**\*\*\*Please address text in red, text is considered an outline and customize to your facility needs and priorities.**

**PHARMACY SERVICE BUSINESS PLAN**

**Executive Summary**

This plan is an evaluation of the Pharmacy Service’s current staffing conditions to justify the hiring of resources to support full integration of Clinical Pharmacy Specialists (CPS) to support PACT. Optimizing the role of the CPS in working collaboratively with providers, care-teams and Veterans improves medication use, clinical outcomes, and access to care as described in the [Fact Sheet-Optimizing the CPS to Improve Access](http://vaww.infoshare.va.gov/sites/ClinicalPharmacy/PBM%20Position%20Statements/CLINICAL%20PHARMACY%20PRACTICE%20FACT%20SHEETS/Fact_Sheet-Optimizing%20the%20Clinical%20Pharmacy%20Specialist%20To%20Improve%20Access_FINAL042016.pdf). Nationally, CPS roles described in [VHA Handbook 1108.11. Clinical Pharmacy Services](http://vaww.va.gov/vhapublications/ViewPublication.asp?pub_ID=3120) encompass a variety of key areas and settings from managing complex anticoagulation clinics, treatment of chronic disease states in primary care (e.g., diabetes, hypertension, dyslipidemia), to acute and chronic management of specialty care conditions. Strong practices describe that achieving staffing recommendations of one CPS per three primary care providers (1 CPS: 3600 primary care uniques) helps to “free up” PACT provider time for more acute and urgent issues. This ratio results in access improvements for the PACT Provider up to 27% (as demonstrated in the [Gold Status Project-Improving Access to Primary Care Utilizing CPS](https://www.vapulse.net/login.jspa?referer=%252Fvideos%252F5711)).

In addition, centralized anticoagulation services should be optimized to promote staffing ratios of one CPS per five primary care teamlets or one CPS to 400 anticoagulation patients (with adequate ancillary support; ratios are lower if support is not realized as described in [VHA Directive 1033](http://vaww.va.gov/vhapublications/ViewPublication.asp?pub_ID=3129)). It is also outlined in this directive that an Anticoagulation Program Manager should be allocated to the facility and have adequate administrative time to support the program at the facility level:

**From the VHA Directive 1033:** “The anticoagulation program manager is allotted an adequate amount of administrative time to perform leadership functions for the anticoagulation management program, including quality assurance, promoting evidence-based practice, and coordinating educational activities related to anticoagulation both inside and outside the anticoagulation management program. ***NOTE:*** *On average, 4 to 6 hours of administrative time per week is recommended based on strong practices identified. Four to 6 hours may not be sufficient administrative time for this position, particularly at larger, more complex facilities. At large, multi-campus referral facilities, 8 hours or more per week may be necessary.”*

In order to effectively optimize CPS roles, resources must be allocated to CPS positions as well as the provision of support for the CPS provider in this advanced practice role. Optimized practice includes ensuring the CPS has a broad, practice-area-based scope of practice to allow for full comprehensive medication management services, co-located space with the teams and patients for which they provide care, nursing and ancillary support for their direct patient care activities, and activities that may be allocated to other team members are ensured.

This request includes an additional FTE to support *insert positions requested* in order to optimize healthcare delivery and improve Veteran access to healthcare in our PACT clinics.

**Background**

Clinical Pharmacist Specialists (CPS) provide direct patient care for the medical center in City and all Community Based Outpatient Clinics (CBOC). The CPS function under a scope of practice and provide chronic disease state management including, but not limited to hypertension, hyperlipidemia, diabetes, COPD/asthma, heart failure, anticoagulation, endocrinology, hepatitis C, gout, osteoporosis, BPH and tobacco cessation. However, the CPS undertake responsibilities that do not allow them to perform at the top of their licensure and take away time from direct patient care including triaging patients, performing vitals, non-formulary drug requests reviews, and scheduling (customize to reflect operational tasks completed by CPS at site).

Please include statement here in regards to what the pharmacy service has done to utilize their current org chart efficiently.

**Rationale and Benefits to [Facility Name]**

In Month Year, the Facility Name initiated Phase I of The Diffusion of Excellence (DOE) project: Increasing Access to Primary Care with Pharmacist Providers. The project is described in significant detail in the [PBM Fact Sheet-Optimizing the CPS Role to Improve Access.](https://vaww.infoshare.va.gov/sites/ClinicalPharmacy/PBM%20Position%20Statements/CLINICAL%20PHARMACY%20PRACTICE%20FACT%20SHEETS/Fact%20Sheet_Optimizing%20the%20CPS%20to%20Improve%20Access_FINAL042016.pdf) Describe pharmacist to team ratio in implementation teams (i.e. One PACT Pharmacist Provider teamed up with three Blue Team Providers). The data demonstrates the initial results have been impressive and mirrored that of the Madison VAMC Gold Status Project endorsed by VA Secretary Dr. Shulkin.

