

Pharmacists in Primary Care Practices and Clinics

PUBLISHED ARTICLES

1) Altavela JL et al, "A Prospective Trial of a Clinical Pharmacy Intervention in a Primary Care Practice in a Capitated Payment System." J Manag Care Pharm. 2008;14(9):831-43

SETTING: This was a prospective, controlled study comparing 2 internal medicine practices.

CONCLUSION: Compared with patients of PCPs who received no input from a clinical pharmacist, patients of PCPs who received clinical pharmacist recommendations were more likely to have several medication-related issues addressed, including medication nonadherence, untreated indications, However, total medical (excluding pharmacy) costs for the intervention and comparison groups were not significantly different.

2) Bajcar JM et al, Collaborative medication management in a team-based primary care practice: an **explanatory conceptual framework**. Res Social Adm Pharm. 2005 Sep;1(3):408-29

CONCLUSION: The proposed Team Approach to Medication Management framework can be used to guide discussions and decisions among the different health care providers working in primary care to define both direct and indirect roles that health care practitioners and patients play in collaborative medication management.

3) Berdine HJ, Development, Implementation, and Evaluation of a Pharmacist Medication/Disease Management Service in an Urban Primary Care Physician Office Practice, Annals of Pharmacotherapy (prepublication).

The purpose of this project is to describe the development, implementation, and evaluation of a pharmacist managed medication therapy/disease state management clinic in a family medicine office.

SETTING: The physician office is located in downtown **Pittsburgh, Pennsylvania**, six blocks from the campus of Duquesne University

CONCLUSION: The development and implementation of a pharmacist-managed clinic in a family practice office is a tremendous opportunity to enhance patient care. This type of service applied to a diabetes patient population resulted in positive patient health outcomes.

4) Boudreau DM et al, Collaborative Care Model to Improve Outcomes in Major Depression, Ann Pharmacother 2002;36:585-91

SETTING: To develop a pharmacist intervention to improve depression care and outcomes within a primary care setting.

CONCLUSION: The study is a unique, ongoing trial that may have important implications for the treatment of depression in primary care.

5) Caballero J et al, Development and outcomes of a psychiatric pharmacy clinic for indigent patients, *Am J Health-Syst Pharm.* 2008; 65:229-33

SETTING: Su Clinica Familiar (SCF) is a community health center in **Texas's Lower Rio**

Grande Valley that sees over 30,000 patients a year, 20% of whom have a psychiatric disorder.

CONCLUSION: psychiatric pharmacy clinic in an underserved region appeared to benefit patients' mental health and save money.

6) Carter BL et al, A Cluster Randomized Trial to Evaluate Physician/Pharmacist Collaboration to Improve Blood Pressure Control, *J Clin Hypertens (Greenwich).* 2008;10:260–271

This project was supported by the National Heart, Lung, and Blood Institute, 1 R01 HL069801-01A1

SETTING: Two family medicine clinics at a major teaching hospital in the **mid-western** United States.

CONCLUSION: An intervention involving physician/pharmacist collaboration that focused on optimizing and intensifying medications was associated with significant reductions in BP and improvements in BP control. This study was the first to include 24-hour BP monitoring to objectively confirm clinic pressures. These improvements were correlated with increased intensity of medication use, which suggests that the model had an effect to overcome suboptimal medication regimens. The intervention also improved medication adherence in the small number of patients with poor adherence without increasing adverse effects. This study suggests that for clinics or health systems that have clinical pharmacists, their reallocation to provide more direct patient management may significantly improve BP control. **[IOWA]**

7) Carter BT et al, How Pharmacists Can Assist Physicians With Controlling Blood Pressure, *J Clin Hypertens.* 2003;5:31–37.

CONCLUSION: The profession of pharmacy has changed significantly in recent years. This has led to innovations in which the pharmacist has become a critical interdisciplinary team member. Studies within integrated health systems have demonstrated that when pharmacists are included as members of these teams, control rates for hypertension increase. In addition, drug interactions, nonadherence, and costs can be reduced. The new Healthy People 2010 goals for hypertension require a much more intensive approach in order to achieve desired blood pressure control rates. It will be very difficult to achieve the goals for control rates in hypertensive populations without significant participation by pharmacists. It is important for health systems and group practices to include pharmacists as an integral part of the team that cares for these patients.

