

Establishing **Pharmacist-supported Ambulatory Clinics**

Q&A

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PP&P: What pharmacist-supported clinics do you operate at the University of North Carolina (UNC) Health Care System?

CM: The pharmacy department has established an endocrinology clinic, which is where I work, and we have one pharmacist in the family medicine clinic and another in our hematology/oncology clinic. The family medicine pharmacist is responsible for anticoagulation, pharmacotherapy, and general disease management such as diabetes and heart failure, and a smoking cessation clinic is in development. Our hematology/oncology pharmacist is responsible for pain/symptom management, chemotherapy induced anemia, first cycle chemotherapy education, and anticoagulation management. The smoking cessation program will be rolled out in this clinic as well. We are in the process of placing a pharmacist in the chronic pain management clinic and are working to further enhance the presence of the pharmacist currently working in our geriatric clinic.

We also have pharmacist-supported clinics as part of the UNC Internal Medicine Clinic. These clinics were established by the UNC School of Medicine and are partially funded by the School of Pharmacy. The Internal Medicine Clinic offers pharmacist services for anticoagulation, diabetes, pain management, and smoking cessation.

PP&P: How are ambulatory clinics that are in need of pharmacist support identified?

CM: Lately, we have been identifying the ambulatory clinics in our health system that are pursuing quality certifications, such as National Committee for Quality Assurance (NCQA) certification. My position, for example, was originally proposed when the endocrinology department applied for NCQA certification for diabetes, and we are targeting other clinics now as they apply for NCQA certification. In these circumstances, a pharmacist can help collect and analyze data pertaining

to certification, identify areas of deficiency, and develop and implement system or process changes to improve those areas. If the areas of deficiency are related to clinical parameters (e.g., A1C, blood pressure, lipids), the pharmacist can use their clinic to improve the identified parameters through targeted clinical interventions.

Another way of identifying the need for pharmacist support is through data analysis. Clinics that have a high number of patient visits, chronic patient management needs, significant medication expense, and long patient wait lists have been targeted for pharmacist placement. Because our institution has a lot of data supporting the benefits of pharmacists helping to manage patients in various chronic disease states, identifying areas of need has recently been pretty straightforward. In the absence of such data, determine where there are areas of high risk, such as anticoagulation management, for pharmacists to focus their efforts. Data on ER visits and incidence of readmission after discharge also will help identify these high-risk areas. In addition, it is helpful to survey physicians to learn where additional non-physician provider services are needed.

PP&P: What are some of the future plans for pharmacist-supported clinics at your health care system?

CM: We are currently considering an automatic referral process in the endocrinology clinic to increase patient volume. Simply waiting for providers to refer patients to the clinic is an inefficient process. So, for example, if a patient with diabetes has an A1C over nine, they would automatically be referred to the pharmacist clinic, or if a patient needed to see a physician outside of regularly scheduled visits (usually every 12 weeks) then that patient would automatically be referred to the pharmacist clinic instead for that closer follow up. Of course, the physician would be able to override the automatic referral if necessary.

We also are looking at having a pharmacist rotate through multiple clinics as opposed to working in just one. This would allow us to build



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services in more than one place at a time, with the intent of eventually raising the clinic volume to support a full-time pharmacist. Currently, our cardiology clinic is applying for certification for its heart and stroke program, so we are hoping to establish a pharmacist there. Under this model, that pharmacist could work a few days a week in the cardiology clinic and then the other days in another clinic.

Another option is to provide pharmacist support to some of the outlying primary care practices that are within a 30- or 40-minute drive of the central health system in Chapel Hill. Because many of these practices are strapped for resources, it might be beneficial to have a pharmacist come in one day a week to see patients at these offices.

PP&P: How does pharmacist support in the ambulatory setting benefit the hospital financially?

CM: A pharmacist can have a direct impact on a hospital's bottom line. For example, when patients requiring close monitoring are seen by the pharmacist, the physician is then free to see a new patient in that time slot. Because new patient visits are reimbursed at a higher rate than returning patients, this leads to increased revenue for the clinic.

