Pharmacists' PatientCare Services Digest

Building Momentum. Increasing Access.

March 2016

Developed by the American Pharmacists Association

Dear Colleague,

Advancing the practice of pharmacy is crucial to the mission of APhA. In 2015, APhA forged ahead with our work to expand access to pharmacists' patient care services. The Patient Access to Pharmacists Care Coalition (PAPCC), of which APhA is a founding member, advanced the quest to pass federal legislation.

In 2015, the PAPCC launched a successful media initiative to promote the role pharmacists can play in filling the gap many patients face in accessing care. APhA also maintains strong partnerships with state pharmacy associations, many of which experienced important achievements in expanding pharmacists' roles and obtaining new payment opportunities in the past year.

APhA addresses the needs of an evolving profession through collaborations, such as the development of the Joint Commission of Pharmacy Practitioners' *Pharmacists' Patient Care Process*, and through provider education and training, such as the recently launched ADAPT program that prepares pharmacists for expanding patient care roles. Through these and other initiatives, APhA is helping pharmacists transform their roles to better meet patients' needs through team-based care.

This Digest, based on an environmental scan of pharmacists who deliver patient care services, reports on evolving trends, successes, and barriers for the profession in this transformation. The Digest identifies emerging distinct pathways for the provision of patient care services, including a community-based pathway and an integrated health organization pathway, and explores opportunities, developing infrastructures, and challenges.

All of us thank the researchers who were involved both in the expert advisory panel for the environmental scan as well as in the development of this Digest for their insight and guidance to advance pharmacists' patient care services and promote provider status.

Sincerely,

Thomas E. Menighan, BSPharm, MBA, ScD (Hon), FAPhA
Executive Vice President and Chief Executive Officer
American Pharmacists Association

Contents

Introduction 2

Professional Initiatives to Advance Provider Status for Pharmacists 6

Center for Medicare and Medicaid Innovation: Grant Awardees 9

Profile: Hawaii Pharm2Pharm Service Model 10

Profile: Wisconsin Pharmacy Quality Collaborative 11

The Perspective of Pharmacists Providing Patient Care Services 12

Profile: Community Care Of North Carolina 18

Profile: Working to Implement Provider Status in Washington State 24

Conclusions 28

References 29

Pharmacists' Patient Care Services Survey Advisory Board

Jon C. Schommer, PhD
Professor
University of Minnesota
College of Pharmacy
Minneapolis, Minnesota

Lourdes G. Planas, PhD
Assistant Professor
University of Oklahoma
Health Sciences Center
College of Pharmacy
Oklahoma City, Oklahoma

William R. Doucette, PhD
Professor
University of Iowa
College of Pharmacy
Iowa City, Iowa

Introduction

A substantial body of evidence has shown that patient outcomes improve and costs decrease when pharmacists provide care to patients with a variety of health conditions. For example, one study of patients in ambulatory health care settings found that pharmacists who provided medication therapy management (MTM) were able to resolve drug therapy problems and increase the percentage of patients achieving therapeutic goals. In addition, performance on quality measures improved in patients receiving services from pharmacists and total health expenditures decreased from $11,965 to $8,197 per patient.[1]

More recent data have demonstrated that pharmacists in chain community pharmacy settings also confer benefits when providing medication-related services. In a recent study, pharmacists working at a national chain improved medication adherence by 3% and produced health care savings of $164 per patient over 6 months. Patients involved in the study also had almost 2% fewer hospital admissions and nearly 3% fewer emergency department visits.[2]

Although the benefits of pharmacists' patient care services have been clearly demonstrated, patient access is often limited by the general lack of coverage of such services by third-party payers. This remains an important barrier to widespread service implementation and increases the costs of health care as a result of patients seeking care in more costly settings. Recognition and coverage of pharmacist-provided patient care services by payers would create more incentives for pharmacists, pharmacy owners, and pharmacist employers to expand the services offered and to integrate these services into evolving care delivery models. With coverage, the business model should more adequately support patient access to these services.

Despite these challenges, pharmacists in the United States are increasingly being utilized to expand patient access to care, improve patient outcomes, and manage overall health care costs. In 2015, there was increasing support for pharmacists' patient care services at a federal level and a number of states advanced practice and payment opportunities for pharmacists to provide such services.

The Centers for Medicare and Medicaid Services (CMS) announced in January 2015 that it is testing and expanding new value-based payment models that can improve health care quality and reduce total health care costs.[3] This initiative includes a shift toward increasing accountability for both quality and total cost of care and a greater focus on population health management as opposed to payment for specific services. The focus on outcomes and cost in these systems can yield a multitude of practice opportunities for pharmacists.

Federal Activities to Improve Access to Pharmacists' Services

In 2015, Congress considered legislation that would improve access to pharmacists' services in Medicare Part B and Medicare Part D. In addition, federal regulatory activities are underway that have the potential to expand access.

Legislative Activities

Medicare Part B does not pay for pharmacists' services because pharmacists are not considered "providers" under federal law. Because many other third-party payers structure their plans to align with Medicare laws, regulations, and policies, this situation hinders payment to pharmacists from a wide range of sources.

The American Pharmacists Association (APhA) is part of a coalition of national pharmacy organizations called the Patient Access to Pharmacists' Care Coalition (PAPCC).[4] The PAPCC helped to develop federal legislation that promotes the value of pharmacists and pharmacists' services. The legislation, originally introduced in the U.S. House of Representatives in 2014 (H.R. 4190) and reintroduced/introduced in the House (H.R. 592) and Senate (S. 314) in 2015, amends title XVIII of the Social Security Act to provide coverage for pharmacists' services through Medicare Part B. The legislation will enable patient access to, and payment for, Medicare Part B services by state-licensed pharmacists in medically underserved communities, provided such services are within pharmacists' scope of practice. The legislation has strong bipartisan support, obtaining 262 cosponsors in the House and 41 cosponsors in the Senate as of January 2016.

Another bill under consideration by Congress, the Medication Therapy Management Empowerment Act of 2015 (S. 776), would expand the pool of patients who qualify for MTM services under Medicare Part D. Currently, patients are eligible under Part D only if they have multiple chronic conditions, and only about 8% actually received the service in 2011.[5] The bill would allow patients with a single chronic condition that has been shown to respond well to improved medication adherence to receive services. Conditions included in the bill are cardiovascular disease, chronic obstructive pulmonary disease, hyperlipidemia, and diabetes. Eligibility criteria related to the number of Part D drugs and cost thresholds remain unchanged. This bill would be an important step in improving patient access to MTM programs in Medicare Part D.

Regulatory Activities

The Centers for Medicare and Medicaid Services (CMS) requirements for Medicare Part D plans in 2016 include several new provisions that have the potential to impact patient care services provided by pharmacists, including MTM and medication reconciliation. Changes include the following:[5]

- Beginning in 2016, CMS will include comprehensive medication review completion rates in star ratings for Medicare Part D plans.
- CMS has expanded eligibility for post-discharge medication reconciliation; all beneficiaries who are members of Medicare Advantage are now eligible for this service.
- CMS will test the National Committee for Quality Assurance's asthma quality measure to determine whether these measures are appropriate for older adults.

Additionally, in September 2015, CMS announced plans for a new model aimed at testing methods of optimizing medication use among Medicare Part D beneficiaries.[6] The Part D Enhanced Medication Therapy Management model aims to determine whether providing certain Medicare Prescription Drug Plans with added incentives and options to create innovative programs will help to attain the overall objectives of MTM programs that focus on optimizing medication use.

