Patient Centered Medical Home: Developing, Expanding and Sustaining a Role for Pharmacists

Hae Mi Choo, Pharm.D.
Stu Rockafellow, Pharm.D.
Trisha Wells, Pharm.D.
Tami Remington, Pharm.D.
Leslie Shimp, Pharm.D.
Heidi Diez, Pharm.D.
Annie Sy, Pharm.D.

Introduction

Health-Care Facility
- 8 Health-Care Centers
- 110,169 Unique Patients
- 148.8 Non-Pharmacist Full Time Equivalents
- 2.5 Pharmacist Full Time Equivalents

Background
- Traditional Health Care Model
  - Time-limited, face-to-face appointments
  - Does not do ED of care coordination across providers
  - Does not prepare patients to take an active role in managing their health
- Patient-centered Medical Home (PCMH) Model
  - Definition: Patient-centered, multifaceted source of personal primary health care based on a relationship between the patient and physician, formed to improve the patient’s health across a continuum of referrals and services
  - Promotes coordination of care and patient self-management

Purpose
- To form a partnership to integrate pharmacists into PCMH model at general medicine and family medicine practices

Description of the Program

Objectives
- Develop consistent, reproducible pharmacist practice at primary care clinics
- Improve experiential teaching
- Rationale for health centers to pay for pharmacists
  - Provision of chronic disease management and improvement in key quality metrics
  - Revenue generation from T-code billing and pay-for-performance programs
- New funding arrangements
  - Salary supplemented with revenue from clinics and T-code billing
  - Primary care health centers designed as PCMH by Blue Cross Blue Shield of Michigan
- Pharmacists received approval from University of Michigan Health Systems Credentialing Committee
  - Collaborative Practice Agreement detailing Scope of Practice reviewed and signed by all physicians

Rationale for health centers to pay for pharmacists
- Improve experiential teaching
- Develop medication care plan and reconcile medication lists
- Prioritize problems
- Talk with physicians regarding recommendations
- Set follow-up appointments to implement changes
- Patient encounters ranged from 43 to 232
- Patients seen per half day ranged from 2.2 to 6 (n=0.76)

Table 1. Description of Pharmacist Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Center 1a</th>
<th>Center 2</th>
<th>Center 3b</th>
<th>Center 4</th>
<th>Center 5</th>
<th>Center 6</th>
<th>Center 7</th>
<th>Center 8</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poly-pharmacy assessment</td>
<td>1082</td>
<td>914</td>
<td>563</td>
<td>118</td>
<td>121</td>
<td>92</td>
<td>461</td>
<td>310</td>
</tr>
<tr>
<td>Hyperlipidemia (HL)</td>
<td>48%</td>
<td>57%</td>
<td>58%</td>
<td>32%</td>
<td>38%</td>
<td>32%</td>
<td>47%</td>
<td>46%</td>
</tr>
<tr>
<td>Diabetes (DM)</td>
<td>3.0%</td>
<td>4.5%</td>
<td>5.0%</td>
<td>3.8%</td>
<td>3.0%</td>
<td>2.8%</td>
<td>4.2%</td>
<td>3.6%</td>
</tr>
<tr>
<td>Hypertension (HTN)</td>
<td>10%</td>
<td>12%</td>
<td>14%</td>
<td>13%</td>
<td>15%</td>
<td>17%</td>
<td>18%</td>
<td>14%</td>
</tr>
<tr>
<td>Hypo/hyperglycemia</td>
<td>1.0%</td>
<td>1.5%</td>
<td>1.5%</td>
<td>1.2%</td>
<td>1.3%</td>
<td>1.2%</td>
<td>1.4%</td>
<td>1.3%</td>
</tr>
<tr>
<td>Medication error</td>
<td>3.0%</td>
<td>3.5%</td>
<td>3.3%</td>
<td>2.9%</td>
<td>3.1%</td>
<td>2.7%</td>
<td>3.3%</td>
<td>3.0%</td>
</tr>
</tbody>
</table>

Experience with the Program

- Average number of patients seen increased from year one to year two
- PCMH pharmacists generated $154,831 in revenue via T-codes
- 70% of visits were face-to-face, ranging from 49% to 94% among clinics

Conclusion

- Opportunities presented by incentive programs were capitalized on to promote the inclusion of pharmacists in multidisciplinary, collaborative efforts to improve the quality of patient care
- Partnerships among departments and leadership with a common vision were critical to initiating and expanding pharmacist involvement
- Developing a consistent model of direct patient care for all PCMH pharmacists was vital to expansion and sustainability

References