Our family medicine clinic is working toward automatically scheduling appointments with pharmacists for those patients who are discharged from the inpatient family medicine service. The goal is to decrease the rates of readmission and improve the transition of patient care, thus creating cost savings.

We also have benefitted from decreased drug costs with pharma-

cist driven initiatives in the clinics. For example, in our hematology/oncology clinic the pharmacist was able to decrease drug costs by identifying inappropriate prescribing practices for the treatment of anemia.

PP&P: What are some points of consideration for selling pharmacist-supported clinics to administration?

CM: Billing for pharmacy services can certainly be a justification point. In addition, it is important to collect data that identifies the needs of the institution. Use the data to identify those practice sites and areas of patient care that are challenging or inefficient, and then demonstrate how a pharmacist can help with this. The pharmacist in the Internal Medicine anticoagulation clinic used this methodology when starting her clinic. She compared the percentage of INRs in therapeutic range for the present model of a nurse-run clinic to the data available across the state and in the published literature for pharmacist-run clinics.

With the pay-for-performance model taking hold in health care, there are additional opportunities to justify pharmacist support in clinics. For example, one can make a case for having pharmacist support to help a clinic acquire NCQA certification. Certification often results in higher reimbursement from payers, while the lack of certification can mean a drop in reimbursement levels.

In addition, institutions with a residency program or a relationship with a school of pharmacy can demonstrate the added value of student or resident rotation sites.

Key Considerations for Establishing Pharmacist-Supported Clinics

- Collect data to identify the targeted practice's need for pharmacist support.
- Determine the legislative requirements of your state for pharmacists to practice in clinics, as well as the requirements of the institution. At UNC the process for granting a pharmacist privileges to see patients is called credentialing. This process starts with being nominated by a medical division (i.e., endocrinology, family medicine, internal medicine, hematology/oncology, anesthesiology) to apply for privileges through that department. The pharmacist is then asked to complete an application that includes information such as education, certification, licensure, work experience, references, liability insurance, planned clinical privileges, and supervising physician. The application is submitted to the Office of Medical Staff Services and undergoes a detailed verification. Once the verification is complete, the application is forwarded to the Credentialing Committee, which either grants or denies privileges. This process takes three to six months at UNC. If your institution does not have a pharmacist credentialing process, review your institution's procedures for other non-physician providers, such as nurse practitioners or physician assistants.
- Educate yourself on the billing methods for pharmacist services at your different practice sites.
- Identify champions not only within the pharmacy department, but also in the physician and nursing groups. Look to progressive-minded individuals who are not afraid to rock the boat to enact change.
- Use your collected data and your physician or administrative champions to determine where there is a need for pharmacist support.
- Rally the support of the nursing and clinical staff within the practice site and educate these individuals on what pharmacists can do.
- Begin the licensing/credentialing process (whether it is through your state or your institution) as soon as possible as this can take several months to complete.
- Establish logistical plans for office space, scheduling (including the number of patients seen per day/half day, length of patient visit, pharmacist hours, etc.), and documentation requirements.
- Devote significant time to discussing how pharmacy services will be billed with your revenue management/billing department. A good shortcut is to find a pharmacist who is doing this elsewhere and have their revenue management/billing department representative speak directly to someone in your revenue management/billing department. This can help avoid miscommunication.
- Invest time at the practice site: Establish relationships with the physicians and nursing staff there and work to identify practice needs and appropriate system or process changes, such as automatic referrals.
- Recognize that launching a new ambulatory service can be a long, involved process, often taking 12 to 18 months to complete. Make sure that all involved are aware of this.

PP&P: What were some of the challenges in establishing these clinics?

CM: Most clinic staff have never worked with a pharmacist in this setting, and often do not understand the value that pharmacy brings to the table. Thus, one of the biggest challenges is educating the physicians, nurses, and other staff in ambulatory clinics on the merit of the pharmacist's role, and sometimes that requires demonstrating what pharmacy can do. Once the staff sees the improvement in a patient's disease state as a result of a pharmacist's intervention, they can understand the benefit of having a pharmacist on the team.

