

107TH CONGRESS
1ST SESSION

S. 1024

To amend the Public Health Service Act to provide for a public response to the public health crisis of pain, and for other purposes.

IN THE SENATE OF THE UNITED STATES

JUNE 13, 2001

Mr. WYDEN (for himself, Mr. SMITH of Oregon, Mr. ROCKEFELLER, and Mr. BREAUX) introduced the following bill; which was read twice and referred to the Committee on Health, Education, Labor, and Pensions

A BILL

To amend the Public Health Service Act to provide for a public response to the public health crisis of pain, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

4 (a) SHORT TITLE.—This Act may be cited as the
5 “Conquering Pain Act of 2001”.

6 (b) TABLE OF CONTENTS.—The table of contents for
7 this Act is as follows:

Sec. 1. Short title.
Sec. 2. Findings.
Sec. 3. Definitions.

TITLE I—EMERGENCY RESPONSE TO THE PUBLIC HEALTH
CRISIS OF PAIN

- Sec. 101. Guidelines for the treatment of pain.
- Sec. 102. Patient expectations to have pain and symptom management.
- Sec. 103. Quality improvement projects.
- Sec. 104. Pain coverage quality evaluation and information.
- Sec. 105. Surgeon General's report.

TITLE II—DEVELOPING COMMUNITY RESOURCES

- Sec. 201. Family support networks in pain and symptom management.

TITLE III—REIMBURSEMENT BARRIERS

- Sec. 301. Reimbursement barriers report.
- Sec. 302. Insurance coverage of pain and symptom management.

TITLE IV—IMPROVING FEDERAL COORDINATION OF POLICY,
RESEARCH, AND INFORMATION

- Sec. 401. Advisory Committee on Pain and Symptom Management.
- Sec. 402. Institutes of Medicine report on controlled substance regulation and the use of pain medications.
- Sec. 403. Conference on pain research and care.

TITLE V—DEMONSTRATION PROJECTS

- Sec. 501. Provider performance standards for improvement in pain and symptom management.
- Sec. 502. End of life care demonstration projects.

1 SEC. 2. FINDINGS.

2 Congress finds that—

3 (1) pain is often left untreated or under-treated
4 especially among older patients, African Americans,
5 Hispanics and other minorities, and children;

6 (2) chronic pain is a public health problem af-
7 fecting at least 50,000,000 Americans through some
8 form of persisting or recurring symptom;

9 (3) 40 to 50 percent of patients experience
10 moderate to severe pain at least half the time in
11 their last days of life;

1 (4) 70 to 80 percent of cancer patients experi-
2 ence significant pain during their illness;

3 (5) one in 7 nursing home residents experience
4 persistent pain that may diminish their quality of
5 life;

6 (6) despite the best intentions of physicians,
7 nurses, pharmacists, and other health care profes-
8 sionals, pain is often under-treated because of the
9 inadequate training of clinicians in pain manage-
10 ment;

11 (7) despite the best intentions of physicians,
12 nurses, pharmacists, mental health professionals,
13 and other health care professionals, pain and symp-
14 tom management is often suboptimal because the
15 health care system has focused on cure of disease
16 rather than the management of a patient's pain and
17 other symptoms;

18 (8) the technology and scientific basis to ade-
19 quately manage most pain is known;

20 (9) pain should be considered the fifth vital
21 sign; and

22 (10) coordination of Federal efforts is needed to
23 improve access to high quality effective pain and
24 symptom management in order to assure the needs

1 of chronic pain patients and those who are termi-
2 nally ill are met.

3 **SEC. 3. DEFINITIONS.**

4 In this Act:

5 (1) CHRONIC PAIN.—The term “chronic pain”
6 means a pain state that is persistent and in which
7 the cause of the pain cannot be removed or other-
8 wise alleviated. Such term includes pain that may be
9 associated with long-term incurable or intractable
10 medical conditions or disease.

11 (2) END OF LIFE CARE.—The term “end of life
12 care” means a range of services, including hospice
13 care, provided to a patient, in the final stages of his
14 or her life, who is suffering from 1 or more condi-
15 tions for which treatment toward a cure or reason-
16 able improvement is not possible, and whose focus of
17 care is palliative rather than curative.

