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Improving State Pain Policies: Recent Progress and Continuing Opportunities

Aaron M. Gilson, PhD; David E. Joranson, MSSW; Martha A. Maurer, MSSW, MPH

ABSTRACT The National Institutes of Health reports that 100 million Americans suffer from chronic pain, including pain associated with the disease of cancer. Painful conditions can strike anyone, including cancer patients and cancer survivors. Unrelieved severe pain can limit a person's functioning and sometimes even destroy the will to live. When the quality of pain relief provided is inadequate, it is usually the result of failures to apply existing knowledge about pain and its treatment, including the appropriate use of opioids. But pain relief also can be affected by the regulatory environment and fear of being investigated for excessive prescribing. The importance of evaluating and improving policies governing pain management has been recognized by national and international authorities, including the Institute of Medicine and the World Health Organization. A pilot examination of state laws and regulatory policies demonstrated that they contained a number of outdated medical concepts and prescribing restrictions and did not contain key elements of law that can make pain management a priority for licensed medical practitioners. The Pain & Policy Studies Group developed a research program to evaluate US federal and state policy governing the medical use of pain medication. This article describes 3 national policy evaluations and how the results are being used to document improvements in state pain policies. An emerging role for clinicians and their professional organizations to improve their state's pain policies is discussed. (*CA Cancer J Clin* 2007;57:341–353.) © American Cancer Society, Inc., 2007.

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INTRODUCTION

The National Institutes of Health (NIH) reports that 100 million Americans suffer from chronic pain, including pain associated with the disease of cancer,¹ and recent research suggests that between 14% to 100% of people with cancer experience pain, depending on chronicity, severity, and site of cancer.² Pain is one of the most common physical complaints on a person's admission into the health care system, and moderate to severe pain is frequently reported to be experienced throughout hospitalization, during treatment, and even after discharge. The costs of pain, both emotional and financial, can be enormous. Unrelieved severe pain at any stage of the disease can limit a person's functioning, productivity, and ability to interact socially; sometimes pain destroys the will to live. A recent estimate published in *The Journal of the American Medical Association* indicated that unrelieved pain annually exceeds 61 billion dollars in lost productivity.³ Increasingly, unrelieved pain is becoming recognized as a significant public health problem in the United States.

Efforts to address unrelieved cancer pain can interact with another public health problem—that of drug abuse and addiction. Cancer patients who need opioids are sometimes perceived as addicts. Patients, health care practitioners, and regulators sometimes misunderstand addiction and can erroneously label a patient with pain as an “addict,” even though the person is only physically dependent on a legally prescribed medication for pain (A.M.G., D.E.J., M.A.M., unpublished data, 2007).^{4–6} Those who incorrectly perceive addiction as an inevitable or even a likely outcome of opioid analgesic therapy may be at risk for not providing or receiving adequate pain management and may even doubt the legality of the practice.^{6,7}

Pain management that is based on inaccurate or outdated information about opioids and addiction can negatively impact quality of care and result in devastating consequences for the patient. It is becoming clear that such obsolete

concepts stem from viewpoints of the medical community that were abandoned years ago.⁸⁻¹⁰ These views have been slow to disappear from popular culture, continue to influence some practitioners and regulators, and are even present in some state policies that govern professional practice and the prescribing of opioid analgesics.

Inadequate pain management is the result of many factors, including (1) health care professionals' knowledge and attitudes about opioid prescribing^{7,11-14}; (2) patient reluctance to use opioids for pain relief (including the family's reaction to such treatment)¹⁵⁻¹⁷; and (3) practitioner concern about regulatory scrutiny.¹⁸⁻²¹ Also included among these potential barriers are restrictive drug control and health care policies governing the medical use of prescription medications for pain management, palliative care, or end-of-life care. These policies typically take the following forms:

- "Laws," which is a broad term that refers to rules of conduct with binding legal force adopted by a legislative or other government body at the international, federal, state, or local levels. Laws can be found in treaties, constitutional provisions, and decisions of a court, and include both statutes and regulations. The most common laws are the statutes enacted by a legislature, such as an Intractable Pain Treatment Act, or those that create prescription monitoring programs or pain advisory councils, or regulations that license health care facilities.
- "Regulations" are an official policy issued by an agency of the executive branch of government pursuant to statutory authority. Regulations are found in the state administrative code. Regulations have binding legal force and are intended to implement the administrative policies of a statutorily created agency. For example, regulations issued by licensing boards, according to a state's administrative procedures statute, govern professional conduct and establish what conduct is or is not acceptable for those regulated by the agency (such as physicians, osteopaths, pharmacists, and nurses). Regulations of state agencies may not exceed the agency's statutory authority.
- "Guidelines" are an officially adopted policy issued by a government agency to express the

agency's attitude about, or position on, a particular matter. While guidelines do not have binding legal force, they may help those regulated by an agency to better understand the regulating agency's standards of practice. A number of state medical boards have issued guidelines regarding the medical use of opioid analgesics that describe conduct the board considers to be within the professional practice of medicine (some pharmacy and nursing boards have issued similar guidelines). Guidelines may also include an officially adopted position statement that appears in a position paper, report, article, letter, or agency newsletter. In this context, the term "guidelines" does not refer to clinical practice guidelines.