In addition, navigating the billing system can be extremely difficult because there are many different approaches to billing for pharmacist services. It is very much a "frontier," and most individuals are not familiar with how one can and cannot bill as a pharmacist provider.

PP&P: Do you have any recommendations for those interested in implementing pharmacist-supported clinics?

CM: First, evaluate the total patient volume for the practice site in comparison to the number of patients the pharmacist would need to see to justify your proposal. Also, it is important to *not* base your entire proposal on the ability of the pharmacist to generate clinical revenue. Given the limitations in growing patient volumes and the current level of pharmacist salaries, that approach can be challenging. So, beyond billing for clinical services, build your proposal on quality initiatives, include the opportunity for increased billing on the part of physicians, and emphasize the value of students and residents rotating through the site.

PP&P: How do you measure outcomes for these programs?

CM: We track the number of patient visits and the corresponding revenue generated. We also collect data on specific quality measures. For example, in the diabetes clinic, we track changes in A1C, blood pressure, and lipids (if applicable), and medication usage such as aspirin, ACE inhibitors, and angiotensin receptor blockers (ARBs). In the anticoagulation clinic, we track the time in therapeutic INR range. In addition to quality of care measures, physician and patient satisfaction can be tracked via surveys, and physician billing can be monitored to determine the impact of adding a pharmacist to the clinic on the number of new patients that physicians are seeing.

PP&P: What factors have contributed to the success of your clinics?

CM: Having the support of pharmacists, physicians, and administrative staff has contributed significantly to the success of these clinics. Establishing a clinic is not easy an easy process; you have to be willing to break down barriers, navigate roadblocks, and take innovative approaches as this is a new venture for many facilities. Assigning determined, persistent, and creative staff to these projects can ease the process.

We also relied heavily on the experiences of others who have successfully implemented pharmacist ambulatory care services, so we were able to learn from their mistakes and minimize the time between initially proposing one of these positions to establishing a well functioning clinic. For example, the pharmacists in our Internal Medicine Clinic have found that waiting for physician referral is not sufficient to ade-

Cost Justification of Pharmacists in Ambulatory Clinics



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Demonstrating the benefits the clinic will receive with pharmacist support helps justify the added cost of placing a pharmacist there. Fortunately, at UNC we have a long history of demonstrating the value pharmacists provide in clinics. Because of this, there is a positive impression of what we can do to improve patient care. As we have approached expanding our role in the ambulatory care clinics, we have been able to bill facility fees in hospital-based clinics for our patient care visits. In addition, we have helped provide better clinic throughput by managing chronic patient visits, allowing the physicians more time to see new patients and conduct procedures, which contributes to a stronger bottom line.

We also have helped to reduce patients' waiting time in the clinics, which increases the referring physician's and patient's satisfaction levels. We have aided in faster clinic infusions of medications, allowing us to see more patients in the same period of time. Finally, we are involved with clinic quality improvement measures, helping individual clinics achieve NCOA recognition. With these various activities and quality initiatives, the care our pharmacists provide in the ambulatory care clinics offsets their salary.

To ensure the continued support of administration, it is also important for pharmacy to provide regular reports demonstrating the effectiveness of pharmacist interventions. We provide monthly tracking of patient quality outcomes to our clinic leadership, hospital administrators, and key physician leaders. All pharmacist visits and outcomes are tracked and then trended over time to demonstrate the pharmacist's contributions to the clinic. We also work to document the other variables that our pharmacist has contributed to, including allowing physicians to see new patients, decreasing clinic waiting times, and improving quality indicators for the clinic.

quately build the pharmacist clinic volume. Based on this, we are moving to an automatic referral model in our clinics.

PP&P: What is the future for pharmacist-run clinics in the ambulatory care setting?

CM: Ideally, the presence of pharmacists in clinics would become routine. One of the biggest barriers right now is legislation that does not keep up with pharmacist capabilities. Fortunately, North Carolina is progressive in that sense and the state Board of Pharmacy worked closely with the Board of Medicine to establish the Clinical Pharmacist Practitioner certification that grants us prescriptive authority. If more states allowed pharmacists to work under collaborative practice agreements, pharmacists could have a positive impact on many practice settings. ■

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