The many benefits CPs bring to FMRPs include resident education and improved patient care.1,2 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.3 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.4 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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Response to “Expanding the Possibilities for Pharmacy-Family Medicine Residency Collaboration” and “Clinical Pharmacists in Family Medicine Residency Programs: Tackling the Billing Barrier”

TO THE EDITOR:

We would like to thank Drs Bell et al and Dr Castelli for their interest in our article and thoughtful commentary about pharmacists as educators and practitioners. We do believe there has been growth in interprofessional education as seen by significant pharmacist incorporation as educators in family medicine residency programs (FMRPs). However, it is difficult to compare historical data on the prevalence of pharmacists within FMRPs with our data. The most recent publication that surveyed pharmacists within FMRPs was in 2002, which noted a pharmacist prevalence of 27%.1

While our survey found an increase in pharmacist prevalence within FMRPs to 45%, this was a survey of FMRP program directors, not pharmacists themselves.2 This is a significant limitation to the comparison due to the varying source of the information. A replicative survey of pharmacists that would be more comparable to the historical data has been completed and is currently under peer review for publication.

We appreciate the added enthusiasm of these authors regarding clinical pharmacy practice. This expansion in ability has been granted through the increased coursework of the Doctor of Pharmacy (PharmD) degree, postgraduate residency training opportunities, and recognition via board certifications.3 Even with these advances in education and training, the term clinical pharmacy remains the standard language among the physician literature, and the practice readiness of PharmD graduates is highly debated within the pharmacy profession as a whole.4-6 Similar to physician training, where one needs the time and volume of residency experiences to develop knowledge, judgment, and skill to practice competently, pharmacists in clinical roles are more prepared with postgraduate training.

The expansion to our discussion on billing and payment models for pharmacists providing direct patient care is welcomed and insightful. FMRP program directors are less likely to understand the idiosyncrasies of pharmacist billing considering the billing process and compensation for clinical pharmacy services often varies by state. Bell et al and Castelli have broadened our discussion and provide vital examples of functional billing systems for expansion of pharmacist utilization in direct patient care. Until a national format of billing for pharmacy services is created, value-based payment models, including Medicare Advantage and the Merit-Based Incentive Payment System, are a good focus for increased compensation for improved patient outcomes through interprofessional collaborative practice.7

Overall, we agree with Drs Bell et al and Castelli. Interprofessional education and practice of pharmacists and physicians can improve educational and patient outcomes. With advocacy, a national billing platform for interprofessional practice, acceptance, and standardization of education and patient care models can become a reality.

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