These policies establish parameters for legitimate medicine that may impinge on patient care decisions about pain management, palliative care, and end-of-life care. Medical professionals' comfort when treating pain often is influenced by what their state policies say about this practice or by what medical professionals believe the policies say.²²⁻²⁶ Many states have policies that create barriers to patients getting their pain treated adequately or are silent about recognizing pain relief as part of quality health care practice; it is these types of policies that need improvement. Modern pain policies should reassure practitioners that pain management is an accepted, and even expected, part of quality patient care and address the fear that prescribing for pain will result in investigation and possible sanctions. Figure 1 describes the significant increase in adoption of policies relating to pain management by state legislatures and practitioner licensing boards.

The nature of the relationship among state policy, professional practice, and patient care is complex, but it is clear that policy has the potential to either promote or interfere in pain management. For example, Intractable Pain Treatment Acts (IPTAs) are laws intended to improve access to pain management by granting physicians immunity from regulatory sanctions for prescribing opioids to patients with intractable pain, which could include cancer pain. Historically, however, many IPTAs have imposed *more* requirements and restrictions on opioid prescribing for pain,

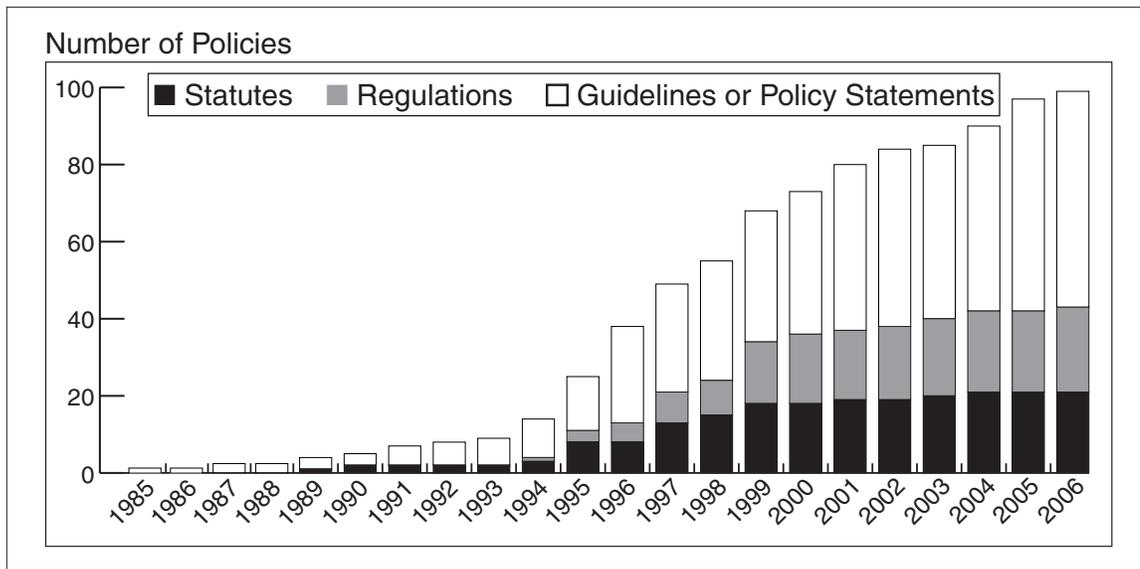


FIGURE 1 Recent Trends in State Pain-specific Policy, 1985–2006. Source: University of Wisconsin Pain & Policy Studies Group, 2006.

which can have the effect of greater, rather than less, government regulation over the use of controlled substances to manage pain.²⁷ Immunity under an IPTA may not apply to physicians who prescribe to patients whose pain does not satisfy the definition of “intractable pain.” Some IPTAs suggest that the use of opioids for “intractable pain” is not within the ordinary practice of medicine or do not authorize treatment access for patients with pain who also have an addictive disease. In addition, IPTAs typically do not contain statements aimed at enhancing pain management and access to care. Some states have recognized these characteristics and have worked to remove ambiguities and restrictions from IPTAs. Instead of statutes, many states have chosen to develop guidelines or regulations containing language aimed at enhancing pain management.

