

Provider Perceptions of Pharmacists in Primary Care–Based Accountable Care Organizations

TINA JOSEPH, PHARMD, BCACP; GENEVIEVE M. HALE, PHARMD, BCPS, BCCP, CPH;
AND CYNTHIA MOREAU, PHARMD, BCACP, CPH

ABSTRACT

Clinical pharmacists are in an ideal position to manage multiple aspects of patient care within value-based care models. In 2015, Nova Southeastern University College of Pharmacy founded the Accountable Care Organization Research Network, Services, and Education (ACORN SEED), a team of pharmacy practice faculty dedicated to using innovative approaches to patient care while providing unique learning experiences for pharmacy students by partnering with primary care–based accountable care organizations in the South Florida region. In this article, we describe our experiences with ACORN SEED, addressing provider perceptions and creating methods to overcome several challenges to clinical pharmacist integration, including (1) providing value, (2) collaborative practice, and (3) workflow disruption. Overcoming these challenges is critical for organizations aiming to expand pharmacist integration to improve patient outcomes and reduce health care costs.

The American Journal of Accountable Care. 2021;9(1):24–27

New payment models launched by CMS have been catalysts in shifting health care reimbursement from fee-for-service to value-based care models. The alternative payment model (APM) is a payment approach that incentivizes the provision of high-quality and cost-effective patient care. Two examples of APMs include the Medicare Shared Savings Program and the Next Generation Accountable Care Organization (ACO) Model.^{1,2} ACOs with a focus on primary care providers are becoming increasingly commonplace in practice.

Clinical pharmacists are in an ideal position to manage multiple aspects of patient care, especially within primary care–based ACOs. In 2015, Nova Southeastern University College of Pharmacy (NSUCOP) founded the Accountable Care Organization Research Network, Services, and Education (ACORN SEED), a team of pharmacy practice faculty dedicated to using innovative approaches to patient care while providing unique learning experiences for pharmacy students by partnering with ACOs in the South Florida region.³ Three pharmacy faculty members provide services in 3 different primary care provider offices. These pharmacists perform services approximately 2 times per week by meeting independently with patients or during patients' appointments with their providers, assessing medication appropriateness, performing telephone consults and follow-ups, and making recommendations to the provider. In an article published in *The American Journal of Accountable Care*[®] in 2017, we described the initial steps it took to develop a strategic partnership between a college of pharmacy and a primary care–based ACO.⁴

In this article, we describe our experiences with ACORN SEED regarding provider perceptions and the methods we developed to overcome several challenges to clinical pharmacist integration, including (1) providing value, (2) collaborative practice, and (3) workflow disruption.

CHALLENGES

Providing Value

Integration of pharmacists in primary care–based ACOs is a potential solution to the looming crisis in access to primary care.⁵ In 2017, the American Medical Association created the STEPS Forward initiative to help physicians improve patient care. One way to enhance patient care, raise physician satisfaction, and support practice sustainability is clear: embedding pharmacists into the practice.⁶

As medication experts, clinical pharmacists are the ideal health care providers to manage pharmacotherapy in patients with chronic diseases. Because we had limited resources in terms of number of pharmacy faculty and time, we were able to leverage our training of pharmacy students to help provide clinical services. Our previous and ongoing initiatives target chronic obstructive pulmonary disease, cardiovascular disease (notably, hypertension, heart failure, and dyslipidemia), diabetes, transitions of care, and adherence.^{7–12} These initiatives were mutually agreed on by the ACO corporate team, clinical providers, and pharmacists as a way to help provide value and measure success. We met quarterly with the ACO corporate team to discuss progress and opportunities for further integration and expansion and to provide transparency. In 2017, NSUCOP created a postgraduate year 2 (PGY2) Ambulatory Care Pharmacy Residency program graduating 2 residents yearly, which increased our capacity to provide pharmacy services while providing a unique learning opportunity for pharmacists. Once our pharmacy team was able to show initial success when working closely with the corporate team and clinical staff, this encouraged more involvement of pharmacy.

Our providers perceived pharmacists as very valuable, especially when embedded in their practice. Additionally, providers believed that clinical pharmacists help improve performance on Patient/Caregiver Experience ACO Quality Measures 1 through 7¹³ and that there is a return on investment in hiring a clinical pharmacist. Having solidified beneficial experiences with our pharmacy team, the ACO corporate team justified the salary of a full-time pharmacist and hired a graduate of the aforementioned PGY2 Ambulatory Care Pharmacy Residency Program to further expand their pharmacy services. This unique position was designed to build on the foundation of existing pharmacy clinical services while also adding initiatives targeting high-cost medications, insulin programs, and transitions of care services. Our future goals as a pharmacy team include providing telehealth services through call centers on campuses at NSUCOP as a method to deliver patient care and help provide hands-on experience for our students, which is especially vital throughout the coronavirus disease 2019 pandemic.

