Board-Certified Psychiatric Pharmacists and Their Potential Role in Addressing Behavioral Health Workforce Shortages

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Board-certified psychiatric pharmacists (BCPPs) are doctorate-level, board-certified experts in managing medications for people living with psychiatric disorders, including substance use disorders. BCPPs work as part of an integrated health care team that provides comprehensive medication management focused on optimizing medication-related outcomes and ensuring the safety of the prescribed medications. The authors describe BCPP education and training, settings in which BCPPs practice, and in what roles. Current policies that limit BCPP involvement in behavioral health care and proposed solutions to support the role of BCPPs in addressing behavioral health workforce shortages are discussed.

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The National Center for Health Workforce Analysis predicts a shortage of more than 59,000 psychiatrists by 2036, along with significant shortages of other behavioral health providers, such as mental health and addiction counselors (1). In its report (1), the Health Resources and Services Administration cites scope-of-practice and reimbursement issues as contributors to these shortages.

People with serious mental illnesses (such as schizophrenia, bipolar disorder, or major depression, and their related spectrum disorders) have mortality rates two to three times that of individuals without such illnesses, with 60% of those rates attributable to inadequately treated comorbid conditions such as diabetes and cardiovascular disease (2, 3). This vulnerability is further compounded by multiple chronic conditions and complex medication regimens for individuals living with mental illness. In addition, some medications used to manage psychiatric disorders, such as antipsychotics and mood stabilizers, may cause or exacerbate medical conditions (4). Board-certified psychiatric pharmacists (BCPPs) are experts in medication management and are therefore uniquely positioned within health care teams to help optimize medication use and improve care coordination. Therefore, adding BCPPs to health care teams may help address the psychiatric workforce shortage.

BCPP EDUCATION, TRAINING, AND CREDENTIALING

In the United States, pharmacists hold a doctor of pharmacy (Pharm.D.) degree and are licensed in the state(s) in which they practice. BCPPs are pharmacists who have completed additional specialized clinical training or experience, typically 1 year of an accredited postgraduate general residency program, followed by a second year focused on the treatment of patients with psychiatric disorders. The training includes direct patient care in inpatient and outpatient behavioral health settings with additional experiences in areas such as neurology, substance use disorders, and chronic pain, as well as child and adolescent, geriatric, and consultation-liaison psychiatry. BCPPs are trained in interviewing, evidence-based communication, nonpharmacologic treatments for psychiatric disorders, rating scale administration and interpretation, and evaluating laboratory tests.

To become board certified, pharmacists must pass a Board of Pharmacy Specialties certification exam demonstrating expertise in optimal psychiatric medication use. BCPPs renew certification every 7 years by passing an exam or completing recertification continuing education materials. As of this writing, 1,456 BCPPs are active in the United States (5). BCPPs work in a wide range of health care systems, including academic, federal, state, county, private, community, managed care, or forensic agencies, and in settings such as hospitals, behavioral health facilities, primary care clinics, and telehealth delivery.

COLLABORATIVE PRACTICE AGREEMENTS

All states allow pharmacists to enter into a collaborative practice agreement (CPA), collaborative drug therapy management, or scope of practice with a licensed provider (collectively referred to as CPAs hereafter). These mechanisms are used to document a formal relationship between a BCPP and a

prescriber (such as a medical doctor, a nurse practitioner, or a physician assistant, as defined by state law) in which the medical provider delegates authority to perform specific tasks to the pharmacist, within state scope-of-practice regulations. The agreement outlines the activities and responsibilities of the pharmacist, which may include patient assessment, prescribing medication (initiation, modification, or discontinuation), laboratory testing, and drug monitoring, as well as documentation of the pharmacist's assessment, clinical findings, and plan of care. The extent of the authority delegated to the pharmacist varies by state (https://naspa.us/blog/resource/swp#unique-identifier-continuum). A CPA improves efficiency by allowing the BCPP to make changes at the point of care rather than specifying recommendations for the caring physician to execute later, thereby reducing physician burden and obviating delays in care adjustment. In 10 states, pharmacists may hold a Drug Enforcement Administration license (https://www.deadiversion.usdoj.gov/drugreg/practioners/mlp_by_state.pdf). Given the recent removal of the X waiver, pharmacists who hold a license in these states can prescribe medications to treat patients with opioid use disorder through a CPA.

BCPP ROLES

BCPPs are integrated into multidisciplinary teams in which they collaborate with other clinicians. The primary role of BCPPs is to evaluate and optimize medication regimens for patients with psychiatric disorders, providing a service that complements the roles of other health care professionals on the team. BCPPs meet face to face with patients in a private setting. BCPPs strive to help patients meet clinical, patient-centered, and medication-related treatment goals for both psychiatric and general medical conditions, using the evidence-based process of comprehensive medication management (CMM) (https://gtmr.org/what-is-the-comprehensive-medication-management-process).