Research and clinical experience also demonstrate that a patient’s health care situation can be disrupted by the mistaken belief that opioid use leads to addiction. Addiction is distinct from physical dependence or tolerance. Ordinarily, practitioners could learn correct medical concepts through professional education; however, evaluations of medical and nursing texts have identified the use of erroneous definitions of addiction.^{28,29} Recent consensus definitions of addiction, physical dependence, and tolerance were created by the American Academy of Pain Medicine, the American Pain Society, and the

American Society of Addiction Medicine to clarify differences among the concepts and promote their appropriate use:

- “Addiction: 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.
- Physical Dependence: A state of adaptation that is manifested by a drug class-specific syndrome that can be produced by abrupt cessation, rapid dose reduction, decreasing blood level of the drug, and/or administration of an antagonist.
- Tolerance: 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.”²⁸

Clinicians should know their state’s policies. For example, it is important to know whether a law or regulation defines addiction, and if so, whether the definition is correct or not. If correct, state policy is on the side of modern medicine and treatment of pain and would not stigmatize patients who need opioid analgesia. An incorrect definition of addiction in state law would permit a patient with pain to be characterized as addicted or “drug dependent,” and

thereby support the belief that pain patients treated with opioids are at risk for becoming addicted. An incorrect definition also could confuse medical regulators or law enforcement who must evaluate complaints that physicians are addicting their patients. As will be seen, states' policies that define terms relating to addiction have been carefully evaluated, along with several other types of policies, for their potential to enhance or impede pain management.

The overall goal is for state policies to enhance patients' chances of gaining access to appropriate pain management. This goal is more likely to be accomplished in a state where the regulatory environment is characterized by policies adopted by the legislature and medical regulatory board that make pain management an essential part of quality medical practice, address practitioners' concerns about being investigated, and define addiction correctly. This is less likely in a state where the laws and professional practice policies are silent about whether pain management is a priority, have provisions with potential for confusing pain patients with addicts, and tightly restrict medical prescriptions. Even when individual health care professionals are knowledgeable and comfortable about pain management and the appropriate use of medications, additional barriers created by policies in some states can make it more difficult to achieve quality care for patients, including those experiencing pain from the disease of cancer or from its treatment, or cancer survivors.

Improving state policy is a necessary complement to the many ongoing state-level initiatives designed to educate health care professionals about the appropriate use of pain medications and to inform the general public about the availability of pain treatment options. Most importantly, positive state policy change will remove barriers and enhance appropriate access to pain medications for people who experience severe cancer pain during the course of their illness and beyond. Clinicians have been active in policy change for years, often as part of a multidisciplinary team.

A number of international and national health care and regulatory authorities, including the World Health Organization,^{30,31} the International Narcotics Control Board,^{32,33} the Institute of

Medicine,³⁴⁻³⁶ the American Cancer Society (ACS),¹⁸ the American Pain Society,³⁷ and the NIH,³⁸ have recognized the imperative to evaluate and improve pain policy. To help achieve this objective, a systematic research methodology was created to improve the quality and consistency of US federal and state policy affecting patients' pain care. This article will describe the research framework used to evaluate, grade, and track changes to state policies affecting pain management, palliative care, and end-of-life care. The clinicians' role in improving their state's pain policies also is discussed.

THE POLICY RESEARCH PROGRAM

Over the last decade, the University of Wisconsin Pain & Policy Studies Group (PPSG) developed a research program to improve US drug control and health care regulatory policies related to pain management, palliative care, and end-of-life care. The program was initially supported by grants from the Robert Wood Johnson Foundation. The PPSG began developing a policy-research methodology for use in evaluating federal and state policies, resulting in a series of policy reports entitled "Achieving Balance in Federal and State Pain Policy: A Guide to Evaluation" (Evaluation Guide)³⁹⁻⁴¹ and "Achieving Balance in State Pain Policy: A Progress Report Card" (Progress Report Card).^{42,43} The 2 most recent policy-evaluation reports (called Evaluation Guide 2006⁴¹ and Progress Report Card 2006⁴³) were supported by grants from the ACS and the Susan G. Komen Breast Cancer Foundation and through a partnership with the Lance Armstrong Foundation. This paper describes selected findings from these most recent reports.

The Evaluation Guide 2006 was issued in September 2006 and presents the results of a criteria-based evaluation of federal and state policies relating to pain management and palliative and end-of-life care and, in particular, the use of opioid analgesics. The results are expressed in a profile for the federal policies and for each state and the District of Columbia. The PPSG collected and evaluated all state statutes and regulations governing the prescribing, dispensing, and administering of controlled substances; medical, osteopathy,

and pharmacy practice; as well as other policies from health care regulatory agencies, including all state medical and pharmacy boards.

