How to Guide

Visiting Your Local Legislator
Have your voice heard

There is nothing more powerful than your voice talking to your local Congressional Representatives or Senators about the issues you face when dealing with pain. It will be the stories you tell and issues that you relate to them or their staff that can impact their opinions about the dilemmas that you face. There are several issues for people who are seeking to obtain access to care in order to improve the quality of life and increase function while reducing the sense of suffering that pain can cause.

We realize that it is extremely difficult for you to do a visit in Washington, DC. The cost of the trip, the long hours of travel and the time away from work and family can present insurmountable obstacles. That is why we are asking you to make plans this September to visit them in your own community. Every legislator has local offices, places where you can visit to have your voice heard.

We have designed this tool kit to help you reach out to your local legislators so that you can schedule an appoint to visit their office. We will provide you with:

- how to make the appointment,
- a sample letter of request,
- what to do during the visit and the follow up.

It is our hope that you will make the effort during September to tell those who represent you in Washington, DC the issues you face as you seek a solution to live a life of pain.
Meeting with Your Legislator: *Tips for a Successful Experience*

**Step One: Scheduling an Appointment**

- 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 Congressperson X, briefly summarize the purpose for the meeting, and list the names of those who will attend with you.
- 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.
- 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!).

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❖ You can also develop a fact sheet about your organization, the population it serves, its
reach nationally or internationally, support/contact you may have in your home state
and any bills that have been introduced in your respective states.

**Step Four: Thank You, Thank You**

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

To find your elected officials, go to: [https://www.usa.gov/elected-officials](https://www.usa.gov/elected-officials)
there you will find both state and federal officials.
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 Congresspersons ___________’s constituent. I am calling to set up an appointment with Congressperson __________ and/or his staffer to discuss the importance of pain care today and the National Pain Strategy. May I please speak to his/her scheduler?

To scheduler:
Hello. My name is _________ and I am Congresspersons ___________’s constituent. I am calling to set up an appointment with Congressperson __________ and/or his staffer to discuss the importance of pain care today and the National Pain Strategy.

September is Pain Awareness Month and all across the country people like me 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 ___?

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 the month:
Is there a time when the Congressperson __________ and/or his staffer is available to meet?

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 Letter of Thanks

Dear Congressperson X:

Thank you for meeting with me.

Insert paragraph referencing something you talked about or how your visit relates to the mission of your association to combat chronic pain.

The National Pain Strategy 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 effort 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

_____ National Pain Strategy

_____ 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?  Yes____  No____  Not Sure____

Comments:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Additional Comments on the Overall Experience:

________________________________________________________________________
Checklist for Visit

4-5 Weeks Prior to Meeting Date

___  Review information included in this kit about National Pain Strategy

___  Please contact Partners for Understanding Pain with any questions you might have.

3 Weeks Prior to Meeting Date

___  Contact others in your area who are scheduled to take part in the event and confirm their participation.

2 Weeks Prior to Meeting Date

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

Week Prior to Meeting Date

___  Review materials (especially fact sheets, survey information, overview of National Pain Strategy and 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 you and others who will join you during your visit
   - Any notes you have made about important points you would like to make during the visit.

Day of Meeting

___  Make sure to bring all items listed directly above.

___  Review Meeting with Your Legislator: Tips for a Successful Experience.
Resources
Talking Points

PROTECTING ACCESS TO CARE

Recommendation: Department of Health and Human Services (DHHS) should continually evaluate the impact of legislative, regulatory and enforcement measures to protect against unintended consequences that threaten legitimate patient access to appropriate care, including the appropriate use of opioid medications.

PAYMENT AND COVERAGE POLICIES

Recommendation: The Centers for Medicare and Medicaid Services (“CMS”), with outreach to private payors, should do a comprehensive review of payment and coverage policies that may serve to promote opioid prescribing to the detriment of other therapies.

PUBLIC EDUCATION

Recommendation: DHHS should implement the Institute of Medicine’s 2011 recommendation in Relieving Pain in America to undertake a national public education campaign on pain management which includes information on (1) the role prescription opioids play as one therapeutic option for some patients with some conditions, (2) the safe use and disposal of such drugs, and (3) the risks to patients and society when such drugs are used for non-medical purposes or without appropriate clinical oversight.