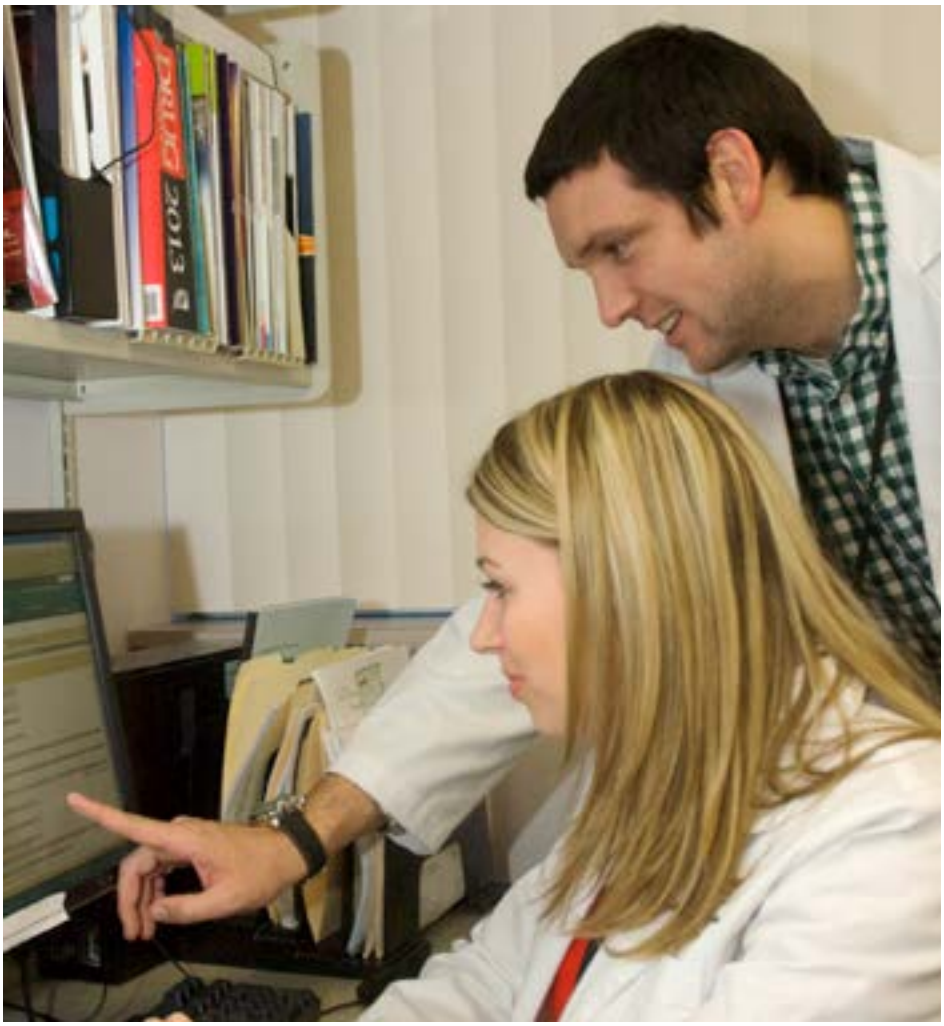
CMS will test the impact of giving prescription drug plans stronger incentives and flexibility to improve prescription drug safety and efficacy. The goal of this model is to optimize medication use and improve care coordination in Medicare. CMS will begin testing the model in 2017.

State-Level Activities

Throughout 2015, many states took legislative and regulatory action that supports pharmacists' provision of patient care services. These actions followed the release of a report from the National Governors Association that addressed the inclusion of pharmacists as members of integrated health care teams.[7] The report highlights numerous states that have expanded pharmacists' scope of practice, integrated pharmacists into chronic care delivery teams, and developed other team-based models of care that include pharmacists. The report concludes that, "The integration of pharmacists into team-based models of care could potentially lead to improved health outcomes. To realize that prospect, states should consider engaging in coordinated efforts to address the greatest challenges pharmacists face: restrictions in [collaborative practice agreements], recognition of pharmacists as health care providers to ensure compensation for direct patient care services, and access to health [information technology] systems."[7] Many state-level activities have been designed to address these challenges. Some of the most notable initiatives took place in California, Oregon, North Dakota, and Washington State.

California

In 2013, California passed S.B. 493, which established that pharmacists in the state are considered health care providers and expanded their scope of practice. Many of the regulations required for implementing the law were finalized in 2015. These provisions allow all pharmacists to:



- Furnish self-administered hormonal contraceptives pursuant to a statewide protocol.
- Furnish prescription nicotine replacement products for tobacco cessation pursuant to a statewide protocol.
- Furnish prescription travel medications recommended by the Centers for Disease Control and Prevention.

In addition, pharmacists may earn recognition as an Advanced Practice Pharmacist (APP). To do so, they must fulfill two of the following three criteria:

- Earn certification in a relevant area of practice, such as ambulatory care, critical care, oncology pharmacy, or pharmacotherapy.
- Complete a postgraduate residency program.
- Have provided clinical services to patients for at least 1 year under a collaborative practice agreement or protocol with a physician, APP-credentialed pharmacist, collaborative drug therapy management (CDTM) pharmacist, or health system.

Pharmacists who earn the APP recognition are authorized to:

- Perform patient assessments.
- Order and interpret tests related to drug therapy.
- Refer patients to other health care providers.
- Initiate, adjust, and discontinue drug therapy pursuant to an order by a patient's treating prescriber in accordance with established protocols.
- Participate in the evaluation and management of diseases and health conditions in collaboration with other health care providers.

Oregon

Oregon passed provider status legislation for pharmacists in June 2015. H.B. 2028 took effect immediately when it was signed into law. This law:

- Clarifies that pharmacists can be paid for clinical services.
- Expands existing laws related to CDTM to make them less restrictive.

- Authorizes the development of statewide protocols for various clinical services, including smoking cessation and travel medicine.

The law allows both private and public health insurers in Oregon to compensate pharmacists for provision of clinical services. It is anticipated that this law will lead to greater availability of pharmacist-provided patient care services in the state.

North Dakota

In 2015, North Dakota passed four bills that include provider status language for pharmacists. S. 2173 expands collaborative practice agreement opportunities for pharmacists by removing barriers and allowing pharmacists to initiate patient assessments and perform point-of-care testing. Another bill, S. 2320, created an MTM program for patients receiving Medicaid. A third bill, H.R. 1102, defined pharmacists as providers of service for pain programs and other services under workers' compensation. Finally, S. 2104 expanded pharmacists' prescriptive authority for naloxone rescue kits.

Washington State

In May 2015, Washington State passed S.B. 5557, which requires commercial or private health care plans in Washington to enroll pharmacists into their provider networks; furthermore, the law mandates that these plans pay pharmacists for the patient care services they provide if the services are within a pharmacist's scope of practice and if the plan would pay a physician or other health care provider for providing the same service. Although many states consider pharmacists to be providers, this is the first law that specifically requires third-party payers to provide compensation for pharmacists' services. The state's Medicaid and public employee health plans also intend to participate, even though they are not required to by law.

Pharmacists practicing in organizations that have credentialing processes already in place could start participating in January 2016. The program will go into effect for community clinics and pharmacies in 2017. Health systems that have internal credentialing are now able to bill for pharmacists' services using full evaluation and management payment codes rather than relying on other mechanisms such as incident-to billing or facility fee overhead billing to receive compensation.[8]

Professional Initiatives to Advance Provider Status for Pharmacists

APhA spearheads efforts to educate legislators and regulators about the role of pharmacists in improving patients' health in order to support the development of policies that will improve patient care. APhA works at many levels to help guide development of laws and regulations that allow pharmacists to serve the needs of their patients both in traditional pharmacy roles and emerging patient care activities. In addition, APhA has led several programs and initiatives that are designed to help prepare the profession of pharmacy to realize its full potential.

Education and Development to Advance the Profession

Providing pharmacy professionals with the education and training necessary to deliver optimal patient care is a key component of APhA's dedication to advancing the practice of pharmacy. APhA's continuing pharmacy education resources are comprehensive and relevant to pharmacy practice trends.

In-depth educational programs, such as certificate training programs, are primarily constructed to instill, expand, or enhance practice competencies. Pharmacists may complete certificate programs on MTM, cardiovascular disease risk management, immunizations, and diabetes care. APhA's certificate training programs have been invaluable to pharmacists in advancing their roles in patient care services and have served as a catalyst for developing partnerships with other organizations that work to improve public health. Additionally, advanced training programs in travel health services, patient care skills, and preceptor training further contribute to opportunities for professional development. APhA also has expanded community pharmacy residency training to support the needs of an evolving health care system.

In 2015, APhA launched the ADAPT training program, which prepares pharmacists to employ new skills systematically with standardized tools and processes for medication assessments, patient interviews, care plans, and documentation. The program is designed to support pharmacists as they incrementally enhance and transform their own practice over the duration of the program.

Board of Pharmacy Specialties

The Board of Pharmacy Specialties (BPS), an autonomous certification agency of APhA, improves patient care through recognition and promotion of specialized training, knowledge, and skills in pharmacy and specialty board certification. The ultimate goal is to elevate the level of care provided by the profession and advance the practice of pharmacy for all pharmacists by demonstrating pharmacists' capabilities. BPS currently offers certification for the following specialties:

- Ambulatory Care
- Critical Care Pharmacy
- Nuclear Pharmacy
- Nutrition Support Pharmacy
- Oncology Pharmacy
- Pediatric Pharmacy
- Pharmacotherapy
- Psychiatric Pharmacy

As of 2015, more than 24,000 pharmacists have earned BPS recognition. This credential is increasingly being considered an important indicator of a pharmacist's patient care abilities. For example, it is one of the criteria for earning the APP recognition in California.

