**How to Use this Template:**

*The following National Pain CPS CCA Template was created by the PBM Clinical Pharmacy Practice Office with standard components that foster clinical pharmacy practice standardization.* S*pecific components, are editable and may be modified by the facility depending on the role of the Pain CPS and practice setting, how patients are prioritized for Pain CPS services, and administrative oversight responsibilities. This document is intended to be used as a guide and specific elements that optimize the role of the Pain CPS may be added for based on individual site needs and is used in conjunction with the CPS Scope of Practice. When using this template, this top section should be removed.*

*If questions arise regarding this template, please reach out to the PBM Clinical Pharmacy Practice Office (CPPO)* *ClinicalPharmacyPracticeOfficeCPPO@va.gov*

**PURPOSE:** The purpose of this document is to establish the responsibilities, accountability, and resources for the professional activities of the Pain Clinical Pharmacy Specialist (CPS).

**PAIN CPS PROVISION OF CARE:** ThePain CPS is an advanced practice provider with a high level of autonomy and exercise independent decision making within their Scope of Practice (SOP). Comprehensive medication management (CMM) by the Pain CPS Provider is primarily through direct patient care activities. Core activities outlined in the individual SOP include medication prescriptive authority, assessments, consults, laboratory and test ordering abilities for Pain Care Practice. The Pain CPS SOP **does not include diagnosing;** collaboration will occur with new and/or changing diagnoses.

* The Pain CPS provides CMM for chronic pain management conditions, including but not limited to neuropathic pain, low back pain, fibromyalgia, and osteoarthritis. In addition, the Pain CPS performs risk assessment and mitigation including urine drug screening and interpretation, universal precautions, opioid tapering and monitoring, substance use disorders (SUD) screening and treatment (e.g., tobacco, alcohol, opioid) and appropriate referrals. *Enter additional CPS management roles as applicable (e.g. low complexity Mental Health conditions, peri-operative pain management).*
* The Pain CPS may perform physical assessments necessary to evaluate and monitor for initiation and modification of medication therapy management to ensure appropriate response.
1. Patient Care Visits include but are not limited to:
	* Face to Face patient visits
	* Telephone visits
	* Telehealth visits (CVT, CCHT, VA Video Connect)
	* Same day or walk-in visits
	* Transitions of care appointments and after recent hospital discharges
	* Shared Medical Appointments (SMAs) or group visits
2. Patient Care Activities: Functions compliment patient care visits and focus on providing safe and effective medication use in our Veterans. These include but are not limited to:
	* Prescribing (initiating, adjusting, discontinuing) medications, including controlled substances when the CPS has controlled substance prescriptive authority, ordering and monitoring labs, placing appropriate referrals for other testing/services as outlined per SOP
	* Screening for suicide risk and SUD as part of CMM
	* Engaging patient in treatment referral and referral for evaluation as clinically indicated
	* Using necessary clinical screening tools to evaluate and assess patients (e.g., PEG, AUDIT-C)
	* Performing population management and high-risk patient identification activities, including risk mitigation implementation (e.g., OEND, UDS)
	* Participation in team huddles and meetings
	* Involvement in clinical leadership activities, including committee/workgroup participation
	* Participation in safety initiatives, research, and quality assurance
	* Providing continuing education and staff education opportunities
	* Following consistent processes including return to clinic (RTC) procedures for appointment scheduling and patients who no-show
* Responding to E-consults
* Review pending consults within the appropriate time-frame
* Referring patients to a higher level of care when appropriate
* Training, precepting, and mentoring Pharmacy students and residents

**REFERRALS FOR CARE:** Clear and standardized processes for referral of patients to the CPS Provider is important to ensure appropriate Veterans are referred to the CPS. Methods for referrals can include:

* Provider referral (e.g., providers alerting clerk to schedule, adding the CPS as a cosigner to an Electronic Medical Record (EMR) note, or directing care through a hand-off)
* Formal consult (chart or E-consults)
* Self-Referral Direct Scheduling (PSDS)
* Population management (e.g., patients identified based on a database such Stratification Tool for Opioid Risk Mitigation (STORM), Academic Detailing dashboards, or new initiatives)
* Interdisciplinary team meeting referral
* Scheduler referral (e.g., patients with expressed medication issues, alert Pain CPS)
* Pain Management Leadership
	+ Identification of patients who require follow-up based on a database, such as the clinical dashboard, National or VISN dashboards, Stratification Tool for Opioid Risk Mitigation (STORM), or other initiatives
* Pharmacy leadership
	+ Identification of patients by a nationally-conducted MUE, VISN, or facility
	+ Direction of cross coverage requirements on behalf of another CPS on leave
* Cross coverage needs on behalf of another Pain care provider on leave
* *Enter facility specific processes as applicable.*

