mhc
MENTAL HEALTH CLINICIAN

GUEST EDITORIAL Open Access

Ambitious AAPP vision necessitates bold actions

Marshall E. Cates, PharmD, BCPP, FASHP, FCCP, FALSHP[1]
Cherry W. Jackson, PharmD, FASHP, FCCP, BCPP[2]

How to cite: Cates ME, Jackson CW. Letter to the editor: Ambitious AAPP vision necessitates bold actions. Ment Health Clin [Internet]. 2022;12(2):86-8. DOI: 10.9740/mhc.2022.04.086.

Submitted for Publication: March 2, 2022; **Accepted for Publication:** March 22, 2022

[1] (Corresponding author) Professor and Chair, Department of Pharmacy Practice, Samford University McWhorter School of Pharmacy, Birmingham, Alabama, mecates@samford.edu, ORCID: https://orcid.org/0000-0002-2960-1921; [2] Professor of Pharmacy, Department of Pharmacy Practice, Auburn University Harrison School of Pharmacy, Auburn, Alabama; Clinical Professor, Department of Psychiatry and Behavioral Neurobiology, University of Alabama at Birmingham, Birmingham, Alabama, ORCID: https://orcid.org/0000-0003-1213-5407

Disclosures: Both M.E.C. and C.W.J. are past presidents of the College of Psychiatric and Neurologic Pharmacists. M.E.C. is currently a Speaker for Otsuka Pharmaceutical PsychU and serves on the Board of Directors for the College of Psychiatric and Neurologic Pharmacists. In 2020, M.E.C. served on the Virtual Psychiatric Pharmacist Advisory Board of Alkermes, Inc.

As long-time psychiatric pharmacists and past presidents of the College of Psychiatric and Neurologic Pharmacists (now American Association of Psychiatric Pharmacists [AAPP]), we applaud the article written by our colleagues[1] that outlines the vision of our specialty for the future. As the authors note, the organization has been setting the tone for the growth and evolution of our specialty for the past 25 years. We are now well-positioned in many ways to make substantial strides toward fulfilling our vision statement—A world where all individuals living with mental illness receive safe, appropriate, and effective treatment.[2] The authors[1] offer a bold image of what this vision looks like, and we greatly need this meaningful vision that drives us toward a common goal, establishes a standard of excellence, and bridges the present to the future.[3] A famous quote from Joel A. Barker[4] sums up our position on the matter: "Vision without action is merely a dream. Action without vision just passes the time. Vision with action can change the world." However, as would be expected with an ambitious plan, there are inherent challenges that must be addressed to ensure success.

The scope of what is being suggested is remarkable. It would be a monumental challenge for Board Certified Psychiatric Pharmacists (BCPPs) to be involved in providing care to all patients with psychiatric diagnoses. The Centers for Disease Control and Prevention has reported that 16.5% of adults and 8.4% of children received medication for their mental health in the previous 12 months according to surveys conducted in 2020 and 2019, respectively.[5,6] That roughly translates to 42 million adults and 6 million children based on US Census Bureau data. In terms of treated patients with specific psychiatric disorders in 2020, there were 49 million with anxiety, 48 million with depression, 10 million with attention-deficit/hyperactivity disorder, and 10 million with bipolar disorder.[7] In addition to the call for BCPPs to provide comprehensive medication management (CMM), which is inherently patient centric, the authors[1] propose a population-level psychotropic medication stewardship approach designed to identify those patients who would most benefit from BCPP-provided CMM. Based on our own clinical experience as well as findings from various studies, the reality is that a substantial proportion of patients with psychiatric disorders who receive pharmacotherapy with psychiatric medications could benefit from CMM, whether related to initiation/modification/discontinuation of medication therapy, prevention/resolution of drug interactions or adverse effects, performance of laboratory/other monitoring, improvement of medication adherence, or other important issues. Specific examples supporting our assertion include the following: approximately 50% of patients with schizophrenia, MDD, or bipolar disorder are non-adherent with medication therapy[8]; psychiatric medication polypharmacy is quite common and occurs across a range of disorders[9]; and adverse drug events from psychiatric medication use results in tens of thousands of emergency department visits annually, approximately 20% of which lead to hospitalization.[10]

