Model:

Pharmacists as Part of an Integrated Team of Healthcare Providers

by Artin Dembekjian and Craig Stern, PharmD, MBA

The following model discusses a historical experience of a university-based pharmacist involved with a family practice clinic. The pharmacist was a preceptor for pharmacy students who evaluated patients as part of an integrated team of healthcare professionals. The model provides insight into the establishment of pharmacists as a vital part of an integrated healthcare team based on cognitive services.

Dr. Sam Shimomura PharmD., an Associate Dean at Western University of Health Sciences, School of Pharmacy helped organize and operate a UCI family practice clinic ten years ago.

Business Model Description

The emphasis was on the Ethno-Geriatric population of this Orange County Clinic. This was a teaching model that helped UCSF students learn and work in conjunction with other health care professionals to provide geriatric care. Approximately 4-6 difficult-to-treat elderly patients were seen per day.

What are some of the resource requirements?

The clinic was run by physicians, residents, pharmacists, nurses, medical students and pharmacy students. In addition to the clinic, a pharmacy was available to provide prescriptions for all patients. However, a high level of expertise, such as a PharmD degree and a residency with emphasis on geriatrics, was needed by clinical pharmacists to provide for those complex patients.

Please describe any successes whether they are measurable or anecdotal:

Three of the most important successes achieved in working with this model were providing care for the elderly, developing an understanding of the unique health care needs for different ethnic communities, and educating future pharmacists in geriatric pharmacotherapeutics. Medical and pharmacy students benefited from the multi-specialty interaction and by having a hands-on experience to augment their academic knowledge.

What are some limitations of the model or restrictions that limit its portability?

Patients were pre-selected. Only the most complex cases composed of patients with multiple co-morbidities and high volumes of medications, including prescription and over-the-counter medicines, were chosen for pharmacist intervention. This selection limited the case volume and added to the expertise required for evaluation. However, these patients offered the greatest opportunity for pharmacists to impact patient care.

Business case:

Seniors paid for the services by either their own health plans, government aid, out of pocket and/or university subsidies.

Are there any legal or regulatory issues or restrictions on the model?

There were no restrictions or regulatory issues that hindered this practice. The clinic provided services by all health care professionals.

Since prevention is the key to a healthy society and health care cost savings, screening and identifying elderly patients at high risk should be a priority of pharmacists at these clinics/pharmacies.

Any future plans?

This teaching model is a potential template for pharmacists to expand the scope of their practices to integrate with health care teams. A business model may be developed by pharmacists and pharmacy residents with an emphasis on geriatric populations, with particular focus on certain ethnic populations. This family-practice-based teaching model is potentially transportable to a pharmacy based model or an independent consulting clinic run by pharmacists. This experience is a mixed model of dispensing pharmacy, and durable medical equipment (DME), with the cognitive clinical function. A consulting model may utilize pharmacists to provide recommendations and educate seniors on their medications and/or handling DMEs. Since prevention is the key to a healthy society and health care cost savings, screening and identifying elderly patients at high risk should be a priority of pharmacists at these clinics/pharmacies.

What lesson does this academic model provide for general pharmacy practice?

On the surface the model itself is limited to a teaching setting. However, such models offer insights for integrating pharmacists into teams of healthcare professionals. First, introducing pharmacists during the educational process lead to a parity in experience and appreciation for the expertise offered by each member of the team. Second, patient selection is a key factor in prioritizing resources and time commitments for various services. Third, emphasis on geriatric populations offers a wealth of opportunity for clinical pharmacy services applied to multiply comorbid populations. Fourth, additional opportunities exist for providing clinical services to ethnic populations by appreciating their particular needs.

Perhaps the most significant lesson from this model is that the teaching experience demonstrates that pharmacists can work as valued members of integrated healthcare teams. The challenge is to ensure that the team does not dissolve when pharmacists and physicians leave the teaching setting.

About the Authors

Artin Dembekjian is a 2007 PharmD candidate at the Western University School of Pharmacy.

Craig Stern, PharmD, MBA is President of ProPharma Pharmaceutical Consultants, Inc. in Northridge and currently serves as CPhA's Editorial Review Committee Chairperson.