June 7, 2017

Governor Chris Christie
Chair, President's Commission on Combating Drug Addiction and the Opioid Crisis
Mr. Jared Kushner
Senior White House Advisor

Dear Governor Christie and Mr. Kushner,

On behalf of the 73 undersigned organizations, we thank you for your leadership of the President's Commission on Combating Drug Addiction and the Opioid Crisis ("Commission"). As the Commission advances with its mission to "study the scope and effectiveness of the federal response to drug addiction and the opioid crisis," we respectfully request the Commission to recognize the inter-relationship of the nation's chronic pain and opioid epidemics. Prior federal efforts to curb the opioid crisis have not addressed, or provided funding for, a key element to the solution – the inadequate treatment and research of chronic pain. This is a shortsighted and consequential omission, and we urge the Commission to include comprehensive solutions to address these intertwined crises in its recommendations to the President.

A long-term solution to the opioid crisis will only be achieved by addressing inadequately treated chronic pain. Better chronic pain treatment will improve the lives of millions of Americans, save billions of dollars, and reduce opioid misuse.

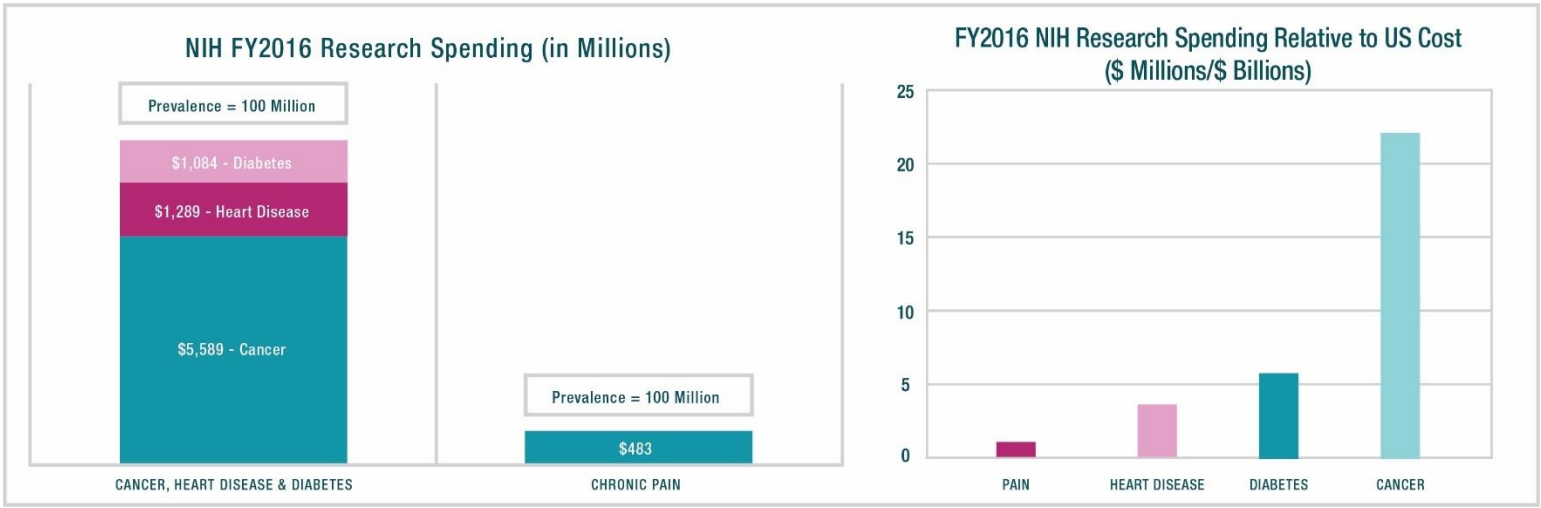
Pain can be both a symptom as well as a chronic illness. Acute pain serves as a normal signal, alerting us that something is wrong and protecting us from further injury, e.g., abdominal pain before a ruptured appendix. But, when pain continues past six months – regardless of the cause – it transitions to chronic pain. Research shows that chronic pain can become a disease in itself, with measurable changes in the brain, spinal cord, and peripheral nervous system. [1]

Chronic pain is the most prevalent, costly, and disabling health condition in the US.

Studies from the National Academy of Medicine (formerly the Institute of Medicine) and Department of Veterans Affairs found that 100 million American adults, and 80 percent of veterans returning from Operation Enduring Freedom and Operation Iraqi Freedom, live with some level of chronic pain, at an annual cost of $560-635 billion in direct medical costs and lost productivity. [2] [3] Further, according to the Centers for Disease Control and Prevention (CDC), painful arthritic, musculoskeletal and back/spine disorders are the leading causes of disability in the US. [4] [5]

Despite the pervasiveness and cost of chronic pain in both our civilian and military populations, funding provided by Congress to (and allocated by) federal agencies to address chronic pain has been grossly inadequate.