Joint Commission of Pharmacy Practitioners

In 2005, the Joint Commission of Pharmacy Practitioners (JCPP) released a vision statement for pharmacy practice in 2015, which called for "pharmacists [to] be the health care professionals responsible for providing patient care that ensures optimal medication therapy outcomes." JCPP worked diligently over the ensuing decade to advance this vision and continues working to support it.[9]

JCPP's vision statement for the profession and strategic plan for reaching this vision were revised in July 2013. The newly adopted vision, "Patients achieve optimal health and medication outcomes with pharmacists as essential and accountable providers within patient-centered, team-based health care," reflects a patient-centered focus and pharmacist accountability for patient outcomes as a member of the health care team.[10]

The updated JCPP strategic plan identifies the need for the implementation of a consistent and widely adopted pharmacists' patient care process, quality measures to measure the value of pharmacists' services, robust health information technology (HIT) to support patient care, and payment for pharmacists' services as key drivers to achieve JCPP's vision for the profession.[10]

JCPP's work to develop a formalized *Pharmacists' Patient Care Process* has been crucial to the articulation and implementation of more standardized

services.[10] Notably, in 2015 the Accreditation Council for Pharmacy Education included the *Pharmacists' Patient Care Process* into new standards for schools of pharmacy to ensure that the next generation of pharmacists is trained using this process. APhA worked throughout 2015 to raise awareness of the process and support its adoption throughout the profession. Additionally, the American Society of Health-System Pharmacists has been working to integrate the process as updates are made to residency accreditation standards.

Pharmacy Quality Alliance

Developing quality measures that are aligned with true improvements in patient care and outcomes is a complex process that must ensure that incentives are appropriately aligned with desired outcomes. The mission of the Pharmacy Quality Alliance (PQA) is to improve the quality of medication management and use across health care settings. PQA measures have been adopted into national programs, such as the CMS star ratings system, which is used to evaluate Medicare Part D prescription drug plans. Pharmacy Quality Solutions, which is a spin-off of PQA, is focused on the adoption of PQA measures in the marketplace using the Electronic Quality Improvement Platform for Plans & Pharmacies, known as the EQuIPP platform.[11]

Developing the Value Proposition

Many programs, such as hospital readmissions prevention and pay-for-performance initiatives, create financial incentives for improving patient medication use. Such programs can provide financial justification for an organization to hire pharmacists to deliver patient care services. APhA has been working to support pharmacists in the development of the business case for the provision of their services in order to leverage these types of programs. A variety of materials designed to support pharmacists in quantifying and communicating their value proposition are under development by APhA.

APhA's 2015 Environmental Scan of Patient Care Services Provided by Pharmacists

In 2007, APhA began conducting periodic environmental scans of providers and payers regarding their involvement with MTM services and reporting the results in a digest. In the surveys conducted from 2007 through 2010, questions focused on provision of MTM services. In 2012 and 2013, the survey was expanded to include questions related to provision of MTM within integrated care models.

In light of evidence that pharmacists are being integrated into systems of care that utilize their expertise for a wide variety of patient care services in addition to MTM services, the 2014 environmental scan surveys covered a broader range of services and examined how pharmacists are impacting access to care. The 2014 survey assessed delivery of patient care services by pharmacists, the value of these services, their impact on patient access, and barriers to further expansion of these services. The purpose of the 2015 environmental scan was to help understand the provision of patient care services by pharmacists during 2015 from provider perspectives and compare the findings with data collected in 2014.

Data from the 2015 survey are reported in this digest. These data offer useful information about the types of patient care services provided by pharmacists, the value of those services, and barriers to increased expansion of pharmacists' services. (Contact APhA at mtm@aphanet.org for more information about survey methods and results.)

Pathways for Providing Care

Findings from the 2015 environmental scan of patient care services provided by pharmacists affirmed that there are two distinct pathways for access to pharmacist-provided patient care. The *community pharmacy* pathway—representing independent, mass merchandiser, national chain, regional chain, and supermarket pharmacies—serves geographically defined communities, offers access to some services without an appointment, is aligned with the provision of prescription drugs, and uses a trusted pharmacist located within the community. Pharmacists working in community pharmacy settings are central to the medication use process and are the most frequently encountered health professionals for many patients. In addition to access and convenience, community pharmacy settings afford the opportunity to coordinate self-care behaviors that overlay prescribed therapies including over-the-counter drugs and nutritional supplements. For patients under the care of multiple prescribers, community pharmacies are ideal for improving continuity and coordination of care across providers and settings. Since many patients visit community pharmacies at frequent and regular intervals, community pharmacists are ideal for improving the quality, safety, efficiency, and effectiveness of prescribed treatments for chronic care.

The *integrated health organization* (IHO) pathway—representing acute care/inpatient hospital, ambulatory care clinic, health-system/outpatient, long-term care, integrated delivery system, and physician office—serves patient populations with targeted needs, often uses embedded pharmacists within a team-based care model, is aligned with payer goals for meeting quality metrics and pay-for-performance targets, and has been expanded based on evidence for how pharmacists have been able to solve problems. Integrating pharmacists into care teams is vital for establishing access to pharmacist-provided care in these sites. Pharmacists working in IHOs are central for medication use in acute care, disease management, and targeted outcome situations. Pharmacists in IHOs help optimize the use of resources, provide unique expertise, and facilitate continuous quality improvement efforts for organizations.

The summary in Table 1 shows how the chronic medication use focus in community settings has unique characteristics compared with the acute and specialty care focus in IHO settings. For example, the survey showed that job titles for community pharmacy settings typically were staff pharmacist, pharmacy manager, pharmacist in charge, and clinical services manager/coordinator, whereas job titles for IHO settings were clinical pharmacist and academic clinical faculty. These differences are consistent with the different patient populations, work systems, work processes, services provided, and desired outcomes that exist in the two settings. Together, the two setting types are addressing both chronic and acute/specialty care.

TABLE 1. TYPES OF PHARMACIES AND COMMONLY REPORTED PATIENT CARE ROLES OF PHARMACISTS IN COMMUNITY AND INTEGRATED HEALTH ORGANIZATION SETTINGS

Setting	Types of Pharmacies	Commonly Reported Patient Care Roles of Pharmacists
Community setting	Independent Mass merchandiser National chain Regional chain Supermarket pharmacies	• Assist patients in managing self-care behaviors (over-the-counter drugs and nutritional supplements) • Improve continuity of care across providers and settings • Improve outcomes of prescribed treatments for chronic care
Integrated health organization setting	Acute care/inpatient hospital Ambulatory care clinic Health-system outpatient Long-term care facility Managed care Physician office	• Coordinate medication use in acute care, disease management, and targeted outcome situations • Help optimize the use of resources • Provide unique expertise in team-based care • Facilitate continuous quality improvement efforts for organizations

Although these pathways are distinct, there is increasing evidence that there are growing inter-relationships between pathways as integration and collaboration across the health care continuum improves. Nationally, there are many efforts underway to link community pharmacy and IHO pathways to create seamless patient-centered care.

Center for Medicare and Medicaid Innovation: Grant Awardees

The Center for Medicare and Medicaid Innovation ("the Innovation Center") has provided Health Care Innovation Awards to study compelling new ideas to deliver better health, improved care, and lower costs for people enrolled in Medicare, Medicaid, and the Children's Health Insurance Program (CHIP), particularly those with the highest health care needs. Award recipients provide services to a wide range of patient populations, from children to the elderly, across the care continuum. Each project is monitored for measurable improvements in quality of care and savings generated over a 3-year period. Awards were issued to private and public organizations that "have a high likelihood of driving health care system transformation and delivering better outcomes."[12]

Several organizations received Health Care Innovation Awards for projects that involve pharmacists in the delivery of patient care services. Each of these projects will culminate in a report that will detail the return on investment provided by pharmacists' services.

Profile: Hawaii Pharm2Pharm Service Model

Karen Pellegrin, PhD, MBA, Director of Continuing Education and Strategic Planning at the University of Hawaii at Hilo College of Pharmacy, described the development of the Pharm2Pharm service model through an Innovation Center award grant. The Pharm2Pharm model is a transitions of care program that improves coordination and collaboration between hospital and community pharmacists. The model was initially implemented in rural counties that had severe physician shortages, and it has been expanded to other areas with high rates of preventable hospitalizations.[13]

Pharm2Pharm was initiated by the Hawaii Community Pharmacists Association to better integrate pharmacists in proactive health care roles that are independent of dispensing. In this model, both community and hospital pharmacists identify patients at high risk of drug therapy problems and work to collaborate with other members of the health care team to resolve them.

