Oral Presentation to the H.E.L.P. Committee on February 14, 2012

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1. I am Dr. Philip A Pizzo, Dean of the Stanford University School of Medicine as well as Professor of Pediatrics and of Immunology and Microbiology. I am a pediatric oncologist and a pediatric infectious disease specialist. Before joining Stanford in 2001, I was the Physician in Chief of the Children's Hospital Boston and Chair of Pediatrics at Harvard Medical School. Prior to that I spent 23 years at the National Cancer Institute as a Senior Investigator, Chief of Pediatrics, and Scientific Director. I have been an elected member of the Institute of Medicine since 1997 and was also elected to the IOM Council in 2006. I chaired the Institute of Medicine's Committee on Relieving Pain in America. A Blueprint for Transforming Prevention, Care, Education and Research.

2. Today I would like to share with you some of the conclusions and recommendations from our IOM Committee. First, the magnitude of pain in the United States is astounding
    a. More than 116 million Americans have pain that persists for weeks to years. That this number does not include children, individuals in nursing homes or chronic care facilities, prisons or the military, makes the impact even more significant.
    b. The total cost of pain are $560-635 billion per year.
        i. This is higher than the costs of cancer, cardiovascular diseases and diabetes together.
        ii. Includes nearly $100 billion annually from federal and state budgets.
    c. The treatments covered by these expenditures doesn't fully alleviate American's pain.
    d. The Committee fully recognizes the magnitude of these expenditures and appreciates that more effective and efficient approach to pain management and preventions must consider cost as well as effectiveness.

3. The 2010 Patient Protection and Affordable Care Act required HHS to enlist the Institute of Medicine to examine pain as a public health problem
    a. Acting through the NIH, the IOM Committee on Pain that I chaired along with Dr. Noreen Clark, Myron Wegman Distinguished University Professor and Director of the Center for Managing Chronic Disease at the University of Michigan, as co-chair, was charged to address the current state of the science regarding pain research, care and education and to specifically:
        i. Review and quantify the public health significance of pain, including the adequacy of assessment, diagnosis, treatment and management of acute and chronic pain in the US.

        ii. Identify barriers to appropriate pain care and strategies to review them.

        iii. Identify demographic groups and special populations and what needs to be done to address their needs.

iv. Identify what scientific tools and technologies are available, what strategies can enhance the training of pain researchers, and what interdisciplinary research is necessary in the short, and long term to advance research and improve diagnosis, care and management.

v. Discuss opportunities for public-private partnerships in support of pain research, care and education.

b. Our committee included 19 members with a wide range of expertise in the broad biopsychosocial aspects of pain – including the ethical, legal, clinical and public health perspectives, along with traditional and complementary medicine began its work in late November 2010. We completed our work over a seven-month period, thanks to the incredible support from the IOM and especially Adrienne Smith Butler, and submitted our report to the Congress and the NIH in June 2011.

i. Reviewed the literature.
ii. Held public meetings and workshops.
iii. Received testimony and comments from more than 2000 Americans.
iv. Commissioned a review on pain's economic burden
v. We concluded that relieving acute and chronic pain is a significant overlooked problem in the US.

4. Our committee first established a number of underlying principles to help guide our work. Among them is that

a. Pain management is a moral imperative;
b. Chronic pain can be a disease in itself;
c. There is value in comprehensive treatment that includes interdisciplinary approaches, with a wider use of existing knowledge and a focus on prevention;
d. We recognized the conundrum of opioids and that this requires balance and additional review but were specifically directed that this topic was not part of the charge of our committee; and
e. We recognized the importance of collaboration of patients and clinicians – in education, management and prevention and that there is a value to a public health approach – to education and management.

5. While we recognize that our focus was on the public health implications of pain, we understood that it is the individual human impact of chronic pain that underscores why this is such an important issue for our families, patients, communities and nation. I offer just a couple of comments from the more than 2000 that we received:

a. *From an advocate*: Treating a pain patient can be like fixing a car with four flat tires. You cannot just inflate one tire and expect a good result. You must work on all four.

b. *From a physician with chronic pain*: Pain management and physical rehabilitation was never addressed in my medical school curriculum nor in my family practice residency. My disability could have been avoided or lessened with timely treatment, and I could still be the provider instead of the patient.

c. *From a clinical pharmacy specialist*: We cannot successfully treat the complexity of pain without treating the whole patient. Insurance companies will pay for useless, expensive procedures and surgeries but won't pay for simple cognitive-behavioral therapy and physical rehab therapy.

d. *From a patient with chronic pain*: I have a master's degree in clinical social work. I have a well-documented illness that explains the cause of my pain. But when my pain flares up and I go to the ER, I'll put on the hospital gown and lose my social status and my identity. I'll become a blank slate for the doctors to project their own biases and prejudices.

