U.S. Department of Veterans Affairs
Veterans Health Administration
Pharmacy Benefits Management (PBM) Services
Clinical Pharmacy Practice Office (CPPO)

Clinical Pharmacist Practitioner (CPP) Role in Substance Use Disorders (SUD)
June 2024

The Clinical Pharmacist Practitioner (CPP) is an integral provider in the provision of comprehensive medication management (CMM) services in Substance Use Disorder (SUD) treatment. Full integration of the CPP in collaborative care roles can significantly improve access to CMM for patients with SUD throughout the VA.

Key Takeaways include:

- In 2022, 3.6 million Veterans had a SUD.[1]
- Multiple factors contribute to limited access to treatment for patients with SUD, including provider education and training, poor integration between primary care and specialty addiction care, absence of systematic assessment for SUD, among others.[2]
- The CPP is uniquely trained to provide CMM services for Veterans with SUD due to their extensive knowledge of medications, clinical pharmacology, pharmacokinetics, pharmacodynamics, and therapeutics. This is a combined skill set that is unique to this group of health care professionals.
- The CPP is a core member of the interprofessional care team, providing CMM services with demonstrated positive impact on SUD care access, Veteran engagement, and treatment retention. Integration of CPPs across the stepped care model improves access to SUD care by increasing the number of prescribers available to treat Veterans, positively impacting quality Strategic Analytics for Improvement and Learning (SAIL) metrics, such as SUD16, as well as Opioid Safety Initiative (OSI) metrics and Psychopharmacology Drug Safety Initiative (PDSI) metrics. CPP CMM services include:
    - Screening for substance and polysubstance use disorders as well as referral for diagnosis
    - Post-diagnosis, initiation and management of medications, medication education and referral for other needed care [e.g., therapy, housing assistance, acute care needs, etc.]
    - Risk mitigation [e.g., Prescription Drug Monitoring Program (PDMP) review, ordering and interpretation of urine drug screens (UDS), provision of opioid overdose education, syringe service programs and naloxone distribution (OEND)] and may take on the role of care coordinator
- When the CPP is a DEA registered practitioner, team and practice efficiency is improved when benzodiazepine management, opioid tapers and other controlled substance prescribing, including buprenorphine, is needed.
- VA facilities have a significant opportunity to expand the CPP workforce and optimize their roles in SUD CMM to bridge gaps in care and provide this much needed Veteran care as a routine part of CPP practice.

SEE FOLLOWING SECTION FOR FULL NARRATIVE OF THESE POINTS

Background

Environmental stressors unique to Veterans have been linked to increased risk of developing a Substance Use Disorder (SUD), including deployment, combat exposure, and post-deployment civilian and reintegration challenges.[3] In 2022, 3.6 million Veterans had a SUD.[1] Alcohol remains the most used substance among Veterans with more than a third of alcohol users reporting binge drinking over the past month and among Veterans aged 18 to 49, 32.7% report using illicit drugs in the past year.[1] [1] When comparing Veterans to the civilian population, Veterans are more likely to use alcohol and report heavy use of alcohol. Of Veteran admissions to substance use centers, 65% of Veterans report using alcohol, more than 10% report the use of heroin, and 6.5% cocaine.[3] Additionally, Veterans are more likely to experience pain and more severe pain compared to their civilian counterparts with Veterans also being twice as likely to die from an opioid overdose.[4,5] In 2022, 107,941 drug overdose deaths occurred, resulting in an age-adjusted rate of 32.6 per 100,00 standard population in the United States according to the Centers for Disease Control necessitating a call to action.

Multiple factors have been identified as contributing barriers to treatment access for patients with SUD, including education and training, poor integration between primary care and specialty addiction care, absence of systematic assessment for SUD, among others.[2] Some vulnerable Veteran populations such as patients with psychiatric comorbidities and the elderly may not wish to seek care outside of their medical home, leading to considerable risk. In addition, medical comorbidities common to the Veteran population are associated with poorer outcomes in SUD and treating comorbid conditions may improve treatment, psychosocial, and functional outcomes. These facts demand a comprehensive, collaborative, interprofessional team approach to treat this high-risk population and provide needed access to care.