The grant funded a pharmacist at each hospital who worked with the admissions team and case managers to identify at-risk patients. The pharmacist engages with the patient's care team while in the hospital, and manages the transition to the community as needed, including close communication with community pharmacists and primary care providers. Post-discharge interventions are not limited to a 30-day window, because, as Dr. Pellegrin explains, it is not possible to resolve all medication problems within 30 days. Patients are generally seen within 3 days of hospital discharge.

The most common drug therapy problem identified by pharmacists is an untreated condition. Other common problems include the need to change the dosage of a medication, switch patients to more appropriate medications, and address adherence issues. Pharmacists are able to implement some interventions but generally must coordinate with the patient's primary care physician to support implementation of recommendations.

A robust state health information exchange has been a crucial component for supporting the program and allowing pharmacists' interventions to be implemented across settings without regard to the patient's insurance coverage, primary care provider, or dispensing pharmacy. This system allows pharmacists to have access to clinical records, including immediate access to laboratory results and dispensing histories for all pharmacies.

The Pharm2Pharm program has allowed pharmacists to be utilized in the health care system in roles that address overall health care costs. The program addresses fragmentation within the health care system and better integrates primary care. Pharmacists participating in the program are receiving compensation for their services through grant funding, however future sustainability remains unclear. Dr. Pellegrin reported that she is investigating a variety of options to make the program sustainable when the grant funding ends. Potential options include incident-to billing, leveraging quality payments to physicians, or contracting with integrated care organizations such as accountable care organizations and other entities that are at risk for an entire population.

Acknowledgement of Federal Funding: The project described is supported by Funding Opportunity Number CMS-1C1-12-0001 from Centers for Medicare and Medicaid Services, Center for Medicare and Medicaid Innovation. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of HHS or any of its agencies.

Profile: Wisconsin Pharmacy Quality Collaborative

Kari Trapskin, PharmD, Vice President of Health Care Quality Initiatives, described how the Wisconsin Pharmacy Quality Collaborative (WPQC) utilized an Innovation Center grant for expansion. WPQC was created by the Pharmacy Society of Wisconsin to improve patient outcomes and reduce costs by improving prescription medication use.

WPQC is a network of accredited pharmacies and certified pharmacists who provide MTM services. The overall objective of the program is to establish a set of pharmacist-provided MTM services and a quality accreditation process. "The accreditation and certification processes allow pharmacists to provide services that are consistent statewide across participating third-party payers and pharmacy providers," notes Dr. Trapskin.

The program uses HIT to identify patients with specific chronic conditions—diabetes, heart failure, asthma, and geriatric syndromes—who are prescribed multiple medications, are undergoing transitions of care, and/or have adherence challenges. Two levels of service are provided by pharmacists to targeted patients. Level 1 services are intervention-based and medication-focused, such as therapeutic interchanges or focused adherence interventions. Level 2 services are more complex, value-added professional services, such as comprehensive medication therapy reviews.

Pharmacists complete a specific certification program in order to deliver the MTM services. Accredited pharmacies will provide MTM services and must have policies and procedures in place that support quality-based best practices for optimal patient outcomes. WPQC provides education and training to pharmacies to support consistent implementation of best practices.

Pharmacists are compensated for their services by third-party payers. The program began as a pilot with two managed care organizations. The state Medicaid program was not an original payer for the program but has since joined. Currently, it is the primary source of patients for the program and, therefore, integral to supporting the sustainability of the program.

The Innovation Center grant was used to fund infrastructure development and expand the program to the entire state of Wisconsin, explains Dr. Trapskin. WPQC used a portion of the grant to hire four regional implementation specialists to support pharmacies in the field. These specialists boosted competence and the abilities of the pharmacists and implemented a specific coaching program for pharmacists. The WPQC program has continued following the completion of the grant.

Acknowledgement of Federal Funding: The project described is supported by Funding Opportunity Number CMS-1C1-12-001 from Centers for Medicare and Medicaid Services, Center for Medicare and Medicaid Innovation. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of HHS or any of its agencies.

The Perspective of Pharmacists Providing Patient Care Services

Responses to the 2015 survey were received from 448 respondents, 374 (83%) of whom reported that they or their organization provide patient care services beyond patient counseling associated with the dispensing of prescriptions. However, not all respondents answered every question.

Medication management was the most commonly provided patient care service.

Patient Care Services

Pharmacists in community settings were more likely to provide immunizations and health and wellness screenings than those in IHO settings. In contrast, pharmacists in IHO settings were more likely to provide disease state management, care transitions services, and other services not listed in the question (e.g., readmissions, anticoagulation/warfarin management, consultations, dosing, drug information, drug regimen review, follow-up for chemotherapy, HIV medication counseling, injection training, pharmacogenetic testing, pharmacokinetics, research, specialty consultations).

Pharmacists in both community and IHO settings commonly applied the same process of care, suggesting that the pharmacy profession has established a widely accepted practice model that is in use in a variety of patient populations, practice settings, and medication use situations.

Pharmacists reported that they provide a wide range of patient care services to manage chronic diseases and improve overall health. These services included:

- 88% Medication management
- 84% Disease state education
- 63% Immunizations
- 60% Medication adherence services
- 58% Disease state management
- 42% Care transitions services including medication reconciliation
- 34% Health and wellness screenings
- 34% Smoking cessation
- 13% Nutrition and weight loss
- 6% Other

Pharmacists reported that they provide chronic disease management services that address numerous chronic conditions. The most commonly targeted conditions were:

- 74% Diabetes
- 62% Hypertension
- 50% Dyslipidemia
- 38% Respiratory diseases
- 35% Conditions requiring anticoagulation
- 33% Chronic heart failure
- 22% Pain disorders
- 21% Mental health
- 14% HIV/AIDS
- 13% Bone or joint disease
- 11% End-stage renal disease
- 9% Alzheimer's disease
- 11% Other

Pharmacists typically perform a number of activities when they provide patient care services, including:

- 83% Collection of data/information from patient
- 82% Assessment
- 82% Modify or recommend modifications to medication therapy to prevent or resolve problems
- 77% Patient education
- 70% Collaborate with other providers
- 68% Development of patient goals/care plan
- 67% Follow-up to monitor and evaluate effectiveness of care plan
- 66% Document assessment or care plan in patient record
- 65% Communicate assessment or care plan to another provider
- 42% Billing

Service Delivery

Overall, 46% of the 374 respondents to the 2015 survey reported that their organization provides patient care services to patients who reside in medically underserved areas (compared with 44% in 2014).

Respondents also were asked about the number of patient care opportunities at their practice. Overall, 74% of pharmacists reported that they could provide patient care to 11 or more patients per week, up from 63% in 2014; 53% were actually providing this amount of service. Community settings were more likely to report that they could serve or did serve 10 or fewer patients per week. IHO settings were more likely to report that they could or did serve more than 50 patients per week. In addition, 56% reported that they could provide 11 or more comprehensive medication reviews per week (Table 2).

46%

of pharmacists reported that their organization provides patient care services to patients who reside in medically underserved areas.

TABLE 2. NUMBER OF PATIENTS TO WHOM PHARMACISTS' PATIENT CARE SERVICES COULD BE PROVIDED AND CURRENTLY ARE PROVIDED IN COMMUNITY AND INTEGRATED HEALTH ORGANIZATION SETTINGS

	Community Setting 2015	IHO Setting 2015	Overall 2015
Number of patients per week for whom patient care services could be provided	n = 61	n = 91	n = 152
≤10 per week	44%	13%	26%
11–50 per week	41%	46%	44%
51–100 per week	8%	19%	14%
>100 per week	7%	22%	16%
Number of patients per week for whom comprehensive medication reviews could be provided	n = 67	n = 80	n = 147
≤10 per week	67%	24%	44%
11–50 per week	25%	54%	41%
51–100 per week	4%	8%	6%
>100 per week	3%	15%	10%
Number of patients per week for whom patient care services are currently provided	n = 64	n = 94	n = 158
≤10 per week	77%	27%	47%
11–50 per week	19%	43%	33%
51–100 per week	2%	10%	6%
>100 per week	3%	21%	14%

Note: Some community setting respondents included immunizations in their answers and some did not. All answers were included regardless of inclusion or exclusion of immunizations. Some IHO setting respondents gave their answers in terms of number of patients per pharmacist per week. Answers provided in this manner were excluded from analysis.

