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UNDERSTANDING PAIN

**Supporting the Pain Care Policy Act of 2005
(House Bill 1020)**



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CONTENTS

- ❖ Meeting with Your Legislator: Tips for a Successful Experience 4
- ❖ If You Can't Go to Washington: Meetings in the Local Offices 5
- ❖ Sample Script for Scheduling an Appointment 6
- ❖ Sample Fax Requesting a Meeting 7
- ❖ Check List for Your Visit 8
- ❖ Sample Letter of Thanks 9
- ❖ Congressional Meeting Evaluation Form 10

Resources

- ❖ Key Messages About Pain 13
- ❖ Pain Facts 15
- ❖ Decade of Pain Control and Research 18
- ❖ How a Bill Becomes a Law 19
- ❖ Summary of the National Pain Care Policy Act 23
- ❖ Full Text of the National Pain Care Policy Act 26
- ❖ Americans Living With Pain Survey (2004) 41
- ❖ America Speaks: Pain in America (2003) 43
- ❖ Lost Productive Time and Cost Due to Common Pain Conditions in the US Workforce (2003) 46
- ❖ A Survey of Pain in America (2002) 47
- ❖ Pain in Maryland (2002) 48
- ❖ Pain in America: A Research Report (1999-2000) 49
- ❖ Organizations and Physicians 50



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***T**he National Pain Care Policy Care Act, House Bill 1020, is an important step toward putting pain at the top of the national health care agenda and ensuring appropriate, equitable care for the 50 million Americans who experience pain daily.*

This bill is the reintroduction of HR 1863, the Pain Care Policy Act of 2003. With its reintroduction, all new co-sponsors must be obtained to show support for this bill. Partners for Understanding Pain, a consortium of more than 75 organizations with an interest in pain issues, supports the passage of this important legislation.

To succeed, we need your help. We plan a day of visits to Capitol Hill to educate our representatives and ask them to co-sponsor and support HR 1020. As an advocate for sound pain care, you can join us; plan to visit your member of Congress on September 14, 2005.

In this guide, you will find tips for scheduling and planning your meeting, information about the bill, and other resources that you can use to make the case for better pain care. Many of these materials were originally developed by the National Vulvodynia Association and we thank them for allowing us to use them in this guide. A list of the Partners organizations also included for your reference.

For more information about the National Pain Care Policy Act and pain advocacy please visit the Partners for Understanding Pain website at www.understandingpain.org.

You also can find resources for supporting this bill at www.painfoundation.org.



Meeting with Your Legislator: Tips for a Successful Experience

Step One: Scheduling an Appointment

- ❖ Because HR 1020 will be considered by the House of Representatives, you will want to meet with the Representative from your district (we'll take on the senate later). If you are unsure who your Representative is, look him or her up at <http://www.house.gov/writerep>
- ❖ **Call as soon as possible to begin the process of scheduling your appointment for September 14th.** Congressman Rodgers will address the group in front of the Capitol from 9:30 to 10:00, so please arrange your meeting for after that, if possible.
- ❖ When you call your elected official's district office, ask to speak with the scheduler (the person who sets up all the legislator's appointments).
- ❖ Using the script provided in your packet as a guide, tell the scheduler that you are a constituent of Congressman X, briefly summarize the purpose for the meeting, and list the names of those who will attend with you.
- ❖ You may be asked to fax a copy of your request to the Representative's office. You can use the sample letter in this kit for a model.
- ❖ Ask for the contact information of the person in the office with whom you should confirm your meeting with when the date gets closer.
- ❖ If you cannot get an appointment, ask for the office address and the name of the person to whom you may mail information.

Step Two: Be Prepared, Punctual, and Accommodating

- ❖ Be prepared to meet with your elected official or his/her staff by reviewing materials provided in this packet and noting any important points you don't want to forget during your meeting.
- ❖ **Dress for success.** Business casual (skirts or dress slacks with jackets or modest tops for women, slacks, jackets, and collared shirts without ties for men) is appropriate and ensures that we will represent the pain community well.
- ❖ Legislators have hectic schedules, so it is crucial that you arrive for your meeting on time and prepared (plan to arrive at least 10 minutes prior to the scheduled meeting time).

- ❖ **Hurry Up and Wait.** It is possible that your legislator may have unforeseen schedule changes the day of your meeting and your meeting may be delayed or interrupted. Be patient and flexible. If your legislator is unable to meet with you, ask to meet instead with his or her aide responsible for health care issues. This individual can carry your message to the elected official.
- ❖ **Life Happens.** If you find yourself running late for any reason, make sure you have the office phone number to call and give them warning. As long as you call ahead, they are most likely to still try to fit you in.

Step Three: Leave Behind Written Materials

- ❖ A fact sheet will be provided to you by Partners for Understanding Pain. Please make sure that you take these with you to your meeting(s) and leave them behind. These materials will give the legislators and their staff an opportunity to review the issues presented during the meeting and begin a file on the issue (they have not heard the last of us!).
- ❖ You can also develop a fact sheet about your organization explaining the population it serves, its reach nationally or internationally, the support you may have in your home state, and any bills that have been introduced in your respective states.
- ❖ Ask members of your local groups to write letters of support for HR 1020 that you can leave with your congressperson.

Step Four: Thank You, Thank You

- ❖ Send a version of the sample thank you letter included with this guide once your meeting is over.

If You Can't Travel to Washington: Meeting Locally

Your legislator has a local office that you can visit if you can't travel to Washington for the September 14th event. Call the local office and request an appointment to meet with your Representative when he or she is in town or ask to speak to the appropriate local aide. Follow the same process you would if you were coming to Washington.



Sample Script for Scheduling an Appointment

The following sample script is provided to assist you in scheduling an appointment with your legislator.

To receptionist:

Hello. My name is _____ and I am Congressperson's _____'s constituent. I am calling to set up an appointment with Congressperson _____ and/or his staffer to discuss the importance of passing HR 1020, the National Pain Care Policy Act of 2005. May I please speak to his/her scheduler?

To scheduler:

Hello. My name is _____ and I am Congressperson's _____'s constituent. I am calling to set up an appointment with Congressperson _____ and/or his staffer to discuss the importance of passing HR 1020, the National Pain Care Policy Act of 2005.

September is Pain Awareness Month and we are also halfway through the Decade of Pain Awareness and Control. People like me from all across the country will be meeting with their government officials to garner support and build awareness of the importance of taking chronic pain issues seriously.

Does Congressperson _____ and/or his staffer have any availability on September 14th, preferably after 10:00 am?

Scheduler answers YES:

Wonderful. Who is the appropriate person in the office for me to contact to confirm this appointment as the date gets closer? **Scheduler Response.** Thank you very much for your time.

Scheduler answers NO, Congressperson X and/or his/her staff is unavailable to meet during that week:

Is there a time when Congressperson _____ and/or his staffer is available to meet, perhaps in the home district?

Scheduler answers YES: Wonderful. Who is the appropriate person in the office for me to confirm this appointment as the date gets closer? **Scheduler Response.** Thank you very much for your time.

Scheduler answers NO: I am sorry that he/she is unavailable to meet in person. In this case, I would like to mail some materials to his/her office for review. To whom should these be directed? **Scheduler Response.** Thank you very much for your time.



Sample Fax Requesting a Meeting

Your Address
Date xx, 2005

Congressman _____
_____ Office Building
Washington, D.C. 20515
Fax: _____

Dear Congressman _____:

I hope to arrange an appointment some time on Wednesday, September 14, to discuss with you HR 1020 (the National Pain Care Policy Act) and the importance of improving resources for pain management in America today.

It is important that we take pain seriously: Chronic pain has a daily impact on the lives of 50 million Americans and their families and costs our economy an estimated \$100 billion in direct costs and lost productivity.

PARAGRAPH ABOUT YOUR ORGANIZATION OR PERSONAL REASON FOR SUPPORTING THE BILL

Our meeting will be part of a coordinated visit to the Hill by {your organization} and other pain advocacy groups engaged in Partners for Understanding Pain, which you can also learn more about on our web site.

Please let me know if you or a staff member will be able to meet with me on September 14. You may call me at _____, write to the address above, or email me at _____.

Yours truly,



Checklist for Your Visit

6 Weeks Prior to Meeting Date

- ___ Contact others in your area who will be attending meetings with you to confirm availability.
- ___ Call office(s) and set up your meeting(s) for September 14.
*See *Meeting with Your Legislator: Tips for a Successful Experience* and *Sample Script for Scheduling an Appointment* for step by step instructions

4-5 Weeks Prior to Meeting Date

- ___ Review information in this packet about this project, Partners for Understanding Pain and chronic pain.
Please direct *any* questions you have to Penney Cowan (916-632-0922) or Nicole Kelly (412-521-2410).

3 Weeks Prior to Meeting Date

- ___ Contact others in your area who are scheduled to attend meetings with you and confirm their participation.

Partners will be sending a mass email at this time requesting those who are not attending meetings to write to their legislators during the week of September 14. You may also write a letter or request friends and family members to write letters in support of HR 1020 at this time.

2 Weeks Prior to Meeting Date

- ___ Contact legislators' offices to confirm meeting date(s) and time(s).

Week Prior to Meeting Date

- ___ Review your materials (especially the resources in this guide and any handouts that you will be bringing with you to the meeting).
- ___ Gather materials you will need for your meeting:
 - ❖ Handouts for Legislators (Fact Sheet)
 - ❖ Contact information for any others who will join you at the meeting
 - ❖ Contact information for the offices you will visit
 - ❖ Letters you and/or others have written in support of this effort
 - ❖ *Key Messages* to review prior to meeting
 - ❖ Any notes you have made about important points you would like to make during the meeting

Day of the Meeting

- ___ Make sure to bring all items listed directly above.
- ___ Review *Meeting with Your Legislator: Tips for a Successful Experience*.



Sample Letter of Thanks

Dear Congressperson X:

Thank you for meeting with me on September 14 to discuss support of the National Pain Care Policy Act of 2005 (HR 1020).

