Highly Effective Health Care Teams: Maximizing the Role of the Pharmacist in Medication Therapy Management

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Objectives

- Describe the benefits and limitations of collaborative practice models in various patient care settings.

- Recognize the importance of aligning incentives in a “pay for performance” model that includes all providers.

- Discuss the rationale for collaborative models of care that deliver enhanced patient and economic outcomes.

- Describe the impact of poor adherence on clinical and economic outcomes for patient and stakeholders.

- Describe points within the medication use system in which technology can be employed to enhance patient outcomes.
Scope of the Challenge

- Two of three patients leave doctor’s office/OV with a prescription
- 3.8 billion prescriptions filled in 2012
- 40% of the US population receive four or more prescriptions every year

Baby Boomers:
- 20% this population take > 10 daily medications
- 10,000 per day age > 65

1 out of 3 people **NEVER** fill their prescriptions

Nearly 3 out of 4 Americans do not take their medication as directed

**Medication Non-Adherence Cost $300 Billion/Year**

45% of the population has 1 or more chronic conditions that require medication

More than 1/3 of medication-related hospital admissions are linked to poor adherence
National Medication Adherence Campaign*

“Drugs don’t work in patients who don’t take them!”

C. Everett Koop, Former U.S. Surgeon General

* Lead by the National Consumers Leagues (NCL)
www.nclnet.org/health
The new silent killer....

Unmanaged Medication Use
Why are patients not taking their medications?

- Cost
- Side effects
- Forgetfulness
- Complex regimens
- Stretch/extend dosing days
- Doubts about effectiveness
“Most methods of improving adherence have involved combinations of behavioral interventions and reinforcements in addition to increasing the convenience of care, providing education information about the patient’s condition and the treatment and other forms of supervision or attention ...Given the many factors contributing to poor adherence to medication, a multifactorial approach is required, since a single approach will not be effective for all patients.”

—NEW ENGLAND JOURNAL OF MEDICINE, from “Adherence to Medication” www.nejm.org August 4, 2005
One-third of a primary care physician’s (PCPs) time is spent on activities related to chronic care management, includes managing complex medications regimens.

There are multiple models of care where pharmacists are practicing within the full scope of their education/licensure on healthcare teams where improved patient outcomes have been demonstrated through medication management services.

Pharmacist are well positioned to manage patients’ medication regimens in concert with PCPs as recognized health care providers both at the State and Federal levels as they are well educated & trained to do so.
Patient Safety and Clinical Pharmacy Services Collaborative (PSPC)

- Health Resources and Service Administration, Office Pharmacy Affairs Initiative started in 2008.

- **Aim:** The Patient Safety and Clinical Pharmacy Services Collaborative (PSPC) is committed to saving and enhancing thousands of lives a year by achieving optimal health outcomes and eliminating adverse drug events through increased clinical pharmacy services for the patients we serve.

- Initially focused on Safety-Net Organizations, expanded in 2011-12: Currently 450 teams, in 1,000 organizations.
High-Risk Patients

- In 2013, PSPC faculty using national statistics, estimated that roughly 17% of the United States population is high-risk, about 52 million Americans.
- 18 million or 35% of the high-risk populations have chronic conditions that are persistently not under control.
- 96 PSPC teams indicated that their average high-risk patient has:
  - 5 Chronic Conditions
  - 8 Medications
# Gaps in Chronic Illness

<table>
<thead>
<tr>
<th>Measure</th>
<th>Avoidable Events</th>
<th>Avoidable Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of Beta Blocker after first MI</td>
<td>62,000 heart attacks over 20 years</td>
<td>$18.7 Million</td>
</tr>
<tr>
<td>Lack of Lipid Management</td>
<td>14,600 major coronary events</td>
<td>$87 Million</td>
</tr>
<tr>
<td>Uncontrolled Hypertension</td>
<td>15,900 major cardiovascular events</td>
<td>$463 Million</td>
</tr>
<tr>
<td>Uncontrolled Diabetes HgA1C</td>
<td>14,000 strokes, MI</td>
<td>$563 Million</td>
</tr>
<tr>
<td>Inappropriate drug use in Elderly</td>
<td>&gt;40% of serious life-threatening ADEs</td>
<td>$7.6 Billion</td>
</tr>
</tbody>
</table>

18 Million People in High Risk Population

Estimated PSPC Cost per Patient per Year $1,000

Estimated Investment PSPC Delivery System $18 Billion

MN Study Financial Benefits of Medication Therapy Management: $1 MTM = $12 HC Savings