**PATIENT CARE COORDINATION:** A collegial relationship with mutual consultation and referral exists with the collaborating provider(s) and the Pain CPS Provider(s). Consultation with an appropriate physician or other appropriate provider is required for advanced patient care management beyond the Pain CPS Provider’s SOP (e.g., diagnosis, change in risk) or when changes occur in the patient’s condition (e.g., inpatient admission, deterioration of condition). Care coordination is designed to maximize Pain CPS Provider efficiency and clinic capacity, provide CMM to as many Veterans as possible, and improve Veterans access and quality of care. Patients may be handed-off from the CPS clinic, back to the PCP or other appropriate team member, when:

* Patient is at goal and/or medications optimized
* Patient is non-adherent or refusing modifications to their medication regimen
* Patient is non-adherent with disease monitoring as recommended by Pain CPS
* Patient is at interim goal or trending towards goal
* Rules not followed for repeat no-shows or same-day cancelations by the patient
* Treatment recommendations not followed by referring provider
* *Enter facility specific processes as applicable*

*Note: Team collaboration is paramount to positive outcomes, particularly for patient’s non-adherent to medications and/or monitoring or those resistant to medication recommended changes. Team discussions should include an assessment of team services and resources most appropriate for the patient at that time or potential consultation to specialty services as needed.*

* Primary Care/Pain leadership Responsibilities:
	+ Ensure the Pain CPS Provider is incorporated in pertinent staff/provider meetings and interdisciplinary team meetings to optimize the team’s provision of care
	+ Ensure the Pain CPS Provider is involved with identification of high-risk patient populations that may benefit from more comprehensive care
	+ Ensure that a physician or other LIP is available (either by phone or face-to-face) to assist with management of patients that present with new diagnoses or episodes that require advanced patient care management that is outside of the Pain CPS Provider’s SOP (e.g., inpatient admission, deterioration of condition)
	+ Ensure that the Pain CPS Provider, in coordination with their teams, may use data sources for population management of patients
* Pain CPS Provider Responsibilities:
	+ Verify whether Veteran referral is within clinic policies and SOP (e.g. patient has established diagnosis)
	+ Document the patient visit and clinical pharmacy services in an EMR progress note
	+ Communicate directly (e.g. warm handoff) with the appropriate physician or LIP if:
		1. Significant change in the treatment course occurs (e.g., change in diagnosis)
			1. The Pain CPS Provider collaborates with the provider who is authorized to diagnosis to review the treatment plan, determine an updated treatment plan as clinically indicated, and determine next steps of care
			2. Collaboration is documented in the EMR with the LIP adding an addendum to the Pain CPS note or a separate encounter
		2. When advanced patient care management is required that is outside the Pain CPS Provider SOP (e.g. inpatient admission, deterioration of condition)
		3. When prescriptions of controlled substances are required and the Pain CPS does not have controlled substance prescriptive authority
* Document when transitioning the care of the Veteran back to the referring provider as outlined in the care coordination section of this document.
	+ Directly address Veterans who no-show (face to face, telephone, and other appointment modalities) in a consistent manner
	+ Coordinate with other primary, specialty, and other pertinent care providers as needed to promote optimal patient outcomes
	+ Update the CPRS Problem list when appropriate (facility specific).
		1. In situations where a new diagnosis is being considered, the CPS Provider will involve the provider who is authorized to diagnose to verify a new diagnosis with documentation in CPRS.
		2. In situations where a confirmed diagnosis is not in the CPRS problem list, the CPS Provider will document the date and title of the CPRS note authored by the provider who is authorized to diagnose and update the problem list.

**CLINIC SPACE AND ANCILLARY SUPPORT:** The Pain CPS Provider is co-located with other team members and provided the same clerical and ancillary support given to other providers on the team when they are providing direct patient care. The Pain CPS requires a private workspace suitable for patient care when seeing patients face to face (F2F) or Clinical Video Telehealth (CVT) or a shared workspace with access to a direct patient care space. Workspaces should be within close physical proximity to the patient care team to facilitate interaction and accessibility. Consistent ancillary support for Pain CPS Providers, like other providers on the team, is reqruired to ensure seamless, organized, and efficient patient care.