Thus, the current situation is one in which relatively few patients with psychiatric disorders are receiving the necessary CMM services from BCPPs. Simply put, in order to fulfill the vision as put forth by the authors, we will need a vast expansion in the number of BCPPs. The 2

basic routes to board certification in the specialty field are traditional training or clinical experience. Over the past several years, there have been approximately 100 postgraduate year (PGY) 2 psychiatric pharmacy residency positions, with a fill rate close to 94%.[11] Unless the number of residency positions (and applicants) increase, we can expect a steady addition of only about 100 psychiatric pharmacists per year to the workforce. While there are undoubtedly many pharmacists with enough practice experience in psychiatric pharmacy to meet eligibility requirements to sit for the BCPP certification examination, there could be a variety of barriers that prevent them from doing so, such as a lack of incentives from employers (eg, payment for examination/annual fee/recertification continuing education, salary increase, opportunity for advancement). The educational considerations that the authors delineate for pharmacy students, PGY1 residents, and practicing pharmacists are important drivers of crucial workforce expansion in that they can lead to increased numbers of BCPPs and support of psychotropic medication stewardship. We also agree with the authors[1] that all colleges and schools of pharmacy should have a BCPP on faculty. Aside from providing pertinent instruction, these faculty members could be instrumental in developing and fostering students' interest in pursuing a career in psychiatric pharmacy.

Another significant challenge is funding. In terms of reimbursement for services, pharmacists are still not recognized as providers by Medicare, and opportunities for payment to pharmacists for patient-care services provided through state Medicaid programs are generally limited.[12-14] Although health insurance companies can choose to reimburse pharmacists for cognitive services, the fact of the matter is that they still inadequately cover mental health care despite mental health parity laws, and many mental health providers do not even accept insurance because of inadequate payment models.[15] Unfortunately, payers are inclined to concentrate on the initial investment of reimbursing pharmacists for providing CMM instead of taking the long-term view, supported by multiple research studies, that improved patient outcomes will quickly lead to an overall decrease in the cost of patient care. Finally, while some health care systems such as the Veterans Health Administration have invested heavily in hiring psychiatric pharmacists, many health care systems have not. There could be various reasons for this, but one that stands out is limited funding. For example, nearly all member organizations of the National Council for Mental Wellbeing acknowledged difficulty in recruiting mental health workers, and additional funding to hire qualified staff was cited as one of the possible solutions.[16] Somewhat related to this is the issue of prescriptive authority. Whereas the authors of the vision paper note a fairly large percentage of psychiatric pharmacists with prescriptive authority, nearly 30% of those who completed the survey worked in federal practice settings, which are generally more progressive in this regard. Mental health facilities and clinics with limited funding might be tempted to hire nurse practitioners and/or physician assistants with training in mental health, instead of psychiatric pharmacists, since they have prescriptive authority and provide services that are reimbursable.

We call upon AAPP as the voice of our specialty to coordinate the bold actions that will be necessary to see this vision come to fruition. We believe that an incremental approach can realistically extend our reach to more and more patients with psychiatric disorders while the number of BCPPs expands to necessary levels. Objective milestones should be coupled with strategic initiatives that could focus on specific psychiatric disorders, psychiatric medication classes, patient populations, pharmacotherapy issues, etc. AAPP should work through both professional affairs and government agencies to advocate for funding PGY2 residency programs and BCPP incentivization. AAPP should intensify efforts related to fostering the interest of pharmacy students, PGY1 residents, and practicing pharmacists in psychiatric pharmacy. Reimbursement for BCPP-provided CMM services for patients receiving psychiatric medications is of the utmost importance in terms of adding clinical positions, residency positions, and BCPPs. Provider status through Medicare has been the proverbial brass ring in this regard, and we should continue to seek this important goal despite agonizingly slow progress; however, we should also concentrate on influencing Medicaid and health insurance companies. AAPP should continue to sponsor and coordinate research that objectively demonstrates the value of BCPPs, which would be useful in generating more reimbursement opportunities. Moreover, AAPP should strive to convince payers to consider long-term versus short-term financial models concerning reimbursement of BCPPs for provision of CMM services. Finally, AAPP should spearhead efforts of psychiatric pharmacists in systems outside of Veterans Affairs practice settings to obtain prescriptive authority and attempt to persuade health care systems to invest in the hiring of psychiatric pharmacists. Now that we have this vision, it is time to get to work.