Estimated Reduction in Health Care Spending

$18 Billion x $12 = $216 Billion

The Inter-Professional (IP) Care Team

PSPC Patient-Centered Inter-Professional Team Approach

- IT – 23%
- Clerical/Scheduler – 22%
- Medical Records – 19%
- Financial – 18%
- Executive Leaders – 11%

Administrative Support:
- Pharmacists – 92%
- Physicians – 74%
- Nurses – 67%
- Medical Aide – 33%
- Social Workers – 32%
- Nurse Practitioner – 28%
- Dietician – 22%
- Comm. Health Worker – 21%

Core Clinical

Patient

http://www.medsmatter.org/
Alliance for Integrated Medication Management (AIMM)

- The Alliance for Integrated Medication Management (AIMM) is a nonprofit organization working to expand, extend and accelerate the work of the Patient Safety and Clinical Pharmacy Services Collaborative (PSPC).
  http://www.medsmatter.org

- Founding organizations include: American Association of Colleges of Pharmacy, American Nurses Association, American Pharmacists Association, American Society of Health-System Pharmacists and Apexus (340B/Vendor).

- Formerly known as the Patient Safety and Clinical Pharmacy Services Alliance.
AIMM to Improve Health Care

2011 National Performance Report summarizes 55 PSPC Collaborative teams. After six to 12 months:

- Diabetes patients who had A1c levels “out of control,” 35% achieved desired levels;
- Hypertension, 43% achieved desired blood pressure levels;
- Dyslipidemia and persistently high cholesterol levels, 37% achieved desired levels; and
- Anticoagulation medications who had International Normalized Ratio (INR) levels consistently out of control, 51% achieved INR levels in the safe range.

Once a diagnosis is made, pharmacists manage disease and provide patient care.
Patient-Centered Primary Care Collaborative (PCPCC)

Founded in 2006, the Patient-Centered Primary Care Collaborative (PCPCC) is dedicated to advancing an effective and efficient health system built on a strong foundation of primary care and the patient-centered medical home (PCMH).

- **Disseminate results and outcomes** from medical home initiatives and clearly communicate their impact on patient experience, quality of care, population health and health care costs.

- **Advocate for public policy** that advances and builds support for primary care and the medical home, including payment reform, patient engagement, and employer benefit initiatives.

- **Convene health care experts, thought leaders, and consumers** to promote learning, awareness, and innovation of the medical home model.

http://www.pcpcc.org/
http://www.pcpcc.org/guide/patient-health-through-medication-management
Pharmacist-Based Interventions

- Initiatives like the “Asheville Project,” the longest-running test using pharmacist interventions to improve patient adherence and improve health outcomes self-insured population.
  - 295 HTN/dyslipidemic patients
  - 275 diabetic patients
  - 148 asthma patients

- **Diabetes Ten City Challenge** modeled after Asheville.

- **Project IMPACT: Diabetes**
Total Healthcare Costs by Length in Program

Sick Days

Prior to Program
AVERAGE SICK DAYS/YEAR
PRIOR TO PROGRAM & EACH YEAR FOR 
5 YEARS OF PROGRAM

Take Away Points Asheville Project

- Patients maintained meaningful clinical improvements (HA1c, LDL, HDL,
- Patient behavioral changes (sick days declined).
- Increased use of pharmaceutical claims:
  - Rxs for Diabetes $488 to $1702 PPPY
  - Rxs for Other Diagnoses $666 to $1393 PPPY
- REDUCED Insurance claims for direct medical costs: $6096 to $1584 PPPY

In light of the co-morbidities associated with diabetes, physicians felt that not only should the diabetes drugs be monitored/managed, but that the pharmacist also should manage drugs used to treat hypertension and hyperlipidemia.
Pharmacist-Based Interventions

• Collaborative drug therapy management (CDTM) like the **Minnesota Medicaid** through which pharmacists and physicians voluntarily enter into agreements to jointly manage a patient’s drug therapy.

• 40 states have laws that allow CDTM and others are developing or reviewing proposed legislation to enable CDTM for improved disease and drug therapy management.
Comprehensive Medication Therapy Management Services

- Sample: 22,694 Minnesota Medicaid patients who received comprehensive medication therapy management services: April 1, 2006 to September 1, 2010

- Majority of the practices were clinic-based and the service was provided in close proximity by 263 pharmacists

- 85% of the sample had one or more DTPs, 45% had three or more & 27% had five or more drug therapy problems identified and resolved during the study period

- These 22,695 patients experienced 88,556 drug therapy problems in the two years studied.
# Drug Therapy Problems

