PROFILES IN SENIOR CARE PHAR

Bryan Bray, PharmD

His diverse services are viewed as a key component of optimal care by interdisciplinary colleagues and patients alike. Bryan Bray tells how he carved out an innovative practice niche on the expanding frontier of community-based senior care pharmacy.

In an attractive two-story brick building on Westover Terrace in Greensboro, North Carolina, Bryan Bray, PharmD, sees patients in a busy internal medicine practice. The "Patient Guide to Greensboro Medical Associates" lists Bray as one of eight physician extenders, along with three nurse practitioners and four physician assistants. These extenders are in collaborative practice with the building's 17 physicians, who also specialize in gerontology, cardiology, endocrinology, gastroenterology, hematology/oncology, and rheumatology.

Although it is not listed in the brochure, a bold black-and-white sign in front of the building lists "Senior Care" at the top of the list of physician specialties. Several of the physicians, physician assistants, and nurse practitioners are responsible for the care of elderly patients in nursing facilities, and this core group is called, appropriately, the "Senior Care Group." Bray's position as physician extender at Greensboro Medical Associates evolved directly from his professional relationship with one of the Senior Care Group's internal medicine physicians as he practiced as a consultant pharmacist for PharMerica at local nursing facilities.

First Steps

With the administrative support of Larry Long, senior pharmacy manager at PharMerica's Greensboro site, Bray marketed his services in anticoagulation drug therapy monitoring to Art Green, MD, an internist and gerontologist. Bray and Green had established a solid professional relationship over the years, as they both interacted as consultant pharmacist and physician at one of the larger facilities they visited that used PharMerica's anticoagulation service.

Green's experience with Bray and his company had been a positive one, which was further enhanced when Bray requested that Green serve as a general medicine clerkship preceptor for the University of North Carolina's (UNC) External Doctor of Pharmacy program in January 1998. Green agreed to be a preceptor for Bray's full-time, one-month required clerkship in general medicine. Having a physician as a preceptor in the UNC external PharmD program is not common, but Bray saw an opportunity for advanced learning in a practice he had come to appreciate and admire.

Anticoagulation Monitoring

In November 1998, Bray, as an employee of PharMerica and contractor to the clinic, began providing anticoagulation drug therapy monitoring services for Greensboro Medical Associates. He made a positive impression on the staff at the clinic during his clerkship in early 1998, but implementation of the clinic still took several months, as details needed to be discussed and agreements reached regarding clinic hours covered, office/work space provided, referral protocols, approved medical record

forms, reimbursement methods, equipment availability, and the contract between the clinic and PharMerica.

Bray and Long marketed the service to the clinic as much as to their own company. Time spent in the physician office and not in the facilities as a consultant created a void in consultant coverage that needed to be filled. Serving as director of clinical services has its advantages, however, and Bray, with Long's support, was able to overcome any potential obstacles or challenges presented by either group. The anticoagulation service became a reality, and Bray became a physician extender in the clinic.

A Gratifying Testimonial

"I love him! I have been seeing Bryan since he started here two years ago. This is so much better than the way it was before I started seeing him. I used to go to the lab, have my blood drawn, and then, in two or three days, I would get a phone call to let me know how my blood was and what dose of my medication I needed to be on. This is quicker and more convenient for me."

That's how one of Bray's patients—a frail-appearing yet very conversational 70-year-old woman on warfarin therapy for prophylaxis of deep venous thrombosis and stroke—describes the positive impact of his services.

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Jane Thompson

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At this visit, she is complaining that being on anticoagulant therapy is "ruling" her life. Bray is in the process of adjusting her dose in order to achieve an international normalized ratio (INR) value in the recommended range. Her INR had been too high at the last visit; at this visit it is subtherapeutic. Bray discusses her diet with her, asks the usual questions he asks during anticoagulation clinic follow-up visits, examines the leg in which a thrombus had developed in the past, listens to her heart, and phones in a new warfarin prescription to her pharmacy.

"Being able to make an intervention, a change in pharmacotherapy or an educational/counseling intervention, and seeing the impact on patient care is what I enjoy most about working in this practice setting," says Bray. "I like making changes in patients' drug regimens and being responsible for the outcomes. I like the professionalism this setting creates for the pharmacist. The patients see me as the authority on medications, and the physicians use me as a resource for medication and therapeutic questions. I have to stay on top of the current literature, and I like this learning experience. Not to mention the fact that I get to apply this knowledge on a day-to-day basis and witness the outcomes."

