May 20, 2015

Re: National Pain Strategy (NPS) by the Interagency Pain Research Coordinating Committee (IPRCC)

The Gerontological Society of America (GSA) is pleased to provide comments on the National Pain Strategy recently released for comment by the IPRCC. GSA is the largest multi-disciplinary professional membership organization of researchers studying all facets of aging on a national and international scale. The Society’s members include physicians, nurses, biologists, psychologists, social workers, economists, health policy experts, and others interested in expanding scientific knowledge related to aging. Because of the breadth and depth of our members’ interests and scholarship in gerontology and geriatric practice, GSA’s strengths in this knowledge domain may be of benefit to the National Pain Strategy authors as it concerns older adults’ unique needs. The following comments have been developed with input from GSA members in medicine, nursing, health policy, social work and the law, and ethics.

The National Pain Strategy

GSA applauds the comprehensiveness and focused approaches to improve pain care in America. We support the broad areas in which targeted actions can move the agenda forward to address the crisis of pain and its impact on our society. The report has many strengths, and we are particularly pleased to see appropriate emphasis on biopsychosocial dimensions of pain and self-care strategies. We also recognize the challenges in addressing the unique issues for subpopulations, as part of a comprehensive population-level plan. In light of these goals and challenges, GSA is compelled to provide comment and recommendations about the population our organization represents, which is a large and growing proportion of the population served by this report.

Pain Management Needs of Older Adults

The pain management needs of older adults are of paramount concern to our organization. In the fall of 2011, GSA issued two special publications to our members, the first highlighting the Institute of Medicine’s (IOM) groundbreaking report, *Relieving Pain in America* (2011), and the second focusing on the FDA’s changes on acetaminophen dosing and the impact of those changes on older adults. Other publications include a special report on studies of pain in older adults by GSA members and a policy-to-practice brief on the Affordable Care Act (2010) and its impact on pain care. In light of this high level of engagement by our members in issues that concern older adults’ access to adequate pain management, GSA continues to advocate for recognition of the challenges and needs of this vulnerable subpopulation.

The fastest growing segment of the population is those over 65 years of age, with 10,000 new people achieving this landmark each day (Administration on Aging, 2012). By 2040, the U.S. health care system will be challenged by 82 million older adults, many of whom are Medicare beneficiaries and have multiple chronic conditions (Centers for Medicare & Medicaid Services [CMS], 2014; Lochner, Goodman, Posner, & Parekh, 2013). Chronic diseases, including cardiovascular disease, diabetes mellitus, degenerative joint disease, osteoporosis, cancer, and peripheral neuropathies, are more prevalent in older adults and are often associated with persistent pain problems (Bruckenthal, Reid & Reisner, 2009). Research shows a strong association between chronic illness, multimorbidity, and pain prevalence and intensity, especially among aging Americans (IOM, 2011).
Pain is a common enemy of older individuals, with the prevalence of persistent pain ranging from 25% to 50% in community-dwelling elders (MacFarlane et al., 2011; Tsai, Liu, & Chung, 2010) and 50% to 85% in institutionalized older adults (Gianni et al., 2010; Smith et al., 2010; Tse, Leung, & Ho, 2012). Untreated or ineffectively treated moderate to severe persistent pain can cause great harm in older individuals, resulting in loss of functional independence, disability and impaired physical function, impaired social interactions, increased anxiety and depression, impaired cognitive function, altered nutrition and sleep, and overall decreased quality of life—all contributing to increased use of health care resources and costs (Griffin, Harmon, & Kennedy, 2012; IOM, 2011; Johansen, Lindbak, Stanghelle, & Brekke, 2012; Shega et al., 2012). Disparities in pain management for vulnerable elders have been widely recognized as a public health problem (IOM, 2011; Mayday Fund, 2009).

Clinicians caring for older adults with persistent pain are particularly challenged to balance concerns about medication harms with benefits to function and quality of life. Additionally, older individuals are more vulnerable to both the potential harm of unrelieved pain and the medications used to treat it (Arnstein & Herr, 2013). Increased vulnerability to side effects and drug interactions exist in older adults due to differences in drug distribution, metabolism, and elimination (Gupta & Avram, 2012; Milton, Hill-Smith, & Jackson, 2008), as well as the challenges of multiple comorbid conditions and polypharmacy (Evans et al., 2012). Analgesics are integral to treatment of moderate to severe pain, yet most drugs contain some element of heightened risk in older adults (Brandt, Hanna, & Walters, 2013). Thus, clinicians need an armamentarium of options that can be considered based on the unique circumstances of each older person. With appropriate precautions (American Geriatrics Society Panel, 2009), analgesics can be part of a comprehensive treatment plan in older adults that is based on a careful risk-benefit evaluation, includes planned reassessment and monitoring of outcomes, and incorporates nonpharmacological and alternative interventions along with analgesic treatment.

