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# IOM Report Calls Attention to the Pain Crisis and Recommends a Biopsychosocial (Integrative) Model of Care

By ALFRED ANDERSON, MD, DC, PRESIDENT, BOARD OF DIRECTORS

**O**n July 29, the IOM submitted to Congress was the first-ever, high-level, comprehensive report on the “state of pain” in the United States. Called *“Relieving Pain in America: A Blueprint for Transforming Prevention, Treatment, and Research,”* the 300+ page document sends a loud and clear message to our government and the American public that pain is a major public health problem that has to be addressed on multiple levels. According to the report, more than 100 million Americans suffer with chronic pain, and the economic cost of pain is at least \$560 to \$635 billion. The stated purpose of the document is to provide a “blueprint” for achieving a “cultural transformation” to “prevent, assess, treat, and understand pain of all types.” The table below lists the key components of the report. The Academy applauds the IOM Committee for this landmark study and is proud to say that Past Board President Rick Marinelli, ND, served as one of its esteemed members.

But what does this report mean for the Academy in terms of our mission and work, and what implications does it have for the pain management/medicine community, the public, and policymakers? The Academy leadership has just begun to tackle these questions, and two members of our staff, Lennie Duensing, Executive Director, and Bob Twillman, Director of Policy and Advocacy, are serving on committees that will be exploring concrete ways to “operationalize” the IOM Committee’s recommendations.

For the Academy, this document has several implications, particularly in the clinical and policy arenas. First and foremost, the report supports our core integrative mission. Woven throughout the document is the concept that optimal care requires an interdisciplinary, biopsychosocial approach: “Ideally, most patients with

severe pain would obtain care from an interdisciplinary team, as opposed to a specialist who might focus on a narrow range of treatments and have a restricted view of how pain is affecting the patient.”

The report also supports the Academy’s emphasis on individualized, patient-centered care. It says, “...effectiveness of pain treatments depends greatly on the strength of the clinician-patient relationship; pain treatment is never about the clinician’s intervention alone, but about the clinician and patient (and family) working together.” These are the understandings upon which the Academy was founded. It is why, for the past 22 years, the Academy’s doors have been opened to clinicians representing a wide number of disciplines, both allopathic and complementary and alternative; why we have provided education on a wide range of treatment modalities and how they can be incorporated into a comprehensive treatment plan; why we have presented information about the latest pain research; and why we have encouraged a team approach to pain management. In fact, the Academy has been the only professional pain management organization that has truly and consistently done this.

Additionally, the IOM report states that “remediating the mismatch between current knowledge and its application will require a cultural transformation in the way clinicians and the public view pain and its treatment.” The authors’ concept of this transformation involves identifying and ultimately removing barriers to care at the system, the clinician, and the patient levels.

## Transforming the System

On a superficial level, the system focuses on the current reimbursement policy and research emphasis, but it is much deeper than that. The authors fully support the idea of treating the biological–cognitive–emotional aspects of pain

and acknowledge that our health system in general is not designed to support comprehensive and interdisciplinary approaches to health care, including pain management.

Ironically, when I started practicing medicine more than 30 years ago, I worked with other clinicians in Minneapolis to create a very successful integrative pain management program that centered on physical rehabilitation and exercise, as well as biofeedback and other cognitive behavior therapies. We had remarkable success in restoring function in most of our patients, so it was disheartening when insurance companies would no longer cover the treatment. Most of the truly good, balanced programs were shut down because of payor issues, not patient outcomes.

The report also questions where pain belongs in the realm of medical conditions. Is it a discrete disease state or part of many others? Is it true, as the authors question, that because “pain belongs to everyone, it belongs to no one”? What is the outcome of this quandary? The report goes on to say that “The existing clinical (and research) silos prevent cross-fertilization of ideas and best practices.” Although academically based pain clinics implement the comprehensive, interdisciplinary approaches to pain assessment and treatment that appear to work best in managing chronic pain, they are few in number and increasingly constrained by a reimbursement system that continues to discourage interdisciplinary practice.

**TABLE 6-1 Blueprint for Transforming Pain Prevention, Care, Education, and Research  
IMMEDIATE: Start now and complete before the end of 2012**

Recommendation	Actors	Key Elements of Recommendation
<b>2-2. Create a comprehensive population-level strategy for pain prevention, treatment, management, and research</b>	Secretary of Health and Human Services (HHS)	Involve multiple federal, state, and private-sector entities, such as the National Institutes of Health (NIH), Food and Drug Administration (FDA), Centers for Disease Control and Prevention (CDC), Agency for Healthcare Research and Quality (AHRQ), Health Resources and Services Administration (HRSA), Centers for Medicare and Medicaid Services (CMS), Department of Defense (DoD), Department of Veterans Affairs (VA), the outcomes research community and other researchers, credentialing organizations, pain advocacy and awareness organizations, health professions associations (including pain specialty professional organizations), private insurers, health care providers, state health departments, Medicaid programs, and workers compensation programs
<b>3-2. Develop strategies for reducing barriers to pain care</b>	HHS Secretary, AHRQ, CMS, HRSA, the Surgeon General, Office of Minority Health, Indian Health Service, the VA, DoD, large health care providers (eg, accountable care organizations)	Key part of the strategy envisioned in Recommendation 2-2
<b>3-4. Support collaboration between pain specialists and primary care clinicians, including referral to pain centers when appropriate</b>	CMS, the Department of Veterans Affairs, DoD, health care providers, pain specialists, pain centers, primary care practitioners, pain specialty professional organizations, primary care professional associations, private insurers	The pain specialist role includes serving as a resource for primary care practitioners
<b>5-1. Designate a lead institute at the National Institutes of Health responsible for moving pain research forward, and increase the support for and scope of the Pain Consortium</b>	NIH	Involve pain advocacy and awareness organizations; foster public-private partnerships