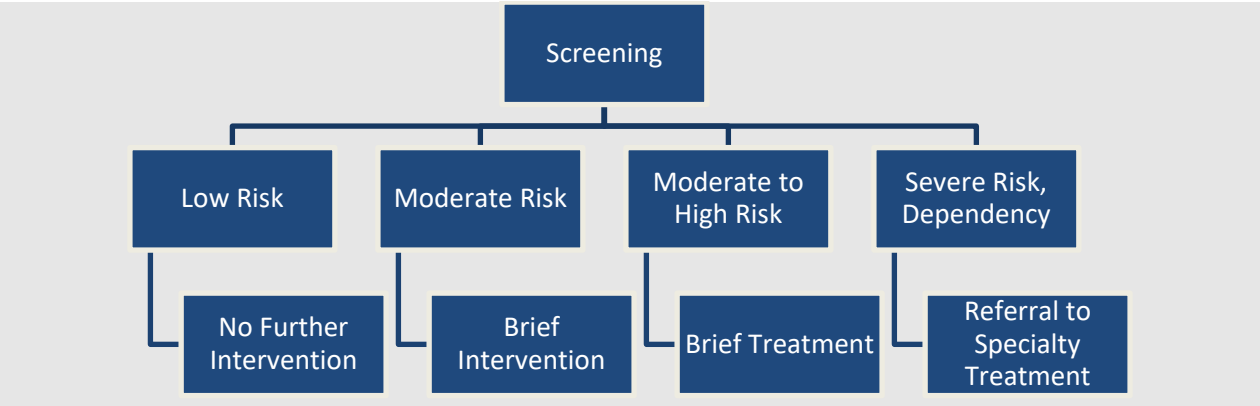
CLINICAL PHARMACY PRACTITIONER (CPP) PROVIDER PRACTICE IN SUBSTANCE USE DISORDERS (SUD)

The CPP is an Advanced Practice Provider who is authorized, under a scope of practice, to provide Comprehensive Medication Management (CMM) in a variety of practice settings as described in VHA Handbook 1108.11 Clinical Pharmacy Services. In this role, the CPP is a core member of the interprofessional care team with demonstrated positive impact on SUD care access, quality of care, Veteran engagement and satisfaction, and treatment retention (see Evidence Bibliography – Clinical Pharmacy Practice in Substance Use Disorder). [6-14] In addition to prescribing, CPP roles and responsibilities include executing therapeutic plans, physical and objective disease assessment, utilizing quantitative instruments to screen for and address addiction and withdrawal, ordering labs and diagnostic tests, taking corrective action for identified drug-induced problems, making referrals to maximize positive outcomes, and obtaining and documenting informed consent for treatments and procedures. The CPP applies the principles of team-based care and population management to proactively identify Veterans who may benefit from CPP services with a focus on at-risk Veterans, risk mitigation opportunities, and harm reduction strategies. Collectively, these activities focus on treatment appropriateness, effectiveness, safety, and adherence for SUD in addition to co-morbid care needs. In support of a collaborative, team-based approach, the VHA Directive 1160.04 VHA Programs for Veterans with Substance Use Disorders includes CPPs in the description of disciplines to support SUD outpatient clinical teams and intensive outpatient programs. Additionally, the VHA Directive 1160.01 Uniform Mental Health Services in VHA Medical Points of Services includes CPPs in the definition of MH providers.

Integration of CPPs across the stepped care model significantly improves access to SUD care by increasing the number of prescribers available to treat Veterans and positively impacting quality SAIL metrics, such as SUD16 as well as OSI and PDSI metrics. Through implementation of Screening, Brief Intervention, and Referral to Treatment (SBIRT), the CPP is an integrated practitioner who addresses unhealthy substance use to improve prevention and treatment of Veterans at-risk for SUD **(Figure 1)**.[15] As CPPs practice along the continuum of the stepped model of care, they also play a significant role in the referral of Veterans to

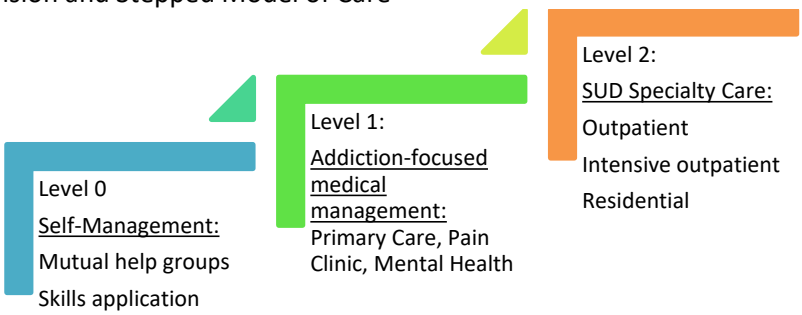
Residential Rehabilitation Treatment Programs (RRTP) and inpatient detoxification, as well as the providing CMM for opioid use disorder (OUD), alcohol use disorder (AUD), stimulant use disorder (StimUD), polysubstance use, and cannabis use. The Fact Sheet - CPP Role in Opioid Safety further describes the CPP role in opioid safety outcomes.