If more resources are invested in pain programs, they should be invested in additional training for health care practitioners to strengthen their pain assessment and pain management skills.

Focus on Population Health

The NPS recognizes the important impact of pain, not only in individuals and families but also for communities and society at large, establishing it as an important public health priority. GSA endorses this approach and applauds the elevation of the problem of pain to a public health crisis, which can bring additional and different resources and partners to the table to address the challenges of ensuring that all Americans, including elders, receive quality pain care.

In addressing pain care broadly, translation of evidence-based assessment and treatment practices into consistent clinical care is an ongoing priority and consideration for scientists focused on improving pain care (Herr et al., 2012; Titler et al., 2009). The lack of consistent implementation of evidence-based practices is particularly notable in the case of older adults across care settings (Gianni et al., 2010; Maxwell, Dalby, Salter, Patten, Hogan, & Hirdes, 2008; Herr et al., 2010). Concerted efforts must focus on methods to speed translation of research findings into practice (Kruger & Light, 2010; Mao, 2009), particularly the study of methods that speed the adoption of evidence-based protocols (Attieh et al., 2013; Collins, 2011). Further interdisciplinary team-based research is imperative to increase the evidence base and to move knowledge into consistent practice for all patients with pain, but particularly for vulnerable elders.

GSA is particularly concerned about inadequate and inappropriate pain assessment and management in the older adult population and requests that the NPS highlight vulnerable elders as a priority subpopulation for which disparate assessment and treatment is obvious and for which translation of science to public health approaches will be important.
Focus on Prevention and Care

Advancement of prevention goals for the older adult population will require more attention to public health promotion. Recognition of pain as a public health problem will provide an important foundation for policy development in this area. A critical issue for the older adult population is engaging in care planning and establishing appropriate goals of care, including pain prevention and pain management goals.

We ask that the NPS explicitly address goals of care and care planning for older adults that focus on pain prevention, access to good foods and green space, and participation in age-friendly, healthy environments and communities that promote elders’ independence and reduce functional disabilities.

Focus on Disparities

GSA acknowledges the NPS identification of pain disparities as an area of emphasis and its listing of older adults as one subpopulation of concern. Pain is a highly prevalent condition in older adults, and underrecognition and undertreatment has been consistently demonstrated across care settings (Mayday Fund, 2009; IOM, 2011). Elders with pain often have associated symptoms or conditions that contribute to the pain experience and complicate effective management of pain (Block & Cianfrini, 2013; Moriarty, McGuire, & Finn, 2011; Smith, Hameed, Cross, Sahota, & Fox, 2013). The challenges of effectively managing pain are particularly notable in patients with chronic, complex, or progressive diseases, which are common in older adults (Johansen et al., 2012). Furthermore, underrecognition and undertreatment of pain increases in those with limited communication abilities, including elders with dementia (CMS, 2014). Although evidence-based tools are available for assessing pain in such nonverbal cases, in light of the challenges identified in the assessment, evaluation, and treatment of pain in older adults, GSA calls for more humanistic responses to the pain experiences of older adults that will be sensitive to older adults’ social-ecological contexts and person-centered care needs (Morrissey, 2011), as well as effective in enabling access to comprehensive assessment and multimodal treatment.

Given the growing segment of older adults in U.S. society and the unique challenges in improving pain care in elders, we request a stronger emphasis in the NPS on priority for improved education, funded research, and policy changes to improve the state of pain in older adults.

Focus on Service Delivery and Reimbursement

The Medicare Hospice Benefit, a program overseen by CMS, is the primary financing mechanism for hospice care for older adults. Hospice care is a comprehensive, interdisciplinary palliative care delivery model (Center to Advance Palliative Care, 2014) that provides pain and symptom management, as well as psychosocial, emotional, and spiritual support services to patients with serious illness, many of whom are older adults. However, the policy on financing and reimbursement for hospice care may have unintended consequences, particularly in limiting access to care for older adults with serious illness who might otherwise benefit clinically from the comprehensive care provided through hospice. For example, older adults who are frail or have cognitive impairment either might not meet the 6-month requirement, or might meet the requirement but live longer than anticipated and not be recertified. Certain older adults may still need to access the type of comprehensive palliative care that hospice programs provide even after discharge from hospice, possibly through non-hospice palliative care programs.

We urge the NPPS to address financing for non-hospice palliative care to ensure adequate pain care for frail elders at all stages of the illness trajectory.
Focus on Professional Education and Training

Interdisciplinary approaches to pain management are necessary to optimize the health and well-being of older adults (Berkman, 2011; IOM, 2011; Mayday Fund, 2009), who often have complex health care and palliative needs. Pain is multidimensional in nature. Interdisciplinary and collaborative approaches to pain care involving physicians, nurses, psychologists, social workers, pharmacists, physical therapists, chaplains, and professionals from other disciplines are considered best practices in pain management (Gatchel, McGearry, McGearry, & Lippe, 2014). Accordingly, the health and palliative care needs of older adults call for interdisciplinary approaches that integrate and coordinate multimodal therapies to pain management (Berkman; IOM; The Mayday Fund).