Pharmacists were asked to report with whom they collaborate when providing pharmacists' patient care services. Table 3 summarizes the findings for this question. Respondents from community and IHO settings were similar for the two most common collaborator types (i.e., physicians and nurse practitioners). Respondents from IHO settings were more likely to report collaborating with other types of health care providers as well.

TABLE 3. WHEN PROVIDING PHARMACISTS' PATIENT CARE SERVICES, WITH WHOM DO YOU COLLABORATE?

	Community Setting	IHO Setting	Overall
Physicians	85%	85%	85%
Nurse practitioners	70%	73%	72%
Other pharmacists	38%	61%	51%
Pharmacy technicians	31%	26%	28%
Other (specify)	2%	20%	12%
Other included:	Physician assistants	Behavioral health Care managers Counselors Dieticians Human resources Mental health Naturopaths Nurses Occupational therapists Physician assistants Physical therapists Social workers Specialists	

Credentials

The 2015 survey revealed an increased focus on credentialing by payers to grant authorization to render specific services. Regarding specific credentials or training required by payers, pharmacists in community settings were more likely to report needing specific training (e.g., certificate programs) than those in IHO settings; on the other hand, pharmacists in IHO settings were more likely to report that payers required PharmD training, Pharmacy Board specialty certification, and residency training (Table 4). It is noteworthy that each of these three types of credentials/training increased significantly for IHO settings between 2014 and 2015.

TABLE 4. CREDENTIALING REQUIREMENTS IN COMMUNITY AND IHO SETTINGS.

	Community Setting	IHO Setting
Do any of your payers require specific credentials or training to provide these services to their patients? (% Yes)	n = 110 30%	n = 150 23%
If Yes, what specific credentials or training do payers require?	n = 33	n = 34
Specific training (e.g., certificate training programs)	73%	50%
Disease or condition-related certification (CDE, CAE)	30%	35%
PharmD	18%	79%
Pharmacy Board specialty certification (BCACP, BCPS, CGP)	9%	38%
Residency	0%	50%
Other	18%	18%

Other (Community) included: Board Certified-Advanced Diabetes Management, case by case review, class, immunization certificate, Mirixa and Outcomes training, MTM certification, National Provider Identifier. Other (IHO) included: APhA certificate training programs, continuing pharmacy education, credentialing, fellowship, Mirixa certification, MTM training, plan-specific training, registered pharmacist or advanced practice registered nurse, Outcomes training, Wisconsin Pharmacy Quality Collaborative.

BCACP = board certified ambulatory care pharmacist; BCPS = board certified pharmacotherapy specialist; CAE = certified asthma educator; CDE = certified diabetes educator; CGP = certified geriatric pharmacist; MTM = Medication Therapy Management; PharmD = doctor of pharmacy.

Challenges

Participants were asked to report the level of significance posed by a variety of challenges when providing patient care services (Table 5). The pattern of responses was similar for community and IHO settings, but the means were significantly less (P <0.05) for IHO settings for most challenges. This pattern of findings was similar for both 2014 and 2015 surveys.

TABLE 5. CHALLENGES TO PHARMACIST-PROVIDED PATIENT CARE SERVICES IN COMMUNITY AND IHO SETTINGS

	Community Setting	IHO Setting	*P* Value
Balancing provision of patient care services with other demands on pharmacists' time	4.2	3.3	<0.001
Pharmacists have inadequate time	4.2	3.1	<0.001
Lack of insurance companies paying for these services	4.1	3.7	0.03
Billing challenges	3.9	3.7	0.11
Payment for pharmacists' patient care services is too low	3.8	3.6	0.19
Inadequate support staff	3.8	3.2	<0.001

TABLE 5. CHALLENGES TO PHARMACIST-PROVIDED PATIENT CARE SERVICES IN COMMUNITY AND IHO SETTINGS (CONTINUED)

	Community Setting	IHO Setting	*P* Value
Lack of collaborative relationships with physicians/prescribers	3.7	2.4	<0.001
Patients are uninterested or decline to participate	3.7	2.8	<0.001
Trouble communicating/marketing to patients	3.6	2.8	<0.001
Barriers to collecting/accessing patient information	3.6	2.5	<0.001
Documentation difficulty	3.5	2.9	<0.001
Patients do not keep appointments	3.5	3.1	<0.001
Available space is inadequate	3.2	3.1	0.36
Difficulty determining patient eligibility	3.0	2.3	<0.001
Inadequate training/experience	3.0	2.3	<0.001
Too few patients needing the services to justify the cost	2.7	2.0	<0.001
Management does not support provision of patient care services	2.3	2.1	0.34

Items were rated on a 5-point scale from 1 = very insignificant to 5 = very significant. Means are reported.

Patients Receiving Services

Respondents were asked to provide information regarding the referral source for patients participating in their pharmacists' patient care services and programs. For community settings, significantly more referrals were received through MTM vendors. For IHO settings, referrals were more likely through collaboration with other practitioners and other methods, such as employer-based programs, hospital programs, mental health provider programs, and transitional care units (Table 6).

TABLE 6. MEAN PERCENTAGE OF PATIENTS RECEIVING SERVICES BASED ON REFERRAL SOURCE

	Community Setting	IHO Setting	*P* Value
A medication therapy management vendor (e.g., Mirixa, Outcomes)	58%	10%	<0.001
Identification by a pharmacist in your practice	14%	16%	0.44
Collaboration with another practitioner (e.g., physician, nurse practitioner, pharmacist)	9%	47%	<0.001
Self-referral	10%	6%	0.07
A health plan (e.g., private payer, accountable care organization, medical home)	7%	10%	0.29
Other	1%	11%	<0.001

Respondents were asked about the types of coverage for patient populations to whom they provide patient care services. Pharmacists in community settings were more likely to serve patients whose coverage was through various types of traditional health plans. Those in IHO settings were more likely to serve patients receiving inpatient and discharge services as part of an inpatient stay or through federal benefits, medical homes, special needs plans, and accountable care organizations (Table 7).

TABLE 7. TYPES OF PATIENT POPULATIONS TO WHOM PHARMACISTS' PATIENT CARE SERVICES ARE PROVIDED

	Community Setting	IHO Setting
Patients with commercial insurance (health and/or prescription coverage)	65%	51%
Patients with Medicare Advantage plans	69%	50%
Patients with Medicare supplemental plans	69%	51%
Beneficiaries in a state Medicaid program	46%	47%
Patients with Medicare stand-alone prescription drug plans	51%	33%
Patients covered under PPO plans	43%	35%
Patients covered under HMO/managed care plans	39%	37%
Self-paying patients (fee-for-service)	31%	33%
Patients with self-insured health/prescription benefit coverage	31%	35%
Patients of a specific employer benefit group	27%	27%
Hospital discharge patients	25%	51%
Patients with health savings accounts	24%	24%
Acute care patients	24%	40%
Patients covered under traditional health indemnity plans	21%	19%
Patients with Medicare special needs plans	15%	24%
Beneficiaries in the federal sector (DoD, PHS, VA)	13%	26%
Patients in medical home models	7%	31%
Patients in accountable care organizations	7%	17%
Other	3%	8%

(Percent reporting "Yes"; multiple responses were allowed.)

DoD = Department of Defense; HMO = health maintenance organization; PHS = Public Health Service; PPO = preferred provider organization; VA = Veterans Affairs.

Profile: Community Care Of North Carolina

Community Care of North Carolina (CCNC) is a primary care case management organization that contracts with the state to care for the vast majority of North Carolina's Medicaid patients through more than 1,800 patient-centered medical homes. CCNC coordinates care for the state's most vulnerable patients by partnering with and sharing information with hospitals, medical and behavioral health providers, and others in the medical neighborhood, including pharmacy.

According to Huyla G. Coker, PharmD, a Clinical Pharmacist who provides transitions of care services, "CCNC is building a Community Pharmacy Enhanced Services Network [CPESN] and developing processes of care and relationships between the medical home care team and community pharmacy." Patients who are at high risk of not achieving optimal outcomes from their medications and have multiple chronic conditions may be referred to participating pharmacies based on availability of enhanced services to meet patient-specific needs. CCNC is utilizing a $15 million Center for Medicare and Medicaid Innovation Health Care Innovation Award to demonstrate community pharmacy's role in improving health care quality and reducing costs within the medical home model.