PROFESSIONAL EDUCATION

Support positive incentives to promote physician education on safe and effective clinical practice with respect to prescribing opioids and other controlled substances as part of pain medicine diagnosis and treatment. Including teaching the balanced approach to pain management by including all the therapies and interventions needed to manage pain.

Most medical students and other health professionals receive insufficient training in both pain management and addiction medicine, including responsible prescribing practices, during their undergraduate and graduate training programs. There is a need for many to supplement core curricula through CME, particularly for primary care physicians.

RESEARCH

Recommendation: (a) NIH, with Congressional support, should increase both basic and translational research funding directed at developing new pain management therapies.

Opioids are frequently prescribed for pain patients because (1) they are available and (2) at least for many patients and conditions, they work. They are also relatively inexpensive. Even
practitioners knowledgeable about the adverse side-effects experienced by some patients, or concerned by the potential for abuse and diversion, are highly motivated to reduce patient suffering. Particularly in primary care environments, without specialized and sub-specialized pain medicine expertise, opioids are the obvious “tool in the toolkit.” Practitioners in all settings need more alternative tools, and finding them will require a significant increase in research efforts.

ADAPTED FROM: PAIN CARE COALITION  A National Coalition for Responsible Pain Care  American Academy of Pain Medicine • American Pain Society • American Society of Anesthesiologists
KEY MESSAGES ABOUT PAIN

❖ Pain is the number-one cause of adult disability in the United States and affects one in three people or about 100 million Americans.

❖ Pain costs an estimated $560 to $635 billion annually in lost workdays, medical expenses, and other benefit costs.  

❖ 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.

❖ 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, however, doing so is an extremely powerful form of communicating the issue and often times elicits understanding

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1 (IOM, Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education, and Research, 2011)
and empathy. You do not need to provide personal graphic details of your struggle. The most important points for you to discuss (briefly) are:

1) how chronic pain has impacted your life (e.g., things that you are now unable to do because of the disorder)

2) 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)

3) how treatments for chronic pain have helped (or not helped) your condition and how they have affected you (e.g., side effects)
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 individual’s life long, it needs to be taken seriously. A integrative 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 (approximately 100 million people) suffer 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.

American Chronic Pain Association © 2018
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.

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 a 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.
A Comprehensive Population Health-Level Strategy for Pain

EXECUTIVE SUMMARY

In 2010, the National Institutes of Health (NIH) contracted with the Institute of Medicine (IOM) to undertake a study and make recommendations “to increase the recognition of pain as a significant public health problem in the United States.” The resulting 2011 IOM report called for a cultural transformation in pain prevention, care, education, and research and recommended development of “a comprehensive population health-level strategy” to address these issues. In response to the report, the Assistant Secretary for Health, Department of Health and Human Services (HHS) asked the Interagency Pain Research Coordinating Committee (IPRCC) to oversee creation of this National Pain Strategy (NPS). Experts from a broad array of public and private organizations explored areas identified in the core IOM recommendations—population research, prevention and care, disparities, service delivery and reimbursement, professional education and training, and public awareness and communication. A companion effort is underway to address the IOM’s call for further research to support the cultural transformation.

As articulated in the IOM report, efforts to reduce the burden of pain in the United States cannot be achieved without an expanded and sustained investment in basic and clinical research on the biopsychosocial mechanisms that produce and maintain chronic pain and development of safe and effective pain treatments. As a first step to respond to the full set of research recommendations of the IOM, the IPRCC and the NIH completed a comprehensive analysis of the existing federal pain research portfolio. The next step is development of the Federal Pain Research Strategy which will complement the NPS. It will identify gaps in our research agenda and recommend directions for new research to guide federal entities in their support of essential pain research programs.

