Committee Spotlight

ad hoc Collaborative Pharmacy Practice

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Q1. Please describe the practice setting where the pharmacy service is located. (Include healthcare setting, practice size, patient volume, provider type(s), pharmacy/resident utilization, and type of patient interaction).

The Saint Louise Family Medicine Center is a patient-centered medical home that is part of Saint Thomas Medical Partners and has affiliations with Ascension Saint Thomas Rutherford and the University of Tennessee. The clinic was originally founded in 2010 in an effort to provide care to indigent patients and this remains a central mission to its clinicians. In 2014, the UT Family Medicine Residency program began training medical residents and reached its full complement of twenty-four residents with the class of 2017-2018. The clinic is staffed by these medical residents, in addition to seven attending physicians, two full-time nurse practitioners, and two part-time nurse practitioners. Saint Louise is fortunate to have substantial support staff and services including licensed practice nurses, medical assistant, a licensed clinical social worker, a dietician, a patient navigator, and others. In 2015, Saint Thomas Rutherford began offering clinical pharmacy support one half-day per week, and expanded to full-time support in 2017.

I provide comprehensive medication management to established patients with chronic conditions under a broad collaborative practice agreement that spans 14 areas of practice, including diabetes, hypertension, heart failure, asthma, COPD, and hepatitis C. I provide these services by both face to face and telehealth modalities to patients through over 200 encounters each month. I precept a required Ambulatory Care rotation for our PGY-1 residents at Saint Thomas Rutherford and am beginning a new PGY-2 in Ambulatory Care starting this July. I hold a joint faculty appointment with the University of Tennessee College of Pharmacy and College of Medicine, and am active in teaching both in didactics and experiential learning for both medicine and pharmacy learners. In addition to my clinical and teaching activities, I am a passionate voice for patient access to pharmacist clinical services.

Q2. Why was the pharmacy service developed? (Describe any compelling data collected prior to implementation).

The pharmacy service was developed by our now-Director of Pharmacy, Julie Hudgens. In addition to working with one of our attending physicians to establish a transitions of care clinic for patients with heart failure one half day per week, she also began providing collaborative support to our residents for patients with diabetes and anticoagulation needs. When the Community Benefits department heard of the great value she was providing our patients, they encouraged us to apply for funding for a full time position.

Q3. What training, certification, credentialing, and practice agreement is utilized by the practice setting pharmacist(s)?

I completed my PGY-1 and PGY-2 in Ambulatory Care at the VA Tennessee Valley Healthcare System in Nashville and Murfreesboro, TN. I am dual board certified in Pharmacotherapy and Ambulatory Care. As mentioned previously, I provide patient care services under a collaborative practice agreement.

Q4. What outcomes are being measured to evaluate the model's success? (Clinical metrics, revenue, cost-savings, patient satisfaction, etc.)

I report quarterly quality assurance metrics regarding pre-/post-PharmD hemoglobin A1c, blood pressures, heart failure, and COPD admissions/readmissions. Additionally, I calculate A1c >9 for the clinic annually.

Q5. How have you made this service sustainable? (Include billing, reimbursement, etc.)

While I think the clinical value speaks for itself, I have been an active advocate for pharmacists pursuing reimbursement as providers for as long as we remain under a fee-for-service model. I have successfully enrolled with two major commercial health insurers and am hopeful to begin billing E/M visits in the next few weeks. Additionally, I was an early enroller in the TennCare MTM program. I am even more excited about the additional advancements being made in the TennCare MTM program, including increased reimbursement and reduced administrative burdens.

Q6. How did you gain support of administrators, providers, and other key stakeholders to implement your practice model?

When you have a clinically significant impact on your patients, especially the tough ones, your providers will notice. Be mindful of their pain points and accessible to offer help, even if it is not your passion area. For example, medication access and drug information are two "soft skills" pharmacists have that providers don't consciously think about being a needed skill—however, when you begin providing those services and fill in that gap for them you soon become indispensable.

For administrators, realize that most full time clinicians do not track their outcomes. It can be burdensome to incorporate into your busy schedule, but when you are able to prove what your providers are seeing with data, that carries a lot of weight with administrators. You don't have to get IRB approval to do this—just a simple spreadsheet tracking your before and after outcomes is usually enough. It also helps to be a good storyteller—before meeting with an administrator, reflect on some of the impactful patient visits you've had over the past month, so you can share those concrete stories.

Q7. What are some lessons learned while implementing your practice model that you would like to share with other pharmacists?

Whether formal or informal, do a needs assessment at baseline and periodically to ask what are the needs of your practice site. Sometimes this may reveal that a service you were planning on offering

duplicates another resource available in the community. Continuing with that service anyway may end up causing confusion and tension.

On the flip side, there may be a need that is not being met that you are ideal to fill. Even if that need would require some learning and stretching on your part! For example, one of our physicians wanted to start a hepatitis C clinic. This required me committing to learning a new disease state and new patient assistance program workflows, but now that expertise has increased my value to our clinic and our administrators.

Q8. What have you and/or your practice implemented in response to the COVID-19 pandemic?

Our Pharmacotherapy Clinic has always operated under the philosophy that if a patient doesn't need to be seen face-to-face in the clinic that we will provide their care via telehealth. This naturally resulted in about a 30-40% of follow-ups occurring via telehealth even prior to the pandemic. After the pandemic began, we were very quickly able to adapt to telehealth visits (primarily via phone) and now are seeing about 90% of our patients this way. Like others in our clinic, we are taking advantage of real-time video visits as well. For patients who do need to come to the clinic, we are limiting their exposure as much as possible. For example, we are going out to patients' cars to check INRs so they don't have to come in.

This pandemic has emphasized the value of pharmacist care to patients with chronic conditions. Whereas clinic volumes have been down for the majority of our providers, my clinic has been busting at the seams in providing chronic care to patients who are not able to see their regular physician in clinic due to workflow adjustments and social distancing. Thankfully, I have had strong learners last month and this month that have been able to be true pharmacist extenders as they help me handle this extra volume!