The Central Principle of Balance

Policy-evaluation methods should be based on valid principles. PPSG identified and defined a central policy principle called Balance as a fundamental principle of drug regulation and medical ethics, which was used as the basis for this evaluation of policies. The principle is derived from long-standing national and international consensus, which asserts that efforts to control abuse and diversion of opioid analgesics should not interfere with relieving patients' pain and suffering and that drug regulatory policy should not contradict current medical and scientific knowledge. The principle is explained in more detail elsewhere.⁴¹ In short, balanced state policies should not create barriers to appropriate health care practice and patient care and should also support pain management, including the use of controlled substances as an essential part of quality medical practice. The principle of Balance does not sanction the use of medications outside an established system of control, recognizing that only properly licensed health care practitioners can use opioid analgesics for legitimate medical purposes in the course of professional practice.

Authoritative Support for Balanced Policies

A number of governmental and national organizations, such as Congress,⁴⁴ the National Conference of Commissioners on Uniform State Laws,^{45,46} and the Federation of State Medical Boards of the United States, Inc. (the Federation),⁴⁷ have recommended that controlled substances and medical practice policy should be balanced. Indeed, since 1994, the PPSG has assisted the Federation in developing model policies and educating state medical boards about the need for them to encourage better pain management and address the fear of investigation among physicians in their states.^{19,48,49} To promote consistency in medical regulatory policy, in 1998 the Federation adopted a policy template for boards to use when creating policy in their states entitled "Model Guidelines for the

Use of Controlled Substances for the Treatment of Pain" (Model Guidelines).⁵⁰ In May 2004, the Federation's House of Delegates unanimously adopted a revision of the Model Guidelines called "Model Policy for the Use of Controlled Substances for the Treatment of Pain" (Model Policy).⁵¹ The revision is substantially similar to the 1998 guidelines, but also encourages state boards to address failure to treat pain as subject to professional discipline, which has been identified as an important need for state policy.^{52,53} At this time, 28 states have adopted or adapted either the Model Guidelines or Model Policy.

Evaluation Criteria

The principle of Balance was used to derive 16 evaluation criteria. Each criterion relates to 1 of 2 categories: (1) positive provisions—policy language that can *enhance* pain relief; and (2) negative provisions—policy language that can *impede* pain relief (see Table 1 for the complete list of the criteria). The clinical and policy justification for each criterion can be found at www.painpolicy.wisc.edu/Achieving_Balance/EG2006.pdf (in Section VII).

The Evaluation Guide 2006 contains suggestions for professionals and organizations to use the findings in policy-change activities. In addition, model language drawn from several authoritative sources is provided for templates for revising policy. The Evaluation Guide 2006 is accessible on the PPSG Web site for easy access, and its availability was communicated to a large audience of health care professionals and state pain and regulatory organizations.

Evaluation Guide Findings

The evaluation of state policies in 2006 identified a number of instances of restrictive or ambiguous language that has the potential to interfere in pain management. Such language is generally found in older state laws and regulations and does not reflect current standards of professional practice, including language that fulfills the following characteristics:

- Confuses physical dependence with addiction (in 16 states);
- Suggests that opioids should only be used after other treatments have failed (in 16 states);

TABLE 1 Criteria Used to Evaluate State Pain Policies

<p>Positive provisions: criteria that identify policy language with the potential to enhance pain management</p> <ol style="list-style-type: none"> 1. Controlled substances are recognized as necessary for the public health 2. Pain management is recognized as part of general medical practice 3. Medical use of opioids is recognized as legitimate professional practice 4. Pain management is encouraged 5. Practitioners' concerns about regulatory scrutiny are addressed 6. Prescription amount alone is recognized as insufficient to determine the legitimacy of prescribing 7. Physical dependence or analgesic tolerance is not confused with "addiction" 8. Other provisions that may enhance pain management <ul style="list-style-type: none"> Category A: issues related to health care professionals Category B: issues related to patients Category C: regulatory or policy issues <p>Negative provisions: criteria that identify policy language with the potential to impede pain management</p> <ol style="list-style-type: none"> 9. Opioids are considered a treatment of last resort 10. Medical use of opioids is implied to be outside legitimate professional practice 11. Physical dependence or analgesic tolerance are confused with "addiction" 12. Medical decisions are restricted <ul style="list-style-type: none"> Category A: restrictions based on patient characteristics Category B: mandated consultation Category C: restrictions regarding quantity prescribed or dispensed Category D: undue prescription limitations 13. Length of prescription validity is restricted 14. Practitioners are subject to additional prescription requirements 15. Other provisions that may impede pain management 16. Provisions that are ambiguous <ul style="list-style-type: none"> Category A: arbitrary standards for legitimate prescribing Category B: unclear intent leading to possible misinterpretation Category C: conflicting (or inconsistent) policies or provisions
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- Prohibits prescribing to pain patients with addictive disease or a history of substance abuse (in 9 states);
- Restricts the amount of pain medication that can be prescribed and dispensed at one time (in 9 states);
- Restricts the amount of time that a Schedule II prescription is valid to less than 2 weeks (in 5 states).