- ▶ Insert paragraph referencing something you talked about or how the bill relates to the mission of your association to combat chronic pain

The National Pain Care Policy Act can play an important role in promoting and advancing the understanding of chronic pain. By focusing public attention on pain, ensuring the education of professionals in pain care, enhancing research and the sharing of new information about pain, and addressing the needs of all who experience pain, this bill will greatly enhance the quality of life of those with pain and pay economic dividends for decades to come.

Again, I/we greatly appreciate your time and we look forward to assisting you in advancing this legislation.

Sincerely,

Your signature
Your Association



Congressional Meeting Evaluation Form

Your Name: _____

Date: _____

Other Volunteer(s) Present:

I met with (name, title)

in the Office of Congressperson

Topics Discussed (check those that apply):

_____ Personal Story

_____ Importance of HR 1020

_____ Content of HR 1020

_____ Ways Congressperson can help

_____ Other; please specify:

Reaction:

Overall Reaction of Congressperson/Staffer:

(1= unresponsive, cold; 10=very empathic, wants to know how to help and who to contact in the future)

1 2 3 4 5 6 7 8 9 10

Specific Reaction:

Please list any comments made by the person you met with that stuck out in your mind:

Were any questions brought up to which you did not know how to answer, so that we may get back to them with the proper information?

Did he or she seem willing to be contacted in the future when Partners would like their help with legislation, NICHD, etc? Yes_____ No_____ Not Sure_____

Comments:

Additional Comments on the Overall Experience:

Please return this form by email to ACPA@pacbell.net or fax to 916-632-3208.



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RESOURCES



KEY MESSAGES ABOUT PAIN

- ❖ **Pain is a major health issue.**
 - ❖ Pain is the number-one cause of adult disability in the United States and affects one in three people or about 50 million Americans.
 - ❖ Unmanaged pain can slow the rate of recovery for surgical patients and affect the quality of outcomes.
 - ❖ Cancer patients who experience breakthrough pain are hospitalized and visit the emergency room more often than patients whose pain is under control.
 - ❖ According to an omnibus survey of 1,000 Americans conducted for Partners for Understanding Pain, 34 percent of respondents said they currently live with ongoing pain.
 - ❖ In spite of its pervasiveness, few physicians receive more than a few hours of formal training on pain management

- ❖ **Pain is a major economic issue.**
 - ❖ According to the National Institute for Occupational Safety and Health, pain costs \$100 billion annually in lost workdays, medical expenses, and other benefit costs.
 - ❖ Skyrocketing health care costs leave some, especially senior citizens, minorities, and the urban and rural poor, unable to get treatment that can help them manage their pain.

- ❖ **Pain is a major social issue.**
 - ❖ Long-term, unmanaged pain can cause people to withdraw from family and friends and leave them unable to care for children, hold steady jobs, and at times even face a personal future.
 - ❖ Pain has an impact on the fabric of society well beyond the individual, effecting his or her spouse or partner, children, family, and community.

- ❖ **Personal Story (Optional)**

You do not have to share your personal story during your visit, but doing so is an extremely powerful form of communicating the issue and often times elicits understanding and empathy. You do not need to provide graphic personal details of your struggle. The most important points for you to discuss (briefly) are:

- ❖ how chronic pain has impacted your life (e.g., things that you are now unable to do because of the disorder)
- ❖ your struggle to find a knowledgeable provider (e.g., how much time passed before you were diagnosed, how many doctors you had to visit before finding help)
- ❖ how treatments for chronic pain have helped (or not helped) your condition and how they have affected you (e.g., side effects)
- ❖ what HR 1020 can do to help you? Why is it important to support the bill from your point of view?



PAIN FACTS

Pain touches each one of us at one time or another. Pain can begin for many different reasons. Yet as common as pain is, the medical community is just beginning to understand and better address the many forms of pain.

Partners for Understanding Pain developed this fact sheet to provide information and to distinguish among the three types of pain— acute, chronic, and cancer pain.

CHRONIC PAIN

Currently there is no cure for chronic pain and, as a condition that can affect individuals life long, it needs to be taken seriously. A multidisciplinary treatment approach can help people with chronic pain regain control of their lives and reduce their sense of suffering.

Key Facts:

- ❖ Chronic pain lasts. Pain is considered chronic when it continues beyond the usual recovery period for an injury or an illness. It may be continuous or come and go.
- ❖ Chronic pain, sometimes called persistent pain, can be very stressful for both the body and the soul and requires careful, ongoing attention to be appropriately treated.
- ❖ Chronic pain is often intractable, as the cause of pain cannot be removed or treated.
- ❖ Chronic pain is the number one cause of adult disability in the United States.
- ❖ Chronic pain can touch nearly every part of a person's daily life. It also has an impact on the family and, because of its economic and social consequences, it affects us all.
- ❖ Chronic pain can be a source of frustration for the health care professionals who seek to provide care and assistance.

Incidence:

- ❖ The American Chronic Pain Association (ACPA) estimates that one in three Americans or 75 to 150 million people (*Elliott, Smith, Penny, Smith, & Chambers, 1999, Harstall, 2003*) suffers from some type of chronic pain.

Causes:

- ❖ Lower back problems, arthritis, cancer, RSDS, repetitive stress injuries, shingles, headache, and fibromyalgia are the most common sources of chronic pain. Others include diabetic neuropathy, phantom limb sensation, and other neurological conditions.

ACUTE PAIN

Acute pain has a distinct beginning and end and is the result of illness or injury. This type of

pain usually can be largely relieved with appropriate treatment, as can cancer pain. It is important that the pain be taken seriously and managed as part of sound patient care.

Key Facts:

- ❖ Acute pain may be mild and last just a moment. It also can be severe and last for weeks or months, as does pain from a burn, pulled muscle, or broken bone.
- ❖ The cause of acute pain is known and, as you heal, the pain will lessen and finally go away.
- ❖ Acute pain usually starts suddenly, may be sharp, and often triggers visible bodily reactions such as sweating, an elevated blood pressure, and more. Acute pain is generally a signal of rapid-onset injury to the body and it resolves when pain relief is given or the injury is treated.
- ❖ Most of the time medication and other treatment can greatly relieve acute pain. Pain management is an important part of effective total care.
- ❖ Pain should be considered the fifth vital sign, along with respiration, pulse, blood pressure, and core temperature.

Incidence:

- ❖ Muscle pain, one of the most common types of acute pain, affects 53 percent of Americans.
- ❖ Lower back pain is the most common form of acute pain and is the fifth most common cause for all physician visits. It is responsible for direct health care expenditures of more than \$20 billion annually.

Causes:

- ❖ Acute pain is triggered by tissue damage such as a skin burn, muscle pain, or a broken bone. It's the type of pain that generally accompanies an illness, an injury, or surgery.
- ❖ Acute pain can manifest in just about any part of the body.

CANCER PAIN

A diagnosis of cancer can be frightening. Among the greatest fears those with cancer express is the fear that they will not be able to cope with the pain so often associated with the disease. Proper pain management can lift a great burden from these individuals.

Key Facts:

- ❖ Not everyone who has cancer experiences pain; those who do may not have it all the time.
- ❖ Ongoing cancer pain can be successfully treated in about 95 percent of people with cancer with the drug and non-drug therapies that are currently available.

- ❖ Along with ongoing cancer pain, sometimes people have acute flares of pain when not all pain is controlled by the medication or therapy. This pain, usually called breakthrough pain, can also be controlled by additional medications.
- ❖ Cancer patients often downplay their pain to doctors for fear that their pain means that their cancer is getting worse or that they will be thought to be complainers.
- ❖ In almost every aspect of cancer treatment—surgery, chemotherapy or radiation—cancer patients follow the lead of their doctors. But when it comes to pain, patients need to assert themselves and be open about the degree of pain they are experiencing.

Incidence:

- ❖ Approximately 30 to 40 percent of Americans diagnosed with cancer experience moderate to severe pain, with 90 percent of people who have a more advanced diagnosis of cancer experiencing significant amount of pain.
- ❖ Sixty to 80 percent of all cancer patients with bone metastases feel pain.

Causes:

- ❖ Most cancer pain is caused by the effects of cancer itself, the side effects of treatment, compression on bones, nerves or body organs, poor blood circulation, blockage of an organ, metastasis, infection, or inflammation.



The Decade of Pain Control and Research 2001 to 2010



In passing HR 3244, Congress officially declared the ten calendar years beginning on January 1, 2001 to be the Decade of Pain Control and Research. President Clinton signed the bill into law in October, 2000. This is only the second named decade in our history, following the Decade of the Brain in the 1990s.

With this designation, brought about through the efforts of the American Academy of Pain Medicine, the American Headache Society, and the American Pain Society, it was hoped that public attention and funding for research would be focused on an under-recognized but very serious issue.

Yet, at the middle of the decade, we have barely begun.

- ❖ Multi-disciplinary pain management units face program-imperiling budget cuts as health care facilities struggle with declining revenues.
- ❖ Skyrocketing pharmaceutical costs leave some, especially seniors, without the means to acquire the medicines that can help them manage their pain.
- ❖ Abuse of medications by a small number of individuals has refueled fears about addiction and reawakened stigmas that keep many from even asking about pain management medicines.
- ❖ Underserved minorities continue to do without.
- ❖ Most physicians still receive little formal education in diagnosing and treating pain.
- ❖ And myths about pain and our potential for managing it prevail in the general population.

The National Pain Care Policy Act was created to address these and other critical issues surrounding pain management today. Its mandate is create a national focus on the issues pain presents and to raise awareness about the sources of pain and the resources now available to people who suffer.



How a Bill Becomes Law

From the Vote Smart website: http://www.vote-smart.org/resource_govt101_02.php

A. Legislation is Introduced - Any member can introduce a piece of legislation

House - Legislation is handed to the clerk of the House or placed in the hopper.

Senate - Members must gain recognition of the presiding officer to announce the introduction of a bill during the morning hour. If any senator objects, the introduction of the bill is postponed until the next day.

- ❖ The bill is assigned a number. (e.g. HR1 or S1)
- ❖ The bill is labeled with the sponsor's name.
- ❖ The bill is sent to the Government Printing Office and copies are made.
- ❖ Senate bills can be jointly sponsored.
- ❖ Members can cosponsor the piece of Legislation.