An Expanded Palette of Services

Within a few months of the start-up of the anticoagulation clinic, Bray added his expertise in diabetes, osteoporosis, asthma and chronic obstructive pulmonary disease (COPD), hyperlipidemia, and hypertension management to the clinic for referral by several clinic physicians who had come to personally trust his judgment and recognize his skills. Having completed three certificate programs in diabetes, asthma, and preventive cardiology as part of his external PharmD clerkship requirements in 1998, Bray was well prepared for the challenge of incorporating a variety of patients into his practice. David Grove, MD, PhD, a cardiologist in the clinic, says, "Bryan does a great job. It is wonderful to have an expert in the field of pharmacotherapy with us." Grove refers patients to Bray for anticoagulation services, as well as "polypharmacy adjustment," and he considers Bray an excellent resource for questions regarding drug interactions.

For Bray to be able to see up to 25 patients in a full day, working Tuesdays and Thursdays and half days on Wednesdays and Fridays, he needs an assistant. Tonya Nelson, a certified medical assistant (CMA), is responsible for performing many duties, making Bray's work as a physician extender much easier and allowing him to spend more time conversing with patients and managing their drug therapy. Nelson, who attended Guilford Technical College and received a two-year associate degree in Applied Science, is employed by PharMerica as a pharmacy technician and assists Bray on Tuesdays and Thursdays, more often if her schedule permits. She checks vital signs and uses the "CoaguChek" machine for INR testing. She brings the patients in from the medical practice's waiting area, documents their vital signs, including weights and CoaguChek results, puts patients at ease while they are waiting to see Bray, and helps Bray locate charts or lab results.

Anatomy of a Busy Practice

The space provided by the clinic for Bray and Nelson consists of a large anteroom with several tall shelves filled with charts, a couple of tables, a chair, and scales like those commonly seen in a physician's office. This is where Nelson brings the patients first and collects the first set of data for the patient visit. Two smaller rooms with windows are located side by side and open directly off the larger room. Charts are placed in clear racks on each door when there is a patient waiting to be seen by Bray. One room is used as an office with a telephone, desk, chair, and two chairs for patients and family members, while the other room is a treatment room with an examination table plus small foot stool and two chairs. Both rooms are used interchangeably for patient consultations. For anticoagulation patient visits, Nelson directs the patient into one of the rooms and checks the INR with one of the practice's two CoaguChek machines. While Bray finishes his visit with one patient in one room, Nelson is checking INRs or making another patient comfortable in the other room until Bray comes in. At the end of the day, he uses his office to make the last of his telephone calls to patients and

pharmacies, as well as to catch up on necessary paperwork.

"Paperwork is probably the least enjoyable part of this job," Bray says. "Often I feel as though I just document information to satisfy billing purposes only, and it has nothing to do with the patient's problem. I've spent a lot of time making sure I understand the documentation guidelines. To some degree, I face the same pressures that physicians do under a fee-for-service format. There are patients who need more time, especially for education and monitoring purposes, but because of the fee I receive for that particular encounter, I have to move things along and see a certain number of patients per hour. This creates pressure and often makes me run behind, which is stressful."

Bigger Things Ahead?

North Carolina's Clinical Pharmacist Practitioner Act, recently passed by the state legislature, provides guidelines and requirements for collaborative practice, including necessary documentation, between pharmacists and physicians. A pharmacist who meets these requirements is designated a "clinical pharmacist practitioner" (CPP) and works with a supervising physician in collaborative practice.

Very similar to regulations governing physician assistants and nurse practitioners, the new North Carolina law requires that the supervising physician review and countersign chart documentation and orders written by the CPP within seven days. What is new for pharmacists in this

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state is that when this act becomes law, Bray will be able to write prescriptions on his own, without having to leave his office every time he writes a prescription to track down a supervising physician to cosign it. The CPP's progress notes will be signed off as reviewed by the supervising physician within seven days, comparable to the procedure for physician assistants and nurse practitioners.

According to the Clinical Pharmacist Practitioner Act, Bray's services must be specific in regard to the patient, the pharmacist, the physician, and the disease. To meet this requirement, Bray's patients are referred to him by physicians for the initial visit. The referral form states the patient's name, Bray's name, the referring physician's name, and the reason for the referral, which is usually anticoagulation monitoring or management of a specific disease—for example, diabetes, hyperlipidemia, hypertension, asthma/COPD, and osteoporosis.

Sometimes polypharmacy is the reason for referral. Although not classified specifically as a disease, polypharmacy is a valid problem that physicians face every day, especially in the older adult population. Being able to refer these particular patients to a pharmacist is advantageous in a busy medical practice.