8) Davidson MB, Detailed Treatment Algorithms for Effective Nurse- and Pharmacist-Directed Diabetes Care, *The Diabetes Educator*, Vol. 35, No. 1, 61-71 (2009)

SETTING: Clinical Center for Research Excellence, Charles R. Drew University, **Los Angeles, California.**

The purpose of this article is to provide treatment algorithms proven to be effective in meeting the standards of care of the American Diabetes Association to nurses and pharmacists who are given the authority to make independent clinical decisions (under the overall supervision of a physician).

9) Devine EB et al, Strategies to optimize medication use in the physician group practice: The role of the clinical pharmacist. *J Am Pharm Assoc* 2009;49:181–191.

SETTING: Community-based, multispecialty, physician group practice located in the north **Puget Sound** area between 2003 and 2007.

CONCLUSION: In 2006–2007, 71% of our hypertensive patients received generic agents compared with a network average for receiving generic agents of 43%, while the proportion of patients with controlled blood pressure increased from 45% to 60%. We saved \$450,000 in inpatient costs for deep venous thrombosis. Clinical pharmacists employed in a physician group practice can optimize medication use, improve care, and reduce costs.

10) Dickerson LM et al Formation of a primary care pharmacist practice-based research network, *American Journal of Health-System Pharmacy*: Volume 64(19)1 October 2007p 2044-2049

RESULTS: A total of 81 pharmacists in 48 practice sites were recruited to join the PBRN. Most practice sites were located within family medicine residency programs, and the majority were affiliated with a community hospital or health system. Half of participating practices had 300-599 ambulatory care visits per week. Pharmacists in the PBRN spent their time performing direct patient management and had collaborative practice agreements with physicians. Patient revenue was used to cover pharmacist salaries in about one fifth of the practice sites. Pharmacists in the PBRN reported participation in diverse educational activities, such as point-of-care resident education and curbside consultation in the clinic hallways or their office.

CONCLUSION: Eighty-one pharmacists from 48 primary care practice sites in **11 states** were recruited to join a PBRN. These pharmacists provided descriptive data regarding their practice site, characteristics of patients served, and clinical services provided as a first step in collaborative research efforts.

11) Green BB et al, Effectiveness of Home Blood Pressure Monitoring, Web Communication, and Pharmacist Care on Hypertension Control
JAMA. 2008;299(24):2857-2867

<http://jama.ama-assn.org/cgi/content/full/299/24/2857>

Trial Registration clinicaltrials.gov Identifier: **NCT00158639**

SETTING: A 3-group randomized controlled trial, the Electronic Communications and Home Blood Pressure Monitoring study was based on the Chronic Care Model. The trial was conducted at an integrated group practice in **Washington state**, enrolling 778 participants aged 25 to 75 years with uncontrolled essential hypertension and Internet access. Care was delivered over a secure patient Web site from June 2005 to December 2007.

CONCLUSION: Pharmacist care management delivered through secure patient Web communications improved BP control in patients with hypertension.

12) Helling DK et al, Kaiser Permanente Colorado Region Pharmacy Department: Innovative Leader in Pharmacy Practice, J Am Pharm Assoc. 2006;46:67–76.

SETTING: One of eight regions of the nation’s largest nonprofit health maintenance Organization

CONCLUSION: The **Colorado Region Pharmacy Department** has been recognized as a leader in pharmacy practice through the development of innovative services that provide exceptional patient care.

13) Hunt JS, et al, “A Randomized Controlled Trial of Team-Based Care: Impact of Physician-Pharmacist Collaboration on Uncontrolled Hypertension,” J Gen Intern Med 23(12):1966–72

SETTING: Providence Primary Care Research Network-Providence Physician Division, **Beaverton, OR, USA**

CONCLUSION: Patients randomized to collaborative primary care-pharmacist hypertension management achieved significantly better blood pressure control compared to usual care with no difference in quality of life or satisfaction.

14) Isetts BJ et al, Clinical and Economic Outcomes of medication therapy management services: the **Minnesota** experience. J Am Pharm Assoc January 2009

SETTING: Six ambulatory clinics in Minnesota

CONCLUSION: Patients receiving face-to-face MTM services provided by a pharmacist in collaboration with prescribers experienced improved clinical outcomes and lower total health expenditures. Clinical outcomes of MTM services have chronic care improvement and value-based purchasing implications, and economic outcomes support inclusion of MTM services in health plan design.