B. Committee Action - The bill is referred to the appropriate committee by the Speaker of the House or the presiding officer in the Senate. Most often, the actual referral decision is made by the House or Senate parliamentarian. Bills may be referred to more than one committee and it may be split so that parts are sent to different committees. The Speaker of the House may set time limits on committees. Bills are placed on the calendar of the committee to which they have been assigned. Failure to act on a bill is equivalent to killing it. Bills in the House can only be released from committee *without* a proper committee vote by a discharge petition signed by a majority of the House membership (218 members).

Committee Steps:

1. Comments about the bill's merit are requested by government agencies.
2. Bill can be assigned to subcommittee by Chairman.
3. Hearings may be held.
4. Subcommittees report their findings to the full committee.
5. Finally there is a vote by the full committee - the bill is "ordered to be reported."
6. A committee will hold a "mark-up" session during which it will make revisions and additions. If substantial amendments are made, the committee can order the introduction of a "clean bill" which will include the proposed amendments. This new bill will have a new number and will be sent to the floor while the old bill is discarded. The chamber must approve, change or reject all committee amendments before conducting a final passage vote.
7. After the bill is reported, the committee staff prepares a written report explaining why they favor the bill and why they wish to see their amendments, if any, adopted. Committee members who oppose a bill sometimes write a dissenting opinion in the report. The report is sent back to the whole chamber and is placed on the calendar.
8. In the House, most bills go to the Rules committee before reaching the floor. The committee adopts rules that will govern the procedures under which the bill will be considered by the House. A "closed rule" sets strict time limits on debate and forbids the introduction of amendments. These rules can have a major impact on whether the bill

passes. The rules committee can be bypassed in three ways: 1) members can move rules to be suspended (requires 2/3 vote) 2) a discharge petition can be filed 3) the House can use a Calendar Wednesday procedure.

C. Floor Action

1. Legislation is placed on the Calendar

House: Bills are placed on one of four House Calendars. They are usually placed on the calendars in the order of which they are reported yet they don't usually come to floor in this order - some bills never reach the floor at all. The Speaker of the House and the Majority Leader decide what will reach the floor and when. (Legislation can also be brought to the floor by a discharge petition.)

Senate: Legislation is placed on the Legislative Calendar. There is also an Executive calendar to deal with treaties and nominations. Scheduling of legislation is the job of the Majority Leader. Bills can be brought to the floor whenever a majority of the Senate chooses.

2. Debate

House: Debate is limited by the rules formulated in the Rules Committee. The Committee of the Whole debates and amends the bill but cannot technically pass it. Debate is guided by the Sponsoring Committee and time is divided equally between proponents and opponents. The Committee decides how much time to allot to each person. Amendments must be germane to the subject of a bill - no riders are allowed. The bill is reported back to the House (to itself) and is voted on. A quorum call is a vote to make sure that there are enough members present (218) to have a final vote. If there is not a quorum, the House will adjourn or will send the Sergeant at Arms out to round up missing members.

Senate: debate is unlimited unless cloture is invoked. Members can speak as long as they want and amendments need not be germane - riders are often offered. Entire bills can therefore be offered as amendments to other bills. Unless cloture is invoked, Senators can use a filibuster to defeat a measure by "talking it to death."

3. Vote - the bill is voted on. If passed, it is then sent to the other chamber unless that chamber already has a similar measure under consideration. If either chamber does not pass the bill then it dies. If the House and Senate pass the same bill then it is sent to the President. If the House and Senate pass different bills they are sent to Conference Committee. Most major legislation goes to a Conference Committee.

D. Conference Committee

1. Members from each house form a conference committee and meet to work out the differences. The committee is usually made up of senior members who are appointed by the presiding officers of the committee that originally dealt with the bill. The representatives from each house work to maintain their version of the bill.
2. If the Conference Committee reaches a compromise, it prepares a written conference report, which is submitted to each chamber.
3. The conference report must be approved by both the House and the Senate.

E. The President - the bill is sent to the President for review.

1. A bill becomes law if signed by the President or if not signed within 10 days and Congress is in session.
2. If Congress adjourns before the 10 days and the President has not signed the bill then it does not become law ("Pocket Veto.")
3. If the President vetoes the bill it is sent back to Congress with a note listing his/her reasons. The chamber that originated the legislation can attempt to override the veto by a vote of two-thirds of those present. If the veto of the bill is overridden in both chambers then it becomes law.

F. The Bill Becomes A Law - once a bill is signed by the President or his veto is overridden by both houses it becomes a law and is assigned an official number.

GLOSSARY OF TERMS

House Legislative Calendars

The Union Calendar - Deals with bills that would raise revenues and spending bills (appropriations).

The House Calendar - Deals with public bills that do not raise revenue or appropriate any money or property.

The Consent Calendar - Deals with bills that are not controversial and are passed without debate. This calendar is called on the first and third Monday of each month.

The Private Calendar - Deals with claims against the U.S.

Types of Legislation

Bills - Denoted with HR in the House and S in the Senate and then followed by an assigned number. This is the most common form of legislation.

Private Bill - A bill that deals only with specific private, personal, or local matters other than with general legislative affairs. The main kinds include immigration and naturalization bills (referring to particular individuals) and personal-claim bills.

Public Bill - A legislative bill that deals with matters of general concern. A bill involving defense expenditures is a public bill.

Resolution - HRes or SRes. This type of legislation is adopted only by the house that introduces it, and deals with issues concerning the operation of that house only.

Concurrent Resolutions - H Con Res or S Con Res. This type of legislation does not become law. It deals with issues that relate to internal matters in both the House and the Senate.

Joint Resolutions - HJ Res or SJ Res. These treated much the same as bills with the exception of joint resolutions which propose amendments to the Constitution. A two-thirds

majority in both the House and the Senate must approve proposed amendments, and then the Joint Resolution is sent to the states for ratification instead of the President.

Other Terms

Calendar Wednesday - A procedure of the House of Representatives whereby Wednesdays may be used to call the roll of the standing committees for the purpose of bringing up any of their bills for consideration from the House or Union Calendar.

Cloture - Is a motion in the Senate to limit debate. It takes 60 votes to invoke cloture. Invoking cloture will end a filibuster.

Committee of The Whole - The members of the House of Representatives organized into a committee for the consideration of bills and other matters. Most House business is transacted in the Committee of the Whole so that the formal requirements of its regular sessions, such as having a quorum of one-half the membership, can be avoided.

Co-Sponsor - Additional members (after the original sponsor) who join on to support a bill.

Discharge Petition - In the House, if a committee does not report a bill within 30 days after the measure is referred to it, any member may file a discharge motion. Once offered, the motion is treated as a petition needing the signatures of a majority of members (218 if there are no vacancies). After the required signatures have been obtained, there is a delay of seven days. Thereafter on the second and fourth Mondays of each month, except during the last six days of a session, any member who has signed the petition must be recognized, if he/she so desires, to move that the committee be discharged. Debate on the motion to discharge is limited to 20 minutes, and, if the motion is carried, consideration of the bill becomes a matter of high privilege.

Filibuster - An attempt to defeat a bill in the Senate by talking indefinitely, thus preventing the Senate from doing any other work. From the Spanish *filibustero*, which means a "freebooter," a military adventurer.

Germane - Pertaining to the subject matter of the measure at hand.

Hopper - Box on House Clerk's desk where members deposit bills and resolutions to introduce them.

Morning Hour - The time set aside at the beginning of each legislative day for the consideration of regular, routine business. The "hour" is of indefinite duration in the House, where it is rarely used.

Rider - A provision, unlikely to pass on its own merits, added to an important bill so that it will "ride" through the legislative process.

Sponsor - The original member who introduces a bill.

Veto - The power of a president, governor, or mayor to kill a piece of legislation by not signing it into law. From Latin term *veto* - "I forbid."



HR 1020: NATIONAL PAIN CARE POLICY ACT

A Summary

Section 1: Short Title

Provides that the title of the bill shall be the “National Pain Care Policy Act of 2005.”

Section 2: White House Conference on Pain Care

Authorizes a White House Conference on Pain Care. The purposes of the conference would be to:

- increase the awareness of pain as a significant public health problem;
- assess the adequacy of diagnosis and treatment of pain care;
- identify barriers to appropriate pain care; and
- establish an agenda for the Decade of Pain Control and Research, stimulating public and private sector efforts to improve the state of pain care research, education, and clinical care by the year 2010.

Section 3: National Center for Pain and Palliative Care Research

Establishes a National Center for Pain and Palliative Care Research at the National Institutes of Health. Primary functions of the Center would include:

- Supporting clinical and basic science research into the causes and effective treatments for pain
- Initiating a comprehensive program of collaborative interdisciplinary research among schools, colleges, and universities;
- Establishing a national agenda for conducting and supporting pain research, including acute pain; cancer and HIV-related pain; chronic and intractable pain; and other painful conditions;
- Coordinating all pain research and related activities being carried out at NIH; and
- Issuing an annual report on the state of public and private funding for pain care research.
- Establishes a National Pain and Palliative Care Research Center Advisory Board at NIH.
- Authorizes six regional pain research centers.
- Requires a national consensus conference of prominent researchers and clinicians in the field of pain care research and treatment.

Section 4: Pain Care Education and Training

Requires the Agency for Healthcare Research and Quality (AHRQ) to:

- collect and disseminate protocols and evidence-based practices regarding pain and palliative care clinicians and the general public; and
- fund education and training programs for health care professionals in pain and palliative care.

Section 5: Public Awareness Campaign on Pain Management

Requires the Secretary of DHHS to develop and implement a national outreach and awareness campaign to educate consumers, patients, families and other caregivers on:

- the significance of pain as a national public health problem;
- the risks to patients if pain is not properly treated;
- the availability of treatment options for different types of pain;
- the patient's right to have pain assessed and treated across health care settings; and
- where patients and other consumers can go for help in dealing with pain.

Section 6: Pain Care Initiative in Military Health Facilities

Requires the Secretary of Defense to develop and implement a pain care initiative in all military health care facilities to ensure that all personnel receiving treatment in military health care facilities are assessed for pain at the time of admission or initial treatment, and that they receive appropriate pain care.

Section 7: Pain Care Standards in Medicare Advantage Plans

Requires managed health care plans that offer Medicare Advantage plans to older persons to offer appropriate care for the treatment of patients in pain, including specialty and tertiary care for patients with intractable pain.

