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.