CPC
Comprehensive Primary Care

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Practice Spotlight 8

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This week's Spotlight takes a deeper look at **comprehensive medication management,** one of the three advanced primary care strategies in Program Year 2014 Milestone 2. Two practices have been profiled for this article — OU Physicians has included pharmacists in its practice for 10 years and Associates in Family Medicine hired it's pharmacist in July 2013. Their pharmacists have had evolving roles in the integration process that other CPC practices may see in their own work as they undertake comprehensive medication management.

OU Physicians

OU Physicians *is an academic group practice affiliated with the University of Oklahoma School of Community Medicine. Employing nearly 190 providers, OU Physicians operates five clinical sites in Tulsa. Two clinics serving about 14,000 patients are CPC sites. In addition to pediatrics and internal medicine, OU Physicians offers services in adult diabetes, dermatology, obstetrics and gynecology, nephrology, pediatrics, perinatal medicine, psychiatry and surgery.*

ASSOCIATES IN FAMILY MEDICINE, P.C.
Quality Care for Life

Associates in Family Medicine *of Fort Collins, Colo., operates eight clinical sites; three clinics are CPC sites with 48,000 patients. Services include family medicine, gynecology and obstetrics, pediatrics, sports medicine and urgent care along with ancillary services such as imaging/radiology, complementary medicine, lactation consultation, senior care and workplace care. AFM employs 50 providers, including midlevels, and about 80 nurses.*

About 10 years ago, the pharmacy program at the University of Oklahoma added an ambulatory care rotation to its training. While the pharmacy school's objective was to round out students' education with additional experience in a clinical setting and increased patient interaction, the academic practices receiving these students saw potential for a new dimension to comprehensive care.

"Having a pharmacist on the team who could consult and meet with patients would surely affect quality levels," said **William Yarborough, MD**, medical director of internal medicine for OU Physicians. "The potential for improved patient care was obvious. The barrier was the financial turf. How do you support the pharmacist over time?"

From the left: William Yarborough, MD, medical director, and Katherine O'Neal, PharmD, BCACP, CDE, OU Physicians

Associates in Family Medicine leadership wrangled with the same dilemma. Through a HealthTeamWorks demonstration project, AFM CEO **James Sprowell, MD**, was introduced to potential grant opportunities that would provide short-term funding for an embedded pharmacist. Unfortunately the grant dollars did not materialize, but the prospect continued to intrigue Dr. Sprowell, especially as newly trained providers joined AFM's growing practice.

These providers' training emphasized an interdisciplinary approach, including pharmacists and licensed social workers on care teams. Dr. Sprowell recognized that the need for transformation in family medicine stemmed not only from increasingly complex patients and systemic issues, but also from changes in the providers themselves. This wave of providers is prepared to deliver care in a new way. So are pharmacists.

CPC practices are encouraged to refer to the* Program Year 2014 Implementation and Milestone Reporting Summary Guide*, pages 16–18, for an implementation framework for medication management. Included in this section of the implementation guide are key questions practices should work through as they plan this work.

Amy L. Stump, PharmD, BCPS, and John C. Cawley, MD, Associates in Family Medicine of Fort Collins, Colorado.

How pharmacist training has changed

When the majority of pharmacy training programs became doctoral programs (Doctor of Pharmacy or PharmD) in 2004, the field's intent shifted away from a product focus and toward a patient-centered profession.

After completing pre-pharmacy work of two to four years, students enroll in a four-year professional/graduate training program. About one-third of the curriculum is clinical and experiential training that includes work in fields such as cardiology, oncology, family medicine, pediatrics and geriatrics. Additional coursework includes patient assessment, pathophysiology, disease management, clinical guidelines and more. Post-graduate training options include general and specialized residency training programs. Training in Ambulatory care is keeping pace with demand at this time, but if jobs open in primary care, university programs are likely to expand training options.

What happens when a pharmacist is on the care team

Dr. Yarborough advises practices to use a pharmacist's time strategically to address risk areas and improve quality. At OU Physicians, **Katherine O'Neal, PharmD, BCACP, CDE**, initially focused on a medication management strata of patients who were at high risk for serotonin syndrome.

"I also worked with the nurses who do follow-up with patients as they transition through care settings," Katherine said. "Another piece of my day is to work on a combination of same-day or same-hour requests. As the care management team visits with patients, I can get pulled in for a consult."

Katherine is included on the care team for patients with multiple ED visits or hospitalizations and patients with high-risk meds or complex regimens. She may review charts before patients are seen or during the encounter with a warm hand off from the provider.