Section 8: Pain Care Standards in TRICARE Plans

Requires similar protections for military personnel and dependents enrolled in TRICARE plans.

Section 9: Annual Report on Medicare Expenditures for Pain Care Services

Requires CMS to submit to Congress an annual report on Medicare expenditures for pain and palliative care.

Section 10: Pain Care Initiative in Veterans Health Care Facilities

Requires the Secretary of the VA to develop and implement a pain care initiative in all VA health care facilities to ensure that all veterans receiving treatment in those facilities are assessed for pain at the time of admission or initial treatment, and that they receive appropriate pain care.

National Pain Care Policy Act of 2003 Endorsements

American Academy of Pain Management
American Adhesions Support Group, Inc.
American Chronic Pain Association
American Medical Association
American Pain Foundation
American Society of Anesthesiologists
American Society of Pain Management Nurses
Medtronic
Men's Health Network
National Chronic Pain Society, Inc.
Oncology Nursing Society
Pain Care Coalition

The Full Text of the Bill

108th CONGRESS 1st Session

H. R. 1020

To declare adequate pain care research, education, and treatment as national public health priorities, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

March 1, 2005

Mr. ROGERS of Michigan introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committees on Ways and Means, Armed Services, and Veterans' Affairs, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

To declare adequate pain care research, education, and treatment as national public health priorities, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE- This Act may be cited as the `National Pain Care Policy Act of 2005.

(b) TABLE OF CONTENTS- The table of contents of this Act is as follows:

Sec. 1. Short title; table of contents.

Sec. 2. White House Conference on Pain Care.

Sec. 3. National Center for Pain and Palliative Care Research.

Sec. 4. Pain care education and training.

Sec. 5. Public awareness campaign on pain management.

Sec. 6. Pain care initiative in military health care facilities.

Sec. 7. Pain care standards in Medicare Advantage plans.

Sec. 8. Pain care standards in TRICARE plans.

Sec. 9. Annual report on Medicare expenditures for pain care services.

Sec. 10. Pain care initiative in veterans health care ----facilities.

SEC. 2. WHITE HOUSE CONFERENCE ON PAIN CARE.

(a) CONVENING- Not later than June 30, 2006, the President shall convene a conference to be known as the White House Conference on Pain Care (in this section referred to as the 'Conference').

(b) PURPOSES- The purposes of the Conference shall be to--

(1) increase the recognition of pain as a significant public health problem in the United States;

(2) assess the adequacy of diagnosis and treatment for primary and secondary pain, including acute, chronic, intractable, and end-of-life pain;

(3) identify barriers to appropriate pain care, including--

(A) lack of understanding and education among patients, providers, regulators, and third-party payors;

(B) barriers to access to care at the primary, specialty, and tertiary care levels; and

(C) gaps in basic and clinical research on the symptoms and causes of, and potential treatments to improve, pain care; and

(4) establish an agenda for action in both the public and private sectors that will reduce such barriers and significantly improve the state of pain care research, education, and clinical care in the United States by 2010.

(c) CHAIR- The Secretary of Health and Human Services shall serve as the chair of the Conference.

(d) AUTHORIZATION OF APPROPRIATIONS- For the purpose of carrying out this section, there are authorized to be appropriated such sums as shall be necessary for fiscal year 2006.

SEC. 3. NATIONAL CENTER FOR PAIN AND PALLIATIVE CARE RESEARCH.

(a) ESTABLISHMENT- Section 401(b)(2) of the Public Health Service Act (42 U.S.C. 281(b)(2)) is amended by adding at the end the following:

(H) The National Center for Pain and Palliative Care Research.'.

(b) OPERATION- Part E of title IV of the Public Health Service Act (42 U.S.C. 287 et seq.) is amended by adding at the end the following:

Subpart 7--National Center for Pain and Palliative Care Research

SEC. 485I. ESTABLISHMENT.

(a) ESTABLISHMENT- The Secretary shall establish within the National Institutes of Health a center to be known as the National Center for Pain and Palliative Care Research (referred to in this subpart as the 'Center').

(b) DIRECTOR- The Center shall be headed by a Director (referred to in this subpart as the 'Director of the Center'), who shall be appointed by the Director of NIH after consultation with experts in the fields of pain and palliative care research and treatment.

(c) POWERS OF SECRETARY AND DIRECTOR- For purposes of section 405, the Center shall be treated as a national research institute.

(d) GENERAL PURPOSES- The general purposes of the Center are--

(1) to improve the quality of life of individuals suffering from pain by fostering clinical and basic science research into the biology of pain and the causes of and effective treatments for pain;

(2) to establish a national agenda for conducting and supporting pain and palliative care research in the specific categories described in paragraphs (3) and (4);

(3) to identify, coordinate, and support research, research training, and related activities (including the development of new and the refinement of existing treatments) with respect to both primary and secondary pain, including--

(A) acute pain;

(B) cancer and HIV-related pain, particularly at the end of life;

(C) back pain, headache pain, and other chronic and intractable pain; and

(D) other painful conditions;

(4) to identify, coordinate, and support research, research training, and related activities with respect to palliative care;

(5) to conduct and support pain and palliative care research, research training, and related activities that have been identified as requiring additional, special priority as determined appropriate by the Director of the Center and the Advisory Board established under subsection (e);

(6) to coordinate all pain and palliative care research, research training, and related activities being carried out among the national research institutes or in any such institute;

(7) to ensure the prompt and effective dissemination of current and future research results to improve patient access to and provider delivery of pain and palliative care;

(8) to initiate a comprehensive program of collaborative interdisciplinary research among schools, colleges, and universities, including schools of medicine and osteopathy, schools of pharmacy and pharmacology, schools of nursing, schools of dentistry, schools of physical therapy, schools of occupational therapy, and schools of clinical psychology, comprehensive health care centers and systems, and specialized centers of pain research or treatment; and

(9) to report not less than annually on the state of public and private funding for pain and palliative care research and the adequacy of such funding, taking into account the specific categories described in paragraphs (3) and (4).

(e) ADVISORY COUNCIL-

(1) IN GENERAL- The Center shall have an advisory council to be known as the National Pain and Palliative Care Research Center Advisory Board (in this section referred to as the 'Advisory Board').

(2) MEMBERSHIP- The Advisory Board shall be established and maintained in accordance with section 406, except that--

(A) the appointed voting members shall include--

(i) representatives of the broad range of medical, health, and scientific disciplines involved in research and treatment related to the categories of pain and palliative care described in paragraphs (3) and (4) of subsection (d), including individuals with expertise and training in pain medicine, clinical psychology, physical medicine, and rehabilitative services (including physical therapy and occupational therapy), pharmacy and pharmacology, nursing, and dentistry; and

(ii) representatives of painful patients; and

(B) the nonvoting ex officio members shall include--

(i) the Director of the National Cancer Institute;

(ii) the Director of the National Institute of Dental and Craniofacial Research;

(iii) the Director of the National Institute of Child Health and Human Development;

(iv) the Director of the National Institute of Nursing Research;

(v) the Director of the National Institute of Allergy and Infectious Diseases;

(vi) the Director of the National Institute of Arthritis and Musculoskeletal and Skin Diseases;

(vii) the Director of the National Institute of Mental Health;

(viii) the Director of the National Institute of Neurological Disorders and Stroke;

(ix) the Director of the National Institute on Drug Abuse;

(x) the Director of the National Institute on Disability and Rehabilitation Research;

(xi) the Director of the National Institute of Biomedical Imaging and Bioengineering; and

(xii) the Director of the National Bioethics Advisory Commission.

(3) DUTIES- The Advisory Board shall advise, assist, consult with, and make recommendations to the Director of the Center regarding the matters set forth in subsection (d), including coordination, research, funding, and purposes.

(f) ESTABLISHMENT OF REGIONAL PAIN RESEARCH CENTERS-

(1) ESTABLISHMENT- To facilitate and enhance the research, research training, and related activities to be carried out by the Center, the Director of NIH, in consultation with the Director of the Center and the Advisory Board, shall establish not less than 6 regional pain research centers, which shall operate as part of the Center.

(2) FOCUS AND DISTRIBUTION-

(A) FOCUS- Not less than 4 of the regional centers established under paragraph (1) shall have as their primary focus 1 of the categories of pain described in subparagraphs (A), (B), and (C) of subsection (d)(3).

(B) DISTRIBUTION- One regional pain research center shall be established in each of the following regions of the United States (as such regions are determined by the Director of the Center):

(i) The Northeast region.

- (ii) The Southeast region.
- (iii) The Midwest region.
- (iv) The Southwest region.
- (v) The West region, including Hawaii.
- (vi) The Pacific Northwest region, including Alaska.

(3) SELECTION- The regional centers shall be selected through a competitive process from among institutions and centers of the type described in subsection (d)(8).

(g) ANNUAL CONSENSUS CONFERENCE ON PAIN AND PALLIATIVE CARE RESEARCH- To assist the Center in the establishment and maintenance of a national agenda for pain and palliative care research, and to ensure that the Center remains abreast of research and clinical developments in both the public and private sectors, the Director of the Center shall convene each year a consensus conference of prominent researchers and clinicians in the field of pain and palliative care research and treatment.

(h) AUTHORIZATION OF APPROPRIATIONS-

(1) IN GENERAL- For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for fiscal year 2006 and each subsequent fiscal year.

(2) REGIONAL CENTERS- Of the amount appropriated under paragraph (1) for fiscal year 2006 and each subsequent fiscal year, not less than \$1,500,000 shall be made available to each of the regional centers established under subsection (f).!

SEC. 4. PAIN CARE EDUCATION AND TRAINING.

(a) PAIN AND PALLIATIVE CARE RESEARCH AND QUALITY- Part A of title IX of the Public Health Service Act (42 U.S.C. 299 et seq.) is amended by adding at the end the following:

SEC. 904. PROGRAM FOR PAIN AND PALLIATIVE CARE RESEARCH AND QUALITY.

(a) IN GENERAL- The Director shall carry out a program to--

(1) develop and advance the quality, appropriateness, and effectiveness of pain and palliative care; and

(2) collect and disseminate protocols and evidence-based practices regarding pain and palliative care, including pain care for terminally ill patients, and make such information available to Federal, State, and local regulatory and enforcement agencies, public and private health care

programs, payors and providers, health professions schools, hospices, and the general public.