15) Kuo GM et al, Collaborative drug therapy management services and reimbursement in a family medicine clinic, Am J Health-Syst Pharm. 2004; 61:343-54

SETTING: Family medicine clinic

CONCLUSION: Establishing a DTMS presents many challenges and obstacles, but they should not lead to discouragement. Rather, pharmacists should be diligent and continue to explore ways in which they could provide optimal medication therapy to patients through appropriate channels that also facilitate reimbursement.

16) Malone R et al, Development and Evolution of a Primary Care-Based Diabetes Disease Management Program, CLINICAL DIABETES • Volume 25, Number 1, 2007

SETTING: University of **North Carolina** [UNC] Enhanced Care Diabetes Program

CONCLUSION: Structured care programs in clinical settings can overcome barriers to high quality care. We feel the primary care-based structured care program in our academic internal medicine practice is a model experience that can be replicated in other practices.

17) Michael EE, et al Evaluation of 4 Years of Clinical Pharmacist Anticoagulation Case Management in a Rural, Private Physician Office, J Am Pharm Assoc. 2003; 43:630–6.

SETTING: Rural, private physician office in **Mt. Vernon, Iowa**

CONCLUSION: A clinical pharmacist can provide anticoagulation case management services safely and effectively in a private physician office, and the service is highly valued by both patients and providers. We believe case management is an optimal method for systematically monitoring outpatient anticoagulation therapies and is preferable to usual medical care.

18) Monte SV, “Clinical and economic impact of a diabetes clinical pharmacy service program in a university and primary care–based collaboration model.” J Am Pharm Assoc. 2009;49:200-208.

SETTING: Regional primary care group in **Buffalo, NY**

CONCLUSION: In this CPS model, there were initial and sustained reductions in the primary diabetes endpoints and a high rate of improvement for accompanying metabolic parameters. Concurrent with clinical improvements, total direct medical costs were reduced despite an increase in antidiabetic medication and total medication costs.

19) Murray MD, et al, “Effect of a Pharmacist on Adverse Drug Events and Medication Errors in Outpatients With Cardiovascular Disease” Arch Intern Med. 2009;169(8):757-763.

clinicaltrials.gov Identifiers: **NCT00388622 and NCT00388817**

SETTING: Participants for both trials were recruited at the outpatient practices of **Wishard Health Services, Indianapolis, Indiana**. Wishard is located on the campus of Indiana University School of Medicine at Indianapolis and is part of a city-county teaching hospital serving the socioeconomically disadvantaged and medically vulnerable population of Marion County, Indiana

CONCLUSION: The results of this post hoc analysis suggest that pharmacist intervention to improve medication use in adult outpatients with cardiovascular disease decreases ADEs and MEs. While these findings were the result of a pooled estimate involving 2 studies, the effects were consistent within individual studies. Most of the events (90%) derived from individuals with complicated cardiovascular disease such as heart failure who had more complicated drug regimens.

The focus of the intervention was aimed at improving adherence and medication use by pharmacists spending more of their time instructing patients on the appropriate use of their medications, drug monitoring, and communication with patients’ primary care physicians.

20) Nichol A et al, “The Pharmacist as Physician Extender in Family Medicine Office Practice”, J Am Pharm Assoc. 2006;46:77–83.

SETTING: Clinical pharmacy physician-extender practice in a private medical office and direct compensation to pharmacist, **Columbus, Ohio**

CONCLUSION: Working in a private physician office practice provides a unique means of providing pharmaceutical care with reimbursement for the pharmacist.

21) Nkanash NT, et al “Clinical outcomes of patients with diabetes mellitus receiving medication management by pharmacists in an urban private physician practice.” Am J Health-Syst Pharm. 2008; 65:145-9

SETTING: Johns Hopkins Community Physicians [**Maryland**]; pharmacy clinic located within the physician’s practice

CONCLUSION: Integrating a pharmacist into a private physician practice significantly improved patient glycemic control and maintained patients’ weight and the number of patients at blood pressure goal. Clinic adherence with ADA recommendations was sustained.

22) Pottie, K et al “Narrative Reports to Monitor and Evaluate the Integration of Pharmacists Into Family Practice Settings.” Ann Fam Med 2008;6:161-165. DOI: 10.1370/afm.815.

SETTING: In the IMPACT project (Integrating Family Medicine and Pharmacy to Advance Primary Care Therapeutics),¹ we aimed to improve drug therapy using an innovative care model that over a 1-year period integrated nondispensing pharmacists into family practices across **Ontario**. We implemented this nascent program in 7 group family practices that had 7 to 14 physicians per practice.