Findings and recommendations from the IOM report guided the development of the National Pain Strategy (NPS). These included:

- The public at large, and people with pain, would benefit from a better understanding of pain and its treatment in order to encourage timely care, improve medical management, and combat stigmatization.
- Increased scientific knowledge regarding the pathophysiology of pain has led to the conclusion that chronic pain can be a disease in itself that requires adequate treatment and a research commitment.
- Chronic pain is a biopsychosocial condition that often requires integrated, multimodal, and interdisciplinary treatment, all components of which should be evidence-based.
• Data are lacking on the prevalence, onset, course, impact, and outcomes of most common chronic pain conditions. The greatest individual and societal benefit would accrue from a focus on chronic pain.
• Every effort should be made to prevent illnesses and injuries that lead to pain, the progression of acute pain to a chronic condition, and the development of high-impact chronic pain.
• Significant improvements are needed to ensure that pain assessment techniques and practices are high-quality and comprehensive.
• Self-management programs can improve quality of life and are an important component of acute and chronic pain prevention and management.
• People with chronic pain need treatment approaches that take into account individual differences in susceptibility for pain and response to treatment, as well as improved access to treatments that take into account their preferences and are in accord with best evidence on safety and effectiveness.
• Treatments that are ineffective, whose risks exceed their benefits, or that may cause harm for certain subgroups need to be identified and their use curtailed or discontinued.
• Much of the responsibility for front-line pain care rests with primary care clinicians who are not sufficiently trained in pain assessment and comprehensive, evidence-based treatment approaches.
• Greater collaboration is needed between primary care clinicians and pain specialists in different clinical disciplines and settings, including multispecialty pain clinics.
• Significant barriers to pain care exist, especially for populations disproportionately affected by and undertreated for pain and need to be overcome.
• People with pain are too often stigmatized in the health care system and in society, which can lead to delayed diagnosis or misdiagnosis, bias in treatment, and decreased effectiveness of care.

The objectives and action plans developed in this report to address the core IOM findings and recommendations are summarized below by work group topics and include:

**Population Research**

Understanding the significance of health problems in a population is a core public health responsibility. To increase the quantity and quality of what is known about chronic pain within the U.S. population, the NPS recommends specific steps to increase the precision of information about chronic pain prevalence overall, for specific types of pain, and in specific population groups and to track changes in pain prevalence, impact, treatment over time, to enable evaluation of population-level interventions and identification of emerging needs. It also recommends development of the capacity to gather information electronically about pain treatments, their usage, costs, effectiveness, and safety.
Prevention and Care

Prevention of acute and chronic pain, especially primary prevention strategies, needs greater emphasis throughout the health care system, including delivery of long term services and supports, and in environments where injuries are likely to occur (e.g. the workplace), and among people at increased risk of developing chronic pain. When chronic pain develops, treatment should begin with a comprehensive assessment, followed by creation of a care plan that can evolve over time to address the full range of biological, psychological, and social effects of pain on the individual. The NPS recommends strengthening the evidence base for pain prevention strategies, assessment tools, and outcome measures— particularly those relevant for primary care—in part through the development of new, rigorously researched approaches. It also recommends improvements in pain self-management programs that can help affected individuals improve their knowledge, skills, and confidence to prevent, reduce, and cope with pain, and minimize treatment risks and adverse effects.

Disparities

Pain is more prevalent or disabling and/or care is inadequate in certain vulnerable populations including people with limited access to health care services, racial and ethnic minorities, people with low income or education, children, older adults, and those at increased risk because of where they live or work, or because of limited communication skills. Many of these groups face additional problems of stigmatization and bias in pain care. To eliminate disparities and promote equity in pain assessment and treatment, the NPS recommends efforts aimed at increasing understanding of the impact of bias and supporting effective strategies to overcome it; increasing access to high-quality pain care for vulnerable population groups; and improving communication among patients and health professionals.

Service Delivery and Payment

Evidence suggests that wide variations in clinical practice, inadequate tailoring of pain therapies to individuals, and reliance on relatively ineffective and potentially high risk treatments such as inappropriate prescribing of opioid analgesics, or certain surgical interventions, not only contribute to poor quality care for people with pain, but also increase health care costs. The NPS recommends a population-based, biopsychosocial approach to pain care that is grounded in scientific evidence, integrated, multimodal, and interdisciplinary, while tailored to an individual patient’s needs. Research and demonstration efforts are needed that build on current knowledge, develop new knowledge, and support further testing and diffusion of model delivery systems.