(b) DEFINITIONS- For purposes of this section:

(1) The term `palliative care' means the comprehensive active, total care of patients whose disease or medical condition is not responsive to curative treatment or whose prognosis is limited due to progressive, far-advanced disease. Palliative care includes treatment to reduce or alleviate pain and other distressing signs and symptoms. The purpose of such care is to eliminate, alleviate, or manage the patient's pain and suffering and thereby enhance the quality of life.

(2) The term `pain care' means the evaluation, diagnosis, treatment, and management of primary and secondary pain, whether acute, chronic, persistent, intractable, or associated with the end of life.'

(b) EDUCATION AND TRAINING IN PAIN AND PALLIATIVE CARE- Part D of title VII of the Public Health Service Act (42 U.S.C. 294 et seq.) is amended--

(1) by redesignating sections 754 through 757 as sections 755 through 758, respectively; and

(2) by inserting after section 753 the following:

SEC. 754. PROGRAM FOR EDUCATION AND TRAINING IN PAIN AND PALLIATIVE CARE.

(a) IN GENERAL- The Secretary, in consultation with the Director of the Agency for Healthcare Research and Quality, may make awards of grants, cooperative agreements, and contracts to health professions schools, hospices, and other public and private entities for the development and implementation of programs to provide education and training to health care professionals in pain and palliative care.

(b) PRIORITIES- In making awards under subsection (a), the Secretary shall give priority to awards for the implementation of programs under such subsection.

(c) CERTAIN TOPICS- An award may be made under subsection (a) only if the applicant for the award agrees that the program carried out with the award will include information and education on--

(1) professionally recognized means for diagnosing and treating pain and related signs and symptoms, including the medically appropriate use of controlled substances;

(2) applicable laws on controlled substances, including the degree to which misconceptions concerning such laws or the enforcement thereof may create barriers to patient access to appropriate and effective pain care;

(3) comprehensive interdisciplinary approaches to the delivery of pain and palliative care, including delivery through specialized centers of pain care treatment expertise; and

(4) recent findings, developments, and improvements in the provision of pain and palliative care.

(d) PROGRAM SITES- Education and training under subsection (a) may be provided at or through health professions schools, residency training programs, and other graduate programs in the health professions, entities that provide continuing medical and pharmacy education, hospices, and such other programs or sites as the Secretary determines to be appropriate.

(e) EVALUATION OF PROGRAMS- The Secretary shall (directly or through grants or contracts) provide for the evaluation of programs implemented under subsection (a) in order to determine the effect of such programs on knowledge and practice regarding pain and palliative care.

(f) PEER REVIEW GROUPS- In carrying out section 799(f) with respect to this section, the Secretary shall ensure that the membership of each peer review group involved includes individuals with expertise and experience in pain and palliative care.

(g) DEFINITIONS- For purposes of this section:

(1) The term 'palliative care' means the comprehensive active, total care of patients whose disease or medical condition is not responsive to curative treatment or whose prognosis is limited due to progressive, far-advanced disease. Palliative care includes treatment to reduce or alleviate pain and other distressing signs and symptoms. The purpose of such care is to eliminate, alleviate, or manage the patient's pain and suffering and thereby enhance the quality of life.

(2) The term 'pain care' means the evaluation, diagnosis, treatment, and management of primary and secondary pain, whether acute, chronic, persistent, intractable, or associated with the end of life.'

(c) AUTHORIZATION OF APPROPRIATIONS- Section 758 of the Public Health Service Act (as redesignated by subsection (a)(1) of this section) is amended in subsection (b)(1)(C)--

(1) by striking 'sections 753, 754, and 755' and inserting 'section 753, 754, 755, and 756'; and

(2) by striking '\$22,631,000' and inserting '\$37,631,000'.

(d) TECHNICAL AMENDMENT- Paragraph (2) of section 757(b) of the Public Health Service Act (as redesignated by subsection (a)(1)) is amended by striking '754(3)(A), and 755(b)' and inserting '755(3)(A), and 756(b)'.

SEC. 5. PUBLIC AWARENESS CAMPAIGN ON PAIN MANAGEMENT.

Part B of title II of the Public Health Service Act (42 U.S.C. 238 et seq.) is amended by adding at the end the following:

NATIONAL EDUCATION OUTREACH AND AWARENESS CAMPAIGN ON PAIN MANAGEMENT

SEC. 249. (a) ESTABLISHMENT- Not later than June 30, 2006, the Secretary shall establish and implement a national education outreach and awareness campaign described in subsection (b) to provide information to the public on responsible pain management, related symptom management, and palliative care.

(b) REQUIREMENTS- The Secretary shall design the public awareness campaign under this section to educate consumers, patients, their families, and other caregivers with respect to--

- (1) the incidence and importance of pain as a national public health problem;
- (2) the adverse physical, psychological, and financial consequences that can result if pain is not appropriately diagnosed or treated;
- (3) the availability, benefits, and risks of all pain management and palliative care treatment options;
- (4) the right of patients to have their pain promptly assessed, appropriately treated, and regularly reassessed, and to have their treatment adjusted if needed;
- (5) the availability in the public, non-profit, and private sectors of pain management-related information, services and resources for consumers, patients, their families, and other caregivers, including information on--
 - (i) appropriate assessment, diagnosis and treatment options for all types of pain and pain-related symptoms; and
 - (ii) conditions for which no widely accepted treatment options are yet available; and
- (6) other issues the Secretary deems appropriate.

(c) COORDINATION-

- (1) LEAD OFFICIAL- The Secretary shall designate one official in the Department of Health and Human Services to oversee the campaign established under this section.
- (2) AGENCY COORDINATION- The Secretary shall ensure the involvement in the public awareness campaign under this section of the Surgeon General of the Public Health Service, the Director of the Centers for Disease Control and Prevention, and such other representatives of

offices and agencies of the Department of Health and Human Services as the Secretary determines appropriate.

(d) **UNDERSERVED POPULATIONS-** In designing the public awareness campaign under this section, the Secretary shall take into account the need to reach underserved populations who are disproportionately under-treated for pain.

(e) **GRANTS AND CONTRACTS-** The Secretary may make awards of grants, cooperative agreements, and contracts to public agencies and private non-profit organizations to assist with the development and implementation of the public awareness campaign under this section.

(f) **AUTHORIZATION OF APPROPRIATIONS-** For purposes of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of fiscal years 2006, 2007, and 2008.

SEC. 6. PAIN CARE INITIATIVE IN MILITARY HEALTH CARE FACILITIES.

(a) **REQUIREMENT-** Chapter 55 of title 10, United States Code, is amended by adding at the end the following new section:

Sec. 1111. Pain care

The administering Secretaries shall develop and implement a pain care initiative in all health care facilities of the uniformed services. Implementation shall occur no later than January 1, 2006, in the case of inpatient care, and January 1, 2007, in the case of outpatient care. The initiative shall be designed to ensure that all members of the uniformed services and their dependents receiving treatment in health care facilities of the uniformed services--

(1) are assessed for pain at the time of admission or initial treatment, and periodically thereafter, using a professionally recognized pain assessment tool or process; and

(2) receive appropriate pain care consistent with recognized guidelines and practice parameters for the assessment and treatment of primary and secondary pain, including acute, chronic, and intractable pain.'

(b) **CLERICAL AMENDMENT-** The table of sections at the beginning of such chapter is amended by adding at the end the following new item:

1111. Pain care.'

SEC. 7. PAIN CARE STANDARDS IN MEDICARE ADVANTAGE PLANS.

(a) **IN GENERAL-** Section 1852(a) of the Social Security Act (42 U.S.C. 1395w-22(a)) is amended by adding at the end the following new paragraph:

(6) **PAIN CARE STANDARDS-**

(A) IN GENERAL- Each Medicare Advantage organization shall provide appropriate care for the treatment of patients in pain that--

(i) is consistent with recognized guidelines and practice parameters for the assessment and treatment of primary and secondary pain, including acute, chronic, and intractable pain;

(ii) includes evaluation and treatment of illnesses that frequently accompany serious pain, including depression, other mental health disorders, sleep disturbance, and substance abuse;

(iii) provides medical and other health services through physicians and other practitioners credentialed or experienced in pain medicine;

(iv) provides for referral of patients with chronic pain as defined in subparagraph (B)(i) to specialists, and, where appropriate, to a comprehensive multidisciplinary pain management program as defined in subparagraph (B)(ii);

(v) continues treatment for as long as treatment is required to maximize the quality of life and functional capacity of the patient; and

(vi) permits physicians and other practitioners experienced or credentialed in pain medicine to make clinical decisions with respect to the need for and the extent and duration of pain care services.

(B) DEFINITIONS- For purposes of this paragraph:

(i) CHRONIC PAIN- The term 'chronic pain' means severe, persistent, or recurrent pain that interferes with the activities of daily living, and has not been significantly reduced or ameliorated despite reasonable treatment efforts for a period of 6 months.

(ii) COMPREHENSIVE MULTIDISCIPLINARY PAIN MANAGEMENT PROGRAM- The term 'comprehensive multidisciplinary pain management program' means an inpatient or outpatient health care facility or program that--

(I) provides at least medical, nursing, mental health, and rehabilitation services through licensed health care professionals;

(II) provides or arranges for the provision of inpatient and outpatient hospital and rehabilitation facility services,

drugs, devices, and other items and services required for the treatment of chronic pain;

(III) provides ongoing patient and professional education for pain management;

(IV) is accredited as a comprehensive pain management program by an accrediting organization approved by the Secretary, including the Joint Commission on the Accreditation of Health Care Organizations or the Rehabilitation Accreditation Commission; and

(V) is directed by 1 or more physicians credentialed in pain medicine, or, where appropriate, dentistry, by a board or boards approved by the Secretary, which shall include the American Board of Pain Medicine and boards recognized by the American Board of Medical Specialists.

(C) COMPLIANCE- A Medicare Advantage organization may comply with the requirements set forth in this paragraph by providing care through its own network of participating providers, or under arrangement with out-of-network providers, but in no event may an organization impose higher costs on its enrollees in the form of deductibles, copayments, premiums, or otherwise in the event appropriate pain care in accordance with the standards set forth in this paragraph is provided out-of-network.'