\*\*\*Tailor reported metrics to those tracked by the facility and what speaks to the facility leadership.

|  |  |  |
| --- | --- | --- |
| Increase PACT CPS ACCESS | PCP to CPS Conversion | PACT CPS Marketing Team Quotes |
| \_\_\_\_% increase access with grid updates, LPN and MSA support | \_\_\_ (number) appointments were converted from PCP to CPS resulting in **\_\_\_(number) PACT provider hours** | Insert quotes from front-line staff |

|  |  |  |  |
| --- | --- | --- | --- |
| Table 2: Diffusion of Excellence Outcomes *[Date Range]* | | | |
| PACT CPS Marketing and Referrals | **Appointment Reminder Calls** | **Population Management** | **CPS Team Integration** |
| Discuss increase in Pharmacist Provider utilization and time saved for PCP | No show rate decreased from **\_\_\_% to \_\_\_%** after initiation of LPN appointment reminder calls. | Discuss Ambulatory Care Readmission Rate, HEDIS measure improvement | Improved team satisfaction and morale – PCPs also requested more PACT CPS to assist with population management, ACSC and HEDIS Measures |

At the [facility name], the clinical pharmacy program consists of a [clinical pharmacy manager?, # CPS and location of CPS] who cover PACT teams. Our current CPS’ have had to take on responsibilities within the PACT teams which do not allow for their efficient optimization within the teams such as triaging patients, performing patient vitals as part of the check-in process, glucometer/blood pressure cuff teachings, scheduling patients, reviewing non-formulary drug requests, and performing routine drug conversions [customize to facility specific challenges]. [Insert progress to address the above issues to increase optimization of CPS. Include additional pharmacy support which may be required.]

*If ancillary support is needed include:*

For each CPS position, it is strongly encouraged that at least 0.2 FTEE be allocated in total to ancillary support staff which may include nursing, medical administrative support, or pharmacy technicians to ensure appropriate support.

*If Anticoagulation needs to be centralized include:*

Furthermore, the National Pharmacy Benefits Management highly recommends centralizing anticoagulation services. [Statement describing current state of anticoagulation management] The PACT pharmacist providers spend approximately \_\_\_% of their direct patient care hours on anticoagulation. This negatively impacts the access they would be able to open for the PACT Teams and results in missed opportunities for panel management and improving SAIL measures. Current recommended staffing ratios based on actual patients assigned from PCMM indicate the following needs and gaps in anticoagulation staffing (excluding the Anticoagulation Program Manager as an FTE), and we do not meet current VHA recommended PACT CPS to PCP ratios for anticoagulation.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Anticoagulation Gap Analysis | | | | |
| Site | **Patients** | **Anticoag FTE** | | **Gap** |
| **Needed** | **Have** |
| Facility Name (Total) |  |  | |  |
|  |  |  | |  |
|  |  |  | |  |
|  |  |  | |  |
| CBOCs (Total) |  |  | |  |
|  |  |  | |  |
|  |  |  | |  |
|  |  |  | |  |

In addition, our Anticoagulation CPS’, CBOC CPS’, and clinical pharmacy technician spend time scheduling patients for follow up appointments. For anticoagulation follow up appointments, the health care providers have been scheduling patients into the anticoagulation clinic through mutual discussion and agreement of a date. Through this process, we have not meet current VHA guidance on scheduling. To comply with VHA Directive 1230, adequate ancillary support for scheduling is key to ensure appropriate follow up for patients on anticoagulation. Approval of the requested FTEE would add members to the clinical model and allow an expansion of clinical pharmacy services, including increased clinical pharmacy interventions to improve provider access and SAIL measures.

*If additional CPS FTE is needed include PACT CPS gap analysis*

Due to these outlined factors, the [facility name] Pharmacy Service is requesting the following:

|  |  |  |  |
| --- | --- | --- | --- |
| New Positions | FTEE | Justifications | Supp. Doc |
| PACT CPS GS-13 | ### | To expand clinical pharmacy services offered to support primary care providers. |  |
| Anticoagulation CPS GS-13 | ### | Centralize Anticoagulation Services and provide sufficient administrative time for the Anticoagulation Program Manager. | Anticoagulation CPS GS-13 |
| Clinical Pharmacy Technician | ### | To assist anticoagulation CPS with coordination of care and scheduling |  |
| Formulary Management CPS GS-13 | ### | To take over adjudication of non-formulary requests and formulary therapeutic conversions and improve access for PACT CPS direct patient care activities. | Adjudicate >1250 NF requests per quarter |
| MSA (if requesting non-pharmacy staff, consider adding Business Office leadership and considering this a consolidated request) | ### | To assist with scheduling for PACT CPS providers in [insert site name] |  |

**Conclusion**

The approval of the requested FTEE is directly aligned with the strategic goals, mission, and vision of [facility name]. This approval would provide a unique opportunity for the [facility name] to improve patient care delivered by the Pharmacy Service as well as to enhance the health care provided to the communities [facility name] serves. The approval will also facilitate an increase in access for our Veterans to health care. Access to timely clinic appointments by primary care patients is critical. Having an adequate amount of CPS by approving the requested FTEE part of the primary care team will allow primary care providers to delegate some of their clinical duties to the pharmacist. This more efficient method of utilizing provider clinic time allows clinic appointment wait times to be more effectively managed. It will afford more time for our PCPs to deal with more emergent, acute matters due to the workload shift from PCPs to CPS. Impacting Veteran access, a current [facility name] high priority, will lead to improved patient satisfaction and quality of care.

**References**

1. VHA Handbook 1101.10, “Patient Aligned Care Team (Pact) Handbook” (Feb 2014). Accessible from <http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=2977>
2. VA PBM Field Guidance, “Pharmacy Business Rules for PACT” Accessible from <http://vaww.infoshare.va.gov/sites/ClinicalPharmacy/PBM%20Position%20Statements/VA%20PBM%20Field%20Guidance%20Pharmacy%20Business%20Rules%20for%20PACT%202-12%20FINAL.pdf>.

1. Taylor CT, Byrd DC, and Krueger K. Improving primary care in rural Alabama with a pharmacy initiative. Am J Health Sys Pharm 2003; 60: 1123-1129.
2. Wagner EH, et al. Chronic Care Clinics for Diabetes in Primary Care. Diabetes Care; 25: 695-700, 2001.
3. Monthly Report Out to Leadership: Diffusion of Excellence [facility name]. Date