CONCLUSION: In conclusion, primary health care research frequently involves multifaceted interventions taking place in community settings. In such research, process evaluation plays an important role in the interpretation of findings. Practical research methods that meet interrelated monitoring and process evaluation goals, such as narrative summary reports, are worth considering. We found the narrative report an engaging and effective multipurpose research tool when exploring the practitioner role in the development of interdisciplinary primary care teams.

23) Ramser KL, et al, Physician-Pharmacist Collaboration in Management of Patients with Diabetes Resistant to Diabetes Care, Diabetes Spectrum pgs 209-214, Vol 21 No 3 2008

CONCLUSION:

“...Physician-pharmacist collaboration in an academic internal medicine clinic is another potential model to target ...”

24) Weber, CA et al, Reduction in adverse symptoms as blood pressure becomes controlled. [Pharmacotherapy](#). 2008 Sep;28(9):1104-14

SETTING: Five university-affiliated primary care clinics

CONCLUSIONS: In both groups, ADR scores improved despite an increase in antihypertensive drug use. Improvements in social support and, to a lesser extent, self-efficacy were associated with improvements in ADR scores. Patients should not expect an increase in distressful symptoms as their blood pressure becomes controlled with antihypertensive drugs, especially when adequate social support is available.

25) Zerumsky K et al, Pharmacist Detection of Peripheral Arterial Disease Through the Use of a Handheld Doppler, (Pharmacotherapy 2005;25(6):797–802)

SETTING: Primary care and consultative outpatient clinic.

CONCLUSION: This pharmacist-initiated screening program increased recognition of peripheral arterial disease in previously unscreened patients. A pharmacist can play a role in a clinic where patients at highest risk are seen. This finding can further assist pharmacists in developing a role in the primary care clinic setting. The clinical pharmacist at the **Benedum Geriatric Center [University of Pittsburgh]** continues to screen patients without documented peripheral arterial disease. As a result of this research, the Benedum Geriatric Center will establish a program for a pharmacist to evaluate patients for peripheral arterial disease and assist in controlling other cardiovascular risk factors

PRESENTATIONS

1) Green C, et al “University Health Connection - An Interdisciplinary Approach To Providing Healthcare in the 21st Century.”

SETTING: The **Ohio** State University. University Health Connection (UHC) is an interprofessional healthcare practice based on a unique wellness and prevention model. The clinic serves employees at a large teaching University providing worksite urgent and primary healthcare, wellness and preventative services, disease management, advanced pharmacy services, and complementary and alternative medicine. The clinic opened in the fall of 1999 and continues to serve employee needs at the University.

CONCLUSION: University Health Connection opened in November of 1999. Since that date, patients have been able to experience an interdisciplinary healthcare clinic providing urgent care, primary care, alternative medicine, nursing and pharmacy services, and connections to University sponsored benefits. The detection of undiagnosed or uncontrolled illness has been, and continues to be, a main goal of UHC. Improvement in goal achievement for chronic disease has been consistently accomplished. Training of 63 current and future pharmacists and 437 members of allied healthcare disciplines has helped to create the future delivery of care. Through innovative practice and the sharing of borders, University Health Connection continues to provide and promote healthcare, wellness and prevention services, and improve the quality of lives of its patients

2) Ragland D, et al “The Impact of Telehealth Counseling on Metered-Dose Inhaler Technique in Rural Arkansas,” poster presentation at APhA annual meeting 2009

SETTING: Telehealth Kids in Delta Schools Project (**Arkansas**)

CONCLUSION: There was significantly greater compliance with inhaler technique at the 3-month follow-up (mean = 5.56 steps performed correctly out of eight steps), when compared to the baseline (mean = 3.44 steps, $p < .01$). Additional enrollments and assessments are on-going.

3) Spitka FN et al “Patient and Provider Benefits of Collaboration with Pharmacy Services in the Family Practice Setting,” Third Annual Health Disparities Conference Poster Presentation Abstract

SETTING: Shands Eastside Community Practice, **Gainesville, FL**

CONCLUSION: Increasing utilization of pharmacy services in the family practice setting allows for pharmacists and providers to form a trusted relationship that broadens each practitioner’s knowledge while providing enhanced care for patients.

