

PAIN CARE COALITION

A National Coalition for Responsible Pain Care

**American Academy of Pain Medicine • American Pain Society
American Society of Anesthesiologists**

May 19, 2015

Walter J. Koroshetz, M. D.
Acting Director
National Institute of Neurological Disorders and Stroke
National Institutes of Health
Building 31, Room 8A52
31 Center Drive MSC 2540
Bethesda, MD 20892

Re: National Pain Strategy

Dear Dr. Koroshetz:

The Pain Care Coalition applauds your Institute for its work in developing the first ever National Pain Strategy (“NPS” or “the Strategy”). The Coalition’s member professional societies were the first organizations to call on government to recognize pain as a public health issue of national concern. Our early advocacy for the National Pain Care Policy Act, joined by the efforts of other national professional, patient and industry groups, led directly to enactment of the important pain care provisions of the Affordable Care Act in 2010. That led in turn to the Institute of Medicine’s groundbreaking 2011 report on pain, *Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education and Research*, and to the establishment of the Interagency Pain Research Coordinating Committee (“IPRCC”) under the leadership of NINDS.

The draft NPS is a direct outgrowth of the IOM report, and is the next critical step in advancing pain care research, education and treatment in this country. Many individual members of the Coalition’s member societies have contributed their time and expertise to its development, either through membership on the IPRCC, or as members of the NPS Oversight Panel and various work groups tasked by the IPRCC with developing different aspects of the Strategy. The Coalition believes this process brought the best minds in both government and the private sector to bear on the issues, and has

generated a draft document that the Coalition is pleased to support in general, and in most of its particulars. Before the draft NPS becomes final, however, we think it can be further improved in several respects, and we offer these comments for your consideration.

Research as a Critical Part of the Strategy

The Executive Summary of the NPS appropriately recognizes, as did the IOM report, that efforts to reduce the burden of pain “will not be achieved without **sustained and indeed expanded investment into basic and clinical research** studies of the biopsychosocial mechanisms that produce and maintain chronic pain”. (Draft NPS p.2, emphasis added.) Some research needs are also mentioned in passing in the body of the draft Strategy. However, unlike population research, basic and clinical research needs are not recognized in the draft as formal elements of the Strategy, or otherwise forcefully emphasized as critically important, which the Coalition believes them to be.

We understand that the work of the IPRCC in developing the NPS is different from the Committee’s statutory responsibilities with respect to the research work of NIH and other Federal agencies, and appreciate the apparent desire to keep some degree of separation between the two. At the same time, given the historic underfunding of pain-related research at NIH, and the widespread recognition, as noted in the Executive Summary, that research is fundamental if the effort is to indeed be comprehensive, the Coalition recommends an expanded treatment of research in the body of the Strategy.

This could be accomplished by designating research as an additional element of the Strategy, on a par with the six focus areas identified in the draft. Alternatively, research could be given significant emphasis in the “Introduction” section of the Strategy. Either could be accomplished without a major expansion of the document by cross-referencing the ongoing work of the IPRCC and the NIH Pain Consortium, that will proceed in tandem with work in the six areas already identified in the draft. For example, with the IPRCC having already completed its inventory of existing Federal pain research efforts, the Strategy could emphasize the critical importance of prompt completion of the multidisciplinary pain research portfolio strategy, already under development by the IPRCC, to guide, and hopefully increase, the future basic and clinical research investment in this area.

Priority for Education and Training

While the Coalition supports all six core elements of the draft Strategy, we recommend that professional education be given particular priority in the final document. Pain medicine specialists of the types represented by the Coalition’s member professional societies understand the complexity of pain care, the difficulties of diagnosis and treatment, and the value of multidisciplinary, multimodal approaches in care of the most difficult cases. But they often arrive at their expertise only after years of specialization and sub-specialization, not because of the grounding in good pain care received in undergraduate or even residency training. If pain care is to be genuinely

transformed in this country, significant educational reforms in medicine and other health professions are necessary.

The Coalition welcomes the draft's focus on "core competencies," and agrees that pain medicine specialists need training in team-based care for complex chronic pain patients. We think this point can be strengthened by slightly revising the last sentence in the second bullet under "Short-term strategies and deliverables" (p.37) to read as follows:

"Extend the expectation of competency in team-based pain care, as reflected in the content of licensing examinations, to include nursing, clinical pharmacy, clinical health psychology, and other relevant health professional training schools and programs."

Important efforts are already underway to improve pain education across the professions, and across the continuum of professional training from undergraduate, to graduate, to continuing education throughout a clinician's career. But the barriers to change are real and substantial. Educators, accreditors, licensing bodies, payors and regulators must fully engage with the professions to drive change if this goal of the NPS is to be accomplished. Prioritizing professional education within the final NPS will advance the cause.

Professional training and expanded research efforts go hand-in-hand. Even the most experienced clinicians need more evidence-based tools and strategies to treat individual patients and to advance the field. A more robust research effort will help build training infrastructure, and make careers in pain care more attractive to young clinicians and researchers.

Responsibility for Action and Accountability for Results

Implementation of a comprehensive National Pain Strategy can alleviate suffering and improve the lives of countless millions of Americans who now suffer from acute and chronic pain. But realizing ambitious long-term goals and advancing more modest short-term strategies will require leadership from the top, assignment of responsibility to both governmental agencies and private sector organizations, and continuing accountability for progress.

The draft NPS identifies "stakeholders and collaborators" in each of the six core areas, but stops short of designating lead agencies or individuals as "in charge" of implementation. The Coalition understands the likely reticence of NINDS, much less a group like the IPRCC, to assign responsibility to others in government, but believes that successful implementation of the NPS will require just such designation of responsibility. The Coalition recommends, therefore, that either the final NPS document, or a parallel effort led by the HHS Secretary's office, designate one or more lead agencies within HHS for each of the six core areas of the Strategy.

We believe the NPS will be most effective if there is also a mechanism—whether an advisory committee, task force or work group—to provide continuing oversight of its

implementation, demand accountability from those who are designated to lead the effort, produce periodic progress reports for use of top Departmental management, and ensure transparency to the public.

Resources for Implementation

By relying on the expertise of the IPRCC and the cadre of subject matter experts it identified to develop the draft NPS, DHHS has produced a potentially transformative document at almost no cost to the government. Effective implementation of the strategies outlined in the NPS, however, cannot be accomplished without the commitment of adequate resources. Some specific tasks will be short term and relatively low cost. Others, like basic and clinical research, must be long lasting and much more resource intensive if they are to be successful.

The Coalition recommends that DHHS develop a funding plan and strategy for each of the core areas included in the draft Strategy. This could be included in the final Strategy document, or could be a parallel effort. Either way, it must aggressively identify both existing funding sources and areas where newly targeted Congressional appropriations will be necessary. Furthermore, DHHS agencies must be willing to use “the power of the purse” to advance the goals and objectives so forcefully articulated in the Strategy. For example, grant and contract funding opportunities that support educational institutions should incentivize aggressive adoption of the recommended core competencies in pain care training, not reward those who continue to resist these changes.

I hope these brief comments will be helpful to you and your staff as the National Pain Strategy is finalized, and the hard work of implementation is begun. The Pain Care Coalition, its member societies, and the tens of thousands of professionals they represent, stand ready to help in any way we can. We look forward to working with you in this critically important effort.

Respectfully submitted,



James P. Rathmell, M.D.
Chairman

CC: Linda Porter, Ph. D.