Managing Chronic Pain Far From Comfort Zone

Primary care physicians and pain specialists say they want greater access to educational tools.

BY ROXANNE NELSON
Contributing Writer

SAN ANTONIO — Clinicians in the field vary greatly in their comfort and confidence in assessing and managing chronic pain, according to a survey presented at a poster session at the annual meeting of the American Pain Society.

"Primary care providers are uncomfortable in treating pain and desire help, especially in opioid management," Dr. William McCarberg, director of the chronic pain management program at Kaiser Permanente in Escondido, Calif., said in an interview. "Specialists are more comfortable but also would like help."

The American Pain Society and American Academy of Pain Medicine concluded in a joint consensus statement that undertreatment of pain is unjustified and that chronic pain is often inadequately managed. Recent warnings from the Food and Drug Administration and increased investigations by the Drug Enforcement Agency have helped create a confusing environment for chronic pain management.

The primary objective of the survey was to confirm the perception that there are gaps in education, comfort, and regulatory understanding among practitioners when it comes to prescribing opioids. A secondary objective was to evaluate physicians' perceived need for improved assessment, management, and documentation of chronic pain.

The survey showed that 'primary care providers are uncomfortable in treating pain and desire help, especially in opioid management.'

Physicians in 133 practices (49% primary care physicians, 36% pain specialists, and 15% other), located in five U.S. regions, evaluated their level of knowledge and comfort in assessing and managing patients with chronic pain, using a scale of 1 to 6 (with 1 being "not at all" and 6 being "extremely").

They also rated their interest in additional resources in the areas of time management, patient counseling, and treatment documentation.

A strong interest in greater access to educational tools was observed for both physician education (rated 4.68 by primary care physicians and 5.12 by pain specialists) and patient education (4.82 for primary care and 5.02 for pain specialists), as well as a need for patient counseling resources (5.14 for primary care and 5.39 for pain specialists).

In addition, physicians expressed a strong interest in treatment documentation resources (5.29 for primary care and 5.45 for pain specialists).

"Education was the main concern in primary care" that was expressed by the physicians, Dr. McCarberg said. "Regulatory oversight was judged as an issue as well. Primary care practitioners also felt they did not have enough time to take care of pain patients adequately."

Overall, the pain specialists generally felt more informed on current trends in chronic pain, while the primary care physicians offered far more varied responses, ranging from extremely well informed to very uncomfortable. ■

National Survey: Few Chronic Pain Sufferers See a Specialist

BY ROXANNE NELSON
Contributing Writer

SAN ANTONIO — Lack of nearby pain practices helps explain why only about 5% of U.S. adults with chronic pain ever see a pain specialist, Brenda Breuer, Ph.D., reported at the annual meeting of the American Pain Society.

The finding comes from a survey of 748 pain specialists who responded to a survey that was sent to about 2,500 pain specialists certified by the American Board of Medical Specialties or the American Board of Pain Medicine.

"We felt that if we identified any deficiencies, that would be a first step towards improvement," explained Dr. Brenda Breuer of the department of pain medicine and palliative care at Beth Israel Medical Center, New York.

The specialties, age, and geographic location of the physicians who responded to the survey were similar to those of the nonresponders. Most (74%) had their primary training in anesthesiology, whereas others were trained in physiatry (15.4%), neurology (5.3%), psychiatry (3.0%), and other areas (10.9%)

Overall, analysis of census data showed that individuals residing near pain practices were similar to the general U.S. population. Pain practices were underrepresented in rural areas, and people living near pain specialists tended to have higher incomes and higher education levels that the general population.

Academic physicians, who accounted for about one third of the respondents, were more likely than others to have had their primary training in neurology, and were more likely to have completed a pain fellowship. They were also more likely to be associated with a facility involved in research, to hospitalize patients for aggressive treatment of severe pain, and to have interdisciplinary practices.