Figure 1: Screening, Brief Intervention, and Referral to Treatment (SBIRT)



CPP practice settings for SUD care include but are not limited to the following: PACT, PCMHI, BHIP/General Mental Health, Pain Management, Outpatient Specialty SUD Clinics, Intensive Outpatient Programs, RRTP, Acute Care (e.g., inpatient, emergency department), and Medically Managed Intensive Inpatient SUD. Veterans in rural settings face particular barriers to receiving care and access and CPPs help bridge this gap to provide care for SUD treatment. The CPP is integrated into each level of care consistent with the VA Stepped Care Model of SUD treatment: Level 0 and 1, self-care and primary care-based management, progressing through higher complexity care needs with Level 2, Specialty Care **(Figure 2)**.

Figure 2: SUD Provision and Stepped Model of Care



As part of CMM, CPPs manage medication for OUD (mOUD) across practice settings using home-based initiation when appropriate. After an OUD diagnosis has been made, the CPP can initiate and manage naltrexone or buprenorphine (the latter can be done in collaboration with a DEA registered prescriber or by the CPP if they have controlled substance prescribe authority in an unrestricted state). CPPs also address unhealthy alcohol use to prevent or treat AUD, improving access to AUD pharmacotherapy as well as providing medication education to practitioners and patients.[25-26] Similar to OUD, after an AUD diagnosis is made, the CPPs initiate and manage evidence-based pharmacotherapy. The AUD Academy Workbook was created as a self-directed learning guide to provide CPPs with resources and activities to navigate professional growth, development, and competency regarding AUD care, specifically in the

primary care setting. The CPP encourages referral to psychotherapeutic services to improve chances of successful outcomes, and facilitates consultation as indicated. CPPs may directly manage withdrawal management, both in the inpatient and outpatient settings. For Veterans diagnosed with StimUDs, where FDA approved pharmacological treatment options do not exist, contingency management (CM) evidence-based therapy or other appropriate psychosocial resources (e.g., Cognitive Behavioral Therapy (CBT), Recovery-Focused Behavioral Therapy) are appropriate. CPPs have a role in abstinence and adherence CM. Additionally, the CPP is a leader in tobacco cessation programs through CMM and well equipped to work with Veterans with complex comorbid mental health and substance use conditions.[6-15, 25-29] The CPP recognizes that any SUD can be associated with medical conditions and other negative health consequences, and as a component of CMM, the CPP facilitates linkage with necessary services.