Professional Education and Training

Although pain is one of the most common reasons for health care visits, most health profession education programs have yet to give it adequate attention. The NPS recommends steps to improve discipline-specific core competencies, including basic knowledge, assessment, effective team-based care, empathy, and cultural competency. It encourages educational program accreditation bodies and professional licensure boards to require pain teaching and
clinician learning at the undergraduate and graduate levels. The NPS also recommends development of a web-based pain education portal that would contain up-to-date, comprehensive, and easily accessed educational materials. These training efforts should be made in coordination with current HHS efforts to develop tools for providers to recognize the risk factors and symptoms of opioid use disorders.

**Public Education and Communication**

Key to a cultural transformation in pain care is a greater understanding—among members of the public and people with pain alike—of important aspects of chronic pain and its appropriate treatment. The National Pain Strategy recommends a national public awareness campaign involving public and private partners to address misperceptions and stigma about chronic pain. The learning objectives of the campaign would emphasize the impact and seriousness of chronic pain and its status as a disease that requires appropriate treatment. In addition, an educational campaign on the safer use of pain medications that is targeted to people with pain whose care includes these medications is recommended.

**Next Steps for Implementation**

Sustained efforts across HHS, working through operating divisions, staff divisions, and also with non-governmental partners, will be required in order to implement the public health, clinical, and research initiatives described in this Strategy. These efforts will help to prevent pain, improve patient care and outcomes, assure appropriate patient and provider education, and advance pain-related applied research. The Office of the Assistant Secretary for Health (OASH), in conjunction with HHS operating and staff divisions, will consider the recommendations included in the Strategy and develop an implementation and evaluation plan based on this process.
THE NATIONAL PAIN STRATEGY: A Vision

The objectives of the National Pain Strategy aim to decrease the prevalence of pain across its continuum from acute to high-impact chronic pain and its associated morbidity and disability across the lifespan. The intent is to reduce the burden of pain for individuals, their families, and society as a whole. The Strategy envisions an environment in which:

- People experiencing pain would have timely access to patient-centered care that meets their biopsychosocial needs and takes into account individual preferences, risks, and social contexts, including dependence and addiction.
- People with pain would have access to educational materials and learn effective approaches for pain self-management programs to prevent, cope with, and reduce pain and its disability.
- Patients, including those with low literacy or communication disabilities, would have access to information they can understand about the benefits and risks of treatment options, such as those associated with prescription opioid analgesics.
- All people with pain would be assured of receiving needed preventive, assessment, treatment, and self-management interventions, regardless of race, color, nationality, ethnicity, religion, income, gender, sex, age (neonatal through end of life), mental health and substance use disorders, physical or cognitive disability, sexual orientation and gender identification, geographic location, education, language proficiency, health literacy, or medical condition. All pain-related services would be provided without bias, discrimination, or stigmatization.
- Americans would recognize chronic pain as a complex disease and a threat to public health and productivity. Individuals who live with chronic pain would be viewed and treated with compassion and respect.
- Clinicians would take active measures to prevent the progression of acute to chronic pain and its associated disabilities.
- Clinicians would undertake comprehensive assessments of patients with chronic pain, leading to an integrated, patient-centered plan of coordinated care, managed by an interdisciplinary team, when needed. Treatment would involve high-quality, state-of-the-art, multimodal, evidence-based practices. While most pain care would be coordinated by primary care practitioners, specialists would be involved in the care of patients who have increased co-morbidities, complexity, or are at risk for dependence or addiction.
- Clinicians would receive better education and training on biopsychosocial characteristics and safe and appropriate management of pain. Clinician’s knowledge would be broadened to encompass an understanding of individual variability in pain susceptibility and treatment response, the importance of shared (patient-providers) and informed decision-making, ways to encourage pain self-management, appropriate prescribing practices, how empathy and cultural sensitivity influence the effectiveness of care, and the role of complementary and integrative medicine.
- Payment structures would support population-based care models of proven effectiveness in interdisciplinary settings and encourage multimodal care aimed at improving a full range of patient outcomes.
- Electronic data on pain assessment and treatment would be standardized, and health
systems would maintain pain data registries that include information on the psychosocial/functional impact of chronic pain and the costs and effectiveness of pain management interventions.

