Cutting-edge practice model: An integrated model within a large academic medical center

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At the University of Tennessee Medical Center, we enhanced the level of pharmacy services for all patients by integrating pharmacist activities to reduce unnecessary communication handoffs. This was achieved by incorporating pharmacist specialists into the pharmacy teams covering patient care services, which decreased patient:pharmacist ratios. It was paramount to minimize the nonclinical work of pharmacists by increasing technological support and using nonpharmacists where possible (e.g., dietitians, nurses, certified technicians). Our teams include decentralized pharmacists (clinical staff or specialists) and decentralized pharmacy technicians supporting multiple areas. Although many of the responsibilities of the decentralized clinical pharmacists and pharmacy specialists are the same, the specialists must also provide expert oversight of drug policy and quality assurance.

Initial expansion to other shifts with specialists rather than clinical staff was required because a certain level of expertise is needed in the beginning to set the appropriate expectations. On-call physicians, such as hospitalists and medical residents who work during night shifts, may have many questions and require assistance in prospective design of medication treatment plans. Internal medicine and critical care areas are appropriate starting points for expansion beyond the day shifts because these specialists can address a variety of disease states, regardless of whether patients are admitted to the floor or to the intensive care unit after-hours. For those areas, pharmacy specialists work on the floor round-the-clock, interacting with medical teams when decisions are being made.

Our pharmacy residency program allowed us to fast-track the development of clinical staff, in part by giving us a ready avenue for recruitment. Successful residency training on evening and night shifts led to the recruitment of emergency department pharmacists for a hybrid evening–night shift.

Successful implementation of a round-the-clock integrated pharmacy practice model depends on well-developed decentralized clinical staff, broad capabilities of clinical specialists, sufficient resources to hire the necessary staff, meaningful clinical activities, an investment in student and resident training, and commitment from all involved.

Cutting-edge practice model: Experience in a Veterans Affairs hospital

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The Department of Veterans Affairs (VA) is transitioning to a patient-centered medical home (PCMH) health care model. The PCMH is a patient-driven, team-based approach that delivers efficient, comprehensive, and continuous care.
through active communication and coordination of resources.

The medical home within VA is built on three main pillars: access to health care, care management and coordination, and practice redesign. VA has adopted the term patient-aligned care team (PACT), which is equivalent to the term patient-centered medical home. A PACT comprises a primary care provider, nurse case manager, clinical associate, and clerk. Professionals from other disciplines, such as a clinical pharmacy specialist (CPS), complete the team. The CPSs at our institution serve as midlevel practitioners working under an explicit scope of practice. This scope of practice allows CPSs to prescribe medications, devices, and supplies; order and review the results of laboratory tests; order consultations; perform physical assessment; and develop and document therapeutic plans.

The care management and coordination pillar offers the greatest opportunity for pharmacists in the PCMH. Caring for patients in this model moves away from a "silo" approach to an all-encompassing encounter. This allows the CPS to manage a myriad of diseases, provide comprehensive medication management, target specific patient populations, and assume responsibility for patient outcomes. By providing management of chronic diseases, the CPS helps improve patients’ access to their primary care provider. CPSs are also involved in shared medical appointments and telephonic and virtual care.

Potential barriers to advancing the CPS role include provider acceptance, funding and reimbursement, space and resources, and the lack of qualified pharmacists. Future directions for CPSs may include having a CPS in every medical home, serving as the leader of a PACT, and serving as a primary care provider.