18 (3) FAMILY SUPPORT NETWORK.—The term
19 “family support network” means an association of 2
20 or more individuals or entities in a collaborative ef-
21 fort to develop multi-disciplinary integrated patient
22 care approaches that involve medical staff and ancil-
23 lary services to provide support to chronic pain pa-
24 tients and patients at the end of life and their care-

1 givers across a broad range of settings in which pain
2 management might be delivered.

3 (4) HOSPICE.—The term “hospice care” has
4 the meaning given such term in section 1861(dd)(1)
5 of the Social Security Act (42 U.S.C. 1395x(dd)(1)).

6 (5) MEDICATION THERAPY MANAGEMENT SERV-
7 ICES.—The term “medication therapy management
8 services” means consultations with a physician or
9 other health care professional (including a phar-
10 macist) who is practicing within the scope of the
11 professional’s license, concerning a patient which re-
12 sults in—

13 (A) a change in the drug regimen of the
14 patient to avoid an adverse drug interaction
15 with another drug or disease state;

16 (B) a change in inappropriate drug dosage
17 or dosage form with respect to the patient;

18 (C) discontinuing an unnecessary or harm-
19 ful medication with respect to the patient;

20 (D) an initiation of medication therapy for
21 a medical condition of the patient;

22 (E) consultation with the patient or a care-
23 giver in a manner that results in a significant
24 improvement in drug regimen compliance; or

1 (F) patient and caregiver understanding of
 2 the appropriate use and adherence to medica-
 3 tion therapy.

4 (6) PAIN AND SYMPTOM MANAGEMENT.—The
 5 term “pain and symptom management” means serv-
 6 ices provided to relieve physical or psychological pain
 7 or suffering, including any 1 or more of the fol-
 8 lowing physical complaints—

- 9 (A) weakness and fatigue;
- 10 (B) shortness of breath;
- 11 (C) nausea and vomiting;
- 12 (D) diminished appetite;
- 13 (E) wasting of muscle mass;
- 14 (F) difficulty in swallowing;
- 15 (G) bowel problems;
- 16 (H) dry mouth;
- 17 (I) failure of lymph drainage resulting in
- 18 tissue swelling;
- 19 (J) confusion;
- 20 (K) dementia;
- 21 (L) delirium;
- 22 (M) anxiety;
- 23 (N) depression; and
- 24 (O) other related symptoms

1 (7) PALLIATIVE CARE.—The term “palliative
2 care” means the total care of patients whose disease
3 is not responsive to curative treatment, the goal of
4 which is to provide the best quality of life for such
5 patients and their families. Such care—

6 (A) may include the control of pain and of
7 other symptoms, including psychological, social
8 and spiritual problems;

9 (B) affirms life and regards dying as a
10 normal process;

11 (C) provides relief from pain and other dis-
12 tressing symptoms;

13 (D) integrates the psychological and spir-
14 itual aspects of patient care;

15 (E) offers a support system to help pa-
16 tients live as actively as possible until death;
17 and

18 (F) offers a support system to help the
19 family cope during the patient’s illness and in
20 their own bereavement.

21 (8) SECRETARY.—The term “Secretary” means
22 the Secretary of Health and Human Services.

1 **TITLE I—EMERGENCY RE-**
 2 **SPONSE TO THE PUBLIC**
 3 **HEALTH CRISIS OF PAIN**

4 **SEC. 101. GUIDELINES FOR THE TREATMENT OF PAIN.**

5 (a) DEVELOPMENT OF WEBSITE.—Not later than 2
 6 months after the date of enactment of this Act, the Sec-
 7 retary, acting through the Agency for Healthcare Re-
 8 search and Quality, shall develop and maintain an Internet
 9 website to provide information to individuals, health care
 10 practitioners, and health facilities concerning evidence-
 11 based practice guidelines developed for the treatment of
 12 physical and psychological pain. Websites in existence on
 13 such date may be used if such websites meet the require-
 14 ments of this section.

15 (b) REQUIREMENTS.—The website established under
 16 subsection (a) shall—

17 (1) be designed to be quickly referenced by
 18 health care practitioners; and

19 (2) provide for the updating of guidelines as
 20 scientific data warrants.

21 (c) PROVIDER ACCESS TO GUIDELINES.—

22 (1) IN GENERAL.—In establishing the website
 23 under subsection (a), the Secretary shall ensure that
 24 health care facilities have made the website known
 25 to health care practitioners and that the website is

1 easily available to all health care personnel providing
2 care or services at a health care facility.