Aside from improving patient outcomes in disease state management, pharmacists can provide additional value by

improving provider efficiency and curbing burnout. Our experiences continue to support the integration of clinical pharmacists in outpatient practice settings, where they play an integral part in patient care and improve outcomes for patients.

Collaborative Practice

Primary care–based ACOs support the use of patient-centered integration and interprofessional teams.³ Pharmacists in many states may practice in multidisciplinary care models through collaborative practice agreements (CPAs) with physicians. Through CPAs, pharmacists have the ability to work under a defined protocol to perform assessments, order tests, and administer drugs, as well as initiate, modify, and monitor medication regimens. CPAs vary in scope based on state legislation, practice environment, and pharmacist training.¹⁴ Previous studies' findings have indicated that pharmacists have encountered several challenges when initiating CPAs with physicians, including physician acceptance of the role and reimbursement challenges.¹⁵

Initially, in our experience, few providers felt comfortable entering into collaborative practice with a pharmacist. One of the reasons for this concern is the limited understanding of a CPA and experience when working with a pharmacist. Some providers expressed that they were not comfortable due to concerns of pharmacists practicing outside of their scope of practice. Based on our experience, many providers were unaware of the training of pharmacists. A traditional doctor of pharmacy (PharmD) program consists of a 4-year curriculum, including 3 years of didactic education followed by 1 year dedicated to clinical clerkships. Many pharmacy graduates also seek advanced clinical training through 1 or 2 years of postgraduate residency training. It was important to communicate that part of pharmacists' training is understanding the limitations of their profession, including when to refer to a provider. Additionally, pharmacists may have additional credentials, including board certification. A deeper understanding of pharmacists' training on the part of providers and a trusting provider-pharmacist relationship, with evidence-based protocols delineating tasks of pharmacists, are critical to the success of clinical pharmacist expansion in the primary care setting. Lastly, once we were able to demonstrate value when managing patients, primary care providers began to initiate referrals of patients to pharmacists and felt more comfortable entering into collaborative practice.

Workflow Disruption

Initially, face-to-face interactions between providers and pharmacists were vital to the development of a trusting, interprofessional relationship. However, when considering face-to-face pharmacist integration into a primary care office, it

is important to note that pharmacy services must be tailored to each individual provider in each individual office, as there is variability in primary care workflow including support staff, length of visits, and structure of relationships among members of the clinical team. Our providers must be efficient when completing patient visits; therefore, it was important for pharmacists to make an effort to learn provider preferences regarding workflow and opportunities for improvement from the provider perspective. In addition, it was important for the pharmacist to understand the roles of and develop relationships with all staff members of the medical office. This provided additional support for the integration of pharmacists in the clinic. Initially, each pharmacist in each office had a different workflow to accommodate each provider. Once a trusting relationship was developed and more experience was obtained, our pharmacy team was able to standardize services (ie, adherence, transitions of care, diabetes). One common theme that was noted regardless of the service was the necessity for the pharmacy team to have access to the electronic health record and the ability to document interventions.

CONCLUSIONS

Although our providers perceived pharmacists as valuable in the primary care-based ACO setting, overcoming challenges to provider perceptions regarding providing value, collaborative practice, and workflow disruption was necessary. Overcoming these challenges is critical for organizations that are aiming to expand pharmacist integration to improve patient outcomes and reduce health care costs.

Acknowledgments

We would like to acknowledge Monica Tadros, PharmD, BCPS, BCOP, malignant hematology/bone marrow transplant pharmacist, Baptist Hospital of Miami, Miami, FL; Hong Nguyen, PharmD, clinical pharmacist, St. Mary's Medical Center, West Palm Beach, FL; and Diliam Jouve Gonzalez, PharmD, PGY1 pharmacy resident, Miami Veterans Affairs Healthcare System, Miami, FL.

Author Affiliation: Department of Pharmacy Practice, Nova Southeastern University College of Pharmacy (TJ, GMH, CM), Fort Lauderdale, FL.

Source of Funding: None.

Author Disclosures: The authors report no relationship or financial interest with any entity that would pose a conflict of interest with the subject matter of this article.