There are only six board-certified pain physicians per 100,000 adult chronic pain patients, but it is as yet unclear if there is a shortage of pain specialists.

Respondents whose practices were modality-oriented (29.2%) were more likely than others to have had their primary training in anesthesiology, and were significantly less likely to have interdisciplinary practices, to prescribe and maintain patients on controlled substances, to follow patients longitudinally, and to hospitalize for aggressive treatment of severe pain. They were also more likely than others to treat pain in only one part of the body, such as headaches.

Conversely, multimodality physicians were more likely to use opioids and to collaborate with specialists. They were also likely to have an integrated practice, which included not only physicians who practiced in different specialties, but also a psychologist, a physician assistant, and a social worker.

Board certification does not imply a uniform approach to chronic pain treatment, Dr. Breuer said. Nationally, there are only six board-certified pain physicians per 100,000 adult chronic pain patients, but it is as yet unclear if there is a shortage of pain specialists, she said.

"Future surveys of pain patients are needed to complement physicians' surveys to assess the actual efficacy of pain management," Dr. Breuer said. ■

Part D 'Doughnut Hole' Leaves Some Patients Without Drugs

BY TIMOTHY F. KIRN
Sacramento Bureau

SEATTLE — Patients taking antidepressants and cholesterol-lowering drugs who are in pharmacy-capped plans, like the new Medicare Part D drug benefit, often stop taking their drugs when they reach the cap, Geoffrey Joyce, Ph.D., said at the annual research meeting of Academy Health.

According to his research, anywhere from 6% to 11% of patients in the Medicare Part D program are likely to hit what is known as the "doughnut hole" of coverage in any given year, said Dr. Joyce, a senior economist with the RAND Corp., Santa Monica, Calif.

The so-called doughnut hole is the gap in coverage that goes into effect during a coverage year when a patient's drug expenditures reach $2,250, and continues until the expenditures reach $5,100. Prior to reaching the doughnut-hole gap, beneficiaries have a $250 annual deductible and pay 25% of their drug costs. After expenditures have reached $5,100, catastrophic coverage kicks in and patients pay only 5% of costs. Within the doughnut hole, patients pay 100% of their drug costs.

Many health economists and others have worried that the Medicare Part D patients most likely to spend their way into the doughnut hole are the sickest patients, and that those patients might become noncompliant with their medication regimens when they surpass their $2,250 limit.

Dr. Joyce and colleagues looked at two employer health plans with drug benefits that had a cap on coverage of $2,500, in order to get an idea of what is likely to happen with the Medicare plan.

In the years considered (2003 and 2004), 7% of beneficiaries in one plan and 11% in the other plan hit the cap.

The median time of year when patients hit the cap was September. However, one quarter of the patients who hit the cap did so in June, meaning they had no drug coverage for a full 6 months, Dr. Joyce said.

Patients did not appear to switch from brand-name drugs to generic drugs in any appreciable degree when they reached the cap. However, some patients did stop taking certain drugs. The most common medications the patients stopped taking were antidepressants and cholesterol-lowering drugs.

What was most concerning about those who stopped was that only about 40% of those who stopped then restarted those drugs at the beginning of the new year, Dr. Joyce said.

Previous studies of drug benefit caps have shown that they do reduce plan costs significantly. In one study of a Kaiser Permanente plan, a cap resulted in 31% lower drug costs.

That study found, however, that there may be a price to pay for curtailing drug benefits too drastically, Dr. Joyce noted.

Overall, the Kaiser study found that the capped plan did not result in higher medical care costs. But there were more hospitalizations and more emergency department visits in the capped plan, compared to a noncapped plan. There was also a 22% higher mortality among patients in the capped plan.

Given the higher hospitalization and ED visit rates, the finding that medical-care costs were no higher is probably a statistical anomaly, and is not accurate, Dr. Joyce said.

In this study, the investigators have begun looking at ancillary costs that might be associated with patients' not filling prescriptions they otherwise would have filled. But that work is not completed yet. ■