In addition to state regulations, Bray must follow the rules set by insurance companies for documentation and continuity of care. A patient must be seen by a physician on every third visit to the clinic. Because anticoagulation drug therapy monitoring can require a patient to be seen several times in a month, Bray has to be careful and make sure a physician visit is scheduled between patients' appointments with him to satisfy those requirements. Other requirements by insurance companies include specific documentation regarding the billing of services “incident to” the primary provider.

A supervising physician is assigned to Bray each day he practices at the clinic. It is this physician who cosigns prescriptions for the patients Bray sees, and it is this physician whom Bray bills “incident to” on medical office forms for his own consultations with patients. The medical practice takes care of the actual billing of the insurance companies for Bray's services.

PREREQUISITES OF SUCCESS

When asked what experiences, skills, or characteristics have enabled him to be successful in this type of senior care practice, Bray credits his experience as a nursing facility–based consultant pharmacist for the past 10 years as great preparation for his current activities. “In a lot of ways, I am doing nothing more than extending what I do in a nursing home to a community, office-based setting. The majority of my patients are elderly with multiple chronic diseases and complex, multiple medication regimens.”

Most of the patients Bray sees are taking 7–10 medications and receiving treatment for several comorbid condi-

tions. He is often in a position to identify medication-related problems in patients who have not been referred specifically for polypharmacy evaluations, but rather for disease state management in a particular area. Just as in nursing facilities, a review of medication regimens by a pharmacist in an office-based practice is a valuable and needed service for older patients on multiple chronic medications. Not only is Bray in a position to identify medication-related problems in older patients, he can resolve them himself on site during the clinic visit.

He credits well-developed communication skills for his success in educating his patients about their disease states and pharmacotherapy. "You have to be able to communicate on the level of the patient and be able to give positive reinforcement to 'good behavior,'" he says. Bray asks questions and listens intently to what his patients are saying. He provides feedback to them on what they are doing right and wrong in self-managing their diseases and conditions. In the small amount of time he has to spend with each patient, he strives to make complete assessments of problems, use good clinical decision-making skills to resolve those problems, and communicate a plan of correction to patients in a way they can understand.

Up Close and Personal

Bray's assessments involve a definite physical component. He believes that "pharmacists need to be able to confidently touch patients." It is completely routine for him to have diabetic patients remove their shoes and socks so that he can check their feet for abrasions and wounds or perform a sensitivity test with a fine filament. The stethoscope he wears around his neck is not there for ornamentation. Lung sounds may indicate the need for a higher dose of a bronchodilator metered dose inhaler. He also firmly believes that pharmacists should be able to monitor the use of medications in terms of therapeutic response of their patients. Using his physical assessment skills provides him with data to make his clinical decisions. During his assessments, Bray may discover new findings, or indications of new problems, which are then triaged to the physician for follow-up.

In Bray's words, pharmacists nearly have to have a "brain transplant" in order to successfully coordinate activities in a physician office-based practice. Performing a comprehensive patient assessment and appropriately documenting the findings are not things most pharmacists have been trained to do. The pace can be hectic during the workday. "You don't have time to sit down with a chart for 30 minutes and review it fully. You have to be able to identify important data in the chart quickly, take a very thorough history through a patient interview, assess the patient and the problem and make a clinical decision in a 15- or 30-minute office visit with someone you have never met before."

Unique Rewards

Despite the challenges, Bray really enjoys community-based senior care practice. The patient interaction is quite exhilarating, especially when he is in a position to improve drug therapy. He likes to tell the story of one diabetic patient who came to see him a while back. At the time of the initial visit, the man was using 70 units per day of 70/30 human insulin and his blood glucose was not adequately controlled. After seeing Bray then and during several follow-up visits, he was gradually changed from his insulin regimen to oral therapy and his diabetes is better controlled. Even when his recommendations and interventions don't produce dramatic improvements, Bray enjoys the patient interaction—and the patients say they really enjoy his expert attention.

At another memorable visit, an elderly woman asked Bray to call in a new prescription to her pharmacy. She made the statement that "my pharmacist" is at that particular location. Bray responded in a mock hurt voice, "I thought *I* was your pharmacist." She hastened to reply, "Oh, you *are,* you *are* my pharmacist!"

That patient, and many others Bray has seen, has come to see that pharmacists are not always found working behind the dispensing counter. Increasingly, senior care pharmacists like Bray are found behind desks in physician office–based practices. But don't expect him to stay behind the desk for any length of time. This is one senior care pharmacist who likes to stay moving and make personal contact with the patients in his care. His patients wouldn't have it any other way.