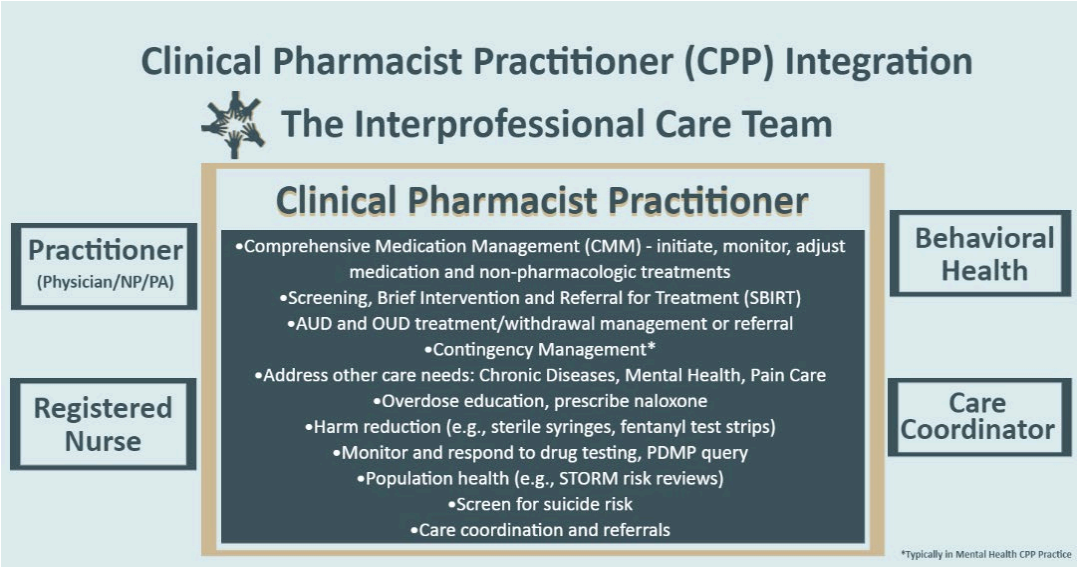
The CPP employs risk mitigation strategies across the spectrum of SUD care including suicide risk assessment and universal precautions and assures co-morbidities are addressed, making needed referrals for care that may be critical to medication treatment for medication retention and treatment outcomes, such as mental health and pain care. The CPP also assesses for opportunities for harm reduction (e.g., unprotected sex, multiple sex-partners, injectable drug administration) and for co-occurring conditions or diseases (e.g., HIV, injection site infection). There are multiple instances of CPP led syringe service programs (SSPs), including a project from the Danville VA Medical Center which was recognized as a 2021 Shark Tank Innovation. Additionally, CPPs are well positioned to identify patients at risk of opioid overdose and prescribe life-saving naloxone. [16-24] As of May 2023, VA has dispensed more than 1 million naloxone prescriptions with CPPs prescribing more than 21% of all naloxone prescriptions ever written and 62% of CPP in the field prescribing this life-saving care. And finally, the CPP may take on the role of care coordinator to ensure risk monitoring and Veteran participation in appointments for needed care.[29] All CPP services in SUD, across the continuum of care, have a global focus on Veteran-centric prevention and treatment of risky substance use, fostering recovering from SUD, normalizing treatment of SUD across care settings, and improving overall patient outcomes.

Table 1 outlines the roles of the CPP across practice settings and **Figure 3** highlights CPP integration on interprofessional teams.

Table 1: CPP Role in SUD Across ALL Practice Settings

CPP Foundational Roles (Primary Care, Inpatient and Emergency Department)	CPP Integration into Substance Use Disorder Collaborative Care (Any setting)
• Screen for SUD when indicated, provide Brief Intervention, treat or Refer for Treatment **(SBIRT)** • Provide patient and caregiver education for SUD, risk mitigation and self-care (e.g., groups, resources) • Use shared decision-making to promote collaborative, evidence-based, patient-centered care and identify realistic, and quality of life goals • Utilize non-stigmatizing language with patients, caregivers, and the healthcare team (including documentation) • Risk Mitigation: ○ Review last urine drug screen (UDS), interpret results, intervene if indicated ○ Query or review last PDMP report, intervene if indicated ○ Identify and address high-risk drug combinations ○ Provide and document overdose education and naloxone education and distribution (OEND) ○ Evaluate appropriateness of opioids and opioid dosing for opioid naïve patients ○ Perform suicide risk screening; when indicated, refer to higher level of care ○ Provide syringe service services to people who inject drugs ○ Refer for other needed care and care coordination	• All foundational roles • Comprehensive medication management for SUD • Utilize motivational interviewing to engage in pharmacological and non-pharmacological treatments for SUD • Provide individualized medication treatment plans and follow-up, including multi-modal pharmacologic and non-pharmacologic options • Initiate, adjust, convert or discontinue medications when clinically indicated • Assess for medication safety & efficacy and modify medication treatment plan to optimize outcomes • Perform targeted risk monitoring as clinically indicated (e.g., order UDS, query PDMP) • Manage medication for OUD (mOUD) pharmacotherapy (in collaboration with DEA registered prescriber if CPP does not have controlled substance prescriptive authority if needed) • Offer and initiate treatment for SUDs • Manage co-morbid needs • Provide harm reduction strategies, when applicable • Interdisciplinary team high risk reviews; provides SUD care consultation; perioperative SUD care management planning and care coordination • Develop perioperative pain management plans for patients with severe chronic pain and on mOUD, history of SUD, prior overdose, or other risk factors