(b) EFFECTIVE DATE- The amendment made by subsection (a) shall apply to contracts with Medicare Advantage organizations as of January 1, 2006.

SEC. 8. PAIN CARE STANDARDS IN TRICARE PLANS.

(a) IN GENERAL- Section 1097 of title 10, United States Code, is amended by adding at the end the following new subsection:

(f) PAIN CARE STANDARDS-

(1) IN GENERAL- Any health care services provided pursuant to any contract entered into under this section shall include the provision of appropriate care for the treatment of patients in pain that--

(A) is consistent with recognized guidelines and practice parameters for the assessment and treatment of primary and secondary pain, including acute, chronic, and intractable pain;

(B) includes evaluation and treatment of illnesses that frequently accompany serious pain, including depression, other mental health disorders, sleep disturbance, and substance abuse;

(C) provides medical and other health services through physicians and other practitioners credentialed or experienced in pain medicine;

(D) provides for referral of patients with chronic pain to specialists, and, where appropriate, to a comprehensive multidisciplinary pain management program;

(E) continues treatment for as long as treatment is required to maximize the quality of life and functional capacity of the patient; and

(F) permits physicians and other practitioners experienced or credentialed in pain medicine to make clinical decisions with respect to the need for and the extent and duration of pain care services.

(2) DEFINITIONS- For purposes of this subsection--

(A) The term 'chronic pain' means severe, persistent, or recurrent pain that interferes with the activities of daily living, and has not been significantly reduced or ameliorated despite reasonable treatment efforts for a period of 6 months.

(B) The term 'comprehensive multidisciplinary pain management program' means an inpatient or outpatient health care facility or program that--

(i) provides at least medical, nursing, mental health, and rehabilitation services through licensed health care professionals;

(ii) provides or arranges for the provision of inpatient and outpatient hospital and rehabilitation facility services, drugs, devices, and other items and services required for the treatment of chronic pain;

(iii) provides ongoing patient and professional education for pain management;

(iv) is accredited as a comprehensive pain management program by an accrediting organization approved by the Secretary, including the Joint Commission on the Accreditation of Health Care Organizations or the Rehabilitation Accreditation Commission; and

(v) is directed by 1 or more physicians credentialed in pain medicine, or, where appropriate, dentistry, by a board or boards approved by the Secretary, which shall include the American Board of Pain Medicine and boards recognized by the American Board of Medical Specialists.

(3) COMPLIANCE- A contractor may comply with the requirements set forth in this subsection by providing care through its own network of participating

providers, or under arrangement with out-of-network providers, but in no event may a contractor impose higher costs on its enrollees in the form of deductibles, copayments, premiums, or otherwise in the event appropriate pain care in accordance with the standards set forth in this subsection is provided out of network.'.

(b) EFFECTIVE DATE- The amendment made by subsection (a) shall apply to contracts as of January 1, 2006.

SEC. 9. ANNUAL REPORT ON MEDICARE EXPENDITURES FOR PAIN CARE SERVICES.

Not later than December 31, 2006, and annually thereafter, the Administrator of the Centers for Medicare & Medicaid Services shall prepare and submit to the Congress a report on medicare expenditures for pain care during the preceding fiscal year. The report shall include the following:

- (1) An estimate of total payments made under part B of the medicare program to physicians specializing in pain medicine.
- (2) An estimate of payments made under such part B to other providers and suppliers for the provision of pain care items and services.
- (3) An estimate of expenditures made under part A of the medicare program for the diagnosis and treatment of pain of inpatients, and an estimate of the percentage of such care that relates to end-of-life care.
- (4) An estimate of expenditures under part C of the medicare program for the provision of pain care items and services through the Medicare Advantage program.
- (5) An estimate of out-of-pocket expenditures by medicare beneficiaries for both prescription and nonprescription pain medications not covered by the medicare program.
- (6) An analysis of trends in both medicare program and medicare beneficiary expenditures for pain care items and services.

SEC. 10. PAIN CARE INITIATIVE IN VETERANS HEALTH CARE FACILITIES.

(a) REQUIREMENT- Subchapter II of chapter 17 of title 38, United States Code, is amended by adding at the end the following new section:

Sec. 1720F. Pain care

The Secretary shall develop and implement a pain care initiative in all health care facilities of the Department. The initiative shall be designed to ensure that each individual receiving treatment in a health care facility under the jurisdiction of the Secretary--

(1) is assessed for pain at the time of admission or initial treatment, and periodically thereafter, using a professionally recognized pain assessment tool or process; and

(2) receives appropriate pain care consistent with recognized guidelines and practice parameters for the diagnosis and treatment of primary and secondary-pain, including acute, chronic, and intractable pain.!

(b) CLERICAL AMENDMENT- The table of sections at the beginning of such chapter is amended by inserting after the item relating to section 1720E the following new item:

`1720F. Pain care.!

(c) IMPLEMENTATION- The Secretary of Veterans Affairs shall implement the pain care initiative required by section 1720F of title 38, United States Code, as added by subsection (a) not later than--

(1) January 1, 2006, in the case of inpatient care; and

(2) January 1, 2007, in the case of outpatient care.

END



Americans Living With Pain Survey (2004)

This 2004 survey was conducted by Roper Public Affairs and Media, on behalf of the American Chronic Pain Association (ACPA) with support from Endo Pharmaceuticals. The survey findings are based on 800 telephone interviews conducted with adults experiencing chronic pain in the United States.

The purpose of this survey was to ascertain:

- ❖ How pain impacts the quality of life for people living with pain.
- ❖ The extent of their communication with doctors.
- ❖ Perceptions and use of various treatment options.

Key Findings:

- ❖ Chronic pain is a serious health condition that some have been living with for a relatively long time and, in most cases, facing it daily.
- ❖ Nearly one half of respondents say their pain is not under control – in particular, those whose pain is ever present, men, and those who are middle aged.
- ❖ Among those who reported having chronic pain, age does not play a significant role in reporting back pain – the most prevalent type of pain. Similar proportions of younger (56% of 18 – 34 year olds), middle aged (50% of 35 – 64 year olds) and older (49% of 65 + year olds) report their back is where they feel the most pain.
- ❖ Those with chronic pain experience difficulties on the job and their personal relationships suffer due to their condition.
- ❖ Chronic pain adversely affects quality of life for people with pain – both in terms of their day-to-day activities and their emotional well-being.
- ❖ People’s attitude toward their pain when it first develops is quite casual. Although, nearly half talk to a doctor about it within a month, nearly as many wait longer with a significant number waiting for over 3 months.
- ❖ Those with chronic pain are just as likely to be taking an OTC medication as an Rx medication; relatively few are only using alternative treatments.
- ❖ Exclusive OTC usage is mainly a function of the nature of the user’s pain, product performance, and financial considerations.

- ❖ Nearly all of those with chronic pain turn to alternative treatments regardless of the medications they are using or the nature of their pain. This would indicate that current Rx and OTC medications by themselves are not providing as much relief as desired or that such usage helps ease the financial burden of treatment.
- ❖ Significant numbers of those with chronic pain have concerns about taking pain medications; their concerns range from potential side effects, the medication being addictive, the need for increased usage over time and the possibility of having to take them for the rest of their lives. Such concerns are higher among women and those who are not exclusive Rx users and vary based on the age of the individual.
- ❖ There is hesitancy to take a narcotic pain reliever among a significant number of those currently taking a Rx medication for their pain, especially among women and those taking OTC medication along with their prescription medication.
- ❖ Those using both Rx and OTC medication for their pain are more likely to be experiencing side effects from the medication than exclusive Rx users. This dual treatment may be required, since the pain being treated this way affects a wider range of everyday activities and relationships with other people than the pain being treated differently.
- ❖ Other factors affecting treatment include the high incidence of taking Rx medication for other health conditions, the belief or possibility that their access to Rx pain medication might be more difficult in the future, as well as currently not getting their Rx prescriptions filled due to financial considerations, especially among those with ever present pain.
- ❖ Most of those with chronic pain do not know if a prescription patch product can provide the same amount of relief as a Rx oral pain medication, primarily because they do not know enough about them and how they work.
- ❖ Non-compliance is a major issue in taking RX medication for pain, especially among those taking both Rx and OTC medications. Side effects and financial factors are the primary causes.

America Speaks: Pain in America (2003)

This 2003 survey was conducted by Peter D. Hart Research Associates as a nationwide survey for Research!America. The purpose of this study was to assess the view of Americans about pain in America. The survey's objectives included gauging Americans' perceptions of how pain sufferers and the medical community deal with the problems of chronic pain.

Key Findings:

- ❖ Much of America is hurting: The majority of adults (57%) in this country have experienced chronic or recurrent pain in the past year.
- ❖ Significant numbers of current pain sufferers have had to make real changes in their lifestyles to accommodate their pain.
- ❖ Levels of sympathy vary, but overall, most people who interact with a chronic pain sufferer on a daily basis are supportive, say the sufferers themselves.
- ❖ Nine in ten current pain sufferers have consulted some type of medical professional to try to ease their pain, and these professionals have prescribed everything from over-the-counter medications to surgery-with mixed results, according to survey respondents.
- ❖ An important disconnect exists between Americans' personal experience with pain and the broad general attitude of society.
- ❖ After all the lifestyle changes, doctor visits, and treatments, people still think that more could be done. In the end, there is hope that long-term remedies can be found and a willingness to fund research toward that end.

Americans in Pain

- ❖ Of the individuals suffering with chronic pain more than three in five have been in pain for more than a year and back pain is the most common type.
- ❖ Individuals under the age of 35 are about as likely as older Americans to have experienced pain.

Dealing with Pain

- ❖ When asked how their pain has affected day-to-day life, three-quarters (75%) of current pain sufferers acknowledge that they have had to make adjustments, including 33% who say they have had to make major adjustments.
- ❖ Among the major adjustments that chronic pain sufferers have made are such serious steps as taking disability leave from work (20%), changing jobs altogether (17%),

getting help with activities of daily living (13%) and moving to a home that is easier to manage (13%).