Functioning within a population health model, each pharmacy has a panel of patients for whom it is responsible. Enhanced pharmacy services are offered to meet specific patient needs. For example, one patient may need assistance with inhaler technique, managing his asthma, and home delivery of his medications due to lack of transportation, while another patient with diabetes, depression, hypertension, and poor health literacy may need a full assessment of opportunities to improve and monitor her medication regimen along with medication synchronization and specialized packaging to promote adherence. Under this model, the most complex patients with multiple chronic conditions and medications receive the most intensive supports with longitudinal follow-up using a care plan that is shared among providers, explains Trista Pfeiffenberger, PharmD, MS, Director of Network Pharmacy Programs and Pharmacy Operations for CCNC. Non-pharmacist staff, including pharmacy technicians and in some cases delivery drivers, are directly involved along with pharmacists in the day-to-day aspects of the program. For example, some pharmacies have specifically trained delivery drivers to observe changes in patient behavior or ask the patient some questions; observations that are out of the ordinary are shared with the pharmacist for follow-up.

The HIT capabilities necessary to support enhanced service offerings of the CPESN pharmacies and foster connections with the rest of the care team are being carefully examined. Select claims data for North Carolina Medicaid beneficiaries, as well as some laboratory results and hospital admission, discharge, and transfer notifications, are available to pharmacists in CCNC's web-based medication management application called PHARMACeHOME. PHARMACeHOME is specifically designed to allow health care professionals with different credentials and in different care settings to contribute information to the patient's longitudinal medication management record. This functionality allows hospital pharmacists to discontinue medications in the system when

The contents of this presentation are solely the responsibility of the author and do not necessarily represent the official views of the U.S. Department of Health and Human Services or any of its agencies. The project described was supported by Grant Number 1C1CMS331338 from the Department of Health and Human Services, Centers for Medicare & Medicaid Services.

the patient leaves the hospital, and this information is then available to the community pharmacist, explains Dr. Coker. Drug therapy problems, medication lists, and pharmacy care plans are documented in the application so that findings can be shared across care settings and with providers in the CCNC medical home.

At present, few CPESN pharmacies have direct access to hospital electronic health records. As a result, many CPESN pharmacies must manually collect and disseminate information needed to support medication reconciliation at a care transition. Pharmacies can request discharge medication lists and summaries from the hospital, or they can utilize the discharge orders given to the patient. Pharmacies without access to the primary care provider EHRs call the practice to request copies of the most recently prescribed medication list. Technicians are widely utilized to perform time-intensive functions including compiling medication lists, sharing care plans, and sending recommendations to providers. With all of the time spent on manual data requests and compilation, Dr. Pfeiffenberger notes that data availability can be a challenging aspect of providing timely transitional care services.

Increasing partnerships with CCNC are helping to streamline these communications. For example, if a CCNC patient is hospitalized, and the patient also utilizes a pharmacy participating in CPESN, CCNC will alert the pharmacy that a patient was in the hospital and the organizations will collaborate to support the patient after discharge. In this case, care managers or other CCNC network staff can often assist with access to discharge summaries or medication lists. Additionally, as more care providers begin to recognize the value of active partnerships with community pharmacy, there is growing support for improved access to the EHR, notes Dr. Pfeiffenberger.

Marketing

In addition to referral sources, pharmacists were asked about marketing strategies that they have successfully used to promote their patient care services. Pharmacists in community settings reported that the most successful strategies were direct contact with patients, word-of-mouth, and health/wellness screening and other in-pharmacy activities. In contrast, those in IHO settings reported collaboration with other health care providers and referrals from physicians and other prescribers were their primary methods for generating patients (Table 8).

TABLE 8. MOST SUCCESSFUL MARKETING STRATEGIES FOR PHARMACIST-PROVIDED PATIENT CARE SERVICES

	Community Setting	IHO Setting
Direct contact with patients	72%	51%
Word of mouth	32%	24%
Health and wellness screening and other in-pharmacy activities	31%	10%
Collaboration with other health care providers	26%	75%
Referrals from physicians and other prescribers	21%	58%
Distribution of printed material including Rx inserts and posters	21%	10%
Developing contractual relationships with payers	17%	6%
Advertisements (print, radio, television)	12%	3%
Social media (Facebook, Twitter)	7%	2%
E-mail communications	3%	5%
Other	3%	5%

Value Associated With Services

The value associated with patient care service delivery includes a number of factors including patient and financial outcomes.

Respondents were asked to rate the significance of factors that add value to their organizations as a result of pharmacist-provided patient care services. Patient satisfaction, professional satisfaction, and quality of care were rated as significant for both community and IHO settings (Table 9).

TABLE 9. SIGNIFICANCE OF PHARMACIST-PROVIDED PATIENT CARE SERVICES FOR PROVIDING VALUE

	Community Setting	IHO Setting	*P* Value
Increased patient satisfaction	4.3	4.2	0.38
Increased professional satisfaction	4.3	4.3	0.91
Increased quality of care/outcomes via quality metrics	4.1	4.4	0.01
Increase in prescription volume/sales	3.4	2.7	<0.001
Increase in patient traffic	3.3	3.1	0.11
Revenue generated from patient care services	3.1	2.7	0.01

Items were rated on a 5-point scale from 1 = very insignificant to 5 = very significant. Means are reported.

Provider organizations measure a number of specific quality metrics that can be impacted by patient care services including health care and financial outcomes (Table 10).

TABLE 10. QUALITY METRICS MONITORED BY PHARMACISTS' ORGANIZATIONS

Measure	% Monitoring
Patient satisfaction	55%
Improved adherence/compliance	55%
Quality measure scores (e.g., HEDIS, star ratings)	52%
Medication over/under utilization	47%
Drug interactions identified and resolved	46%
Number of high-risk medications	42%
Hospitalizations	41%
Volume of prescriptions	37%
Emergency department visits	36%
Improved medication understanding	35%
Number of medication-related problems resolved	35%
Overall health care costs	35%
Use of generics	34%
Revenue from services provided	33%
Therapeutic duplications resolved	33%
Overall medication costs	33%
Costs associated with adverse drug events	32%
Treatment changes to bring therapy in line with treatment guidelines	29%
Patient engagement	26%
Untreated conditions identified and appropriately treated	26%
Use of formulary medications	26%
Other	8%

Other (Community) included: none, percentage of hypertensive employees, reduction of medication use, A1C, net profit, gross margin. Other (IHO) included: disease markers (A1C, blood pressure, low-density lipoprotein), disease management, error tracking, physician time saved, medication possession ratio, responses to recommendations, readmission rate, referrals, referring provider satisfaction. HEDIS = Healthcare Effectiveness Data and Information Set.

Payment for Pharmacist-Provided Patient Care Services

Respondents were asked about payment for pharmacist-provided patient care services. Table 11 summarizes the findings from this set of questions.

TABLE 11. PAYMENT FOR PHARMACIST-PROVIDED PATIENT CARE SERVICES IN COMMUNITY AND IHO SETTINGS

	% of Providers
Are you or your organization billing for pharmacist-provided patient care services? (n = 270)	
Yes	57%
No	31%
Don't know	12%
If Yes, for what proportion of patient care services visits do you receive payment? (n = 153)	
0%	5%
1%–10%	16%
11%–25%	9%
26%–50%	7%
51%–75%	13%
76%–99%	14%
100%	11%
Don't know	26%

Overall, 41% of respondents reported that they use Current Procedural Terminology (CPT) codes for claims processing. A greater percentage of pharmacists in IHO settings used these codes (52%) than in community settings (26%). These pharmacists reported using a variety of codes. Community settings were more likely than IHO settings to use MTM billing codes and immunization administration billing codes. IHO settings were more likely to use incident-to billing codes (Table 12).

TABLE 12. TYPES OF CPT CODES USED BY PHARMACISTS

Code Descriptor	Codes	% Using Code (n = 111)
MTM billing codes	99605, 99696, 99607	57%
Incident-to physician service/ physician office visit billing codes	99211, 99212	37%
Immunization administration	G0008, G0009, G0010	33%
Diabetes self-management training	G0108, G0109	20%
Transitional care management	99495, 99496	17%
Medicare Annual Wellness Visit	G0438, G0439	10%
Facility fee	G0463	8%

CPT = Current Procedural Terminology; MTM = medication therapy management.

Respondents were asked both about the return on investment for developing patient care services in terms of whether they experienced a net loss, net gain, or broke even. In 2015, 54% of pharmacists in community settings and 75% in IHO settings reported either breaking even or achieving a net gain. In addition, pharmacists were asked whether they felt that the investment in developing patient care services was worth it (Table 13).

