Committee Spotlight
ad hoc Collaborative Pharmacy Practice

E. Whitney Aultman, PharmD
Richard Hess, PharmD, CDE, BC-ADM, BCACP
Andrea Long, PharmD
State of Franklin Healthcare Associates

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).

We have three ambulatory care clinical pharmacists practicing in State of Franklin Healthcare Associates (SoFHA), which is physician owned and operated. There are over 11 outpatient clinics servicing internal medicine, family medicine, & pediatrics. These clinics will see an average of over 400 patients daily. Our practice has fourth year pharmacy students most months of the year and often we will have a PGY2 Ambulatory Care resident on service for about 2 months out of the year. One of our clinical pharmacists is focused on diabetes management practicing independently under a CPA, while the other two clinical pharmacists practice broadly in multiple chronic disease states (including COPD, chronic heart failure, mental health, cardiovascular disease, etc.) in a shared appointment model with providers.

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

Pharmacy services were initiated in 2007 with a clinical pharmacist focused on diabetes management. In 2017, pharmacy services in a shared appointment model were initiated as a result of quality improvement measures and insurance value-based agreements (CPC+ & quality measures). Then in 2018, pharmacy services were expanded as a result of Medicaid MTM development following pharmacy provider status changes in Tennessee. Pharmacy services were also expanded as a result of increased provider utilization across the majority of SoFHA clinics.

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

All three clinical pharmacist have received at least PGY1 training and are all Board Certified in Ambulatory Care. There is a clinic-wide collaborative practice agreement in place, which allows pharmacists to practice broadly and is guideline-based.

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

Pharmacists utilize their own documentation to keep record of each patient seen as well as administrative staff having the ability to pull patient volume. However, the majority of position justification comes from quality measure initiatives and value-based agreements with various insurance plans (such as CPC+ & the Tenncare MTM pilot). Patient and provider satisfaction is also documented and has lead to expansion of the clinical pharmacy team.

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

Pharmacists are housed under the umbrella of SoFHA's quality improvement team and help as needed in various projects for the clinic, which has allowed them to become an invaluable member of the healthcare team. Clinical pharmacy services have been sustained through our value-based insurance contracts as well as various CMS programs (CPC+, state Medicaid, & CCM) and mainly seeing patient in a shared appointment model. Specific patients are identified electronically for pharmacist intervention. These patients include but are not limited to: diabetics not on statin, elevated A1c, frequent hospitalizations, & non-adherence.

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

Clinical pharmacy services at SoFHA were initially funded in part through a partnership with a local college of pharmacy (ETSU Bill Gatton College of Pharmacy) allowing for the first clinical pharmacist focused in diabetes management in 2007. In 2017, another co-funded clinical pharmacist position was offered, which coincided with SoFHA's expansion of value-based quality agreements and initiatives. This second pharmacist implemented services in a shared appointment model working in collaboration with providers. Through these efforts, multiple providers requested continued expansion of clinical pharmacy services as it was noted to improve the care they were able to provide their patients. A third clinical pharmacist was hired in 2018, fully funded by the practice site. With the expansion of the pharmacy team, significant impact on various quality measures was achieved resulting in shared savings and improved star measures allowing for support from administration.

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

A majority of our practice model lessons have come from the expansion of our shared appointment model with providers implemented in 2017. It was important to carefully set up the service, taking steps to ensure pharmacists are keeping their activities clinical. Designating pharmacist workspace central to providers, having clerical support staff for schedule creation and patient outreach, and creating a pharmacist opportunities list that identifies high-risk patients were just some of the important aspects considered. We also have regular meetings with our physician champion and administrative staff. Initially, these meeting were every other week when establishing the service, but are now at least twice annually to ensure that pharmacist activities remain clinical and support quality initiatives.

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Q8. What do you hope Collaborative Practice will look like in Tennessee in the next ten years?

As ambulatory care pharmacists practicing in an independent primary care organization, we are eager to increase collaboration between primary care and community pharmacies to help improve patient care and reimbursement through quality metrics (particularly adherence to chronic medications). We would also hope to expand collaboration with inpatient pharmacists particularly for efforts in antibiotic stewardship and transitions of care in high-risk patients.