Do You Feel My Pain?

- ❖ Family members are among the most helpful to chronic pain sufferers. Three in four pain sufferers say that their spouse or significant other is generally supportive and helpful.
- ❖ Doctors (72% supportive and helpful) get high marks, but bosses (51%) earn mixed reviews. In fact, (16%) of pain sufferers who have a boss say that their boss is indifferent and tends to ignore them when the subject of pain comes up.

A Visit to the Doctor

- ❖ Most pain sufferers (63%) have seen their family doctor for help.
- ❖ Forty percent made an appointment with a specialist, such as an orthopedist.
- ❖ Twenty Five percent have visited a chiropractor or a doctor that specializes in pain management (15%).
- ❖ While 43% of pain sufferers have been to only one type of doctor for their pain, a large proportion (38%) have consulted more than one practitioner in the medical community.
- ❖ Treatments for pain have yielded mixed results. Although 58% of those who took prescription medication say that doing so was very fairly effective for their pain, only 41% of those who took over-the-counter medications experienced the same relief. Chiropractic treatments proved effective for 54% of pain sufferers who tried them, while more standard physical therapy was effective for 48%. Fifty-four percent of pain sufferers who had surgery say that it was effective.
- ❖ Overall, 58% of current chronic pain sufferers say that they are very somewhat satisfied with the treatment of their pain.

The Pain Paradox

- ❖ As prevalent and significant as chronic pain is in our society, findings suggest that Americans rate chronic pain as the least problematic item on a list of health issues that includes cancer, obesity, heart disease, alcohol and drug abuse and AIDS.
- ❖ Americans downplay their experience with pain.
- ❖ An overwhelming 84% of adults believe that a person's state of mind influences the experience of physical pain a great deal or a fair amount, suggesting that a person can control his or her pain.

- ❖ In terms of health care costs, people feel by more than two to one that over reacting to one's pain drives up costs more than does under reacting.

The Pain Gap

- ❖ Two-thirds of pain sufferers expect to have to live with at least some pain for the rest of their life, compared with only 30% who expect to become pain-free because of a cure or as a result of treatment medications.
- ❖ Among non-pain sufferers with a close family member or friend who has chronic pain or recurrent pain, a majority (53%) feel that more can be done to ease their loved one's pain.
- ❖ Seven in ten Americans feel that pain research and management should be one of the medical community's top few priorities (16%) or a high priority (55%)
- ❖ Almost six in 10 adults (57%) say they would be willing to pay one dollar more per week in taxes to increase federal funding for the scientific research into the causes and treatment of pain.

Lost Productive Time and Cost Due to Common Pain Conditions in the US Workforce (2003)

Study by Walter Stewart, PhD, MPH (JAMA, 290:2443-2454, 2003)

Data from the American Productivity Audit, a computer assisted telephone survey of health and work, of 28,902 working adults between August, 2001 and July 2002, was used to estimate lost productive time due to headache, arthritis, back pain, and other musculoskeletal conditions expressed in hours per worker per week and calculated in US dollars. Stewart and colleagues evaluated the impact of pain on productivity by estimating lost productive time and economic cost due to painful conditions.

Key Findings:

- ❖ Over half (52.7%) of the workforce surveyed reported having headache, back pain, arthritis, or other musculoskeletal pain in the past two weeks, and 12.7% of all workforce lost productive time in a two-week period due to pain.
- ❖ Headache (5.4%) was the most common pain condition prompting lost productive time: followed by back pain (3.2%), arthritis pain (2%) and other musculoskeletal pain (2%).
- ❖ Overall, workers lost an average of 4.6 hours per week of productive time due to a pain condition.
- ❖ Other musculoskeletal pain (5.5 hours/week) and arthritis or back pain (5.2 hours/week) produced the largest amounts of lost productive time.
- ❖ Headache produced, on average, 3.5 hours of lost productive time per week.
- ❖ Age did not seem to attenuate the findings.
- ❖ Lost productive time from common painful conditions was estimated to be \$61.2 billion per year, while 76.6% of lost productive time was explained by reduced work performance, not absenteeism.

A Survey of Pain in America (2002)

On November 14, 2000, Partners Against Pain, the educational arm of Purdue Pharma, released the findings of a survey of 1,000 pain patients.

Key Findings

- ❖ At least one member of almost half of America's 44 million households (43 percent) suffers from chronic pain due to a specific illness or medical condition.
- ❖ Eighty percent of patients surveyed thought that their pain was a normal part of their medical condition and something with which they must live.
- ❖ For one third of sufferers, their chronic pain was so severe and debilitating, they felt they couldn't function as normal people and sometimes felt so bad they wanted to die.
- ❖ Some 40% said they were uncomfortable discussing their pain and 37% said they felt isolated and alone.
- ❖ One-third of sufferers did not believe people understood how much pain they were in, and one quarter said their families were tired of hearing about it.
- ❖ Fifty six percent of pain patients said that pain interfered with their sleeping, 51 percent said it interfered with their mood; 30% their ability to drive; and 28% their ability to have sexual relations.
- ❖ Those not completely happy with their doctors cited unsuccessful treatment (62%) as the main reason.
- ❖ Patients were so dissatisfied with the efficacy of their prescription and OTC pain control medications that 78% were willing to try new treatments, and 43% said they would spend all their money if they thought it would work.
- ❖ Two thirds said their OTC medications were not effective, and 52% of those taking prescription medications said they were not effective.

Pain in Maryland (2002)

Pain in Maryland was conducted for the American Pain Foundation and the Maryland Pain Initiative by Mason-Dixon Polling & Research, Inc. from February 7-11, 2002. A total of 625 Maryland adults were interviewed statewide by telephone.

Key Findings:

Incidence and Frequency of Pain

- ❖ Nearly half (49%) of all Marylanders suffer from pain. One in three (34%) say that they live with moderate to severe pain.
- ❖ Approximately 1.4 million households (66%) in Maryland have at least one person suffering with pain.
- ❖ As many as 49% say they experience some form of pain on at least a monthly basis. Of these respondents, 40% say that they experience pain everyday, or almost everyday.

Impact of Pain

- ❖ Pain causes the majority of pain sufferers (68%) to feel anxious, irritable, or depressed.
- ❖ More than half of those with pain (59%) say that their pain interferes with their ability to sleep.
- ❖ Forty percent of those with pain say that their pain interferes with their productivity and ability to work.
- ❖ Thirty-one percent of pain sufferers say that their pain interferes with their sexual relations, and 21% say it negatively affects relationships with friends and family.
- ❖ Twenty-five percent of pain sufferers say that their pain causes them to feel helpless and alone.

Attitudes Towards Pain

- ❖ More than half of respondents (65%) say that pain is just something they have to live with or it's just a part of growing old.
- ❖ Sixty-one percent of respondents said that people don't seek help because they are embarrassed and don't want to seem like they are complaining.
- ❖ As many as 78% of those who say they suffer from regular pain, say they have never been referred to a pain specialist.

Pain in America: A Research Report (1999-2000)

One of the most often cited pain surveys, Pain in America was developed for Merck by Ogilvy Public Relations. The survey was conducted in May and June of 1999 by the Gallup Organization. The findings were released on April 6, 2000, by the Arthritis Foundation, the Society of Aging, Business and Professional Women USA, General Foundation of Women's Clubs, MANA (a national Latina organization), and the National Council of Negro Women.

Key Findings:

- ❖ Nine in ten Americans suffered from regular pain (89% reported they have some sort of pain on a monthly or more often basis).
- ❖ Close to 26 million Americans suffered from severe pain. Fifteen percent who experienced pain once a month or more, reported severe pain (this equates to close to 26 million Americans). Forty-six percent reported moderate pain.
- ❖ Close to 42% said they experienced pain daily.
- ❖ On an average, people with moderate to severe pain have lived with it for close to 1.5 years.

Impact of Attitudes Towards Pain:

- ❖ Eighty-three million Americans reported that pain frequently affects their participation in some activities. Forty-three percent of respondents reported that pain affected participation in some activities. Activities most likely to be affected are bending, stooping, or kneeling.
- ❖ Thirty-six million Americans have missed work in the past year due to pain.
- ❖ Fatigue and frustration are commonly associated with pain.
- ❖ Four in five Americans believed aches and pains were a part of getting older and 64% would only see a doctor when they could not stand the pain any longer. Sixty percent said that pain was something you just have to live with, and 55% said they were uncomfortable taking medications. Fifty-four percent said they prefer being alone when they were in pain, and 50% said they were in a bad mood when in pain. Twenty-eight percent said they felt there was no solution for their pain.

Managing Pain

- ❖ Forty-three percent of respondents said they have complete control of their pain. Those with moderate to severe pain reported having less control.
- ❖ Many Americans saw a doctor for pain. Fifty-one percent saw a doctor in the three years prior to the survey.
- ❖ Forty-two percent said they were satisfied that their doctors' completely understood how they felt as a result of their pain. One in three reported that their doctors' understood a lot, but not completely.