## Transforming the Clinician

Although the system is set up to discourage interdisciplinary care, clinicians also face several barriers to its implementation. The report reinforces the idea of improved clinical education and practice and calls for more interaction among the various disciplines that treat people in chronic pain. Again, this philosophy was the foundation for the creation of the Academy and is one that I have personally embraced as a clinician. However, even though clinicians can, in theory, draw on many disciplines in addressing the pain-related needs of individuals and families, it is not always feasible logistically. If you look at the clinical breakdown of Academy members and their commitment to optimal pain treatment, it would be easy to assume that they were, for the most part, part of an integrative program or at least an interdisciplinary team. We don't believe this is so. In fact, research conducted in 2009 showed that most of the physicians interviewed think an interdisciplinary approach is a best practice, but they do not know how to do it if they are not all under one roof. Should primary care practitioners want to engage other types of clinicians, including physical therapists, psychologists, or complementary and alternative medicine practitioners, it may not be easy for them to identify which specific practitioners are skilled at treating chronic pain or how they will do so.

Another barrier is that health care professionals are not well educated in emerging clinical understanding and best practices in pain prevention and treatment. In addition, we don't have well-validated evidence-based guidelines on assessment and treatment for some pain conditions, or existing guidelines are not followed. We wholeheartedly agree with the IOM report that additional basic and clinical research is needed on the underlying

mechanisms of pain, development of new treatments, and comparative effectiveness of existing treatments. Reliable and valid assessment methods are also needed.

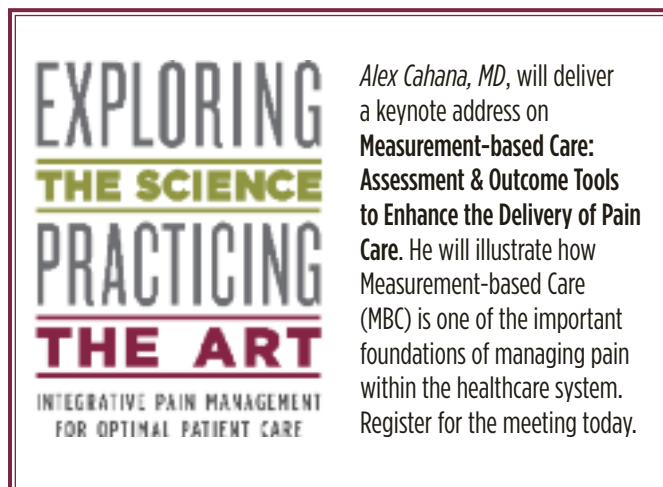
## Transforming the Patient

Patients ultimately pay the price for the barriers that the system and the clinicians confront. They have difficulty getting appropriate diagnosis and treatment and ultimately, reimbursement for their care. Add to this the concerns or skepticism of family and friends and the societal stigma that is applied, consciously or unconsciously, to people reporting pain, particularly if they do not respond readily to treatment. Because pain is often invisible, it is equally questionable and, according to the report, "When people perceive a lack of validation or other negative attitudes in their clinicians, they are more likely to be dissatisfied with treatment and change doctors, as is the case with about half of people with noncancer pain."

We believe that overall this report validates the needs of the patient, and we hope more research funds will go to study some of the noninvasive, nonpharmacologic treatments to offer patients greater choice. In the meantime, we need to educate our patients better about the types of treatment available and also their active role in managing their pain. We fundamentally believe, however, that to succeed we must pull people together to work in a more synergistic relationship. We have to be better than the "sum of our parts" so that people in pain actually get better.

The Academy appreciates the authors' blueprint, and we believe that at the end of the day it will be up organizations like ours to interpret what this cultural transformation looks like and, equally important, how, to "operationalize" it working with the various stakeholders. We would hope that key systems, starting with Medicare and Medicaid, will lead a change in reimbursement policies that will legitimize an integrative model. Because of the structure of the Academy and our core beliefs, we are perfectly positioned to do this. ■

ALFRED V. ANDERSON, MD, DC, is the Medical Director of Medical Pain Management in Minneapolis, Minnesota. Dr. Anderson is also a member of the Minnesota Board of Medical Practice and a fellow of the Federation of State Medical Boards. He is currently President of the Board of Directors of the American Academy of Pain Management and is an author and section editor of the seventh edition of *Weiner's Pain Management*.



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