September 6, 2022

Board of Pharmacy Specialties

2215 Constitution Avenue, N.W.

Washington, DC 20037-2985

Dear BPS Board Members:

We are writing in strong support for the establishment of the pain management pharmacy practice board specialty. The recognition and promotion of specialized training and skills in pain management is of utmost importance given the current needs in the United States, where chronic pain is the most pervasive chronic health condition, with fifty million Americans, or 1 in 6, in daily or near daily pain, and almost 20 million in pain severe enough that it regularly prevents them from engaging in basic life activities and work. Moreover, the co-occurring drug overdose crisis and the current shortage of specialists in pain management have left too many people living with pain with impeded access to appropriate pharmacotherapy services.

The **National Pain Advocacy Center (NPAC)** is a 501(c)(3) nonprofit alliance of clinicians, scientists, public health experts, and people with lived experience of pain or addiction, working together to advance the health and human rights of people with pain. We take no pharmaceutical or industry funding and are currently funded by grants from Open Societies Foundation, the Ford Foundation, and individual donations.

We applaud the BPS Board of Directors (the Board) for its explicit recognition of the “demand [for] a specific body of knowledge and skills to provide effective pain management services to patients with increasingly complex care needs.”[[1]](#footnote-1) The growing recognition of chronic pain as a diagnosis in need of treatment, and the understanding that the best treatment is often delivered in multi-disciplinary teams of which pharmacists can play a critical role, provide strong justifications for this specialty.

People with pain often present complex cases, involving both comorbid conditions and polypharmacy use; they require specialized care and follow up. Indeed, the need for specialized care for people with chronic pain is increasingly being recognized throughout the healthcare ecosystem, as exemplified by the recent Notice of Proposed Rulemaking by the Centers for Medicare and Medicaid Services to create bundle payments for chronic pain management.[[2]](#footnote-2)

To meet the scale and impact of chronic pain in the US, this and other improvements to the national pain management infrastructure are essential. The establishment of the pain management pharmacy practice board specialty will play a critical role in this effort, helping to build and buttress the pain management infrastructure and to bridge existing gaps in care.

Indeed, pharmacists are often at the forefront of patient care. Pharmacists play a vital role in ensuring safe medication use. Pharmacists also work within interdisciplinary teams to address patient needs. Given the shortage of pain specialists in the US, most management of pain has shifted to clinicians working in primary care settings, where collaborative work with skilled pharmacists is especially beneficial.

While other existing pharmacy specialties, such as oncology and psychiatry, may deal with pain issues, these specialties are pain-adjacent, and are unlikely to cover care for a substantial group of patients with long-term pain, A stand-alone pain management specialty is warranted to meet the gaps outlined herein.

For all of these reasons, we strongly support the Board’s efforts. We write further to offer input to the Board on the content of this specialty. We specifically urge the Board to consider educating pharmacists about inequities, disparities, social determinants of health and pain, and medico-legal issues – all of which significantly impact access to pharmacotherapy services.

There is ample evidence of race, ethnic, gender, gender identity, and disability-based bias in pain assessment and treatment.[[3]](#footnote-3) There is also evidence that Black, Indigenous, People of Color generally receive less pain medication than white patients, even after surgery.[[4]](#footnote-4) Both chronic pain and substance use disorder disproportionately impact historically-disadvantaged communities. Specialists must not only possess the clinical skills to manage complex pain syndromes, they should also understand the intersectional issues that affect adequate and timely access to pain care.

Medico-legal competency is similarly important. While pharmacotherapy for pain involves a wide variety of potential medications, many patients with chronic pain currently use controlled medications to manage it. Several patient advocates on NPAC’s Community Leadership Council have experienced significant barriers in accessing proper pain relief and medication, amid increased scrutiny of controlled medication prescribing. These barriers have been compounded for those from traditionally-disadvantaged groups. Clinically appropriate pain management requires individualization and nuance, which are more likely to emerge from a broad understanding of the social, legal and medical landscape.

Finally, we urge the Board to consider soliciting the input of people with lived experience of pain in the development of this specialty. NPAC’s work is achieved through collaboration of its community members with lived experience, and its science and policy experts. Were the Board to consider integration of patient input and patient representation in the development of the specialty core competencies, we would be happy to offer input on defining skills and competencies.

In closing, we sincerely thank you for your efforts to recognize the importance of ensuring quality care for the tens of millions of Americans living with chronic pain. We also thank you for your consideration of our comments.

Sincerely,

Kate M. Nicholson Juan M. Hincapie-Castillo

Kate M. Nicholson, JD Juan M. Hincapie-Castillo, PharmD, MS, PhD

Executive Director President of the Board

1. See BPS Issues Call for Petition in Pain Management Pharmacy Practice, October 20, 2021, <https://www.bpsweb.org/2021/10/20/bps-issues-call-for-petition-in-pain-management-pharmacy-practice/> [↑](#footnote-ref-1)
2. 2023 Physician Fee Schedule and other changes to Part B payment policies, 87 Fed. Reg. 45860 (July 29, 2022). Our comments focus solely on Section 33, Chronic Pain Management and Treatment (CPM) Bundles (HCPCS GYYY1 and GYYY2), 87 Fed. Reg. 45932-45938, <https://www.federalregister.gov/documents/2022/07/29/2022-14562/medicare-and-medicaid-programs-cy-2023-payment-policies-under-the-physician-fee-schedule-and-other> [↑](#footnote-ref-2)
3. *See, e.g.,* Hoffman KM, et al. Racial bias in pain assessment and treatment recommendations, and false beliefs about biological differences between blacks and whites. Proc Natl Acad Sci U S A. 2016 Apr 19;113(16):4296-301. doi: 10.1073/pnas.1516047113. Epub 2016 Apr 4. PMID: 27044069; PMCID: PMC4843483; Yee, Sylvia et al. Compounded Disparities, Health Equity at the Intersection of Disability, Race, and Ethnicity, <https://dredf.org/wp-content/uploads/2018/01/Compounded-Disparities-Intersection-of-Disabilities-Race-and-Ethnicity.pdf>; Samulowitz, Anke et al. “"Brave Men" and "Emotional Women": A Theory-Guided Literature Review on Gender Bias in Health Care and Gendered Norms towards Patients with Chronic Pain.” *Pain research & management* vol. 2018 6358624. 25 Feb. 2018, doi:10.1155/2018/6358624.

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4. *See, e.g*., Lee P, et al. Racial and ethnic disparities in the management of acute pain in US emergency departments: Meta-analysis and systematic review. Am J Emerg Med. 2019 Sep;37(9):1770-1777. doi: 10.1016/j.ajem.2019.06.014. Epub 2019 Jun 5. PMID: 31186154; Sabin J et al. The influence of implicit bias on treatment recommendations for 4 common pediatric conditions: pain, urinary tract infection, attention deficit hyperactivity disorder, and asthma. Am J Public Health. 2012 May;102(5):988-95. doi: 10.2105/AJPH.2011.300621. Epub 2012 Mar 15. PMID: 22420817; PMCID: PMC3483921.

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