PARTNERS *for*
UNDERSTANDING PAIN

RESOURCES: ORGANIZATIONS

American Academy of Nurse Practitioners

Post Office Box 12846
Austin, TX 78711
512-442-4262 x218
www.aanp.org

American Academy of Pain Management

13947 Mono Way, Suite A
Sonoma, CA 95370
209-533-9744
www.aapainmanage.org

American Academy of Pain Medicine

4700 West Lake
Glenview, IL 60025
847/375-4846
www.painmed.org

American Academy of Physical Medicine & Rehabilitation

One IBM Plaza, Suite 2500
Chicago, IL 60611-3604
312-464-9700
www.aapmr.org

American Academy of Physical Medicine & Rehabilitation

101 Main Street, Suite 101
Medford, MA 02155
312-464-9700
www.aapmr.org

American Alliance of Cancer Pain Initiatives

1300 University Avenue, Room 4720
Madison, WI 53706
608-262-0978
www.aacpi.wisc.edu/

American Association of Colleges of Nursing

One Dupont Circle, Suite 530
Washington, DC 20036
202-463-6930 X 238
www.aacn.nche.edu/

American Association of Colleges of Osteopathic Medicine

5550 Friendship Boulevard, Suite 310
Chevy Chase, MD 20815-7231
301.968.4142
www.aacom.org

American Association of Rehabilitations Nurses

4700 West Lake Avenue
Glenview, IL 60025-1485
847-375-4760
www.rehabnurse.org

American Back Society

2647 East 14th Street, Suite 401
Oakland, CA 94601
510-536-9929
www.americanbacksoc.org/home.html

American Cancer Society

1599 Clifton Road, NE
Atlanta, GA 30329
404-417-5801
www.cancer.org

American Chronic Pain Association

Post Office Box 850
Rocklin, CA 95677
800-533-3231
ACPA@pacbell.net
www.theacpa.org

American Hospice and Palliative Care Organization

1700 Diagonal Road, Suite 625
Alexandria, VA 22314
703.837.3149
www.nhpco.org

American Nurses Association

8515 Georgia Avenue, Suite 400
Silver Springs, MD 20910-3492
301-628-5059
www.ana.org

American Pain Foundation

201 North Charles Street, Suite 710
Baltimore, MD 21201-4111
410-783-7292
www.rainfoundation.org

American Pain Society

4700 West Lake Avenue
Glenview, IL 60025-1485
847-375-4874
www.ampainsoc.org

American Physical Therapy Association

1111 North Fairfax Street
Alexandria, VA 22314
703.706.3200
www.apta.org

American Public Health Association

800 I Street, NW
Washington, DC 20001
202-777-2514
www.apha.org

American Sleep Apnea Association

1424 K Street, NW, Suite 302
Washington, DC 20005
202-293-3650
www.sleepapnea.org

American Society of Law, Medicine & Ethics

765 Commonwealth Avenue
Boston, MA 02215
617-262-4990
www.aslme.org

American Society of Peri Anesthesia Nurses

2124 Harmony Woods Roads
Owings Mills, MD 21117
410-955-6432
www.aspan.org

American Society of Peri Anesthesia Nurses

215 Misty Lane
Holt, MO 64048
816-932-2044
www.aspan.org

American Society Pain Management Nurses

7749 Grow Drive
Pensacola, FL 32514-7072
888-342-7766
www.aspmn.org

Arthritis Foundation

1330 West Peachtree Street
Atlanta, GA 30309
404-965-7542
www.arthritis.org

Association of Repetitive Motion Syndrome

Post Office Box 471973
Aurora, CO 80011
303-369-0803
www.certifiedpst.com/arms/

Baylor College of Medicine

Dept. of Physical Medicine & Rehabilitation
1333 Moursund, Suite A-221
Houston, TX 77030
713-799-5086

Brain Injury Association of America

8201 Greenboro Drive, Suite 611
McLean, VA 22102
703-761-0750 x 120
www.biausa.org

Chronic Fatigue Syndrome

Post Office Box 220398
Charlotte, NC 28222-0398
800-442-3437
www.cfids.org

Circle of Friends with Arachnoiditis

Post Office Box 80745
Springfield, MA 01138-0745
413-796-7010
www.cofwa.org

Consortium for Citizens with Disabilities

1331 H Street, NW, Suite 301
Washington, DC 20005
202-408-9514
www.c-c-d.org

Covenant Health System

Covenant Medical Center & Covenant Lakeside
4901 65th Street
Lubbock, TX 79414
806-725-6244
www.covenanthealth.org

Endometriosis Association International Headquarters

8585 North 76th Place
Milwaukee, WI 53223
800-992-3636
Endo@EndometriosisAssn.org
www.endocenter.org

Endometriosis Research Center

630 Ibis Drive
Delray Beach, FL 33444
800-239-7280
endo13@aol.com
www.endocenter.org

Family Caregiver Alliance

690 Market Street
Suite 600
San Francisco, CA 94104
415-434-3388
www.caregiver.org

For Grace

Post Office Box 1724
Studio City, CA 91614
818-760-7635
rsdaware@forgrace.org
www.forgrace.org

Home Caregivers Accreditation of America, LLC

Executive Director
Post Office Box 9203
Fountain Valley, CA 92728-9203
877-947-3472
service@hcaoc.org

Institute for Health and Productivity Management

Gainey Ranch Center
7702 E. Doubletree Ranch, Suite 300
Scottsdale, AZ 85258
480-607-2660
www.ihpm.org

Intercultural Cancer Counsel

6655 Traves
Suite 322
Houston, TX 77030
713-798-5424
www.icc.bcm.tmc.edu

Interstitial Cystitis Association

110 North Washington, Suite 340
Rockville, MD 20850
914-528-9495
www.ichelp.org

Lupus Foundation of America

2000 L Street, NW, Suite 710
Washington, DC 20036
202-349-1155
www.lupus.org

Men's Health Network

Illinois Dept. of Public Health
535 West Jefferson Street
Springfield, IL 62761
217-785-1059
www.menshealthnetwork.org

National Association for the Advancement of Colored People

Post Office Box 766
Heritage, TN 37076
615-847-1154
www.naacp.org

National Association of Social Workers

750 First Street, NE, Suite 700
Washington, DC 2002-4241
202-336-8228
www.nasw.org

National Black Women's Health Imperative

600 Pennsylvania Avenue, SE, Suite 310
Washington, DC 20003
202-543-9311
www.blackwomenshealth.org

National Choric Pain Outreach Association

Post Office Box 274
Millboro, VA 24460
540-862-9437
www.chronicpain.org

National Chronic Pain Outreach

554 Lee Jackson Highway
Staunton, VA 24401
540-885-9501
www.painlinks.org

National Chronic Pain Society, Inc.

Post Office Box 903
Tombell, TX 77377
281-357-4673
www.ncps-cpr.com

National Consumers League

1701 K Street, NW, Suite 1200
Washington, DC 20006
202-835-3323
www.nclnet.org

National Fibromyalgia Association

2238 North Glassell Street, Suite D
Orange, CA 92865
714-921-0150
www.fmawre.org

National Fibromyalgia Partnership, Inc.

Post Office Box 160
Linden, VA 22642-0160
301-869-1279
www.fmpasrtnership.org

National Headache Foundation

820 North Orleans, Suite 217
Chicago, IL 60610-3132
888-NHF-5552
www.headaches.org

National Hispanic Medical Association

1411 K Street, NW, Suite 200
Washington, DC 20005
202-628-5895 x12
www.ahma.org

National Hospice and Palliative Care Organization

1700 Diagonal Road, Suite 625
Alexandria, VA 22314
703-837-3153
www.nhpco.org

National Medical Association

1012 Tenth Street, NW
Washington, DC 20001
202-347-1895
www.nmanet.org

National Urban League, Inc.

120 Wall Street
New York, NY 10005
212-558-5440
www.nul.org

National Vulvodynia Association

Post Office Box 4491
Silver Spring, MD 20914-4491
401-398-0830
www.nva.org

National Women's Health Resource Center

157 Broad Street, Suite 315
Red Bank, NJ 07701
877-986-9472
www.healthywomen.org

Native American Cancer Research

3022 South Nova Road
Pine, CO 80470
303-838-9359
<http://NatAmCancer.org>

Pain & Policy Studies Group

University of Wisconsin
1900 University Avenue
Madison, WI 53226
608-263-7662
www.medsch.wisc.edu/painpolicy/

Newton General Hospital

Pain Management Center
5126 Hospital Drive, NE
Covington, GA 30014
770-385-7933

Pharmaceutical Research & Manufactures of America

1100 Fifteenth Street, NW
Washington, DC 20005
202-835-3400
www.phrma.org

Post-Polio Health International

4207 Lindell Boulevard, Suite 110
Saint Louis, MO 63108
314-534-0475
info@post-polio.org
www.post-polio.org

Progress on Pain

13304 S. Valleyheart Drive, Apartment 102
Sherman Oaks, CA 91423
818-981-3446
www.painandhealth.org

RSDS Association

Post Office Box 502
Milford, CT 06460
203-877-3790
www.rds.org

Sickle Cell Disease Association

200 Corporate Pointe, Suite 495
Culver City, CA 90230-8727
800-421-8453
www.sicklecelldisease.org

Sidney Kimmel Cancer Center at John Hopkins

The John Hopkins Hospital: Dept. of Pharmacy
600 N. Wolfe Street/Carnegie 180
Baltimore, MD 21287-6180
410-502-3578
www.hopkinskimmelcancercenter.org

Southern California Cancer Pain Initiative

1500 East Duarte Road
Duarte, CA 91010
626.359.8111 x 63840
www.sccpi.coh.org

State of Oregon Pain Management Program

3158 NW Greenbrier Place
Corvallis, OR 97330
503-945-7009
www.dhs.state.or.us/publichealth/pain/about/htm

The American Pharmacists Association

2215 Constitution Avenue, NW
Washington, DC 20037
202-429-7521
www.aphamet.org

The National Pain Foundation

3070 South Williams Street
Denver, CO 80210
303-783-6622
www.painconnection.org

The Neuropathy Association

60 East 42nd Street, Room 942
New York, NY 10165
800-247-6968
<http://www.neuropathy.org/about.pl>

The TMJ Association

Post Office Box 26770
Milwaukee, WI 53226
414-259-3223
www.tmj.org

The Unbroken Circle

6811 Tennyson Drive
McLean, VA 22101
703-356-8660
www.theunbrokencircle.org

Trigeminal Neuralgia Association

Post Office Box 785
Barnegat Lights, NJ 08006
352-376-9955
www.tna-support.org

Triumph Over Pain Foundation

2633 North Southport Avenue
Chicago, IL 606114
773-281-8160
www.pain.com

University of Florida Comprehensive Center for Pain Research

1600 SW Archer Road, D10-19
Post Office Box 100444
Gainesville, FL 32610-0444
352.392.1005
<http://www.painresearch.ufl.edu/>

Veterans Affairs Medical Center, Houston, TX

Office of the Chief of Staff (11)
Houston, TX 77030-4298
713-794-7011

Veterans Affairs Medical Center, Houston, TX

Post Office Box 35571
Houston, TX 77235
713-794-7605

Visiting Nurse Association of America

99 Summer Street, Suite 1700
Boston, MA 02110
617-737-3200 X 222
www.vnaa.org

VZV Research Foundation

24 East 64th Street
New York, NY 10021
212-472-3181
www.vzvfoundation.org