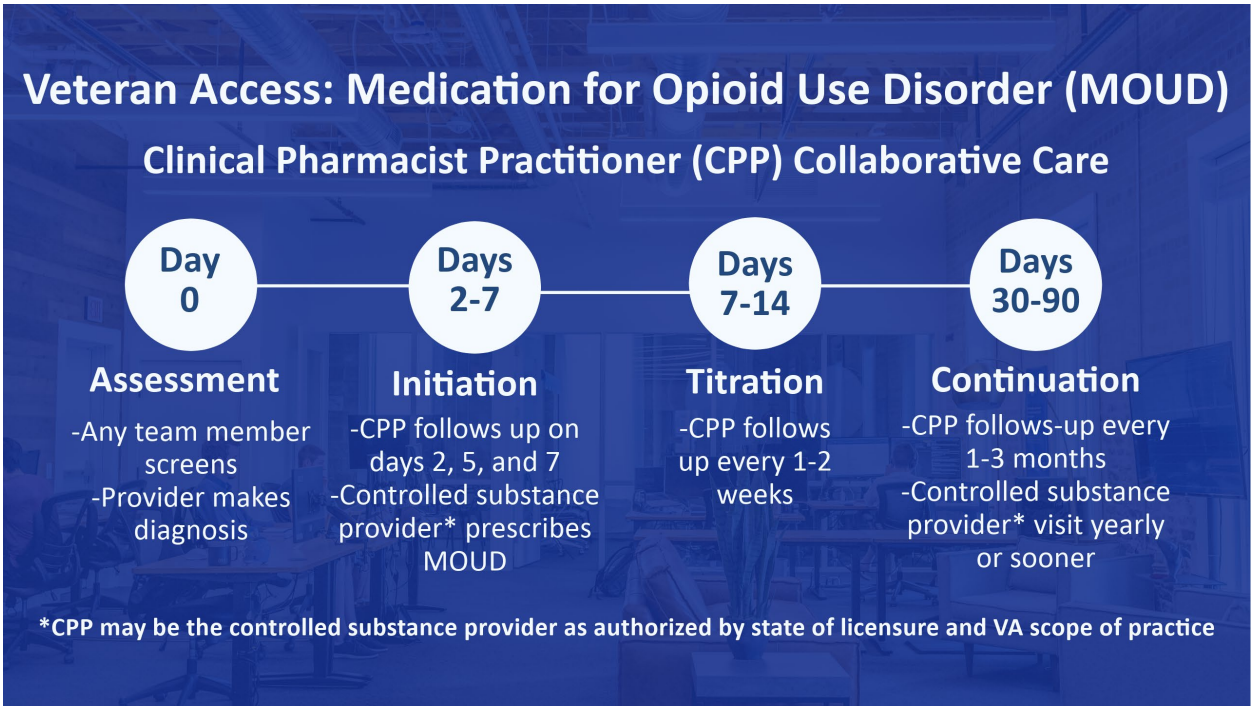
Figure 3: CPP Integration on the Interprofessional Care Team



CPP PRACTICE CONSIDERATIONS

Pharmacy leadership and the facility Executive Committee of the Medical Staff (ECMS) may authorize controlled substance prescribing through the pharmacist scope of practice if the pharmacist's state of licensure (i.e., the statutes and regulations that defines the terms and conditions of the practitioner's license) allows the prescribing and they perform this function in accordance with federal law/regulations, state licensure law/regulations, and VHA Policy. When the CPP is a DEA registered practitioner, team and practice efficiency is improved with benzodiazepine management, opioid tapers and other controlled substance prescribing, including buprenorphine, is needed, particularly in SUD practice. The number of DEA registered CPPs has increased by 1063% from Q3FY20 to Q2FY24. As of Q2FY24, there are 256 DEA registered CPPs across the enterprise and that number is anticipated to grow. This is especially significant given removal of the X-waiver program as part of the Consolidated Appropriations Act, 2023 (H.R. 2617). DEA registered CPPs, when not otherwise restricted by their state of licensure, have authority to prescribe buprenorphine for OUD, thus increasing access to mOUD. From Q3FY23-Q2FY24, 121 DEA registered CPPs prescribed mOUD to 1,366 Veterans at 58 facilities. **Figure 4** demonstrates an example timeline for buprenorphine follow-up for a CPP collaborating with a controlled substance provider or when the CPP is not restricted to prescribe buprenorphine via their own DEA licensure. Detailed information regarding DEA registered CPPs and controlled substance authority is outlined in PBM Guidance Controlled Substance Prescriptive Authority for Pharmacists with additional resources located on the CPPO Controlled Substance Prescriptive Authority SharePoint.

Figure 4: Buprenorphine Timeline Employing the CPP Care Manager Model



For successful integration of the CPP in team-based care, the Care Coordination Agreement (CCA) complements the CPP scope of practice and describes the role of the CPP as part of the interprofessional team. The CCA defines team roles, processes and procedures for the practice area and may be particularly useful for new and evolving practices.