TABLE 13. INVESTMENT IN PHARMACIST-PROVIDED PATIENT CARE SERVICES

	Community Setting	IHO Setting	Overall
Return on investment for patient care services in general	n = 86	n = 89	n = 175
Net loss (2015)	47%	26%	36%
Break even (2015)	28%	24%	26%
Net gain (2015)	26%	51%	38%
From your organization's perspective, has the investment in pharmacists' in patient care services been worth it?	n = 115	n = 157	n = 272
% reporting "Yes"	83%	93%	89%

Year-to-Year Changes

Respondents were asked questions about changes that occurred from 2014 to 2015. Both community and IHO settings were similar in the changes they made in their practices. Table 14 summarizes findings for these questions.

TABLE 14. CHANGES FOR PHARMACIST-PROVIDED PATIENT CARE SERVICES

	Overall
From 2014 to 2015, how much change, if any, did you see in the number of patients receiving pharmacist-provided patient care services?	n = 265
Significant decrease	3%
Moderate decrease	3%
Slight decrease	5%
Remained the same	15%
Slight increase	27%
Moderate increase	19%
Significant increase	15%
Don't know	13%
From 2014 to 2015 what changes, if any, were made in your practice for pharmacist-provided patient care service delivery? (% Yes) — *Check all that apply.*	n = 270
No changes were made	34%
Readjusted pharmacist schedules/hours to facilitate service delivery	26%
Added pharmacist FTEs	25%
New roles for technicians to facilitate pharmacist provision of services	15%
Purchased new technology (tablet software, information systems)	10%
Added technician FTEs	9%
Remodeled facilities	6%
Didn't give it consideration	6%
Purchased automation equipment	5%
Other	7%
If you are contracting for pharmacist-provided patient care services, from 2014 to 2015, what type of change, if any, have you seen in the number of plans offering contracting opportunities for pharmacist-provided patient care services?	n = 221
Significant decrease	2%
Moderate decrease	2%
Slight decrease	2%
Remained the same	17%
Slight increase	15%
Moderate increase	8%
Significant increase	3%
Don't know	50%

Other (Community) included: Added resident, built whole new pharmacy, increased quota for immunizations, more training and resources to improve efficiency, reorganization of workflow, use of pharmacy students, younger pharmacist replaced older pharmacist and implemented services. Other (IHO) included: Added resident, physicians more familiar and comfortable with us, promoted services to physicians, improved workflow and efficiency in processes, social media marketing, vaccine refrigerator, changed from pharmacy technician to medical assistant at front desk.
FTEs = full-time equivalents.

Profile: Working to Implement Provider Status in Washington State

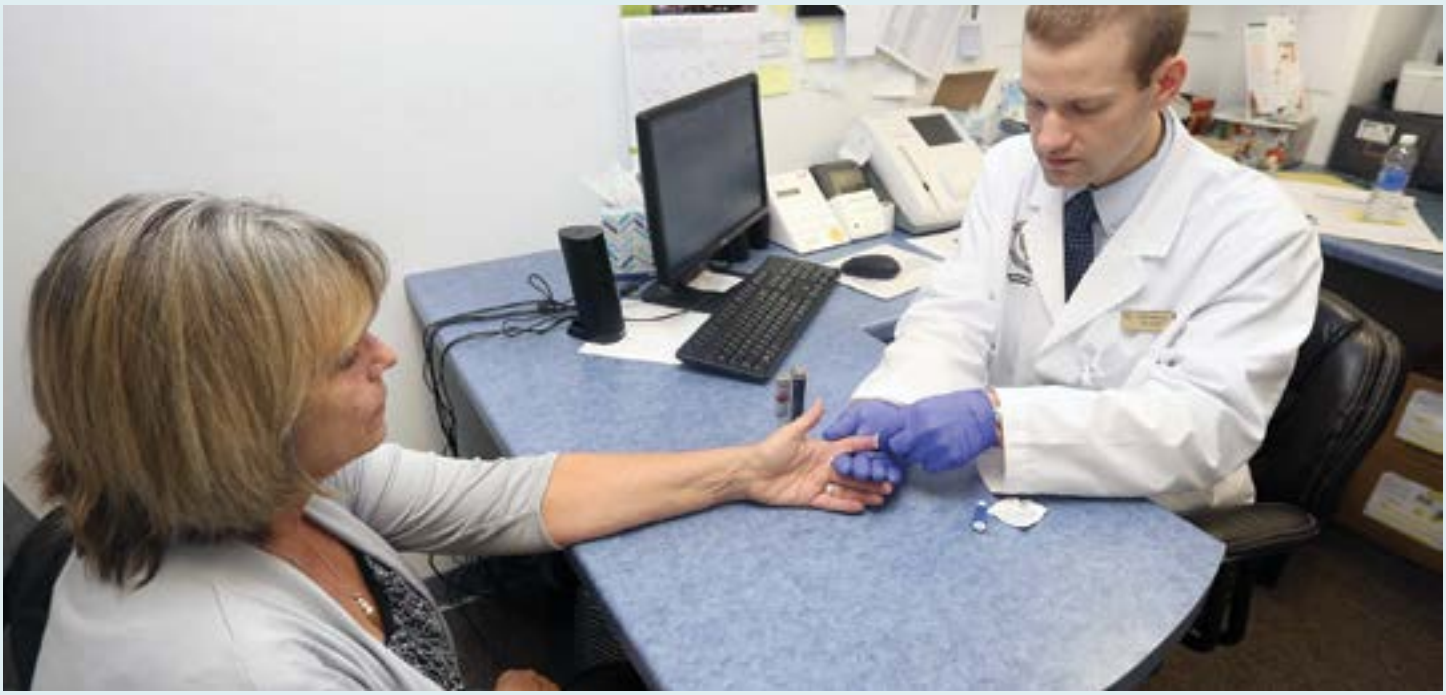
The journey to provider status in Washington State was long, but has achieved notable success. In 2015, the state passed law S.B. 5557, which requires commercial health plans to recognize and pay pharmacists as patient care providers within their participating provider networks as of January 1, 2016 for health systems and January 1, 2017 for community pharmacists. Pharmacists will be compensated for patient care through contracts with insurance plans in the same manner as other care providers. Several pharmacy stakeholders—including the Washington State Pharmacy Association (WSPA), the University of Washington School of Pharmacy, and the Washington State University (WSU) College of Pharmacy—worked collaboratively with medical and hospital associations as well as other stakeholders to support passage of the law, and they are now working to support implementation.[8]

Julie Akers, PharmD, BCACP, Clinical Assistant Professor at WSU, explains that the law closed previous loopholes that allowed insurance companies to exclude pharmacists from their networks. The law clarified that the state's Every Category of Health Care Providers law applies to pharmacists. The law does not require insurance plans to include all pharmacists in its networks, and it does not require coverage for all services provided by pharmacists. Covered services must be within the pharmacist's scope of practice.[14]

The new law did not make any changes to pharmacists' scope of practice, nor does it change requirements for pharmacists to have collaborative practice agreements to initiate or modify prescriptions, notes Dr. Akers. However, the state's pharmacy practice act does allow pharmacists to order and interpret laboratory tests. In addition, the WSPA has developed template forms to support collaborative practice agreements for many different conditions and makes these forms available for others to adapt to their needs.

Dr. Akers described efforts to prepare pharmacists to deliver on the promise of improved access to care under S.B. 5557. These efforts include the development of an online certificate program through the WSPA as well as an 8-hour live training program developed by Dr. Akers and colleagues. This program focuses on patient care screenings and provides a refresher for pharmacists to perform services that will be covered under the new law. This live training is part of a required course for pharmacy students at WSU College of Pharmacy and is facilitated through a grant Dr. Akers received that focuses on patient care service delivery by community pharmacists.

Many health systems utilized pharmacists in various ways prior to the passage



of the law, especially to support the management of chronic conditions such as diabetes and dyslipidemia (although, until now, payment issues have been a barrier to optimizing the use of pharmacists), explains Dr. Akers. The law will expand opportunities for pharmacists to provide patient care services, both in health systems and in community pharmacy settings as payment restrictions are lifted and will provide increased access to services for many acute conditions. Dr. Akers noted that, for example, some community pharmacists perform tests to assess for strep throat or urinary tract infections, and they will be able to examine patients with an otoscope for outer ear infections. Pharmacists then prescribe appropriate therapy through collaborative practice agreements. The new law allows pharmacists to apply to be allowed to bill a patient's medical insurance for this care (instead of requiring the patient to pay out of pocket).

The law calls for a staged implementation. Health care facilities that have internal or delegated credentialing processes already in place may start submitting pharmacists' credentials for privileging in January 2016. The law also calls for an advisory committee to determine credentialing, privileging, billing, and payment processes for community clinics and pharmacies starting in 2017. (Similar to other providers, pharmacists must go through credentialing and privileging processes to be reimbursed.) The advisory committee will provide guidance to employers regarding credentialing and privileging.