6. An overarching conclusion from our report on Alleviating Pain in America is that To reduce the impact of pain and the resultant suffering will require of cultural transformation in how pain is perceived and judged both by people with pain and by the health care providers who help care for them. The overarching goal of this transformation should be gaining a better understanding of pain of all types and improving efforts to prevent, assess and treat pain. The Committees report offers a blueprint for achieving this transformation that included 16 recommendations that addressed

    a. Public health challenges;
    b. Pain care and management;
    c. Education of patients, communities and providers; and
    d. Research.

7. To help establish priorities, the IOM Committee recommended that four of its 16 recommendations be implemented by the end of 2012 and that the remaining twelve recommendations be completed before the end of 2015 and then be maintained on an ongoing basis. These are as follows:

    a. Immediate – Complete by the end of 2012
        i. The Secretary of HHS should create a comprehensive population-level strategy for pain prevention, treatment, management and research to
            1. Coordinate efforts across public and private sector;
            2. Include agenda for developing research;
            3. Improve pain assessment and management programs; and
            4. Improve ongoing efforts to enhance public awareness of pain.

        This should involve multiple federal, state and private sector entities – including the NIH, FDA, CDC, AHRQ, HRSA, CMS, DoD, VA, professional societies and others.

ii. The Secretary of HHS along with other federal, state and private sector entities should develop strategies for reducing barriers to the care of pain – focusing in particular on populations disproportionately affected by and undertreated for pain.

iii. Through CMS, the VA, DoD, health care providers, insurers and others - support collaboration between pain specialists and primary care clinicians, including referral to pain specialists when appropriate.
    1. Given the prevalence of chronic pain, it is not realistic or desirable to relegate pain management to pain specialists alone. There are fewer than 4000 such specialists in the US, with limited geographic coverage. Ideally primary care physicians would coordinate pain management, but such a change cannot be achieved without significant improvements in education and training. Moreover payment systems must be restructured to allow primary care physicians to spend more time with patients with chronic pain and deliver care more effectively. Given the increasing demands on primary care physicians, it would be unfair to add expectations without providing opportunities for education and payment for counseling patients. Similar issues and constraints apply to nurses, psychologists, physical and occupational therapists, pharmacists, and practitioners of complementary and alternative medicine.

iv. The Director of the NIH should designate a lead institute at the National Institutes of Health that is responsible for moving pain research forward, along with an increase in the support for and scope of the Pain Consortium. This should involve pain advocacy and awareness organizations and should foster public private partnerships.

b. Near-term and enduring – complete by 2015 and maintain
    i. Public Health
        1. Improve the collection and reporting of data on pain.
    ii. Care
        1. Promote and enable self-management of pain.
        2. Provide educational opportunities in pain assessment and treatment in primary care.
        3. Revise reimbursement policies to foster coordinate and evidence-based pain care.
        4. Provide consistent and complete pain assessments.
    iii. Education
        1. Expand and redesign education programs to transform the understanding of pain.
        2. Improve curriculum and education for health care professionals.

3. Increase the number of health professionals with advanced expertise in pain care.

iv. Research
    1. Improves the process for developing new agents for pain control.
    2. Increase support for interdisciplinary research in pain.
    3. Increase the conduct of longitudinal research in pain.
    4. Increase the training of pain researchers.

8. These recommendations serve the goal of creating a comprehensive, population-level strategy for pain prevention, management and research. The scope of the problems in pain management is daunting, and the limitations in the knowledge and education of health care professional are glaring. The medical community must actively engage in the necessary cultural transformation to reduce the pain and suffering of Americans. Importantly the cultural and social transformation needed to alleviate pain in America will require the collaboration of the healthcare provider community with patients and their families who are suffering from pain, including their communities, professional societies and advocacy organizations as well as state and federal government. New public private partnerships and a broad concerted level that addresses pain as a public health initiative as well as an individuals source of suffering will be necessary if we are to make progress in alleviating pain. We must all be part of the dialogue and the solution.