4) Wong SF, Implementation of a Pharmacist-Directed Research and Clinical Program

at a Medical Oncology Private Practice Office

Western University of Health Sciences, College of Pharmacy, Pomona, California

SETTING: Hematology Oncology Medical Group of Orange County, INC., **Orange, California**

CONCLUSION: A trained oncology pharmacist in a private practice office has demonstrated to be a great enhancement to benefit the patients, health care providers, administrators and the practice. Furthermore, the economic assessment showed that an oncology pharmacist in a private practice office is cost effective

CONTACTS

ALABAMA

Our practice at the **Jefferson County** department of health is essentially physician office based, as well as that of the **Perry County, AL** residency program and practice model, wherein faculty and the resident work in two offices of physicians. Physicians in the JCDH refer patients to us for diabetes & smoking cessation treatment and monitoring, as well as osteoporosis screening. We also function collaboratively in the adult health outpatient practice with the physicians. I realize that this is public health department based, but there are some unique characteristics of the Jeff Co. Health Department, in that they are privately incorporated.

We are currently crafting the contract with another physician clinic that is just opening here in Birmingham to place a faculty member and operate a pharmacy (and possibly use as a residency training site). This practice will involve pediatrics and adult health and encompass MTM provision and clinical consultative and collaborative. This clinic is to be truly multidisciplinary/interdisciplinary, as it will also involve nurse practitioners from Samford's school of nursing, social work and exercise science/nutrition students, as well as business students in the development of management models in medical practice. It is private, but will be seeking to become a federally qualified health center.

So, this might fit your needs.

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ARIZONA

Developed an MTM clinic in an ambulatory care practice in **Peoria, AZ**. The site is the Arizona Medical Clinic.

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ARKANSAS

Telehealth Kids in Delta Schools Project

Provides asthma care to medically underserved school-aged children in the delta via telemedicine. Dr. Ragland instructs the students in correct metered-dose inhaler technique and provides periodic follow-up assessment and review.

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CALIFORNIA

Myself and another pharmacist are in a physician practice, but we have not published our documentation of services yet.

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I'm part of a geriatrics primary care practice

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I'm in a psychiatric practice, hence the spin on mental health for these articles.

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FLORIDA

I trained as a fellow and practiced in a neurology office and epilepsy foundation clinics as a team member with a neurologist [**Florida**]. Have done it for over 15 years prior to coming here. And we have all been doing it with the cost going to academic pharmacy.

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INDIANA

My background has been in developing pharmacist-managed clinics in primary care physician offices. I am fairly familiar with the medical home model as I was on a healthcare reform committee charged by Gov. Daniels a few years ago.

Unfortunately, those recommendations were passed over; however, it was centered around the medical home with a clear role for clinical pharmacists.

Please find attached a couple of articles that may be of interest to you. I am in the process of writing an article with 2 years of data from a diabetes clinic that I started at Wishard Hospital. For patient's with an average baseline HgbA1c of > 10%, we manage their glycemia, HTN, lipids, etc. If helpful, I'd be happy to send you a summary of the results.

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MARYLAND

UniversityCare, Waxter MD

Medical Director Dr. Jamal Mikdashi

It's an internal medicine practice (an outpt of Univ of MD). I run a Pharmacotherapy Service - I mostly see patients with pain issues, but also diabetes, other chronic diseases, or any medication-related issue.

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MASSACHUSETTS

At Northeastern University - we have 6 faculty (and 1 pending hire to make a total of 7 providing MTM services at CHCs. The CHCs and faculty members are:

- Lynn CHC - Kathy Bungay (she has published articles in General Hospital Psychiatry)
- Whittier Street CHC - Michelle Jacobs (presented posters / abstracts at various

meetings)

- Dimock CHC - Debra Reid (presented posters / abstracts at various meetings)
- Dorchester CHC - Rebekah Sherman (new faculty member)
- Harbor Health Services, Inc (Neponset Health Center, Geiger-Gibson CHC, Mid-Upper Cape CHC) - Robyn White and myself (presented various posters / abstracts)

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MONTANA

I manage an anticoag clinic. These data are unpublished but represent about 10 years of cumulative data. The overall INRs in range is, on average, 15% higher than traditional or physician office managed INRs; the thromboembolic events are half of national cited benchmarks and the major bleeding events are about ½ of the number that is often published in the literature.

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NEW MEXICO

We have pharmacists in our MTM pilot project that are in multiple outpatient settings- chain pharmacies, independent pharmacies, and health-system clinics. I'd be glad to provide additional information about our MTM project as well as activities of other pharmacists/pharmacist clinicians in New Mexico.