3 (2) USE OF CERTAIN EQUIPMENT.—In making
4 the information described in paragraph (1) available
5 to health care personnel, the facility involved shall—

6 (A) ensure that such personnel have access
7 to the website through the computer equipment
8 of the facility;

9 (B) carry out efforts to inform personnel
10 at the facility of the location of such equipment;
11 and

12 (C) ensure that patients, caregivers, and
13 support groups are provided with access to the
14 website.

15 (3) RURAL AREAS.—

16 (A) IN GENERAL.—A health care facility,
17 particularly a facility located in a rural or un-
18 derserved area, without access to the Internet
19 shall provide an alternative means of providing
20 practice guideline information to all health care
21 personnel.

22 (B) ALTERNATIVE MEANS.—The Secretary
23 shall determine appropriate alternative means
24 by which a health care facility may make avail-
25 able practice guideline information on a 24-hour

1 basis, 7 days a week if the facility does not
2 have Internet access. The criteria for adopting
3 such alternative means should be clear in per-
4 mitting facilities to develop alternative means
5 without placing a significant financial burden
6 on the facility and in permitting flexibility for
7 facilities to develop alternative means of making
8 guidelines available. Such criteria shall be pub-
9 lished in the Federal Register.

10 **SEC. 102. PATIENT EXPECTATIONS TO HAVE PAIN AND**
11 **SYMPTOM MANAGEMENT.**

12 (a) IN GENERAL.—The administrator of each of the
13 programs described in subsection (b) shall ensure that, as
14 part of any informational materials provided to individuals
15 under such programs, such materials shall include infor-
16 mation, where relevant, to inform such individuals that
17 they should expect to have their pain assessed and should
18 expect to be provided with effective pain and symptom re-
19 lief, when receiving benefits under such program.

20 (b) PROGRAMS.—The programs described in this sub-
21 section shall include—

22 (1) the medicare and medicaid programs under
23 titles XIX and XXI of the Social Security Act (42
24 U.S.C. 1935 et seq., 1936 et seq.);

- 1 (2) programs carried out through the Public
- 2 Health Service;
- 3 (3) programs carried out through the Indian
- 4 Health Service;
- 5 (4) programs carried out through health centers
- 6 under section 330 of the Public Health Service Act
- 7 (42 U.S.C. 254b);
- 8 (5) the Federal Employee Health Benefits Pro-
- 9 gram under title 5, United States Code;
- 10 (6) the Civilian Health and Medical Program of
- 11 the Uniformed Services (CHAMPUS) as defined in
- 12 section 1073(4) of title 10, United States Code; and
- 13 (7) other programs administered by the Sec-
- 14 retary.

15 **SEC. 103. QUALITY IMPROVEMENT EDUCATION PROJECTS.**

16 The Secretary shall provide funds for the implemen-

17 tation of special education projects, in as many States as

18 is practicable, to be carried out by peer review organiza-

19 tions of the type described in section 1152 of the Social

20 Security Act (42 U.S.C. 1320c–1) to improve the quality

21 of pain and symptom management. Such projects shall

22 place an emphasis on improving pain and symptom man-

23 agement at the end of life, and may also include efforts

24 to increase the quality of services delivered to chronic pain

1 patients and the chronically ill for whom pain may be a
 2 significant symptom.

3 **SEC. 104. PAIN COVERAGE QUALITY EVALUATION AND IN-**
 4 **FORMATION.**

5 (a) IN GENERAL.—Section 1851(d)(4) of the Social
 6 Security Act (42 U.S.C. 42 U.S.C. 1395w–21(d)(4)) is
 7 amended—

8 (1) in subparagraph (A), by adding at the end
 9 the following:

10 “(ix) The organization’s coverage of
 11 pain and symptom management.”; and

12 (2) in subparagraph (D)—

13 (A) in clause (iii), by striking “and” at the
 14 end;

15 (B) in clause (iv), by striking the period
 16 and inserting “, and”; and

17 (C) by adding at the end the following:

18 “(v) not later than 2 years after the
 19 date of enactment of this clause, an eval-
 20 uation (which may be made part of any
 21 other relevant report of quality evaluation
 22 that the plan is required to prepare) for
 23 the plan (updated annually) that indicates
 24 the performance of the plan with respect to
 25 access to, and quality of, pain and symp-

1 tom management, including such manage-
2 ment as part of end of life care. Data shall
3 be posted in a comparable manner for con-
4 sumer use on www.medicare.gov.”.