For older adults who are living through experiences of pain and serious illness, the primary goals of effective pain management are to protect their dignity, maintain or improve function, optimize quality of life, reduce pain levels, prevent and relieve suffering, and respect their values and preferences in the treatment plan. Pain management is recognized as one of the major and essential pillars of a palliative care approach to person-centered and geriatric care (Dahlin, 2009). Both the American Geriatrics Society (2009) and the Institute of Medicine (2011) have been instrumental in bringing national attention to this critical issue affecting U.S. public health. Among the recommendations of the IOM that are critically important to the care of older adults are enabling self-management of pain, eliminating barriers to adequate pain care, and promoting interdisciplinary research and training for those who are conducting research on pain.

The ACA provides a unique opportunity to improve the delivery of education and training pursuant to a comprehensive strategy for pain care. The health system overall is orienting itself toward team-based care. What better and safer way to manage chronic pain than utilizing an interdisciplinary team? The focus of the ACA on population health and its goals to reduce hospitalizations and control costs are critically intertwined with an effective national pain strategy that involves team-based care, provider and patient education and training, and appropriate access to both pain treatment expertise and opioid medications. Medical homes, transition coaching, and other interventions are anchored on effectively managing pain.

The call in the IOM report (2011) for improvements in pain care are timely and appropriate given the urgent and oftentimes neglected needs of vulnerable older adults. This transformation extends to the interdisciplinary professional community. Specialists in pain and palliative medicine, as well as generalists, need to receive ongoing training in principles of pain assessment and pain management and to spend time educating the older adults they serve about the complexities of pain. The hallmark of palliative care is the concept of interdisciplinary collaboration. Hospice has provided an example of successful implementation of the interdisciplinary team model. An interdisciplinary and collaborative approach to pain management and pain care involving physicians, nurses, psychologists, social workers, pharmacists, and chaplains, among a number of other disciplines, is considered best practice across all health care settings. Even in primary care settings, it is incumbent upon health care practitioners to maintain dialogues with members of the other professions and seek support and counsel when appropriate in the assessment and treatment of pain, and in the promotion of health literacy among older adult patients about prevention and access to care.

We believe the NPS must give priority to interdisciplinary education and training that will build the capacity of communities to deliver comprehensive pain and palliative care in across all care settings including community-based settings.
Public Education and Communication

Public education and effective communication about pain also need to be expanded. A priority should be helping both individuals and their caregivers understand the social and relational aspects of pain experience and the impact on family caregivers.

The lack of a comprehensive U.S. policy on informal caregiving heightens risks for older adults and their family caregivers, as documented by AARP and the United Hospital Fund (Reinhard, 2012; Reinhard, Levine, & Samis, 2014). In these studies, the researchers found that family caregivers are performing complex medical and nursing tasks, such as wound care and medication management, for their loved ones, often without proper training. Care provided through these informal caregiving systems is intimately connected with the assessment of pain. Informal caregiving also may be instrumental in avoiding care recipients’ hospitalization or institutionalization.

The essential role of informal care within U.S. social and economic systems is not officially recognized. Informal caregivers receive no income support or tax credit for the care that they provide. In many cases, caregivers may experience enormous financial strain as they struggle to meet the complex medical and social needs of elderly parents or spouses, as well as emotional stress that may detrimentally affect their health. The burdens caregiving imposes also may increase the risk of elder abuse (Reinhard et al., 2014).

A social-ecological approach provides an understanding of caregiving that fully accounts for the multiple contexts (e.g., poverty, housing, geography, income, other social determinants of health) that influence relationships between older adults and caregivers. Notably, such an approach will be helpful in advancing the attainment of the highest standards of health and well-being as framed under human rights conventions (Gostin, 2014). In addition to pain and pain management, standards must include ensuring the dignity of older adults and their caregivers.

It is imperative that the NPS address fully the impact of pain on family caregivers in the design of pain assessment and management strategies, especially heightened risk for vulnerable groups such as frail elders.

In conclusion, GSA expresses strong support for the National Pain Strategy and requests inclusion of emphases on the challenges and strategies to improve pain care for the growing segment of older adults in U.S. society. In light of the strong evidence base supporting comprehensive assessment of older adults’ unique needs for appropriate medical and palliative interventions, as well as pain and symptom management, GSA favors a public health approach to address the issues of effective pain management. Such an approach must be fully integrated into health and social systems at all levels of society and would require substantial investments in training and education for all health care practitioners and members of the public.

Sincerely,

James C. Appleby, RPh, MPH
Executive Director & CEO
References


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