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th># OF PROBLEMS</th>
<th>% OF TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unnecessary drug therapy</td>
<td>4,544</td>
<td>(5%)</td>
</tr>
<tr>
<td>Needs additional drug therapy</td>
<td>29,794</td>
<td>(34%)</td>
</tr>
<tr>
<td>Ineffective – different drug needed</td>
<td>6,834</td>
<td>(8%)</td>
</tr>
<tr>
<td>Dosage too low</td>
<td>20,602</td>
<td>(23%)</td>
</tr>
<tr>
<td>Adverse drug reaction</td>
<td>9,528</td>
<td>(11%)</td>
</tr>
<tr>
<td>Dosage too high</td>
<td>4,854</td>
<td>(5%)</td>
</tr>
<tr>
<td>Non-Adherence / Noncompliance</td>
<td>12,400</td>
<td>(14%)</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>88,556</strong></td>
<td><strong>(100%)</strong></td>
</tr>
</tbody>
</table>
# Medical Conditions

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>% of Patients with the Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypertension</td>
<td>51%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>50%</td>
</tr>
<tr>
<td>Hyperlipidemia</td>
<td>44%</td>
</tr>
<tr>
<td>Gastroesophageal Reflux Disease (GERD)</td>
<td>25%</td>
</tr>
<tr>
<td>Osteoporosis</td>
<td>22%</td>
</tr>
<tr>
<td>Depression</td>
<td>20%</td>
</tr>
<tr>
<td>Prevention of Stroke or MI</td>
<td>20%</td>
</tr>
<tr>
<td>Pain-generalized</td>
<td>18%</td>
</tr>
<tr>
<td>Allergic rhinitis</td>
<td>15%</td>
</tr>
<tr>
<td>Insomnia</td>
<td>14%</td>
</tr>
</tbody>
</table>
Causes of Non-Adherence Drug Therapy Problems

<table>
<thead>
<tr>
<th>Cause</th>
<th># of Problems</th>
<th>% of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does not understand the directions</td>
<td>3,384</td>
<td>(27%)</td>
</tr>
<tr>
<td>Cannot afford the drug product</td>
<td>3,267</td>
<td>(26%)</td>
</tr>
<tr>
<td>Patient prefers not to take</td>
<td>2,334</td>
<td>(19%)</td>
</tr>
<tr>
<td>Patient forgets to take</td>
<td>1,736</td>
<td>(14%)</td>
</tr>
<tr>
<td>Drug product is not available</td>
<td>1,326</td>
<td>(11%)</td>
</tr>
<tr>
<td>Patient cannot swallow/administer drug</td>
<td>3,535</td>
<td>(3%)</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>12,400</strong></td>
<td><strong>(100%)</strong></td>
</tr>
</tbody>
</table>
### Medications Involved in Non-Adherent Behavior

<table>
<thead>
<tr>
<th>Rank</th>
<th>Medication</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Simvastatin (Zocor®)</td>
</tr>
<tr>
<td>2</td>
<td>Metformin HCl (Glucophage®)</td>
</tr>
<tr>
<td>3</td>
<td>Atorvastatin calcium (Lipitor®)</td>
</tr>
<tr>
<td>4</td>
<td>Insulin-variouls</td>
</tr>
<tr>
<td>5</td>
<td>Fluticasone and salmeterol (Advair®)</td>
</tr>
<tr>
<td>6</td>
<td>Lisinopril (Prinivil®; Zestril®)</td>
</tr>
<tr>
<td>7</td>
<td>Albuterol – inhalers (Proventil®; Ventolin®; ProAir®)</td>
</tr>
<tr>
<td>8</td>
<td>Exenatide (Byetta®)</td>
</tr>
<tr>
<td>9</td>
<td>Levothyroxine sodium (Synthroid®)</td>
</tr>
<tr>
<td>10</td>
<td>Rosuvastatin calcium (Crestor®)</td>
</tr>
</tbody>
</table>
### Collaboration with Patient: Interventions to Resolve Non-Adherence Problems

<table>
<thead>
<tr>
<th>Intervention</th>
<th># of Events</th>
<th>% of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient education to clarify instructions and remove barriers</td>
<td>17,371</td>
<td>(64%)</td>
</tr>
<tr>
<td>Changed dosage</td>
<td>2,318</td>
<td>(9%)</td>
</tr>
<tr>
<td>Changed product</td>
<td>1,832</td>
<td>(7%)</td>
</tr>
<tr>
<td>Discontinued drug therapy</td>
<td>1,662</td>
<td>(6%)</td>
</tr>
<tr>
<td>Initiated monitoring plan</td>
<td>1,462</td>
<td>(5%)</td>
</tr>
<tr>
<td>Reinitiated drug therapy</td>
<td>1,198</td>
<td>(4%)</td>
</tr>
<tr>
<td>Provided patient with a reminder device</td>
<td>951</td>
<td>(4%)</td>
</tr>
<tr>
<td>Not resolvable</td>
<td>265</td>
<td>(1%)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>27,059</strong></td>
<td><strong>(100%)</strong></td>
</tr>
</tbody>
</table>
Thrifty White Med Sync Program