5 (b) **EFFECTIVE DATE.**—The amendments made by
6 paragraph (1) apply to information provided with respect
7 to annual, coordinated election periods (as defined in sec-
8 tion 1851(e)(3)(B) of the Social Security Act (42 U.S.C.
9 1395–21(e)(3)(B)) beginning after the date of enactment
10 of this Act.

11 **SEC. 105. SURGEON GENERAL’S REPORT.**

12 Not later than October 1, 2002, the Surgeon General
13 shall prepare and submit to the appropriate committees
14 of Congress and the public, a report concerning the state
15 of pain and symptom management in the United States.
16 The report shall include—

17 (1) a description of the legal and regulatory
18 barriers that may exist at the Federal and State lev-
19 els to providing adequate pain and symptom man-
20 agement;

21 (2) an evaluation of provider competency in
22 providing pain and symptom management;

23 (3) an identification of vulnerable populations,
24 including children, advanced elderly, non-English
25 speakers, and minorities, who may be likely to be

1 underserved or may face barriers to access to pain
 2 management and recommendations to improve ac-
 3 cess to pain management for these populations;

4 (4) an identification of barriers that may exist
 5 in providing pain and symptom management in
 6 health care settings, including assisted living facili-
 7 ties;

8 (5) an identification of patient and family atti-
 9 tudes that may exist which pose barriers in access-
 10 ing pain and symptom management or in the proper
 11 use of pain medications;

12 (6) an evaluation of medical, nursing, and phar-
 13 macy school training and residency training for pain
 14 and symptom management;

15 (7) a review of continuing medical education
 16 programs in pain and symptom management; and

17 (8) a description of the use of and access to
 18 mental health services for patients in pain and pa-
 19 tients at the end of life.

20 **TITLE II—DEVELOPING** 21 **COMMUNITY RESOURCES**

22 **SEC. 201. FAMILY SUPPORT NETWORKS IN PAIN AND SYMP-** 23 **TOM MANAGEMENT.**

24 (a) ESTABLISHMENT.—The Secretary, acting
 25 through the Public Health Service, shall award grants for

1 the establishment of 6 National Family Support Networks
 2 in Pain and Symptom Management (in this section re-
 3 ferred to as the “Networks”) to serve as national models
 4 for improving the access and quality of pain and symptom
 5 management to chronic pain patients (including chron-
 6 ically ill patients for whom pain is a significant symptom)
 7 and those individuals in need of pain and symptom man-
 8 agement at the end of life and to provide assistance to
 9 family members and caregivers.

10 (b) ELIGIBILITY AND DISTRIBUTION.—

11 (1) ELIGIBILITY.—To be eligible to receive a
 12 grant under subsection (a), an entity shall—

13 (A) be an academic facility or other entity
 14 that has demonstrated an effective approach to
 15 training health care providers including mental
 16 health professionals concerning pain and symp-
 17 tom management and palliative care services;
 18 and

19 (B) prepare and submit to the Secretary
 20 an application (to be peer reviewed by a com-
 21 mittee established by the Secretary), at such
 22 time, in such manner, and containing such in-
 23 formation as the Secretary may require.

1 (2) DISTRIBUTION.—In providing for the estab-
2 lishment of Networks under subsection (a), the Sec-
3 retary shall ensure that—

4 (A) the geographic distribution of such
5 Networks reflects a balance between rural and
6 urban needs; and

7 (B) at least 3 Networks are established at
8 academic facilities.

9 (c) ACTIVITIES OF NETWORKS.—A Network that is
10 established under this section—

11 (1) shall provide for an integrated interdiscipli-
12 nary approach, that includes psychological and coun-
13 seling services, to the delivery of pain and symptom
14 management;

15 (2) shall provide community leadership in estab-
16 lishing and expanding public access to appropriate
17 pain care, including pain care at the end of life;

18 (3) shall provide assistance, through caregiver
19 supportive services, that include counseling and edu-
20 cation services;

21 (4) shall develop a research agenda to promote
22 effective pain and symptom management for the
23 broad spectrum of patients in need of access to such
24 care that can be implemented by the Network;

1 (5) shall provide for coordination and linkages
2 between clinical services in academic centers and
3 surrounding communities to assist in the widespread
4 dissemination of provider and patient information
5 concerning how to access options for pain manage-
6 ment;

7 (6) shall establish telemedicine links to provide
8 education and for the delivery of services in pain and
9 symptom management;

10 (7) shall develop effective means of providing
11 assistance to providers and families for the manage-
12 ment of a patient's pain 24 hours a day, 7 days a
13 week; and

14 (8) may include complimentary medicine pro-
15 vided in conjunction with traditional medical serv-
16 ices.

