Expanding the Possibilities for Pharmacy-Family Medicine Residency Collaboration

TO THE EDITOR:
We would like to thank Dr Jarrett and colleagues for their thoughtful article “Clinical Pharmacists as Educators in Family Medicine Residency Programs: A CERA Study of Program Directors.” It is gratifying to note the increasing presence of pharmacists within family medicine residencies (FMRs) since the last survey. We would like to comment on the changing environment that will allow FMR graduates to enter practice settings that support interprofessional collaboration.

First, to expand on the positive findings of this paper, the universal acceptance of the PharmD degree is noteworthy. Every pharmacy graduate in the United States is now prepared to deliver clinical services, making the designation “clinical pharmacist” a misnomer in 2016. Many pharmacists further specialize by completing 1 to 2 years of residency training and board certification, including the newest certification in ambulatory care. These pharmacists are ideally suited as partners in physician practices.

Second, in addition to the provision of pharmacotherapy education in FMRs, pharmacists can provide direct patient care through chronic disease management and monitoring, immunizations, and medication therapy management (MTM), which aims to optimize drug therapy, optimize clinical outcomes, and address barriers to care. Third, with new emphasis on interprofessional education, providers are increasingly recognizing the importance of pharmacist-physician collaboration in providing high-quality patient-centered care. By actively involving pharmacists in the full scope of patient care in FMR programs (as allowed by state licensure), providers are teaching and modeling interprofessional care through the meta-curriculum.

Finally, the perception that payment issues serve as a barrier to incorporating pharmacists into practices is worth challenging. While pharmacists are not yet recognized as Medicare providers, Congress is currently considering legislation to make this a reality in the near future. Under the “incident-to” rules, pharmacists can provide care, as auxiliary personnel, in collaboration with supervising physicians for billable services. New chronic care management (CCM) codes enable pharmacists to provide care within a physician practice for patients with two or more chronic diseases. Medicare Advantage (MA) plans offer pay-for-performance incentives via the Annual Medicare Wellness Visit, by closing care gaps, and by improving the overall Star Rating of the practice. LECOM is beginning a pilot for MA patients whereby the revenue returned to the practice is projected to exceed the cost of adding a pharmacist. In 2019, the Merit-Based Incentive Payment System (MIPS) will increase or decrease adjustments for physician services based on quartile performance ratings per physician. Focus will shift to resource utilization and practice improvements including initiatives such as expanding practice access and promoting beneficiary engagement. Because pharmacists’ skill sets complement MIPS reimbursement foci, adding a pharmacist partner in a practice could dramatically affect CMS payments for the entire group. Since MIPS reimbursement is anticipated to be based on 2017 data, physicians who proactively integrate pharmacists within a team-based care model will be ahead of the curve come 2019.

In summary, we applaud the current state-of-the-art pharmacy collaboration within FMRs and encourage an examination of the expansion of pharmacists’ roles in residency programs. Methodologies do exist to overcome perceived financial barriers to integrate pharmacists in clinical practice settings.

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References

Clinical Pharmacists in Family Medicine Residency Programs: Tackling the Billing Barrier

TO THE EDITOR:
I applaud Jarrett and colleagues for their recent publication “Clinical Pharmacists as Educators in Family Medicine Residency Programs: A CERA Study of Program Directors.” As a clinical pharmacist (CP) working in a family medicine residency program (FMRP), I read this report with much interest. One major finding of the survey was that CPs’ limited ability to bill for clinical services is the top barrier for incorporation into FMRPs.

Growth of CPs in FMRPs has skyrocketed from 2002 to today. Sixty-seven percent of FMRPs now have CPs actively involved in their programs, an increase from 27%. Dickerson and colleagues reported >70% of the pharmacists received part or all of their funding from the FMRP; 36% were fully supported. While not directly asked in the recent survey, this correlates with the “Top barrier to incorporation of a clinical pharmacist.” Thirty-seven percent of all programs identified limited ability to bill as a barrier, while 48% identified none. This would seem to indicate that CPs’ limited billing ability does not affect their incorporation into a majority of FMRPs. FMRPs with CPs have likely identified ways to address billing barriers or realize the many benefits of CPs outweigh such barriers.

The many benefits CPs bring to FMRPs include resident education and improved patient care. However, I am troubled when CPs’ inability to bill is considered a barrier to joining interprofessional health care teams. I believe CPs are a necessary part of the health care team and resident education. To accomplish full integration, FMRPs can consider several ideas for CPs financial justification without focusing on billing. For example, allowing a CP to manage chronic conditions like diabetes, hypertension, and chronic lung diseases may free physicians’ schedules. Physicians can use this freed time to see new patients, expand patient panels, and provide higher revenue-generating services like procedures and home visits. Meanwhile, CPs can identify and solve many issues like therapeutic optimization, adherence, and cost barriers to more effectively manage chronic conditions. This allows an FMRP to indirectly justify a CP while working toward the Triple Aim and impacting resident education. Additionally, CPs can create or enhance several revenue-generating services. Many examples are outlined by the American Society of Health-System Pharmacists. Lastly, the future of CMS reimbursement will be linked to quality. Initiatives like the Merit-Based Incentive Payment System (MIPS) and Alternative Payment Models (APMs) currently exist and will be expanded over the next decade. CPs can augment these value-based programs to ensure maximum reimbursement is obtained.

CPs’ limited ability to bill for clinical services should not deter FMRPs. FMRPs can seek CPs to identify these and other unique ways of addressing financial barriers. The STFM Group on Pharmacotherapy is pharmacist driven and would be a great starting point. The Group on Pharmacotherapy can also assist FMRPs in identifying properly trained CPs to add to their team. The FMRP/CP interprofessional partnership has endless opportunities and is one I hope to see in every FMRP.

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References