

Practical Pearls:

Utilizing Clinical Lipid Specialists in the Patient-Centered Medical Home



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According to the Medical Home Position Statement published by the Association of American Medical Colleges (AAMC), "the medical home is a concept or model of care delivery that includes an ongoing relationship between a provider and patient, around-the-clock access to medical consultation, respect for the patient/family's cultural and religious beliefs, and a comprehensive approach to care and coordination of care through providers and community services...in most cases, the provider of primary or principal care is a healthcare team guided by a generalist."¹

In a recent editorial in the *Archives of Internal Medicine*, Dr. Patrick O'Malley suggests that healthcare providers with disease-specific expertise, in collaboration with primary care providers, will enhance goal-directed care and be a central component of the patient-centered medical home (PCMH). He says, "The most important elements of collaborative care are the establishment of explicit goals and the persistent systematic follow-up to achieve these goals."²

To provide goal-directed care, clinical staff need to be trained to a level of expertise that would be adequate to manage efficiently and effectively specific clinical entities. For example, the PCMH could utilize allied healthcare providers in a collaborative, team-based model to help manage patients with lipoprotein disorders. For those needing additional training, the

National Lipid Association offers different levels of courses, from basic to advanced lipid management, at conferences and through webinars and on-demand modules. Allied healthcare providers also could seek certification from the Accreditation Council of Clinical Lipidology as a Clinical Lipid Specialist (CLS) to "validate their competency in clinical lipidology."³

In addition to disease-specific training and certification, for the healthcare team to be fully operative and deliver efficient care, each member of the team should be functioning at "the maximum of their licensure, skill-set, and abilities...given both authority and responsibility for performing those tasks."⁴

The Journey

Presbyterian Healthcare Services (PHS) cares for around a half-million patients

in New Mexico through 70 Presbyterian Medical Group (PMG) clinics throughout the state. The PCMH journey for PHS started in 2009 with a pilot program at a single site. PMG since has spread this initiative to include 10 primary care clinics and around 70 primary care providers. PMG has received National Committee for Quality Assurance (NCQA)⁵ Level 3 accreditation for ten central New Mexico primary care sites.

One of the more rural PMG sites is the clinic in Belen, NM, in Valencia County. The Belen clinical staff consists of a multi-disciplinary team of five primary care providers (PCP)—two physicians (internal medicine and family medicine) and three nurse practitioners—a social worker, two nurse care managers, a registered dietitian (RD)/certified diabetes educator (CDE) who is working toward obtaining certification as a CLS, and a CLS pharmacist clinician (PhC) specializing in chronic disease management. The advanced practice PhC license for pharmacists is unique to New Mexico and is regulated by both pharmacy and medical boards. PhCs practice as providers with prescriptive authority based on a scope of practice delineated by their supervising physician(s).

With this team in place, the first significant step to establishing the PCMH was implementing the electronic medical record (EMR). The EMR helped to facilitate referrals and communication between primary care providers and the PhC and RD disease management specialists, most often dealing with patients having metabolic syndrome or some component of it.

While they were implementing the EMR, a decision was made to focus on three key areas for interventions in the Belen patient population, one being low-density lipoprotein cholesterol (LDL-C) goal attainment in diabetics. The EMR helped

to identify these patients through a disease registry, which gave the ability to generate patient- and provider-specific reports by disease state. In this case, reports could be generated to list all diabetic patients with an LDL-C > 100 mg/dL for evaluation and intervention by the PCP, PhC or nurse care manager.

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Nurse care managers have been integral to the process, helping the PCP to generate EMR referrals to the PhC or the RD for management of specific clinical entities. At times when PCP access is limited, the care managers also direct patients to see the PhC to bridge the care gap until they are seen by their PCP. This allows the PhC to see the patient for immediate or overdue chronic care issues and discuss with the patient the possibility of being referred for long-term management of lipoprotein disorders—or other chronic diseases—if not at therapeutic goal. If the patient is amenable, then a note saying as much will be sent by the PhC through the EMR to the PCP for review and referral for disease management.

The PCMH also lends itself to patient group visits that have shown to be helpful in chronic disease management. At PMG

PCMH clinics, group visits have been successful and encompassed tobacco cessation and diabetes management. As the Belen clinic moves toward offering group visits, it is likely that lipid and/or metabolic syndrome management through this venue will evolve and utilize the clinical lipid specialist.

The process of becoming an accredited PCMH has helped PCPs more fully utilize the clinical lipid specialist in managing patients with complicated lipoprotein disorders and has allowed the whole team to plan and implement the care of each patient in a more comprehensive manner. The PCMH also has helped to facilitate the functioning of the members of the healthcare team at the level of their training and abilities, delegating the responsibility for a higher level of care. Through the use of the PCMH model, PMG has been able to improve the quality of care for diabetic patients, resulting in better patient outcomes and lower overall costs. ■

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References listed on page 39.