A physician or other provider typically refers a patient to a BCPP when the patient takes a complex medication regimen, has multiple co-occurring disorders, experiences significant adverse reactions, or responds inadequately to treatment. The BCPP meets with the patient to review the medical conditions history and treatment goals and to evaluate all prescription and nonprescription medications and supplements for indication, effectiveness, safety (including consideration of adverse effects and drug interactions), and adherence and any substance use for amount, patient-perceived impact (benefit or harm), willingness to change, and interactions with medications. The impact of psychiatric medications on co-occurring conditions and the effect of managing these comorbid conditions on the psychiatric condition are assessed. Duplicate or unnecessary medications are discontinued if appropriate. A care plan is developed to address medication-related problems, and follow-up appointments assess the impact of medication changes (additions, dose changes, or discontinuations) that may be made by the pharmacist or provider. This process is repeated until patients either reach their treatment goals or experience a deterioration in health.

BCPPs do not replace physicians or other prescribers but rather support and complement their work by focusing on optimizing medication regimens. BCPPs work closely with behavioral health providers, making referrals for diagnostic clarification or therapy, if they are not currently engaged in treatment. BCPPs maintain regular communication and collaboration with other members of the health care team, including coordinating care with specialists or other health systems, to ensure seamless medication treatment during transitions of care. Patients who receive BCPP services continue to see their physician(s) for follow-up care or new problems but may do so less frequently. Having BCPPs on the health care team increases the team's capacity to care for more patients, especially those needing access to behavioral health care. BCPPs can assume some of the responsibilities delegated by the provider through a CPA as outlined above, thereby increasing availability of psychiatric providers to perform tasks, such as diagnostic assessment, that are specific to their scope.

For example, BCPPs may contribute to care by evaluating and addressing adverse metabolic effects of psychotropic medications. Using current guidance for antipsychotic metabolic monitoring and evidence regarding comparative metabolic risk of individual antipsychotics, the BCPP can help identify a medication that manages the psychiatric condition while minimizing the medication's impact on blood glucose and lipid levels (6).

The Veterans Health Administration (VHA) has embraced the role of BCPPs in behavioral health care (https://www.pbm.va.gov/PBM/CPPO/Clinical_Pharmacy_Practice_Office_ResourcesAndTools.asp). As of February 2023, about 521 clinical pharmacist practitioners (CPPs) practiced in behavioral health care in 140 VHA facilities (7). In 2022, behavioral health CPPs had 439,360 patient encounters. In 2023, the VHA approved 30 additional behavioral health CPP positions to be added between 2024 and 2026.

The VHA has also recognized pharmacists as important members of the clozapine treatment team (8). During the COVID-19 pandemic, and in response to changes to the clozapine Risk Evaluation and Mitigation Strategy program, this role was further expanded to include CPPs as clozapine prescribers or assign them the role of clozapine treatment manager for a given facility (9).

Kaiser Permanente Northern California provides a practice model in which pharmacists with psychiatric training provide telehealth-based collaborative CMM to patients with serious and persistent mental illness (10). In its pilot phase, 840 of 968 contacted patients (87%) completed an intake appointment, of whom 73% (N=613) followed up with a pharmacist appointment within 6 months, rating satisfaction with their pharmacist as 93 out of 100. Notably, patients who had left psychiatric care (i.e., had no psychiatric visits in the previous year) reengaged in treatment, with 54% (N=96 of 178) attending follow-up psychiatric pharmacist visits.

BCPPs can be part of the collaborative care model (CoCM), along with primary care providers, behavioral health care managers, and psychiatric consultants, to increase

the number of patients with psychiatric disorders who are treated and retained in the primary care setting. BCPPs can help the primary care physician identify appropriate psychotropic medications and manage co-occurring conditions. Patients with more complex conditions beyond the scope of the primary care setting may be referred to a psychiatrist, improving access to psychiatric care for those who need it the most. Research supports the benefits of incorporating clinical pharmacists into the health care team, including for patients with psychiatric and substance use disorders (11–14).

POLICIES LIMITING BCPP PRACTICE

Although BCPPs provide CMM services in many settings outside of the VHA and Kaiser Permanente systems, current policies limit the positive impact of BCPPs on care. The Centers for Medicare and Medicaid Services (CMS) currently does not include BCPPs on its list of qualified health care professionals under the physician fee schedule and does not pay for BCPP services. In contrast, Medicaid and local or regional health plans in some states pay for pharmacist services, including those provided via telehealth (15). Inconsistent payment, or lack of payment, limits the number of practices that can employ a psychiatric pharmacist and constrains the number of BCPPs practicing in the United States. Additionally, CMS prohibits BCPPs from serving as the psychiatric consultant in the CoCM, limiting the contribution of BCPPs to that model. The CoCM has had limited uptake because of challenges with reimbursement, communication, and colocation (16). CoCM uptake could be expanded by integrating BCPPs into primary care settings where they could serve as the onsite psychiatric medication expert on the team.

PROPOSED SOLUTIONS AND CONCLUSIONS

Policy changes could increase the number of BCPPs available for integration into health care teams and help mitigate the psychiatric workforce shortage. For BCPPs to be most impactful, we recommend that CMS include BCPPs on the list of qualified health care professionals and add BCPP-provided CMM as a covered service. We also recommend that BCPPs be allowed to serve as psychiatric providers in the CoCM in primary care settings to increase access to this evidence-based model of care. Finally, payment for telehealth services provided by psychiatric pharmacists could increase patients' access to mental health and substance use disorder treatments, particularly in rural and underserved areas. If implemented, our recommendations may help address the current behavioral health workforce shortage in the United States.

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