COMMUNITY PHARMACY FOUNDATION

COMPLETED GRANT SYNOPSIS

Demonstrating the Impact and Feasibility of a Business Model which includes a Community-Based Pharmacist in a Patient Centered Medical Home (PCMH) Practice

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Objectives	
1) To document the impact a community pharmacist has on patient outcomes and quality of care when integrated into a patient centered medical home (PCMH) practice 2) To establish a blended billing model through which PCMH pharmacists are compensated for their services and which can be reproduced by other pharmacies	
Methods	
Design	• One-year demonstration project (September 2012-October 1, 2013) • Designated community pharmacist was integrated into an established PCMH practice sixteen hours per week • Inclusion of community pharmacist on the Michigan Primary Care Transformation Project (MiPCT) chronic care management team (CCMT) within the PCMH practice setting
Study endpoints	Objective 1. • 1.1) To successfully integrate into PCMH practice setting • 1.2-1.3) To resolve or avoid drug-related interactions and identify or avoid adverse drug reactions • 1.4) To improve adherence • 1.5) To help the PCMH practice attain clinical and therapeutic goals • 1.6) To attain patient "self-identified" healthy living goals Objective 2. • 2.1-2.7) To document the feasibility of using a variety of billing options which are listed explicitly in the business plan outlined as part of grant proposal

Results

Objective 1.

- 1.1) Integration into the PCMH practice went very well. The community pharmacist quickly became a valued and integral member of the health care team. The pharmacist was given a dedicated workspace and access to the practice's EMR through a secure VPN within the first month of the project. Feedback from all involved remains positive and discussion is underway to continue partnership beyond the terms of grant. The pharmacist has successfully completed her Chronic Care Manager certification through the Health Sciences Institute.

- 1.2-1.3) Of the 543 logged activities that could be categorized within manual Excel tracking system, 172 (31.7%) were related to medication therapy. A majority (71.5%) of these took the form of recommendations made when patients began new therapies. Other related activities included identifying drug-disease interactions, drug-drug interactions, adverse drug reactions, needs therapy, unnecessary therapy, ineffective therapy, and dose/form change.

- 1.4) While only a few patient interactions were primarily about adherence, 159 (29.3%) of the pharmacist's activities were related to follow-up with patients starting new therapies and transitioning between care settings. These efforts helped identify and resolve problems that might have dissuaded adherence if not addressed.

- 1.5) 260 (47.9%) of the 543 categorized activities led directly to a formal recommendation made by the pharmacist to a provider. Given the nature of certain patient interactions, there was not always a need for a formal recommendation. 91.9% of the 260 recommendations were accepted. 60 (11.0%) of the 543 categorized activities involved answering specific drug questions posed by providers and patients.

  Tracking specific biometric outcomes was determined to be outside of the capacity of this grant. Because patients' visits were spread out within and beyond the time period of this grant, it would have been nearly impossible to gather enough data to make statistically sound conclusions. It should be said, though, that all participating in this project have anecdotally reported positive patient outcomes, and patients were incredibly receptive to pharmacist services. In fact, many patients requested appointments with the pharmacist specifically to discuss their medication therapy. Furthermore, the type of work being done (e.g. addressing drug interactions, improving transitions of care, etc.) has been shown to ultimately have a positive impact.

- 1.6) 139 (25.6%) of the 543 logged activities were visits with patients at which "self-identified" healthy living goals were identified. The same challenges existed for tracking ultimate attainment of these long-term goals as are described for the attainment of biometric targets.

Objective 2.

- 2.1-2.7) As of October 1, 2013, 218 (40.1%) of the pharmacists services were billable under six available codes through MiPCT. Services not billed directly include those services not provided to a specific patient (e.g. researching drug information for a provider) or those provided to patients whose insurance is paying per-member-per-month (Medicaid/Medicare @ $2/PMPM) rather than fee-for-service (Blue Cross Blue Shield of Michigan/Blue Care Network/Priority Health). Based on reconciliation data available, 73 of the 218 have been paid year to date. $22,387.00 has been billed for services provided by the pharmacist, and $6,111.94 has been paid to date. $2,628 of the $22,387.00 is still pending.

Conclusion

One cannot dispute that the impact an integrated community pharmacist has on patient outcomes and quality of care in a PCMH practice is great. However, we found that a year for this endeavor was realistically not long enough, especially to properly evaluate third party billing, payment, and sustainability of such a position. The first year of this grant project was focused on integrating a community pharmacist into a PCMH practice and on trying different combinations of billing codes. Based on this foundation and the lessons learned, there is considerable evidence to suggest that a longer term trial of similar nature would be of value to furthering the pharmacy profession.

Significant positive progress towards billing, reimbursement, and sustainability was made between July and October 2013. However, it is recognized that the reimbursement at the time of this synopsis report, on its own, is not yet enough to sustain the presence of a community pharmacist in a PCMH practice. That being said, discussion is underway between PGPA and CFP to continue partnership beyond the terms of the grant even though the money strictly from third party reimbursement is not quite enough to singularly sustain this project. In this way, this demonstration project was successful because while not in the manner initially planned, there is talk of ensuring the sustainability of the project through funding streams outside of the grant. It is strongly believed that should the CCMT continue to progress, this will become a reality within the next year.

Now is the time for community pharmacists to make certain that they are included and recognized as equal members in the new model of health care. With large initiatives like MiPCT looking to establish best practices and finalize billing codes, now is the time for pharmacists to be advocating for a secure role in the PCMH practice model. However, during this formative period of time, it is difficult to sustain an integrated community pharmacist's involvement without additional support and investment.