As demonstrated in the figure (left) below, chronic pain affects the same number of Americans as diabetes, heart disease and cancer combined. Yet, in FY2016, the National Institutes of Health (NIH) invested 95% less in pain research. [6] As shown in the figure (right) below, comparisons of NIH research funding for these same disorders, relative to their societal costs, underscore the severe underfunding of pain research. [7] [8] Further, the NIH has projected a 20 percent decrease in funding for pain research in FY2018. [9]



This longstanding underinvestment in pain research has resulted in a limited number of safe and effective chronic pain treatments, and according to the FDA, a field that is "strikingly deficient" in high-quality evidence to assess risks and benefits of current treatments. [10]

As a result, even highly knowledgeable health care providers are left without clear guidance, and may spend months to years with their patients experimenting with treatments in the hope of finding relief without intolerable side effects. In the interim, and because insurance plans are more likely to cover the costs of medications and procedures (versus other types of therapies), opioids are often prescribed to try to ease pain severity and suffering until another treatment(s) that provides relief is identified through this trial-and-error process.

Reducing the supply of opioids will not, by itself, solve this crisis. We must also accelerate access to existing – as well as discover new – evidence-based pharmacologic, nonpharmacologic and integrative chronic pain treatments.

Doing so is key to ameliorating the opioid epidemic and can be achieved through the following:

1. **Expanding and Expediting Pain Research.** As discussed prior, the federal investment in pain research remains grossly incommensurate with its human and societal burdens. Very little is known about the prevention, causes and mechanisms of chronic pain. Substantial initiatives are urgently needed to develop pain treatments without abuse potential. Further, generating high-quality evidence that can guide clinicians and patients in making informed decisions about safe and effective pain management is imperative. An essential response to the opioid crisis must include an increase in the federal pain research investment. The cost savings of discovering improved chronic pain therapies will far surpass the increased costs of research. Beyond relieving suffering from both chronic pain and substance use disorder, development of improved pain therapies will spur introduction of innovative products with global markets, increase workplace productivity, and reduce expenditures for federal entitlement programs such as Medicaid, Medicare, and Social Security Disability Insurance. A meager 1% reduction of the US costs of pain would translate into approximately $6 billion in annual societal savings.

2. **Transforming Pain Care Through Implementation of the National Pain Strategy.** The state of pain care in America is in chaos. Health care providers receive inadequate education and training on pain, and time and financial constraints deter clinicians from providing high-quality care to those with chronic illness, including chronic pain. Reimbursement strategies also need urgent modification to promote an improved system of integrative care, as currently available, evidence-based integrative pain treatments are desired for use by patients and are cost-effective for payers, yet remain underutilized. The National Pain Strategy (NPS) is the government's first interagency strategic plan to implement a system of safe, effective, evidence-based pain care in America. This improved system is a critical solution to unattended chronic pain and an essential component of any plan to address the opioid epidemic. The Department of Health and Human Services (HHS) released the NPS in March 2016, after a nearly two-year period of thoughtful development among six federal agencies, along with 80 nominated experts from the medical, scientific, patient and advocacy communities. [11] The NPS provides an actionable and achievable roadmap that will generate critical population research and health services data; advance prevention and pain care strategies; improve pain service delivery and reimbursement; advance health care professional education and training; and foster public education and communication strategies. It clearly delineates short, medium, and long-term deliverables, identifies federal and non-federal stakeholders key to achieving its objectives, and provides strategies to measure impact. The Office of the Assistant Secretary for Health (OASH) has been tasked with implementing the NPS. Since the NPS was released 15 months ago, OASH has begun populating members of a Principals' Coordinating Council and Implementation Steering Committee. Although HHS Secretary Dr. Thomas Price recently highlighted the importance of "advancing better practices for pain management" as part of HHS' strategy for fighting the opioid crisis, the NPS remains unfunded and HHS has not begun to formally implement the NPS objectives and deliverables across federal agencies. It is imperative that these efforts commence immediately. [12]

3. **Surveil the Burden of Chronic Pain Through CDC Data Collection, Analysis, and Publication.** Despite the enormous human and economic impact imposed by chronic pain on our nation, there is no concerted effort within the CDC to ascertain and make publicly available high-quality data on chronic pain, apart from two questions on pain prevalence and impact included in the Healthy People 2020 Initiative. Like the CDC's extensive efforts to understand and surveil the opioid epidemic, it is critical that the agency begin to study and surveil the burden of chronic pain. This includes expanding the quantity, quality, and accuracy of data on chronic pain's prevalence, impact, and

treatment over time – overall, for specific chronic pain types, and within specific populations. In addition, national surveillance efforts are needed to evaluate population-level interventions, evaluate the impact of changing public policies, and identify emerging needs.

Several federal agencies have recognized the urgent need to address unattended chronic pain as part of a comprehensive strategy to curb the opioid epidemic, and along with the broader pain community, have made significant progress in recent years to develop extensive plans and initiatives to advance chronic pain treatment, education, and research. [13] [14] [15] [16] [17] Now, support and funding for this vital work is urgently needed from the President and Congress if we are to be successful in mitigating the nation's intertwined epidemics of opioid abuse and chronic pain.