*Note: Consistent ancillary support is paramount to not only team efficiency, but also the Veteran experience. Veterans should be afforded the same expected and actual experience with intake, scheduling and other support when seeing any provider on the team, including the Pain CPS Provider.*

1. Associate Chief of Staff (ACOS), Ambulatory Care Responsibilities:
	* Ensure clinic space to see Veterans is consistent and equipped with the appropriate infrastructure and resources needed to appropriately care for Veterans
	* Ensure appropriate ancillary support (nursing and scheduling) are consistently provided for Veterans seeing the Pain CPS Provider
2. Chief of Nursing Responsibilities :
* Ensure consistent nursing support for all Veterans, including when a Veteran is scheduled with the Pain CPS Provider in their face-to-face clinic or CVT for CMM
	+ Intake vitals by LVN/LPN, Unlicensed Assistive Personnel (health tech or nursing assistant)
	+ Lab draws in outlying clinics
	+ Other routine nursing support responsibilities usual to providers on the team
1. Medical Administration Service (MAS) Responsibilities:
* Ensure consistent scheduling support for all Pain CPS Providers
* Address active consults and RTC orders for scheduling new & follow-up visits
* Contacting no-shows or patient cancellations for rescheduling, including call center MSA staff for patient cancellation calls and after-hours messages
* Include Pain CPS Provider clinics for audiocare appointment reminders or other processes
* Mailing clinic and lab appointment letters for Pain CPS Provider clinics

**OUTPATIENT PHARMACY SUPPORT:** Pain providers, including the Pain CPS provider, will have similar support from Pharmacy Service to handle routine outpatient medication activities. Questions regarding operational aspects of outpatient pharmacy services should be re-directed to outpatient pharmacy staff as appropriate. Outpatient pharmacy activities **not** routinely performed by the Pain CPS include:

* Medication order processing and dispensing; Medication refills/renewals and general pharmacy/medication questions
* Medication storage management and troubleshooting; ward stock/inspections
* Prescription delivery and mail (Local, CMOP, UPS)
* Traveling Veteran refills/procedures
* Non-formulary adjudication

**PERSONNEL MANAGEMENT:** Pain CPS Providers will have core schedules that are established, discussed with the team and adhered to consistently. These core schedules should have allocated time for direct patient care and non-direct care activities.

1. Primary Care/Pain leadership Responsibilities:
	* Ensure a physician or other appropriate provider is available (either by phone or face-to-face) to assist with management of patients that present with new diagnoses or episodes that require a higher level of care such as admission
	* Establish processes for the pain care team for management of patients determined high risk
2. CPS Provider Responsibilities:
	* Leave and clinic cancellation requests comply with established policy and procedures
	* Cancel clinic for planned leave to reduce the workload requirements for cross coverage (in compliance with VA standards for clinic cancellations)
	* Notify clinic teams and pharmacy personnel immediately of planned and unplanned/sick leave and coverage strategies
3. Clinical Pharmacy Leadership/Managers and Assigned Clinic Leadership will ensure contingencies are in place for covering both short and long term leave of the Pain CPS Provider.

**REFERENCES:**

1. VHA HANDBOOK 1108.11, CLINICAL PHARMACY SERVICES <http://vaww.va.gov/vhapublications/ViewPublication.asp?pub_ID=3120>
2. VHA DIRECTIVE 1230, VHA OUTPATIENT SCHEDULING PROCESSES AND PROCEDURES <http://vaww.va.gov/vhapublications/ViewPublication.asp?pub_ID=3218>
3. VHA DIRECTIVE 1232, CONSULT PROCESSES AND PROCEDURES

<http://vaww.va.gov/vhapublications/ViewPublication.asp?pub_ID=3230>

1. VHA HANDBOOK 1907.01, HEALTH INFORMATION MANAGEMENT AND RECORDS, <http://vaww.va.gov/vhapublications/ViewPublication.asp?pub_ID=3088>

**CONCURRENCE (Note: All services with outlined responsibilities should concur. Applicable signatures are noted below.)**

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, Chief of Pharmacy

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_                                             Date \_\_\_\_\_\_\_

, Chief of Primary Care *(as applicable)*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_                                             Date \_\_\_\_\_\_\_

, Chief of Specialty Service *(as applicable)*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_                                             Date \_\_\_\_\_\_\_

, Chief of Staff