Authorship Information: Concept and design (TJ, GMH, CM); acquisition of data (TJ, CM); analysis and interpretation of data (TJ); drafting of the manuscript (TJ, GMH, CM); critical revision of the manuscript for important intellectual content (TJ,

GMH, CM); statistical analysis (TJ); provision of study materials or patients (TJ, CM); obtaining funding (TJ); administrative, technical, or logistic support (TJ); and supervision (TJ).

Send Correspondence to: Tina Joseph, PharmD, BCACP, Department of Pharmacy Practice, Nova Southeastern University College of Pharmacy, 3200 S University Dr, Fort Lauderdale, FL 33328. Email: tjoseph1@nova.edu.

REFERENCES

1. APMs overview. CMS Quality Payment Program. Accessed December 17, 2020. <https://qpp.cms.gov/apms/overview>
2. Mose JN, Jones CB. Alternative payment models and team-based care. *N C Med J*. 2018;79(4):231-234. doi:10.18043/ncm.79.4.231
3. Joseph T, Hale GM, Eltaki SM, et al. Integration strategies of pharmacists in primary care-based accountable care organizations: a report from the Accountable Care Organization Research Network, Services, and Education. *J Manag Care Spec Pharm*. 2017;23(5):541-548. doi:10.18553/jmcp.2017.23.5.541
4. Gernant SA, Hale G, Joseph T, et al. Building partnerships between a college of pharmacy and ACOs: development of the ACORN SEED. *Am J Accountable Care*. 2017;5(3):29-33.
5. Physician supply and demand—a 15-year outlook: key findings. Association of American Medical Colleges. 2019. Accessed February 9, 2021. https://www.aamc.org/system/files/2019-07/workforce_projections-15-year_outlook_key_findings.pdf
6. Choe HM, Standiford CJ, Brown MT. Embedding pharmacists into the practice. American Medical Association. June 29, 2017. Accessed February 8, 2021. <https://edhub.ama-assn.org/steps-forward/module/2702554#section-216048091>
7. Moreau C, Hale GM, Joseph T, Nieves Santiago AA, Maravent S, Steinberg JG. Development and evaluation of physician-precepted advanced pharmacy practice experiences (APPEs) within an accountable care organization (ACO). *Curr Pharm Teach Learn*. 2020;12(4):465-471. doi:10.1016/j.cptl.2019.12.032
8. Boylan P, Joseph T, Hale G, Moreau C, Seamon M, Jones R. Chronic obstructive pulmonary disease and heart failure self-management kits for outpatient transitions of care. *Consult Pharm*. 2018;33(3):152-158. doi:10.4140/TCP.n.2018.152
9. Hale GM, Joseph T, Moreau C, et al. Establishment of outpatient rounds by an interprofessional chronic care management team. *Am J Health Syst Pharm*. 2018;75(10):598-601. doi:10.2146/ajhp170106
10. Hale G, Joseph T, Maravent S, et al. Effect of interprofessional collaboration on quality of life in elderly patients with cardiovascular disease. *J Interprof Educ Pract*. 2018;12:25-28. doi:10.1016/j.xjep.2018.05.004
11. Pape ZA, Hale G, Joseph T, Moreau C, Wolowich WR. Impact of pharmacist-led heart failure tool kits on patient-reported

- self-care behaviors in a primary care-based accountable care organization. *J Am Pharm Assoc (2003)*. 2019;59(6):891-895.e3. doi:10.1016/j.japh.2019.08.006
12. Joseph T, Hale GM, Moreau C, Rosario ED, Logan N, Perez A. Evaluating a pharmacist-led intervention on cardiovascular- and diabetes-related quality measures in a primary care-based accountable care organization. *J Pharm Pract*. Published online December 11, 2020. doi:10.1177/0897190020977740
13. Table: 33 ACO quality measures. CMS. Accessed February 9, 2021. <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/ACO-Shared-Savings-Program-Quality-Measures.pdf>
14. Collaborative practice agreements and pharmacists' patient care services: a resource for pharmacists. CDC. 2013. Accessed February 9, 2021. https://www.cdc.gov/dhds/pubs/docs/Translational_Tools_Pharmacists.pdf
15. Kelly DV, Bishop L, Young S, Hawboldt J, Phillips L, Keough TM. Pharmacist and physician views on collaborative practice: findings from the community pharmaceutical care project. *Can Pharm J (Ott)*. 2013;146(4):218-226. doi:10.1177/1715163513492642