CURRENT ASSESSMENT OF CLINICAL PHARMACY SUBSTANCE USE DISORDER PRACTICE

Figure 5 shows the growth of CPP delivering SUD care by fiscal year. As of Q2FY24, there are 665 CPPs caring for Veterans with SUD (excludes tobacco use disorder encounters), accumulating 199,647 encounters over the past 12 months serving 113,528 Veterans. **Figures 6, 7 and 8** reflect the growing role of CPPs specific to SUD, OUD and AUD care (identified by ICD10 codes and interventions identified through the PhARMD (Pharmacists Achieve Results with Medications Documentation) Tool).

Figure 5. SUD Encounters by a Pharmacist Provider by Fiscal Year and Modality for FY17-FY23

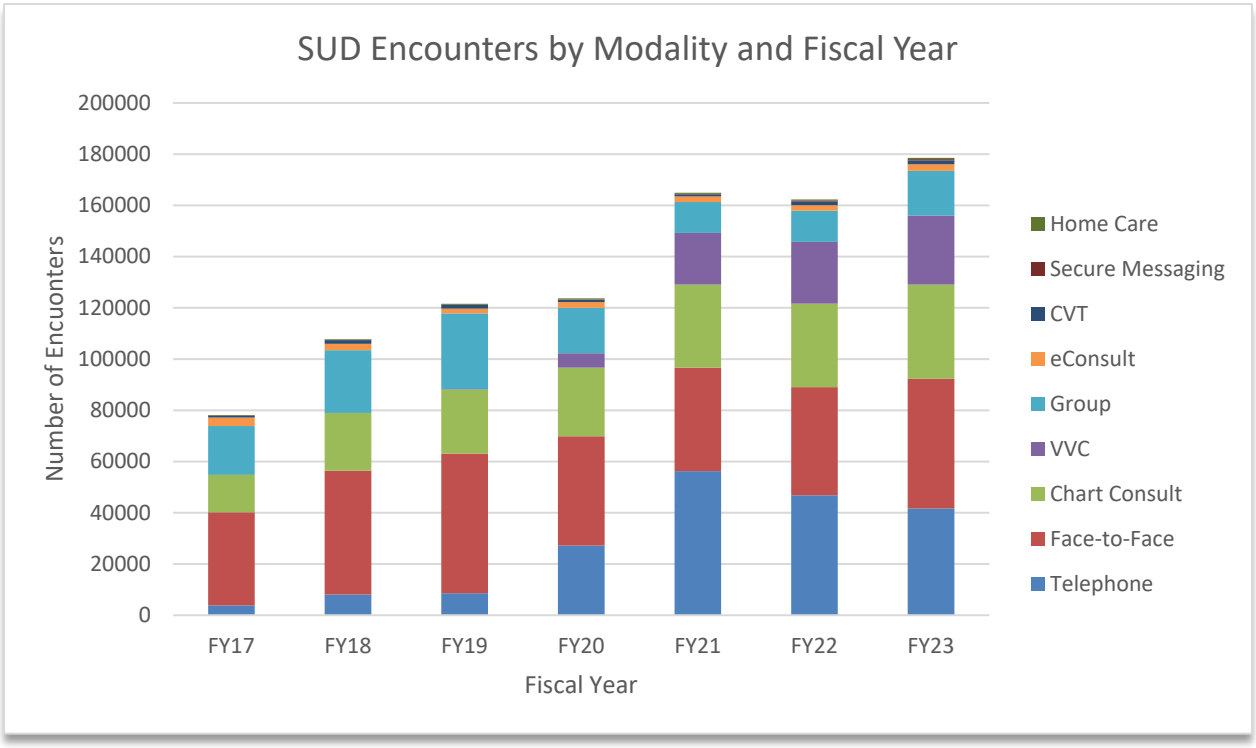


Figure 6. Growth in CPPs Delivering SUD Care Encounters by Fiscal Quarter

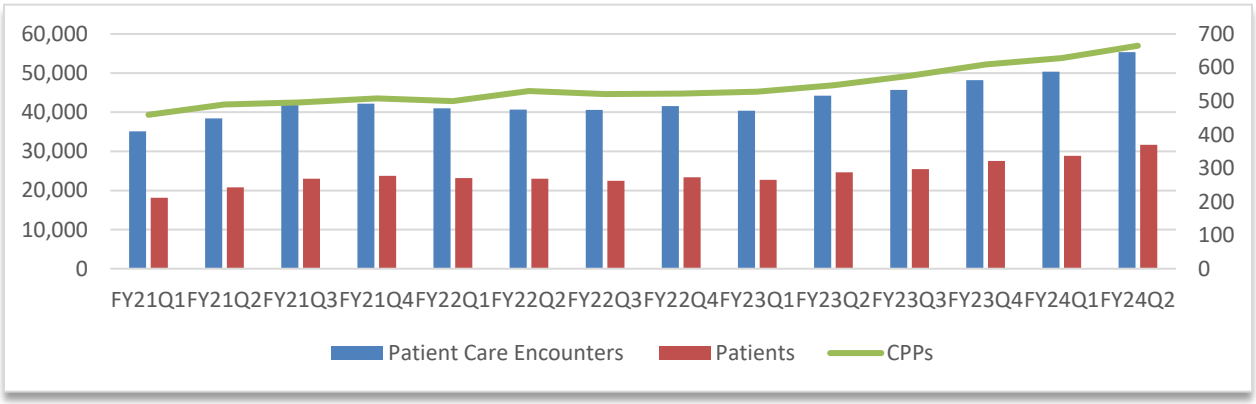


Figure 7. Growth in CPPs Delivering OUD Care Encounters by Fiscal Quarter

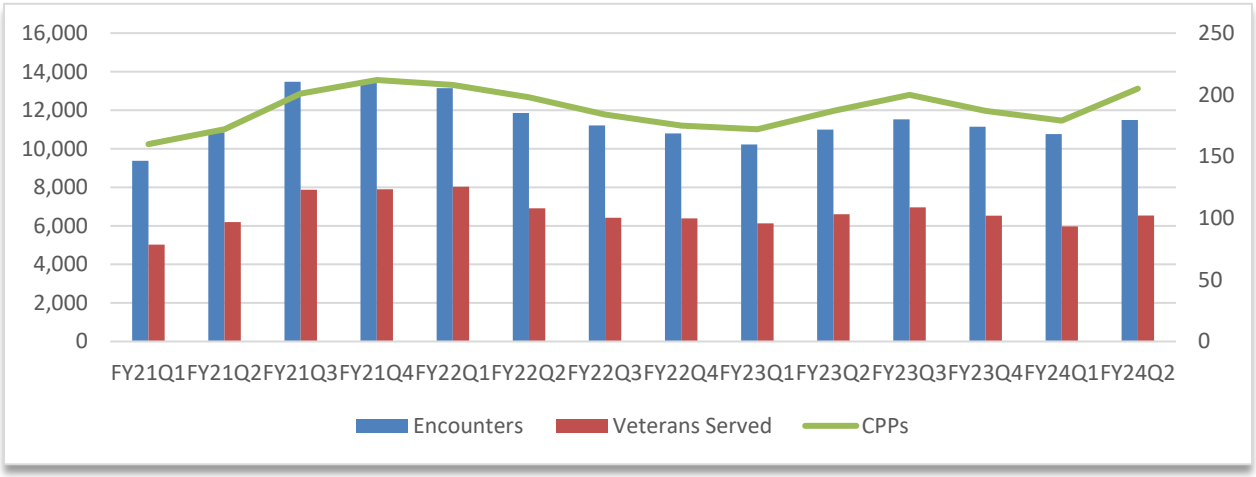
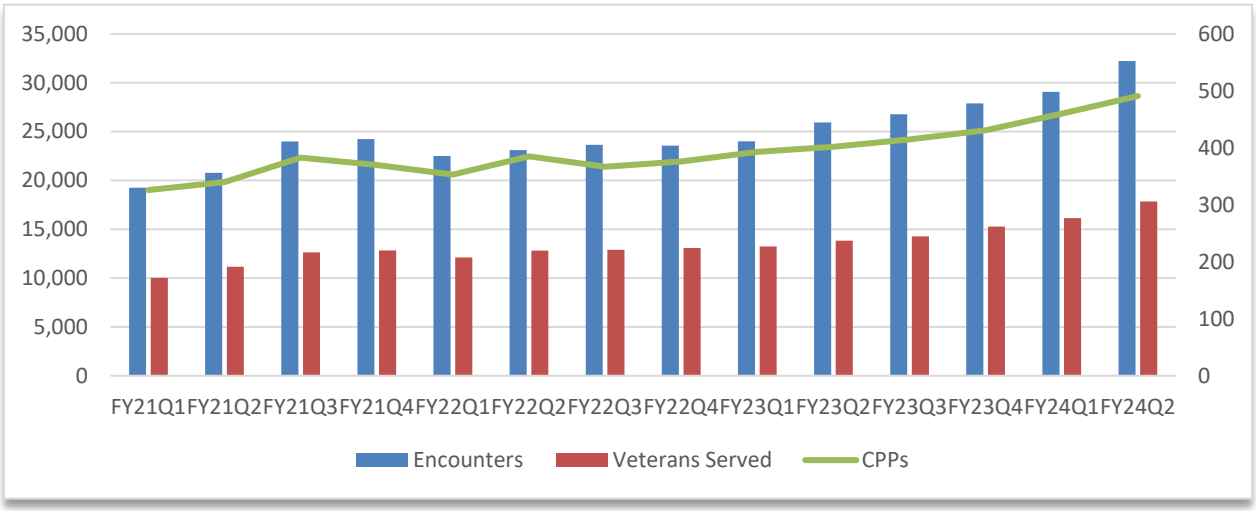