The evaluation also identified policies that could promote effective pain management and increase access to patient care; these are generally more recent regulatory policies of state agencies, rather than laws adopted by legislatures. For example, a number of these state regulatory policies directly address physicians' concerns about regulatory scrutiny, which reports have shown are prevalent and can hinder the availability of opioids for patient pain relief.⁵⁴⁻⁵⁸ In addition, some state policies recognized that pain management and the use of controlled substances

should be integral parts of quality medical practice, that controlled substances are necessary for the public health, and that addiction is not synonymous with physical dependence or tolerance. Without such language, a state's drug control policy is unbalanced because it focuses disproportionately on the abuse potential of opioids.

Interestingly, some states have policies which directly contradict one another. For example, Table 2 shows that 36 states have a policy that correctly defines the concept of addiction (ie, as a psychological and behavioral disorder that is distinct from the normal and expected development of physical dependence and tolerance); 16 states have an incorrect definition. However, 12 states have both types of definitions—at least one policy correctly defines addiction, but another defines the concept incorrectly. Health care professionals in such states have a unique opportunity to achieve more balanced policy by calling attention to these inconsistent policies and to the possible consequences of applying them to the same patient, either by a clinician, a medical regulator, or law enforcement personnel. Such policies typically apply to all patients, including those with cancer. A summary of the policy-evaluation findings for each state appears in Section VIII of the Evaluation Guide 2006 (see www.painpolicy.wisc.edu/Achieving_Balance/EG2006.pdf).

Progress Report Card

After developing the evaluations of state pain policy, it became apparent that groups were using the results and that state policies were being changed by legislatures and licensing boards. PPSG developed a method to compare the states and measure policy changes over time.

State Grades for Balanced Policy

Using policy data from the state profiles, each state was assigned a letter grade for 2000, 2003, and 2006. The grades, as well as the methodology used to calculate them, are reported in the Progress Report Card 2006⁴³ and are available at www.painpolicy.wisc.edu/Achieving_Balance/PRC2006.pdf. State grades can range from A to F. A state with a higher grade has more balanced policy, while a lower grade means that

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TABLE 2 Definitions of Addiction in Each State

Correct Definition (Type of Policy)	Incorrect Definition (Type of Policy)
Alabama (Medical Board Regulation)	Arizona (Controlled Substances Act)
Arizona (Osteopathic Board Guideline)	Colorado (Pharmacy Practice Act)
California (Medical and Pharmacy Board Policy Statements)	Georgia (Controlled Substances Act and Medical Board Guideline)
Colorado (Medical Board Guideline)	Hawaii (Controlled Substances Act)
Connecticut (Medical Board Guideline)	Idaho (Controlled Substances Regulation)
District of Columbia (Medical Board Regulation)	Indiana (Medical Board Regulation)
Florida (Medical and Osteopathic Board Regulations)	Louisiana (Controlled Substances Act)
Hawaii (Medical Board Guideline)	Maryland (Controlled Substances Act)
Idaho (Medical Board Guideline)	Missouri (Controlled Substances Act)
Kansas (Medical Board Guideline and Joint Board Policy Statement)	North Carolina (Controlled Substances Act)
Kentucky (Medical Board Guideline)	New Jersey (Controlled Substances Act)
Louisiana (Controlled Substances Act and Medical Board Regulation)	Nevada (Controlled Substances Act)
Massachusetts (Medical Board Guideline)	Oklahoma (Controlled Substances Act)
Maryland (Medical Board Guideline)	Pennsylvania (Controlled Substances Act)
Maine (Medical Board Regulation)	Tennessee (Intractable Pain Treatment Act and Medical Board Policy Statement)
Michigan (Medical and Pharmacy Board Guideline)	Wyoming (Controlled Substances Regulation)
Missouri (Medical Board Guideline)	
Mississippi (Medical Board Regulation)	
North Carolina (Medical Board Policy Statement)	
Nebraska (Medical Board Guideline)	
New Mexico (Medical Board Regulation)	
Nevada (Medical Board Regulation)	
New York (Medical Board Policy Statement)	
Ohio (Medical Board Regulation)	
Oklahoma (Medical Board Policy Statement)	
Pennsylvania (Medical Board Guideline)	
South Carolina (Medical Board Guideline)	
South Dakota (Medical Board Guideline)	
Tennessee (Osteopathic Board Regulation)	
Texas (Medical and Pharmacy Board Policy Statements)	
Utah (Professional Practice Regulation)	
Virginia (Medical Board Guideline)	
Vermont (Medical Board Guideline)	
Washington (Joint Board Guideline)	
Wisconsin (Pharmacy Board Policy Statement)	
West Virginia (Medical Board and Joint Board Guidelines)	

potential barriers to patient pain relief were found. The Progress Report Card 2006 is the result of policy research, rather than being a “position statement.” The grades quantify the results of the criteria-based policy evaluation. It is understood that a grade may oversimplify a state’s policies and regulatory environment, but a single index to compare states and measure progress over time can draw the attention of state policy makers and health care professionals to the importance of evaluating and changing their regulatory policy to improve pain management. As such, the Progress Report Card 2006, along with the Evaluation Guide, is a tool that government and nongovernment organizations and clinicians can use to achieve more positive and consistent state policy related to the use of controlled

substances for pain management, palliative care, and end-of-life care.

