The Merits of Team-based Primary Care for the Underserved

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INTRODUCTION

The American College of Physicians (ACP) published a recent position statement reminding us about the importance of team-based care models in primary care.[1] Models such as the Patient-Centered Medical Home improve patient outcomes and increase well-being among health care professionals. Despite these benefits and positive attributes, adoption of this approach has been limited in primary care. This brief communication offers the perspective of a pharmacist and primary care physician and the benefit of providing team-based primary care at a safety-net ambulatory clinic in Providence, Rhode Island.

PHYSICIAN'S PERSPECTIVE

An article published in 2022 by Porter and colleagues highlights some of the challenges faced by primary care physicians (PCPs) practicing on their own.[2] This study assigned a panel of 2,500 patients to a hypothetical primary care physician. They concluded that it would require a solo practitioner 26.7 hours per day to provide care, comprising 14.1 hours/day for preventive care, 7.2 hours/day for chronic disease care, 2.2 hours/day for acute care and 3.2 hours/day for documentation. However, a team-based model can help provide the needed assistance to get the same work accomplished in a more reasonable 9.3-hour time frame. Yarnall et al acknowledged the difficulty PCPs face meeting the United States Preventive Services Task Force (USPSTF) recommendations for preventive services due to time constraints when physicians have large panels. They concluded that large number of screening recommendations coupled with large numbers of patients made it difficult to meet preventive care guidelines.[3]

Those of us who provide care for the socially disadvantaged (underinsured, uninsured, and high-needs patients with complex medical co-morbidities) encounter additional patient care challenges. How can we address the patient's medical problems when they are unable to afford the medications we prescribe, or make it to our office on time due to transportation problems? Many of our patients also struggle with housing/food insecurity and health literacy. These social determinants of health contribute to health inequities and pose adverse health consequences for our patients.[4] The additional time needed for medical care under these circumstances cannot possibly be accomplished in a traditional primary care setting with 15-minute appointments. Team-based primary care that provides care coordination, help with medications and health coaching, as well as assistance with transportation is requisite in meeting the global needs of our patients. Primary care re-design that incorporates team-based care is needed or we will continue to offer a model that doesn't work for our patients and physicians, contributing to ongoing poor health care outcomes for the patients and continued frustration and burnout for the physicians.[5] Bodenheimer et al point out that our health care system needs to increase the proportion of health care expenditures going to primary care and make sure physicians are not overloaded with large panels.[6] Questions remain about how to fund staffing efforts to support team-based primary care. Given the current primary care physician shortage, high physician burnout and challenges in treating the underserved, one has to ask why we have been slow to adapt and align with the goals of the most recent ACP position statement.

We are one of three ambulatory sites for the Brown Internal Medicine training program. Dedicated social workers, community health workers, nurse care managers and pharmacists are integrated into our clinic workflows. Our academic, patient-centered medical home model has several interdisciplinary clinics targeted to meet the needs of our patients. In 2017, we started our complex care clinic, to address high utilization. This approach was successful in reducing emergency room and inpatient utilization by 56% for a group of high needs/high cost patients.[7] Pharmacists have been integrated into primary care health care systems for some time[8] and we have found exceptional value working side by side with our clinical pharmacists. The following are examples of situations where clinical pharmacist intervention has proven beneficial for us:

- Homebound patients: Our pharmacists are able to help us come up with creative strategies such as pill packing with home delivery.
- Refills/Prior authorizations: Pharmacist oversight using evidence-based protocols have helped decrease physician in-basket burden.
- Covid: During the initial phase of the Covid pandemic, patients in need of anti-viral treatment required scrutiny for drug interactions and pharmacy availability; team-work allowed for improve efficiency.

- Anticoagulation: Coumadin-based anticoagulation requires patient education and consistent monitoring. We are grateful for the co-management assistance from our pharmacist-run anti-coagulation clinic.
- Patients with poorly controlled diabetes and high blood pressure benefit from co-management with our clinical pharmacist-run diabetic and hypertension clinics.
- Substance use disorders: Treatment with monthly vivitrol, and buprenorphine (both sublocade and brixadi) injections and help with suboxone prescribing

Patients with polypharmacy and those at risk for adverse drug reactions have access to our medical reconciliation clinic to look for opportunities to de-escalate and address the Beer's criteria list for the elderly.

PHARMACIST'S PERSPECTIVE

Clinical pharmacists have various roles in caring for patients in the ambulatory setting, such as completing an accurate medication reconciliation, taking a blood pressure, and developing medication treatment plans. We learn these skills while obtaining our PharmD degree, during clinical rotations, and post-graduate training. Pharmacists are also trained in motivational interviewing, something that is valuable when caring for patients with complex needs. For instance, pharmacists can modify their medication counseling and recommendations for patients who were recently incarcerated and are transitioning home; or patients who may be using insulin but do not have a working fridge or do not have a smartphone to use devices that upload information to an app. Therefore, we are uniquely positioned to help underserved patients navigate the healthcare system.

Working in an underserved, academic setting with other providers and trainees is a valuable opportunity for collaboration. Pharmacists are skilled in tailoring our recommendations to each patient's specific goals and situations, such as affordability, and coaching the providers on the process for accessing medications through payors or discount programs. For instance, a patient without insurance will not be able to afford all the first-line guideline recommended medications, but we can recommend the next best options and at which pharmacy. In addition, pharmacists can assist the provider with ensuring they order all the appropriate ancillary items for a patient, such as specific glucometer and insulin supplies. We can also identify preventive measures and gaps in care, such as recommending and administering immunizations. We provide counseling on how to help a patient improve their adherence to medications by enrolling in pill packing, home delivery, and automatic refill services.

Often physician trainees are not familiar with certain medication challenges the underserved population may face, but after working with a pharmacist, they are better equipped to apply similar principles and approaches to all their patients. For instance, pharmacists can coach physicians on services that may seem intuitive but are often misunderstood, such as pill packing and medication refills. It is a fulfilling experience for pharmacists to have the opportunity to work collaboratively with providers and trainees. Together, we can help patients overcome major barriers and achieve more as a team than individually.

CONCLUSION

Our experience with physician-pharmacist teams improves primary care workflows, and staff well-being. Our high-needs patient population benefits from this model of primary care.

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Disclosures

Both authors declare that they have no conflicts of interest

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