17 (d) PROVIDER PAIN AND SYMPTOM MANAGEMENT
18 COMMUNICATIONS PROJECTS.—

19 (1) IN GENERAL.—Each Network shall estab-
20 lish a process to provide health care personnel with
21 information 24 hours a day, 7 days a week, con-
22 cerning pain and symptom management. Such proc-
23 ess shall be designed to test the effectiveness of spe-
24 cific forms of communications with health care per-
25 sonnel so that such personnel may obtain informa-

1 tion to ensure that all appropriate patients are pro-
2 vided with pain and symptom management.

3 (2) TERMINATION.—The requirement of para-
4 graph (1) shall terminate with respect to a Network
5 on the day that is 2 years after the date on which
6 the Network has established the communications
7 method.

8 (3) EVALUATION.—Not later than 60 days after
9 the expiration of the 2-year period referred to in
10 paragraph (2), a Network shall conduct an evalua-
11 tion and prepare and submit to the Secretary a re-
12 port concerning the costs of operation and whether
13 the form of communication can be shown to have
14 had a positive impact on the care of patients in
15 chronic pain or on patients with pain at the end of
16 life.

17 (4) RULE OF CONSTRUCTION.—Nothing in this
18 subsection shall be construed as limiting a Network
19 from developing other ways in which to provide sup-
20 port to families and providers, 24 hours a day, 7
21 days a week.

22 (e) AUTHORIZATION OF APPROPRIATIONS.—There is
23 authorized to be appropriated to carry out this section,
24 \$18,000,000 for fiscal years 2002 through 2004.

1 **TITLE III—REIMBURSEMENT**
2 **BARRIERS**

3 **SEC. 301. REIMBURSEMENT BARRIERS REPORT.**

4 The Medicare Payment Advisory Commission
5 (MedPac) established under section 1805 of the Social Se-
6 curity Act (42 U.S.C. 1396b–6) shall conduct a study, and
7 prepare and submit to the appropriate committees of Con-
8 gress a report, concerning—

9 (1) the manner in which medicare policies may
10 pose barriers in providing pain and symptom man-
11 agement and palliative care services in different set-
12 tings, including a focus on payment for nursing
13 home and home health services;

14 (2) the identification of any financial barriers
15 that may exist within the medicare and medicaid
16 programs under titles XVIII and XIX of the Social
17 Security Act (42 U.S.C. 1395 et seq., 1396 et seq.)
18 that interfere with continuity of care and inter-
19 disciplinary care or supportive care for the broad
20 range of chronic pain patients (including patients
21 who are chronically ill for whom pain is a significant
22 symptom), and for those who are terminally ill, and
23 include the recommendations of the Commission on
24 ways to eliminate those barriers that the Commis-
25 sion may identify;

1 (3) the reimbursement barriers that exist, if
 2 any, in providing pain and symptom management
 3 through hospice care, particularly in rural areas, and
 4 if barriers exist, recommendations concerning ad-
 5 justments that would assist in assuring patient ac-
 6 cess to pain and symptom management through hos-
 7 pice care in rural areas;

8 (4) whether the medicare reimbursement system
 9 provides incentives to providers to delay informing
 10 terminally ill patients of the availability of hospice
 11 and palliative care; and

12 (5) the impact of providing payments for medi-
 13 cation therapy management services in pain and
 14 symptom management and palliative care services.

15 **SEC. 302. INSURANCE COVERAGE OF PAIN AND SYMPTOM**
 16 **MANAGEMENT.**

17 (a) IN GENERAL.—The General Accounting Office
 18 shall conduct a survey of public and private health insur-
 19 ance providers, including managed care entities, to deter-
 20 mine whether the reimbursement policies of such insurers
 21 inhibit the access of chronic pain patients to pain and
 22 symptom management and pain and symptom manage-
 23 ment for those in need of end-of-life care (including pa-
 24 tients who are chronically ill for whom pain is a significant
 25 symptom). The survey shall include a review of

1 formularies for pain medication and the effect of such
2 formularies on pain and symptom management.

