

EDITORIAL

Pharmacy Practice Model Initiative—It's All About Implementation

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Published in this issue of the journal is an ACCP commentary on the ASHP Pharmacy Practice Model Initiative (PPMI).¹ Overall and as detailed in the commentary, the objectives of PPMI and list of recommendations from summit participants are well aligned with existing positions of ACCP, and there is little to criticize relative to those broad goals. Evolving the practice of health-system pharmacy toward greater patient-centered care delivery that assumes accountability for medication-related outcomes and promotes the appropriate use of technology, technicians, and informatics to shift pharmacist time to higher-value activities is consistent with the advancement of clinical pharmacy. However, as with most good ideas, the challenge with achieving PPMI goals is firmly based on effectively implementing them at the local level. Several potential pitfalls in implementation should be considered and avoided to fully achieve the potential of redesigning the delivery of pharmacy services to transition toward clinical pharmacy's ultimate goal, optimization of patients' medication-related outcomes.

Health-system pharmacy leadership must avoid the risk of "homogenizing" the practice of pharmacists who possess different levels of training, experience, and competence. Practitioners

with expertise in different aspects of pharmacy practice, including clinical specialists, operational and technology experts, and informatics pharmacists, all bring unique perspectives and contributions to optimizing the delivery of safe and effective drug therapy. Vertical integration of these levels of knowledge and expertise, with each pharmacist practicing at the highest level of competence, makes for a strong and efficient pharmacy team. It is not wise or efficient to regress to the mean with an expectation that all pharmacists on the team will perform all pharmacy-related tasks. As such, the PGY2-trained (or equivalent) board-certified clinical pharmacy specialist should provide clinical leadership, education, and training to advance the practice of all members of the team while being accountable for providing comprehensive medication management (CMM) to patients with complex or specialized pharmacotherapy needs.² The goal of raising the level of direct patient care by pharmacists is best achieved by developing a model of education, training, and practice for less clinically oriented pharmacists without detrimentally affecting the high level of practice provided by highly trained and experienced board-certified clinical specialists.

Where and when available, the successful integration of clinical pharmacy faculty into the redesign of pharmacy operational models is of paramount importance. On-site faculty practitioners have the potential to contribute not only to advanced pharmacy practice, but also to the training and education of staff, residents, and

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students. In addition, through the pursuit of scholarly activity, faculty can contribute positively to the reputation and recognition of the pharmacy department. This is an important consideration in the critical recruitment and retention of talented pharmacists who are central to the long-term success of any practice model intended to elevate the professional and patient care contributions of the department locally. It is incumbent on departmental and academic leadership to find common ground that best integrates faculty and trainees into new or evolving practices in a manner that is beneficial to all stakeholders. To eliminate or restrict the contribution of academic partners is shortsighted and may reduce the ability to achieve PPMI's broad goals.

Lack of clarity in the PPMI model regarding expectations for training, credentialing, and practice of clinical pharmacists in specialized areas is unfortunate and should not imply that these practitioners are non-essential members of the pharmacy team. Roles and expectations for PGY2-trained (or equivalent) board-certified clinical pharmacy specialists and faculty should be clearly defined, and health systems should use these practitioners to their fullest potential. Clear demonstration that PGY2-trained pharmacy specialists are essential within new pharmacy practice models for the care of specialized or complex patient populations could be a major step toward achieving the CMS requirement for reinstating PGY2 residency funding that has eluded the profession for more than 10 years.

It is noteworthy that the Ambulatory Care Summit, held in 2014 as a component of PPMI, took positive steps in this direction and reflected a well-thought-out approach to the training and roles of ambulatory care clinical specialists.³ Recommendations from the summit included demonstration of competency through board eligibility/certification and expansion of ambulatory care residency positions and other training opportunities. Briefing documents delineate roles and training for PGY1 and PGY2 practice and even consider a PGY3 residency/fellowship year for advanced subspecialty training and clinical research.⁴ Summit recommendations also reflect a practice model that directly aligns with ACCP's vision, including team-based CMM, a standardized process for patient care, demonstration of care outcomes, and participation in research.

Education, training, credentialing, and privileging of all pharmacists with direct patient care

responsibilities should be considered integral elements of any practice redesign. This will require a significant investment of time and resources, however, and may delay full implementation of a successful model while completing the work to ensure that competent teams are in place. PGY2-trained clinical specialists should be relied on to take a leadership role in this process within their areas of specialty expertise. Launching a practice model with the intent of providing greater patient-centered care without engaging clinical pharmacy specialists who possess the knowledge and skills needed to deliver high levels of care may fail to improve quality of care and patient outcomes.

The PPMI consensus statements outline a variety of specific practice activities for pharmacists that can provide useful guidance for health systems that are transitioning to new models, but these statements should not be interpreted as a checklist of activities for pharmacists to complete. Although we agree with the need to use clinical informatics and clinical decision support tools to identify and prioritize the patients most likely to benefit from CMM by a clinical pharmacist, we argue against the routine use of rules-based task lists to target pharmacist "interventions" as the major clinical focus of a practice model. These system-generated task lists, which direct pharmacist effort on the basis of targeted interventions (e.g., renal dosing, IV to PO switch), typically result in a disconnected, non-accountable approach to providing clinical pharmacy services. Such a focus on single aspects of care, rather than on the comprehensive needs of a patient, is unlikely to lead to the PPMI goal of improved quality of care and better patient outcomes and may affect pharmacists' long-term career satisfaction. A more sophisticated, informatics-driven approach that identifies high-risk patients and leads to a comprehensive, team-based approach to optimizing patients' medication-related outcomes should be the goal of a revised, patient-centric (not task-centric) practice model. In an ideal world, all patients in the acute care setting would receive the full attention of a clinical pharmacist, but in most health-system settings, this is probably impractical, too resource-intensive, and not cost-effective. In the real world, effective clinical decision support tools are needed to drive the most efficient use of limited clinical pharmacist resources, and this should be done in a way that will have the greatest likelihood of improving patient outcomes. We believe the greatest value

will come from applying the principles of CMM for a defined group of high-risk patients.

In summary, we find that the PPMI's goals and objectives are laudable and consistent with the expansion and enhancement of clinical pharmacy practice, but we express concern and caution relative to the effective implementation of new business, operational, and clinical practice structures at the local institutional level. We strongly believe that the effective implementation of any future practice model must preserve and promote the critically important contributions of PGY2-trained board-certified clinical pharmacists. The overall success of PPMI will heavily depend on careful attention by health-system pharmacy leaders to

implementation strategies that truly move the profession forward to better serve patients while enhancing the professional development and career satisfaction of pharmacists practicing in these evolving models.

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