Figure 8. Growth in CPPs Delivering AUD Care Encounters by Fiscal Quarter



SCALABILITY OF CPPs IN SUD

The PBM Clinical Pharmacy Practice Office (CPPO) and the Office of Rural Health (ORH) partnered in FY20 to launch a new enterprise-wide initiative (EWI), "*Leveraging Clinical Pharmacist Practitioner (CPP) Increase Access to Rural Veteran Access (CRVA) with Substance Use Disorder (SUD*)." This EWI affords greater access to medication treatment for rural Veterans with SUD. The CRVA-SUD project focuses on integrating the CPPs into stepped care teams in alignment with the Stepped Care for Opioid Use Disorder (SCOUTT) model with the central priority to promote spread practice across the nation. In this model, the CPP is integrated into the care team and collaborates with the other members of the team, Veterans and caregivers to provide CMM services for SUD, with a particular focus on OUD and AUD. Through EWI funding, 35 CPPs were hired at 34 VA facilities across 17 VISNs with implementation support provided by CPPO. Those CPPs have delivered SUD-focused CMM services for nearly 49,000 Veterans since the inception of the project, with over 66% of care being delivered virtually (telephone, VVC, CVT) to over 50% rural Veterans.

CPPO is excited to continue its partnership with the ORH in Q4FY23 to launch a continuation of CRVA-SUD, now called CRVA Mental Health Rural Expansion and Coordinated Health Efforts in SUD (CRVA MH REACHES). This new initiative will provide funding for 29 MH CPPs at 23 facilities from FY24-FY26 in PCMHI

and BHIP practice areas to include a provision of SUD care. Additionally, CRVA MH REACHES hosted a virtual clinical training focused on concepts of health equity in MH practice in May/June 2024 in alignment with VA's priority to drive health equity. The training was attended by all CRVA MH REACHES CPPs and one MH CPP Change Agent nominated from each of the 18 VISNs to lead diffusion and implement health equity changes to improve Veteran outcomes enterprise wide. The case-based, interactive curriculum consisted of 16.5 continuing education credits spanning comprehensive medication management, integration of health equity into practice, trauma informed care, and health equity approaches to rural, women, LGBTQ+, older, SUD, justice involved Veterans.

CONCLUSIONS

As the efforts to prevent, treat, and foster recovery for Veterans affected with SUD continues, the need to increase the number of practitioners who can adequately provide SUD care has never been more apparent. The CPP is uniquely trained to provide CMM services for Veterans with SUD due to their extensive knowledge of medications, clinical pharmacology, pharmacokinetics, pharmacodynamics, and therapeutics. This combined skill set is unique to this group of health care professionals and has shown to be useful in this patient population. With substantial shortages of practitioners to deliver SUD care continues to plague the nation and VA, integration of the CPP as part of the SUD treatment across practice settings provides a critical avenue for addressing prescriber staffing needs. VA facilities have a significant and important opportunity to expand the CPP workforce and optimize their roles in SUD treatment to bridge the gap in care in alignment with critical goals of VA.

Questions related to this guidance may be directed to the Clinical Pharmacy Practice Office (CPPO) at VHAPBH Clinical Pharmacy Practice Office (CPPO) ClinicalPharmacyPracticeOfficeCPPO@va.gov.

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