3 (b) REPORT.—Not later than 1 year after the date
4 of enactment of this Act, the General Accounting Office
5 shall prepare and submit to the appropriate committees
6 of Congress a report concerning the survey conducted
7 under subsection (a).

8 **TITLE IV—IMPROVING FEDERAL**
9 **COORDINATION OF POLICY,**
10 **RESEARCH, AND INFORMA-**
11 **TION**

12 **SEC. 401. ADVISORY COMMITTEE ON PAIN AND SYMPTOM**
13 **MANAGEMENT.**

14 (a) ESTABLISHMENT.—The Secretary shall establish
15 an advisory committee, to be known as the Advisory Com-
16 mittee on Pain and Symptom Management, to make rec-
17 ommendations to the Secretary concerning a coordinated
18 Federal agenda on pain and symptom management.

19 (b) MEMBERSHIP.—The Advisory Committee estab-
20 lished under subsection (a) shall be comprised of 11 indi-
21 viduals to be appointed by the Secretary, of which at least
22 1 member shall be a representative of—

23 (1) physicians (medical doctors or doctors of os-
24 teopathy) who treat chronic pain patients or the ter-
25 minally ill;

- 1 (2) nurses who treat chronic pain patients or
- 2 the terminally ill;
- 3 (3) pharmacists;
- 4 (4) hospice;
- 5 (5) pain researchers;
- 6 (6) patient advocates;
- 7 (7) caregivers; and
- 8 (8) mental health providers.

9 The members of the Committee shall designate 1 member
10 to serve as the chairperson of the Committee.

11 (c) MEETINGS.—The Advisory Committee shall meet
12 at the call of the chairperson of the Committee.

13 (d) AGENDA.—The agenda of the Advisory Com-
14 mittee established under subsection (a) shall include—

15 (1) the development of recommendations to cre-
16 ate a coordinated Federal agenda on pain and symp-
17 tom management;

18 (2) the development of proposals to ensure that
19 pain is considered as the fifth vital sign for all pa-
20 tients;

21 (3) the identification of research needs in pain
22 and symptom management, including gaps in pain
23 and symptom management guidelines;

1 (4) the identification and dissemination of pain
2 and symptom management practice guidelines, re-
3 search information, and best practices;

4 (5) proposals for patient education concerning
5 how to access pain and symptom management across
6 health care settings;

7 (6) the manner in which to measure improve-
8 ment in access to pain and symptom management
9 and improvement in the delivery of care;

10 (7) the development of ongoing strategies to as-
11 sure the aggressive use of pain medications, includ-
12 ing opioids, regardless of health care setting; and

13 (8) the development of an ongoing mechanism
14 to identify barriers or potential barriers to pain and
15 symptom management created by Federal policies.

16 (e) RECOMMENDATION.—Not later than 2 years after
17 the date of enactment of this Act, the Advisory Committee
18 established under subsection (a) shall prepare and submit
19 to the Secretary recommendations concerning a
20 prioritization of the need for a Federal agenda on pain
21 and symptom management, and ways in which to better
22 coordinate the activities of entities within the Department
23 of Health and Human Services, and other Federal entities
24 charged with the responsibility for the delivery of health

1 care services or research on pain and symptom manage-
2 ment with respect to pain management.

3 (f) CONSULTATION.—In carrying out this section, the
4 Advisory Committee shall consult with all Federal agen-
5 cies that are responsible for providing health care services
6 or access to health services to determine the best means
7 to ensure that all Federal activities are coordinated with
8 respect to research and access to pain and symptom man-
9 agement.

10 (g) ADMINISTRATIVE SUPPORT; TERMS OF SERVICE;
11 OTHER PROVISIONS.—The following shall apply with re-
12 spect to the Advisory Committee:

13 (1) The Committee shall receive necessary and
14 appropriate administrative support, including appro-
15 priate funding, from the Department of Health and
16 Human Services.

17 (2) The Committee shall hold open meetings
18 and meet not less than 4 times per year.

19 (3) Members of the Committee shall not receive
20 additional compensation for their service. Such
21 members may receive reimbursement for appropriate
22 and additional expenses that are incurred through
23 service on the Committee which would not have in-
24 curred had they not been a member of the Com-
25 mittee.

1 (4) The requirements of Appendix 2 of title 5,
2 United States Code.