ED and admissions reports from the main admitting hospital are sent at least daily to OU Physicians.

As the practice delves deeper into CPC work, a more formalized workflow for tracking metrics will be established.

"Although we have had integration, we didn't have the measurement piece," said **Renee Engleking, MPH, RN**, director for clinical operations at OU Physicians. "We're now looking at what processes need to be improved and which measures need our focus. We know we should see a downward trend in readmissions, and that will hone down to disease management numbers, too. We're just not there yet."

When **Amy L. Stump, PharmD, BCPS,** joined AFM in July 2013, some of the practice's providers were unsure how to best use her expertise. Amy brought with her an extensive background in ambulatory care, and the perspective quickly shifted.

"At first they weren't sure about the utility of a pharmacist outside of the price tag," said **John C. Cawley, MD**, one of the practice's family physicians. "I trained with a pharmacist and I knew she could bring that extra support we need for complex patients. The attitude changed rapidly because everyone sees the value of having a pharmacist's time and expertise. It's one of those rare changes that affects the entire practice in a positive way."

When a pharmacist is embedded in the practice, these are the questions that get answered:

"My patient keeps getting readmitted with dizziness. Can you review her meds?"

"My patient calls EMS with hypoglycemia weekly. Can you help with his diabetes?"

"My post-partum patient had a seizure. Neuro says her new meds are safe in breastfeeding. Can you research this?"

"My patient stopped her DM meds and now her A1c is 12%. Can you help?"

Source: Associates in Family Medicine

"I started out by listening," Amy shared. "I would hang out in the nurses' bullpens and listen to their challenges. It helped me pinpoint where the practice needed a pharmacist and where my skills would make difference."

Amy engages in a variety of daily care roles (see inset), as well as runs an in-house focus group for pharmacy-related patient care. Her focus group activities range from administrative functions such as writing policies and protocols for opioids and how to screen for abuse, to operational tasks such as standardizing emergency kits and ensuring medications are stored properly in the clinics.

She has also undertaken four pilot projects: collaborative drug therapy management (warfarin and diabetes), diabetes "pre-visits" with patients, shared medical visits and an anticoagulation clinic.

The anticoagulation clinic grew out of AFM's "small clinic" philosophy for patient care. Clinical sites are kept intentionally small with only a few providers per site to promote a "medical home" culture among patients. To improve tracking and real-time feedback for patients taking anticoagulant drugs, Amy oversaw the purchase of home self-testing meters for these patients and the creation of a secure online portal for reporting results. This allows patients to come to their medical home for appointments with their established PCP, but practice-site nurses can send INRs to the clinic for immediate feedback.

AFM expects having a pharmacist on board to affect outcomes in the near term. QI staff are tracking all diabetes-related measures, especially for patients with an A1c > 9; PIMS (potentially inappropriate medication use in older adults); TTR (time in therapeutic range) for patients taking warfarin and a bleeding/clotting events among those patients; and decreased ED visits and hospitalizations among the practice's high-risk population.

Clinical Pharmacists' Role at AFM

- Chart review
- Curbside consults
- Collaborate with care management team
- Prior authorization processes
- Patient medication access and affordability
- Create evidence-based algorithms and protocols
- Educate providers, nursing and staff
- Pharmaceutical care team member

Other Potential Roles

- Medication reconciliation
- Transitions of care
- More work with SNF patients
- CDTM in more disease state areas (e.g., asthma, hypertension, dyslipidemia, CHF)
- Annual Medicare Wellness visits
- Manage patients with insulin pumps
- Continuous glucose monitoring
- Poly-pharmacy clinics

High-value care and the business case for a pharmacist in primary care

Everyone agrees on two things: pharmacists increase quality of patient care in the primary care setting and it's challenging to find a way to fund those positions. Currently pharmacists are not classified as health care providers in the Federal Social Security Act, although recently introduced Federal legislation may change that. Only Medicare Part D pays medication therapy management (99605, 99606, 99607). When adding a pharmacist to the practice, leadership will need to weigh the return on investment elements, such as cost savings, cost avoidance, shared savings or incentive bonuses in addition to revenue generation.

Although it may not show up on the books, leadership must consider the key payoffs when hiring a pharmacist: improved patient outcomes and increased nursing and provider satisfaction.

Is your practice ready for the Spotlight? Please email Belinda McGhee, belinda.mcghee@tmf.org, with your story suggestions.

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