- These data resources would be used in an ongoing effort to evaluate, compare, and enhance health care systems, identify areas for further research, and assess therapies for quality and value.
- The evolution toward a public health approach to pain prevention and care would be facilitated by epidemiologic, health services, social science, medical informatics, implementation, basic, translational, and clinical research, informed by clinician/scientist interactions.
- Data on the health and economic burdens of chronic pain would guide federal and state governments and health care organizations in their efforts to work toward these objectives. Such data would lay the groundwork for enhancing the effectiveness and safety of pain care overall and for specific population groups and would enable monitoring of the effectiveness of policy initiatives, public education efforts, and changing treatment patterns.
- A more robust and well trained behavioral health work force would be available to support the needs of patients who suffer from chronic pain, including those at risk who need mental health care and substance abuse prevention and recovery treatment.
- The actions in this strategy would be undertaken in the context of the dual crises of pain and opioid dependence, overdose, and death in the United States. Actions to improve pain care and patient access to and appropriate use of opioid analgesics for pain management would be coordinated and balanced with the need to curb inappropriate prescribing and use practices. To achieve this balance a broad range of stakeholders including those engaged in pain care and pain care policies, as well as those working in substance use prevention, treatment, and recovery, would be engaged as the actions of the NPS are undertaken.

**BACKGROUND**

The 2010 Patient Protection and Affordable Care Act (PPACA) Section 4305, required the Secretary of HHS to enter into an agreement with the IOM for activities to increase the recognition of pain as a significant public health problem, identify and reduce barriers to appropriate care, evaluate the adequacy of assessment, diagnosis, treatment, and management of acute and chronic pain across the population, and improve pain care research, education and care. As a result, HHS, working through the NIH, commissioned an IOM study to assess the state of pain care. The IOM report, issued in June 2011, included 16 recommendations for improvements in:

- data collection and reporting
- the availability and effectiveness of pain care
- public, patient, and professional education about pain
- relevant basic, translational, and clinical research

The IOM’s emphasis on pain as a significant public health challenge, amenable to population
health-level interventions, placed a large share of responsibility for implementing these recommendations on federal health agencies (Institute of Medicine, 2011, p. 5). Specifically, Recommendation 2-2 called for creation of “a comprehensive population health-level strategy for pain prevention, treatment, management, and research.”

The following year, HHS created the IPRCC to coordinate all pain research efforts within HHS and across other Federal Agencies. In October 2012, the Assistant Secretary for Health asked the IPRCC to oversee the creation of the comprehensive population health-level strategy envisioned in IOM Recommendation 2-2. The IPRCC and NIH established a framework for developing a National Pain Strategy, in consultation with the Chair and Vice Chair of the IOM Committee.

The six key areas addressed in the National Pain Strategy are:

- population research
- prevention and care
- disparities
- service delivery and payment
- professional education and training
- public education and communication

The IPRCC selected expert working group members to address each of these key areas and created an oversight panel (Appendices A and B) to guide and coordinate the working groups’ interrelated efforts. Nominations for working group and oversight panel membership were solicited from professional societies, federal and state agencies, private foundations, advocacy organizations, and through the Federal Register (Appendix C). The goal was broad representation from relevant public and private organizations, health care providers, insurers, and people with pain and their advocates, as recommended by the IOM committee. The body of this report is structured to reflect the results of the work groups’ deliberations. Each of the six sections includes a statement of the problem and a set of priority objectives with accompanying discrete and achievable deliverables to address the problem. The time frame for completion of deliverables is presented as short (approximately one year), medium (two to four years), and long term (within five years). Stakeholders best positioned to achieve the deliverables are identified and metrics to assess progress are suggested.

The report is intended to initiate a longer-term effort to create a cultural transformation in how pain is perceived, assessed, and treated—a significant step toward the ideal state of pain care. An ensuing companion strategy to address the crucial contribution of research to the NPS objectives also is being developed by the IPRCC.