Progress Report Card Findings

The Progress Report Card 2006 presents state grades for 2000, 2003, and 2006 (see Table 3 and www.painpolicy.wisc.edu/Achieving_Balance/PRC2006.pdf) showing that the quality of pain policies varies greatly across states, but has improved over time. In 2006, 16% of states scored around the average (a grade of C), while 82% scored above the average, and only 2% fell below the average; no state received a grade of D or F. Michigan and Virginia achieved the highest grade (A) and, therefore, have the most balanced policies in the country. Alternatively, Georgia had the lowest grade (D+) and

TABLE 3 State Grades for 2000, 2003, and 2006

States	2000 Grades	2003 Grades	2006 Grades	States	2000 Grades	2003 Grades	2006 Grades
AL	B	B	B+	MT	C+	C+	C+
AK	C	C+	C+	NE	B+	B+	B+
AZ	B	B	B	NV	D+	C	C
AR	C+	C+	B	NH	C	C+	C+
CA	C	C	C	NJ	D	D+	C
CO	C	C	C+	NM	B	B+	B+
CT	C	C	C+	NY	D	C	C
DE	C+	C+	C+	NC	B	B	B
DC	D+	D+	C+	ND	C	C	B
FL	B	B	B	OH	B	B	B
GA	D+	D+	D+	OK	C+	C+	C+
HI	C	C	B	OR	C+	C+	B+
ID	C	C+	B	PA	C+	C+	C+
IL	C	C	C	RI	D+	D+	B
IN	C	C+	C+	SC	C+	C+	C+
IA	C+	B	B	SD	B	B	B
KS	C+	B+	B+	TN	D	C	C
KY	D+	C+	B	TX	C	C	C
LA	C	C	C	UT	C+	C+	B
ME	B	B	B	VT	C	C+	B+
MD	C+	B	B	VA	B	B	A
MA	C	B	B	WA	B	B	B
MI	B	A	A	WV	C+	B	B
MN	C+	C+	B	WI	C	C+	B
MS	C	C	C+	WY	C	C	C+
MO	D+	C+	C+				

the least balanced policies. The text of the specific policy provisions identified for any state can be found in Section VIII of the Evaluation Guide 2006 (www.painpolicy.wisc.edu/Achieving_Balance/EG2006.pdf).

Between 2003 and 2006, 35 states made changes to their policies, but 19 states had policy change sufficient to produce improvement in their grade (see Table 3). Of these 19 states, Rhode Island made the greatest improvement, increasing from a D+ to a B in the last 3 years; this state also was unique because all the improvement resulted from actions by the state legislature. The Rhode Island legislature added positive language to its IPTA and repealed a number of unduly restrictive requirements from the IPTA and the Controlled Substances Act. No state's grade decreased over the entire 6-year evaluation timeframe.

Application of PPSG Policy Resources

In addition to Rhode Island, which had the greatest improvement in the quality of pain

policy between 2003 and 2006, several other state governmental and nongovernmental agencies used PPSG resources or technical assistance, or both, to achieve positive policy change. For example, Connecticut health care and regulatory professionals, along with law enforcement officials, developed an objective to increase the number of positive policy provisions and achieved a higher grade (from a C to a C+). The Connecticut Medical Examining Board created their policy based on the Federation's Model Policy, which promotes the appropriate use of controlled substances for the treatment of pain; the policy was the product of an extensive collaborative effort among the ACS Connecticut Cancer Pain Initiative, the Connecticut State Medical Society, the offices of the Attorney General of the State of Connecticut, the State of Connecticut Department of Public Health, and the PPSG.

North Dakota improved its grade from a C to a B because the Executive Director of the State Medical Association engaged with the legislature to repeal unduly restrictive requirements from its IPTA. The changes deleted from statute

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all references to the term “intractable pain” and extended opioid treatment to patients with pain who also have an addictive disease (although special expertise and monitoring are considered essential for such patients). The revised IPTA, which provides a degree of immunity for physicians who prescribe opioids, improves on the original by covering physician prescribing for all pain and conforming more completely to current medical practice standards.

