoc*. 2003;34:34-40.
- 37 Weissman DE, Block SD. ACGME requirements for end-of-life training in selected residency and fellowship programs: a status report. *Acad Med*. 2002;77:299-304.
- 38 Max MB. Improving outcomes of analgesic treatment: is education enough? *Ann Intern Med*. 1990;113:885-9.
- 39 Weissman DE. Cancer pain education: a call for role models. *J Clin Oncol*. 1988;6:1793-4.
- 40 Ferrell B, Virani R, Grant M, Vallerand A, McCaffery M. Analysis of pain content in nursing textbooks. *J Pain Symptom Manage*. 2000;9:216-28.
- 41 Weinstein SM, Laux LF, Thornby JL. Medical students' attitudes toward pain and the use of opioid analgesics: implications for changing medical school curriculum. *South Med J*. 2000 May;93(5):472-8.
- 42 Mortimer JE, Bartlett NL. Assessment of knowledge about cancer pain management by physicians in training. *J Pain Symptom Manage*. 1997 Jul;14(1):21-8.
- 43 See note 36
- 44 See note 2
- 45 Dalton JA, Carlson J, Blau W, Lindley C, Greer SM, Youngblood R. Documentation of pain assessment and treatment: how are we doing? *Pain Manag Nurs*. 2001 Jun;2(2):54-64.
- 46 Janjan NA, Martin CG, Payne R, Dahl JL, Weissman DE, Hill CS. Teaching cancer pain management: durability of educational effects of a role model program. *Cancer*. 1996;77:996-1001.
- 47 See note 2
- 48 See note 9
- 49 See note 2
- 50 American Pain Foundation. National Pain Care Policy Act of 2009 [Internet]. Baltimore (MD): American Pain Foundation; updated 2009 Jun 23 [cited 2010 Aug 17]. Available from: <http://www.painfoundation.org/take-action/natl-efforts/npcpa.html>
- 51 American Cancer Society Cancer Action Network. Affordable care act: pain management [Internet]. Washington (DC): American Cancer Society Cancer Action Network; 2010 Apr [cited 2010 Aug 19]. Available from: <http://accan.org/pdf/healthcare/implementation/factsheets/hcr-pain-management.pdf>