Pharmacists will need training to meet documentation requirements for care providers. These documentation requirements may differ from those that pharmacists are currently expected to complete and may include elements such as vital signs and care plans. Some pharmacy systems already have functionality for pharmacists to incorporate this type of information, but others require ongoing development. In addition, pharmacists, particularly in community settings, may face challenges accessing the information they need to provide optimal patient care, and they may need to gather information across multiple portals to obtain a complete set of medical records for each patient.

Developing fully integrated HIT systems to support pharmacists and allow for exchange of information across various platforms as pharmacists embrace new roles and adapt to new documentation requirements will be an ongoing challenge. Washington State has a health information exchange, called One Health Port, which is a portal for connecting providers to various different medical record systems. One Health Port performs many different functions, including allowing health care professionals to access the portals of major local health plans and hospitals, providing a statewide health information exchange for health care organizations, streamlining coordination among providers and payers, including development of policies and best practices to support administrative simplification, and addressing statewide credentialing for health plans and hospitals. However, community pharmacies may face challenges with the functions of this system.

Despite the challenges of implementation, this law represents a significant step forward in allowing pharmacists' knowledge and skills to be fully utilized, explains Dr. Akers. The impact of community patient care services provided by community pharmacists on the cost and quality of care is being examined through an ongoing research project, with results expected in a few years.

Services Provided in Integrated Care Models

In 2015, it is estimated that 46% of community setting respondents and 67% of IHO setting respondents were participating in an integrated care model. The most common type of integrated care model in both 2014 and 2015 was a medical home model.

Pharmacists who reported that they participated in at least one type of integrated care model also were asked about what services pharmacists provide within the integrated care model. Table 15 summarizes findings for this question.

It is noteworthy that immunization services were relatively infrequent in integrated care models. This is in contrast with data finding that 90% of all respondents in community settings provided immunizations. (Data not shown.)

TABLE 15. TYPES OF SERVICES PROVIDED BY PHARMACISTS AS PART OF AN INTEGRATED CARE MODEL

	Community Setting	IHO Setting
Patient education	51%	69%
Medication management services	47%	73%
Immunizations	44%	28%
Drug information	41%	61%
Medication adherence services	40%	45%
Chronic disease management	29%	58%
Health screenings	22%	13%
Prescriber education	21%	44%
Care transitions services including medication reconciliation	15%	53%
Prevention and wellness services	15%	22%
Formulary management	13%	34%
Other	1%	1%

Community setting respondents and IHO setting respondents who reported that they participated in at least one type of integrated care model also were asked about how pharmacists are compensated for the services provided in the integrated care models. Pharmacists in IHO settings were most likely to be compensated through salary, whereas fee-for-service was the most commonly reported compensation method for those in community settings. Table 16 summarizes findings for this question.

TABLE 16. HOW PHARMACISTS ARE COMPENSATED FOR PHARMACIST-PROVIDED PATIENT CARE SERVICES IN INTEGRATED CARE MODELS

	Community Setting	IHO Setting
Fee for service	25%	12%
Salaried	22%	50%
Contracted service	9%	10%
Pay for performance	7%	4%
Capitated	1%	3%
Other	7%	13%

Other (Community) included: grant, hourly, not getting paid, study funding, vendor program. Other (IHO) included: bundle payment, cofunded by academic institution, federal facility, integrated into the total, not paid, part of physician visit, polypharmacy education endowment, strategic support from medical center, supported by dispensing revenue, university, VA.
VA = Veterans Affairs.

Conclusions

Overall, findings from the 2014 and 2015 environmental scans on the provision of patient care services by pharmacists were remarkably similar. In the surveys from both years, respondents reported that:

1. There is a continued expansion of pharmacist-provided patient care.
2. Confidence in pharmacists as care providers continues to grow.
3. Pharmacists are reducing gaps in care and improving performance for health plans.
4. Work systems and processes are being aligned with desired outcomes of care.

Findings from the 2015 survey also affirmed a need to address financial and regulatory challenges facing pharmacists. These include the need to update and contemporize pharmacy practice acts and other statutes to facilitate pharmacists' new roles.

Perhaps more importantly, sources of revenue must be developed and expanded to support access to these services and fully realize their value for the health care system.

Other challenges that need to be addressed include infrastructure and process issues, including the need to formalize pharmacist-to-pharmacist referrals so that pharmacists working in different systems have access to complete information and can collaborate, and the need to expand access to EHRs so that pharmacist practitioners have complete information and can share their contributions in the EHR.

While most of the findings from the 2015 survey were similar to those from the 2014 survey, data from the 2015 survey indicated that pharmacists are expanding capacity for improving quality metrics in response to pay-for-performance incentive structures and value-based payment systems. Expansion plans include activities such as adding pharmacists and technicians, and investing in training. The data revealed that payers are increasingly requiring pharmacists to have specific credentials or training to provide patient care services in some settings. Specifically, there were increases in the percentages of IHO setting pharmacists who reported that payers required a PharmD, Pharmacy Board specialty certification, or residency training. It also appears that credentialing and privileging of pharmacists who practice within increasingly complex and sophisticated health care systems are being used to meet the scope of care in particular settings and to grant pharmacists authorization to render specific services.

Ongoing developments that enhance payment opportunities and further support the infrastructure for pharmacists' provision of patient care services will be essential for optimizing the value of pharmacists in the health care system.

References

1. Isetts BJ, Schondelmeyer SW, Artz MB, et al. Clinical and economic outcomes of medication therapy management services: the Minnesota experience. *J Am Pharm Assoc.* 2008;48:203–11.
2. Walgreens Study Shows Pharmacy Interventions Significantly Reduce Health Care Costs and Improve Outcomes [press release]. November 2, 2015. *Business Wire*. Available at: http://www.businesswire.com/news/home/20151102005173/en/. Accessed January 29, 2016.
3. Centers for Medicare and Medicaid Services. Better Care. Smarter Spending. Healthier People: Paying Providers for Value, Not Volume. January 26, 2015. Available at: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheet items/2015-01-26-3.html. Accessed January 20, 2016.
4. Patient Access to Pharmacists' Care Coalition. Available at: http://pharmacistscare.org. Accessed January 29, 2016.
5. Collins S. What to know about Part D for 2016. *Pharmacy Today*. October 2015. Available at: https://www.pharmacist.com/what-know-about-part-d-2016. Accessed January 29, 2016.
6. Centers for Medicare and Medicaid Services. CMS announces Part D Enhanced Medication Therapy Management Model. September 28, 2015. Available at: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2015-Press-releases-items/2015-09-28.html.
7. National Governor's Association. The expanding role of pharmacists in a transformed health care system. January 2015. Available at: http://www.nga.org/files/live/sites/NGA/files/pdf/2015/1501TheExpandingRoleOfPharmacists.pdf. Accessed January 29, 2016.
8. Bonner L; American Pharmacists Association. Washington state law: pharmacists now providers in private health plans. June 1, 2015. Available at: http://www.pharmacist.com/washington-state-law-pharmacists-now-providers-private-health-plans-0. Accessed December 28, 2015.
9. Joint Commission of Pharmacy Practitioners. Pharmacists' Patient Care Process. May 2014. Available at: http://www.accp.com/docs/positions/misc/JCPP_Pharmacists_Patient_Care_Process.pdf. Accessed January 29, 2016.
10. Burns A, Derr S; American Pharmacists Association. Creating consistent patient care delivery. November 20, 2014. Available at: https://www.pharmacist.com/creating-consistent-patient-care-delivery. Accessed January 29, 2016.
11. Electronic Quality Improvement Platform for Plans & Pharmacies. EQuIPP platform. Available at: https://www.equipp.org. Accessed December 3, 2015.
12. Centers for Medicare and Medicaid Services. Health Care Innovation Awards Round Two. Available at: https://innovation.cms.gov/initiatives/Health-Care-Innovation-Awards/Round-2.html. Accessed January 29, 2016.
13. Pellegrin KL. The Daniel K. Inouye College of Pharmacy Scripts: Pharm2Pharm: Leveraging medication expertise across the continuum of care. *Hawaii J Med Public Health*. 2015;74:248–52.
14. Washington State Pharmacy Association. 2015 legislation: patient care services provided by pharmacists. Frequently asked questions about SB 5557. Available at: https://wsparx.site-ym.com/?PharmProviders. Accessed January 29, 2016.

American Pharmacists Association®

Improving medication use. Advancing patient care.

2215 Constitution Avenue NW, Washington, DC 20037 | **pharmacist.com**