References

1. Dopheide JA, Werremeyer A, Haight RJ, Gutierrez CA, Williams AM. Positioning psychiatric pharmacists to improve mental health care. Ment Health Clin [Internet]. 2022;12(2):77-85. DOI: 10.9740/mhc.2022.04.077.
2. College of Psychiatric and Neurologic Pharmacists [Internet]. Lincoln (NE): College of Psychiatric and Neurologic Pharmacists [cited 2022 Feb 25]. Available from: https://cpnp.org/about
3. Unique 2 Brilliance [Internet]. Characteristics of good vision for your organization [cited 2022 Feb 25]. Available from:

https://unique2brilliance.com/consultancy/entrepreneurship/characteristics-of-good-vision-for-your-organization/.
4. Brainy Quote [Internet]. Joel A. Barker quotes [cited 2022 Mar]. Available from: https://www.brainyquote.com/authors/joel-a-barker-quotes
5. Terlizzi EP, Norris T. Mental health treatment among adults: United States, 2020. NCHS Data Brief, No. 419. Hyattsville (MD): National Center for Health Statistics; 2021. DOI: 10.15620/cdc:110593.
6. Zablotsky B, Terlizzi EP. Mental health treatment among children aged 5–17 years: United States, 2019 [Internet]. NCHS Data Brief, No. 381. Hyattsville (MD): National Center for Health Statistics; 2020 [cited 2022 Apr 2]. Available from: https://www.cdc.gov/nchs/products/databriefs/db381.htm?msclkid=fec679a9b2ac11eca63a247935331717
7. Aitken M, Kleinrock M. The use of medicines in the U.S.: spending and usage trends and outlook to 2025 [Internet]. IQVIA Institute for Human Data Science; 2021 [cited 2022 Feb 25]. Available from: https://www.iqvia.com/insights/the-iqvia-institute/reports/the-use-of-medicines-in-the-us#:~:text=Outlook%20to%202025%20Total%20net%20spending%20on%20medicine,reflecting%20a%20compound%20annual%20growth%20rate%20of%200-3%25
8. Semahegn A, Torpey K, Manu A, Assefa N, Tesfaye G, Ankomah A. Psychotropic medication non-adherence and its associated factors among patients with major psychiatric disorders: a systematic review and meta-analysis. Syst Rev. 2020;9(1):17. DOI: 10.1186/s13643-020-1274-3. PubMed PMID: 31948489; PubMed Central PMCID: PMC6966860.
9. Rothschild AJ. The pitfalls of psychotropic polypharmacy. J Clin Psychopharmacol. 2021;41(3):227-32. DOI: 10.1097/JCP.0000000000001400. PubMed PMID: 33905638.
10. Hampton LM, Daubresse M, Chang H-Y, Alexander GC, Budnitz DS. Emergency department visits by adults for psychiatric medication adverse events. JAMA Psychiatry. 2014;71(9):1006-14. DOI: 10.1001/jamapsychiatry.2014.436. PubMed PMID: 25006837.
11. College of Psychiatric and Neurologic Pharmacists [Internet]. Residency program director survey [cited 2022 Feb 25]. Available from: https://cpnp.org/career/residencies/survey
12. Kliethermes MA. Understanding health care billing basics. Pharm Today. 2017;23(7):57-68. DOI: 10.1016/j.ptdy.2017.06.041.
13. Centers for Disease Control and Prevention [Internet]. Pharmacist-provider medication therapy management in Medicaid. Atlanta (GA): Center for Disease Control and Prevention, US Department of Health and Human Services; 2021 [cited 2022 Apr 2]. Available from: https://www.cdc.gov/dhdsp/docs/MTM_in_Medicaid-508.pdf?msclkid=4docc2b9b2ae11ecb6594125d95346a3
14. Medical Billers and Coders [Internet]. 7 Basic facts about billing for clinical pharmacy services [cited 2022 Feb 25]. Available from: https://www.medicalbillersandcoders.com/articles/best-billing-and-coding-practices/seven-basic-facts-about-billing-for-clinical-pharmacy-services.html
15. Bogusz GB. Health insurers still don't adequately cover mental health treatment [Internet]. National Alliance on Mental Illness; 2020 [cited 2022 Feb 25]. Available from: https://www.nami.org/Blogs/NAMI-Blog/March-2020/Health-Insurers-Still-Don-t-Adequately-Cover-Mental-Health-Treatment
16. National Council for Mental Wellbeing [Internet]. Behavioral health workforce is a national crisis: immediate policy actions for states; 2021 [cited 2022 Feb 25]. Available from: https://www.healthmanagement.com/wp-content/uploads/HMA-NCMW-Issue-Brief-10-27-21.pdf