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NORTH CAROLINA

Bryan Bray in North Carolina has a practice in an MD office practice.

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Brooke Rawls (Brooke Rawls [brawls@rxhealthcare.org, (919) 463-5555]) is highly involved in the **Community Care networks in NC**

Robb Malone sends links regarding their **University of North Carolina** Division of General Medicine and Clinical Epidemiology Enhanced Care Disease Management Programs. website <http://www.med.unc.edu/medicine/generalm/enhancedcare.html> All of this work revolved around the pharmacist model.

Troy Trygstad troy@t2email.com is also involved

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OKLAHOMA

We have several of our faculty practices at the University of Oklahoma that fit the models in your request. They are outlined below:

This summary is from a clinic that is integrated with a physician practice for HIV/Hepatitis C medication management and adherence on our campus: our service provides a structured adherence program to our 1400 HIV-infected patients, consisting of medication and adherence assessments at physician office visits, one-on-one counseling for patients initiating new HIV therapy or requiring closer follow-up secondary to poor adherence, pill box fills, and management of patients co-infected with HIV and hepatitis C. During the past year, we conducted over 1200 patient visits. The faculty who practice in this clinic are R. Chris Rathbun, Pharm.D., BCPS AQ-ID, Staci Lockhart, Pharm.D., BCPS, and Michelle Liedtke, Pharm.D., BCPS.

This is a summary from our Pharmacotherapy Clinic which is integrated with a physician practice in our Department of Family Medicine focusing on Diabetes, Asthma, and Anticoagulation:

The notable effect is a reduction in the system's A1c from nearly 12 to around 8 following the implementation of the Pharm.D. activities in the building (1995-1996 compared to 2001-2002). The summary of outcomes from the literature are noted in the attached data that is in the process of being published.

Please contact me if you need more information.

Mike Burton

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TENNESSEE

I am currently working in a private physician's practice with 4 physicians, and two other faculty pharmacists. I don't have any clinical outcomes available, but would be able to pass along limited information on number of patients seen during a scheduled pharmacist appointment. The practice is just 1.5 years old, so our patient numbers may not reflect a well established practice. Let me know if that is the type of information you are looking for. The bulk the referrals we receive include diabetes, anticoagulation, and smoking cessation, with some general medication reviews as well.

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I was asked to reply to a request for information regarding the use of PharmD's in a physician office setting. We currently have 3 positions & 1 post-doc PharmD resident that is within a large multi-specialty private practice medical group. The PharmD's are co-funded (50/50) by the medical practice and the University of Tennessee College of Pharmacy and the resident position is funded completely by the college of pharmacy. Though new in the big scheme of things (the PharmD's have had some presence in the practice for only ~3 years = 1 started in 2005, a second was added in 2006, and a third was added in 2007. We hope to have data in the next year or so on a pilot project we have initiated with the area's largest employer - **Eastman Chemical Company**. We have, through signif negotiations and many hours spent in many meetings have gotten the PharmD's credentialed by Cigna (Eastman is self-insured and can therefore dictate to their carrier terms of the coverage) to be paid for direct care of patients with diabetes, hyperlipidemia, and hypertension. What this means is that patients who are enrolled in this plan (pts are given encentives to participate in the form of \$\$ deposits be put into their HSA that they can use the following year) can receive care

directed by and provided by clinical pharmacist providers - and these providers will be paid at the same level of reimbursement for care, using the same codes, as recognized providers such as MD's, PA's, & NP's. This is one small step in the big scheme of things, but are part of a department called Integrated Health Systems Management, which is simply one department in a larger medical group of >140 providers and >900 employees. The PharmD's serve the role as pharmacotherapy managers on a team that includes diabetes educators, pump specialists, dietician specialists, nurse educators, exercise specialists, behavioral health specialists, a vascular medicine physician and an endocrinologist. I think it is a humble attempt at what is being described as the new model of chronic care - the medical home. I hope this helps. Please feel free to contact me if I can provide any further information to you.

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WASHINGTON

One of the community pharmacy residents at Valley View Clinical Pharmacists in **Monroe, WA** is currently working on an MTM program. Their pharmacy provides clinical services to 15 physicians, PAC, and ARNPs. You can contact

Steve Erickson at 360-794-5555.

Just tell him that I referred you to them. They are in pacific standard time.