3 **SEC. 402. INSTITUTES OF MEDICINE REPORT ON CON-**
4 **TROLLED SUBSTANCE REGULATION AND THE**
5 **USE OF PAIN MEDICATIONS.**

6 (a) IN GENERAL.—The Secretary, acting through a
7 contract entered into with the Institute of Medicine, shall
8 review findings that have been developed through research
9 conducted concerning—

10 (1) the effects of controlled substance regula-
11 tion on patient access to effective care;

12 (2) factors, if any, that may contribute to the
13 underuse of pain medications, including opioids;

14 (3) the identification of State legal and regu-
15 latory barriers, if any, that may impact patient ac-
16 cess to medications used for pain and symptom man-
17 agement; and

18 (4) strategies to assure the aggressive use of
19 pain medications, including opioids, regardless of
20 health care setting.

21 (b) REPORT.—Not later than 18 months after the
22 date of enactment of this Act, the Secretary shall prepare
23 and submit to the appropriate committees of Congress a
24 report concerning the findings described in subsection (a).

1 **SEC. 403. CONFERENCE ON PAIN RESEARCH AND CARE.**

2 Not later than December 31, 2005, the Secretary,
 3 acting through the National Institutes of Health, shall
 4 convene a national conference to discuss the translation
 5 of pain research into the delivery of health services includ-
 6 ing mental health services to chronic pain patients and
 7 those needing end-of-life care. The Secretary shall use un-
 8 obligated amounts appropriated for the Department of
 9 Health and Human Services to carry out this section.

10 **TITLE V—DEMONSTRATION**
 11 **PROJECTS**

12 **SEC. 501. PROVIDER PERFORMANCE STANDARDS FOR IM-**
 13 **PROVEMENT IN PAIN AND SYMPTOM MAN-**
 14 **AGEMENT.**

15 (a) IN GENERAL.—The Secretary, acting through the
 16 Health Resources Services Administration, shall award
 17 grants for the establishment of not less than 5 demonstra-
 18 tion projects to determine effective methods to measure
 19 improvement in the skills, knowledge, and attitudes and
 20 beliefs of health care personnel in pain and symptom man-
 21 agement as such skill, knowledge, and attitudes and beliefs
 22 apply to providing services to chronic pain patients and
 23 those patients requiring pain and symptom management
 24 at the end of life.

25 (b) EVALUATION.—Projects established under sub-
 26 section (a) shall be evaluated to determine patient and

1 caregiver knowledge and attitudes toward pain and symp-
 2 tom management.

3 (c) APPLICATION.—To be eligible to receive a grant
 4 under subsection (a), an entity shall prepare and submit
 5 to the Secretary an application at such time, in such man-
 6 ner and containing such information as the Secretary may
 7 require.

8 (d) TERMINATION.—A project established under sub-
 9 section (a) shall terminate after the expiration of the 2-
 10 year period beginning on the date on which such project
 11 was established.

12 (e) AUTHORIZATION OF APPROPRIATIONS.—There is
 13 authorized to be appropriated such sums as may be nec-
 14 essary to carry out this section.

15 **SEC. 502. END OF LIFE CARE DEMONSTRATION PROJECTS.**

16 The Secretary, acting through the Health Resources
 17 and Services Administration, shall—

18 (1) not later than January 1, 2004, carry out
 19 not less than 5 demonstration and evaluation
 20 projects that implement care models for individuals
 21 at the end of life, at least one of which shall be de-
 22 veloped to assist those individuals who are terminally
 23 ill and have no family or extended support, and each
 24 of which may be carried out in collaboration with do-

1 mestic and international entities to gain and share
2 knowledge and experience on end of life care;

3 (2) conduct 3 demonstration and evaluation ac-
4 tivities concerning the education and training of cli-
5 nicians in end of life care, and assist in the develop-
6 ment and distribution of accurate educational mate-
7 rials on both pain and symptom management and
8 end of life care;

9 (3) in awarding grants for the training of
10 health professionals, give priority to awarding grants
11 to entities that will provide training for health pro-
12 fessionals in pain and symptom management and in
13 end-of-life care at the undergraduate level;

14 (4) shall evaluate demonstration projects car-
15 ried out under this section within the 5-year period
16 beginning on the commencement of each such
17 project; and

18 (5) develop a strategy and make recommenda-
19 tions to Congress to ensure that the United States
20 health care system—

21 (A) has a meaningful, comprehensive, and
22 effective approach to meet the needs of individ-
23 uals and their caregivers as the patient ap-
24 proaches death; and

1 (B) integrates broader supportive services.

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