The Consumer Pain Advocacy Task Force (CPATF) and leaders from the organizations listed below stand ready to work collectively with the Commission, President, Congress, and federal agencies to address these urgent public health crises. Should we be able to provide additional information or assist the Commission's efforts in any way, please contact CPATF Co-Facilitator Christin Veasley by email (cveasley@cpralliance.org) or phone (401-316-2089).

With sincere appreciation,

Academic Consortium for Integrative Medicine & Health
Academy of Integrative Pain Management
Alliance for Balanced Pain Management
Alliance for Headache Disorders Advocacy
Alliance for Patient Access
American Academy of Neurology
American Academy of Pain Medicine
American Academy of Physical Medicine and Rehabilitation
American Association of Naturopathic Physicians
American Association of Nurse Anesthetists
American Cancer Society Cancer Action Network*
American Chiropractic Association
American Chronic Pain Association*
American Headache and Migraine Association
American Headache Society
American Migraine Foundation
American Pain Society
American Physical Therapy Association
American Psychological Association
American Society of Acupuncturists
American Society for Pain Management Nursing, Long Island Chapter
Association of Migraine Disorders
California Society of Interventional Pain Physicians
Center for Practical Bioethics
Center for Translational Pain Medicine, Duke University
Center to Advance Palliative Care
Chicago Hispanic Health Coalition
Chronic Pain Research Alliance*
Clusterbusters
Epilepsy Foundation of Greater Chicago
Families for Intractable Pain Relief
For Grace: Women in Pain
Global Healthy Living Foundation*
Headache & Migraine Policy Forum
Headache Cooperative of New England
Headache Cooperative of the Pacific
Hematology/Oncology Pharmacy Association
Hereditary Neuropathy Foundation*
Integrative Health Policy Consortium
International Pain Foundation*
Lung Cancer Alliance
Massachusetts Pain Initiative
Migraine Research Foundation
Miles for Migraine Races
National Association of Clinical Nurse Specialists
National Association of Social Workers, Michigan Chapter
National Center for Homeopathy
National Fibromyalgia & Chronic Pain Association*
National Headache Foundation
National Patient Advocate Foundation
Oncology Managers of Florida
Pain Action Alliance to Implement a National Strategy*
Pediatric Palliative Care Coalition
Physician Assistants in Hospice and Palliative Medicine
Project Lazarus
Reflex Sympathetic Dystrophy Syndrome Association*
Running for Research Races
Society of Behavioral Medicine
State Pain Policy Advocacy Network*
Tennessee Pain Care Action Network
The American Association of Nurse Practitioners
The Gerontological Advanced Practice Nurses Association
The New York State Pain Society
The Pain Community*
The Pain Society of the Carolinas
The Pennsylvania Pain Society
The Tennessee Pain Society
The TMJ Association*
Trinity Health, Livonia Michigan
United Kentucky Pain Care Action Network
US Pain Foundation*
Virginia Pain Initiative
Wings for Warriors

cc: Mr. Jeff Sessions, US Attorney General
Dr. Thomas Price, US Secretary of Health and Human Services
Dr. David Shulkin, US Secretary of Veterans Affairs
Mr. James Mattis, US Secretary of Defense
Mr. Charlie Baker, Jr., Governor of Massachusetts
Mr. Roy Cooper III, Governor of North Carolina
Mr. Patrick Kennedy, Former US Representative of Rhode Island
Dr. Bertha Madras, Professor of Psychobiology, Department of Psychiatry, Harvard Medical School
Mr. David McKinley, US Representative of West Virginia

** Denotes members of the Consumer Pain Advocacy Task Force (CPATF), a coalition of 16 consumer organizations working to improve the health, well-being, and treatment of those living with life-altering chronic pain. The CPATF is united with one goal – to work collectively to promote, support and monitor the implementation of the National Pain Strategy. For additional information, please contact CPATF Co-Facilitators Amy Goldstein (913-484-2120, info@ConsumerPainAdvocacy.org) or Christin Veasley (401-316-2089).*

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[2] National Academy of Medicine (formerly the Institute of Medicine) Report: *Relieving Pain in America, A Blueprint for Transforming Prevention, Care, Education and Research*. The National Academies Press, 2011. http://books.nap.edu/openbook.php?record_id=13172&page=1.

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[6] NIH Categorical Spending Estimates of Funding for Various Research, Condition, and Disease Categories (RCDC). Accessed June 5, 2017. https://report.nih.gov/categorical_spending.aspx.

[7] NIH Categorical Spending Estimates of Funding for Various Research, Condition, and Disease Categories (RCDC). Accessed June 5, 2017. https://report.nih.gov/categorical_spending.aspx.

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[15] Califf RM, Woodcock J, Ostroff S. A proactive response to prescription opioid abuse. N Engl J Med. 2016 Apr 14;374(15):1480-5. http://www.nejm.org/doi/full/10.1056/NEJMsr1601307#t=article.

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