Although most states improved their grade by adopting health care regulatory policy or repealing restrictive legislation, such as Connecticut, North Dakota, and Rhode Island, 2 states (Arkansas and Hawaii) improved their grades by adopting legislation. Arkansas adopted an IPTA, and Hawaii adopted a Pain Patient’s Bill of Rights. Although intended to improve pain management, these 2 types of pain legislation historically have contained numerous requirements that could actually hamper pain management through excessive requirements and confusing classifications of patients. It appears that these legislatures used the policy-evaluation results to adopt statutes that largely avoid such problems. Consequently, policies designed to improve health care practitioners’ provision of effective pain care for people with cancer can better achieve this important objective.

DISCUSSION

International and national authorities have called attention to the public health crisis of inadequate pain management, recognizing that it is due in part to governmental policies that impede the adequate availability and medical use of pain medications.^{31-33,35,37,38,59-63} This high-level imperative stimulated the PPSG to develop systematic research methods to evaluate policy as a means to enhance proper pain management. This work has been used by nongovernmental organizations (ie, state pain initiatives and ACS state or regional divisions) to work with state legislatures and regulatory boards to improve professional practice policy for pain management, palliative care, and end-of-life care, and the results of such efforts are represented in both the 2003 and 2006 Progress Report Cards. The improvement of state policy typically has been

accomplished by adopting new policies that reflect modern medical and regulatory principles, largely based on the Federation’s model policies, and are more consistent with the public health objective of relieving the suffering of patients experiencing chronic pain. Some states have, to a lesser extent, also repealed restrictive, archaic, or ambiguous policy language, some of which has been present for more than 30 years. There has been substantial progress since the policy-evaluation process began in 2000; for the first time, in 2006, 2 states received an A, but there is much more opportunity for improvement.

The quality of state policies that govern health care practice, in particular the use of essential pain medications, can directly impact medical decision making and, ultimately, patient pain relief. Regulatory policies that recognize pain management as an expected part of quality medical practice and patient care can support professionals who are hesitant to use pain medications out of concern about investigation or discipline by their licensing agency. This information also can be used by patients and patient advocates to gauge whether state policy supports good pain management or whether it needs to change. Alternatively, a regulatory policy environment characterized by restrictive and ambiguous policies can hamper adequate pain treatment. Positive policy change is an essential part to a comprehensive, multifaceted approach to improving pain management and symptom treatment while trying to prevent the abuse and diversion of pain medications.^{43,64}

What Can Practitioners Do to Improve Pain Management in Their State?

Policy change at the state level is often a daunting task for busy health care practitioners. There can be pitfalls and unintended consequences in developing laws, regulations, and other regulatory agency policies. Changes in policy can advance or retard progress, depending on the content and clarity of the policy. However, a better understanding of what can be done to avoid restrictive policy language has resulted in recent statutory development that successfully promotes effective pain care for patients.⁴³

The crucial first step in this process is to examine the state’s policies. Repealing restrictive

statutory language requires engaging with the legislature, while working with the medical, pharmacy, or nursing board is necessary for improving the relevant regulatory policies. To promote effective pain management in a state, the most common and probably the most valuable approach is to create an ad hoc multidisciplinary study mechanism associated with the state government (often called a pain commission, task force, advisory council, or summit meeting). The terms of reference for such collaborations should include the careful study of the legal, financial, systemic, and other barriers to pain treatment for all types of patients with pain, such as chronic cancer pain. The committee, to be most effective, should include both governmental and nongovernmental stakeholders, including a variety of health care disciplines, as well as staff assigned to complete various portions of the study process. This could help establish relationships with legislators, regulators, or other advocates who are willing to champion balanced state pain policies. A committee also can provide opportunities to educate policy makers about potential negative impacts of current law and regulations or to educate about impending policy proposals that could inhibit pain relief for people with cancer.

Although state committees are important legislatively created forums to consider ways to improve pain treatment, palliative care, and end-of-life care, clinicians may find ways to influence positive policy change outside of an organized multidisciplinary team. An effective advocate must know the issues and be able to communicate messages that will resonate. Becoming aware of the current pain management environment in your state, as well as your health care regulatory board's attitude about the use of opioids for pain relief (as suggested by published regulations, guidelines, or policy statements, or through newsletters), can inform the messages necessary for advocacy communication to policy makers. Also, legislators may be more responsive to these issues if you can discuss the potential impact on your patients' care. Finding one or more legislators or regulators who are supportive of pain management issues is imperative to an effective policy change process, since they would likely be the sponsors for any

relevant amendments to law. National organizations, such as the Alliance of State Pain Initiatives (formerly the American Alliance of Cancer Pain Initiatives) (<http://aspi.wisc.edu>), the American Pain Foundation (<http://www.painfoundation.org>), or the Pain Initiative in your state (its contact information can be found through the Alliance of State Pain Initiative's Web site), may be able to assist you in identifying a legislator or regulator in your state who can originate requests for pain-policy reform.

