Secretary Alex M. Azar II
Office of the Secretary
The U.S. Department of Health & Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Secretary Azar,

On behalf of the Consumer Pain Advocacy Task Force (CPATF), a coalition of nonprofit organizations dedicated to improving the lives of patients with chronic pain, we applaud the work of the Pain Management Best Practices Inter-Agency Task Force and commend the recently published Draft Report. The importance of this Task Force cannot be overstated, and our coalition supports the majority of its recommendations.

CPATF bases its work on four key beliefs:

1. Chronic pain is a real and complex disease that may exist by itself or be linked with other medical conditions.
2. Chronic pain is both an under-recognized and under-resourced public health crisis with devastating personal and economic impact.
3. Effective chronic pain care requires access to a wide range of treatment options, including biomedical, behavioral health and complementary treatment.
4. Denying appropriate care to people with chronic pain is unethical and can lead to unnecessary suffering, depression, disability and even suicide.

We are pleased to see these sentiments reflected in the recommendations of the Draft Report. As you are aware, Task Force members came from a variety of specialties and federal agencies, and were carefully selected for their expertise. They worked tirelessly over the last year to produce this Draft report. The result is a series of recommendations that are thorough, well-balanced, and easily endorsed by people with pain and the organizations that represent them.

Perhaps the most important takeaways from the Draft Report are that:

1. Pain is a disease in and of itself, with serious biopsychosocial consequences and a far-reaching impact on quality of life.
2. There is no one-size-fits all or easy fix for chronic pain. Individualized, multidisciplinary, multimodal, coordinated, comprehensive care is vitally important to effective treatment.
3. There are numerous barriers to appropriate pain care, including stigma; a lack of patient, public, and provider education; poor models of care and reimbursement; and inadequate insurance coverage.
4. At a national level, it is urgent to dedicate more resources and funding to understanding the neurobiology of pain; identifying and developing safer, more effective treatments; creating and implementing models of care and reimbursement that are conducive to effective care; and promoting insurance coverage for a wide range of pain relief therapies.

As emphasized by this much-needed Report, chronic pain is the most prevalent, costly, and disabling health condition in the United States. Recent research shows that an estimated 50 million Americans live with chronic pain, 20 million of whom live with high-impact chronic pain or pain that impedes activities of daily living. Pain is the leading cause of long-term disability in the United States and is the number one reason Americans visit their doctor. It also costs at least $635 billion in lost productivity and medical expenses annually.

Despite the impact of pain, as the landmark 2011 Report from the National Academy of Medicine (formerly the Institute of Medicine) found, pain is widely misunderstood, under-recognized, and undertreated. The NIH currently spends less than 2% of its annual budget on pain research. Less than 1% of physicians are specialized in pain management, and medical students receive an average of nine hours of training in pain management. As discussed above, there are few effective treatment options and those that are effective for some are not well-covered by insurance. The unnecessary suffering chronic pain patients experience as a result is undeniable. Clear evidence of this is seen in recent CDC numbers on suicide, which show that at least 10% of Americans who commit suicide have chronic pain.

Neglecting the widespread problem of chronic pain in America has, in part, contributed to the opioid crisis in which we now find ourselves. Lack of investment in basic research in pain at the NIH has meant that we still do not understand the neurobiological basis of pain and have not discovered or developed safer, more effective alternatives to opioids for the treatment of pain. Likewise, lack of investment in research to investigate the effectiveness of nonpharmacological treatments for pain has meant that insurers are reluctant to pay for these options. At the same time, our system of reimbursement has forced physicians to reduce the amount of time spent with patients and virtually eliminate time spent coordinating care. It is easy to see why health care providers were previously quick to choose opioids as a pharmacological solution to pain.

While prescribing reform is necessary, some well-intentioned efforts to solve the opioid crisis have only made the situation worse for people with pain. Sweeping, blanket restrictions on medication have resulted in unintended consequences for pain patients and had an overall chilling effect on pain care. Each group in this coalition has heard from hundreds, if not thousands, of patients who are being stigmatized for their disease and in many cases, denied necessary medical treatment, forcibly tapered off their medication without recourse, or altogether dropped from care by their provider because the provider feels it is too risky to treat them.

As the Report recommends, opioids should not be a first-line treatment for chronic pain and should be used in conjunction with other, non-opioid therapies. They should primarily be considered in the case of severe chronic pain and in the case of moderate pain only when other options have failed. Patients must also be carefully screened for risk factors for abuse, such as a personal or family history of substance abuse.

But the fact remains that for large numbers of Americans living with chronic pain who take their medications responsibly and legitimately, opioids are a vital treatment option that allows them some measure of quality of life. We strongly support the Report's recommendations that patients and doctors must work together to weigh the benefits and risks on a case-by-case basis. In fact, we would recommend the Report go even further and recommend a revision of the CDC guidelines on opioids with greater consideration to their impact on the chronic pain patient population. One-size-fits-all restrictions on dosages and duration of prescriptions ignore the reality that each patient is different, with different diseases, conditions, injuries, surgeries, body chemistries, sizes, weights, disease progression and sensitivity and severity of pain.

In the near term, we must restore balance to opioid prescribing. In the long term, we must invest in the discovery of new, more effective and safer treatment options for people living with pain.

As a nation, we have not dedicated nearly enough resources or funding commensurate with the impact and cost of pain. The Pain Management Best Practices Draft Report represents a significant step forward in correcting this. Now, we must work tirelessly to ensure the Report recommendations are given the attention and funding they deserve.

We applaud the Task Force and thank you for your role in its establishment and your continued support of its important work.

Sincerely,

American Chronic Pain Association
The Center for Practical Bioethics
Chronic Pain Research Alliance
CHAMP (Coalition For Headache And Migraine Patients)
Global Healthy Living Foundation
International Pain Foundation
Interstitial Cystitis Association
National Fibromyalgia & Chronic Pain Association
The Pain Community
RSDSA (Reflex Sympathetic Dystrophy Syndrome Association)
TMJ Association
U.S. Pain Foundation

cc: ADM Brett P. Giroir, M.D.
Vanila Singh, M.D.