The PPSG policy-evaluation tools described in this article can provide guidance about the specific policy change that is needed in every state. For these policy evaluations, the total number of both positive and negative provisions comprises a state's grade. About half of all states must make policy more balanced both by (1) adopting language that promotes pain management; and (2) removing restrictive or ambiguous language that can impede pain management. As a result, to work toward a grade of A, state professionals, agencies, and organizations must first examine the separate 2006 grades for positive and negative provisions (found in Appendix C of the Progress Report Card 2006, located at www.painpolicy.wisc.edu/Achieving_Balance/PRC2006.pdf). More change is needed the farther the grade deviates from an A. The Evaluation Guide 2006 contains the policy language contributing to grades for each state (State Policy Profiles in Section VIII), as well as suggestions to improve state policy (in Appendix C) (www.painpolicy.wisc.edu/Achieving_Balance/EG2006.pdf). The PPSG Web site also contains a database of the full text of each state's laws, regulations, and health care agency guidelines and policy statements adopted to provide guidance for pain management, palliative care, or end-of-life care (www.painpolicy.wisc.edu/matrix.htm).

After a state's policies have been examined, policy-change recommendations must be developed. Again, the Evaluation Guide 2006 is a valuable resource for suggesting specific language that can be used to improve pain policy, which is contained in Section IX. Professional relationships established and cultivated by the multidisciplinary pain commission can be beneficial, and indeed essential, for getting proposals introduced in legislative and regulatory

sessions. Restrictive provisions that are nonsubstantive or uncontroversial, such as those that seem to have legislative support through prior dialogues, often can be removed as additions in clean-up legislation. Such provisions do not have to be addressed in substantive legislation. However, introducing a separate bill may be necessary when there are many statutory or regulatory barriers to pain management, and working with a government sponsor from the majority party would be important.

There are some states in which initiatives have succeeded in making pain management a greater health care priority, including pain-policy development, professional education, and public advocacy. The ACS has had a significant influence on such activities to promote patient pain relief by trying to inform practitioners and the general public through the Cancer Pain Management Advocacy Toolkit.⁶⁵ The Advocacy Toolkit is a CD-ROM of resources and slides to promote care at the state level for patients with cancer, including information about barriers arising from policies addressed in this article and from health insurance and Medicaid policy, as well as cancer pain management in populations at risk. The ACS has hosted pain summits to enhance awareness of pain management issues and to encourage partnering among state medical societies, pain initiatives, and hospice and palliative care organizations to help achieve better patient pain treatment. These approaches are important for establishing or emphasizing the association among state policy, professional practice, and patient care. The ACS is working with state governments and policy makers to ensure that pain policies continue to improve and are put into practice in all the states.

Policy Implementation and Communication Are Essential

Once these initiatives are successful at improving their state's policies that govern health care practice, this must not be considered the final objective. Positive policy change is a crucial first step, but policy change alone is not enough to ensure patient access to pain management and symptom control. Balanced policy with no implementation has little practical value; rather, there must be a sustained commitment to repeated

communication, and policies must be put into practice through advocacy and education. The positive messages from improved policy have to be effectively conveyed to those who implement the policy and are affected by it, including not only practitioners and the public, but also regulatory administrators, investigators, and attorneys. The goal is for the regulatory boards (medical, osteopathic, pharmacy, and nursing) to make their licensees understand that their state policy promotes proper pain management and that health care professionals who responsibly treat pain should not fear their licensing agency. There are many examples of states that have widely disseminated and communicated positive regulatory policy to their licensees and the public, including California, Kansas, Maryland, Minnesota, North Carolina, Ohio, and West Virginia.

CONCLUSION

Achieving more balanced pain policy means identifying and eliminating archaic medical concepts and restrictive provisions that impinge on modern pain medicine; it also means adding policies that recognize pain management as a part of quality medical practice and reassure physicians that there is no risk of unwarranted investigation for appropriate prescribing to patients with severe chronic pain, including cancer patients and survivors. Many health care practitioners who are committed to improving the care of their patients have facilitated progress to improve state pain policy. It is our hope that the principle of Balance will continue to inform the improvement of state policies and that health care professionals and regulatory and law enforcement organizations throughout the United States will participate in increased and sustained efforts to systematically implement those policies.

The principle of Balance also is helpful in conceptualizing the appropriate roles and responsibilities of both health care practitioners and law enforcement officials when addressing pain management and the problems of drug diversion. The main role of practitioners is to treat pain, but they also must avoid contributing to medication abuse and diversion. Alternatively, law enforcement works to stop diversion, but,

in doing so, must not interfere in medical practice and patient care. Thus, the principle of Balance provides a framework for recognizing what should be the common interests of health care and law enforcement: to understand and avoid interfering with each other's work to protect public health and safety.

If state initiatives remain successful at improving health care policy and educating practitioners, patients, and the general public about the appropriate use of opioid analgesics for pain relief, there will be fewer chances for unfortunate and unnecessary situations of patient undertreatment to occur.

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