- 87 pharmacy chain based in Midwest (Minnesota)

- Enrolled 30,000 Thrifty-White Patients with: hypertension, diabetes, or high cholesterol in a 12-month Synchronized Refill program for one year (August 2012-2013)

- 30-day refills for opt-in patients with any conditions, monthly pharmacist consult (note 90-day fill allowed but reduce consults)

- Monthly pharmacist-based appointments, including up to 60 minute comprehensive medication reviews (CMRs) conducted 1-2 times/yr.

- Each of the 87 pharmacies has a private counseling room that connects to the chains telepharmacy patient care center
Thrifty White Med Sync Results

- Largest number of enrollees is between ages 40-55 years

- Patients enrolled in a synchronized refill program were on medication therapy **341 days** out of that 12-month period compared with **235 days** of medication coverage averaged by the control group

- **3.5 Additional Medication Refills** (100 days more of therapy) over the control group

- Proportion of days covered (PDC) in three key disease states >> CMS Star Goals (irrespective of health plan) in Med Sync patients

- As **PDC increased**, the total health care costs decreased
Proportion of Days Covered - CMS Star

Medication synchronization impact on patient adherence

<table>
<thead>
<tr>
<th>Condition</th>
<th>Med sync (n)</th>
<th>Control</th>
<th>5-Star Goal*</th>
<th>4-Star Goal*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypertension</td>
<td>84.6%</td>
<td>61.0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td>86.0%</td>
<td></td>
<td>62.0%</td>
<td></td>
</tr>
<tr>
<td>Cholesterol</td>
<td>84.0%</td>
<td></td>
<td>62.0%</td>
<td></td>
</tr>
</tbody>
</table>

* The Centers for Medicare and Medicaid Services’ 4- and 5-star goals for adherence are shown as a reference point.

Proportion day Covered - Health Plan

Medication synchronization impact on proportion of days covered, by health plan level

<table>
<thead>
<tr>
<th></th>
<th>Hypertension</th>
<th>Diabetes</th>
<th>Cholesterol</th>
</tr>
</thead>
<tbody>
<tr>
<td>Med sync</td>
<td>86%</td>
<td>83%</td>
<td>81%</td>
</tr>
<tr>
<td>Health plan A</td>
<td>87%</td>
<td>83%</td>
<td>82%</td>
</tr>
<tr>
<td>Health plan B</td>
<td>83%</td>
<td>81%</td>
<td>85%</td>
</tr>
<tr>
<td>Health plan C</td>
<td>86%</td>
<td>83%</td>
<td>83%</td>
</tr>
<tr>
<td>5-Star Goal*</td>
<td>60%</td>
<td>60%</td>
<td>60%</td>
</tr>
<tr>
<td>4-Star Goal*</td>
<td>51%</td>
<td>59%</td>
<td>60%</td>
</tr>
</tbody>
</table>

Med Sync Impact on Healthcare Costs

Medication synchronization impact on medical costs

Hypertension (n=7,981)
- 1-19%: $31, $4,847
- 20-39%: $89, $5,973
- 40-59%: $134, $5,113
- 60-79%: $285, $4,977
- 80-100%: $489, $4,483

Diabetes (n=3,260)
- 1-19%: $55, $8,812
- 20-39%: $165, $6,959
- 40-59%: $205, $6,237
- 60-79%: $404, $5,887
- 80-100%: $763, $3,808

Cholesterol (n=2,981)
- 1-19%: $78, $6,810
- 20-39%: $213, $4,786
- 40-59%: $373, $3,452
- 60-79%: $373, $3,452
- 80-100%: $801, $3,124

Proportion of days covered (PDC)

Average Days on Therapy - Disease

Medication synchronization impact on average days on therapy, by disease state

Cardiovascular: Med sync (340.9) vs Control (242.5)
Diabetes: Med sync (345.0) vs Control (253.9)
Hyperlipidemia: Med sync (345.0) vs Control (252.9)
Hypertension: Med sync (348.1) vs Control (249.5)
Mental Health: Med sync (341.4) vs Control (219.7)
Respiratory: Med sync (304.3) vs Control (193.8)
Ulcer: Med sync (319.2) vs Control (210.7)
Other: Med sync (332.7) vs Control (227.8)

1,300 patients enrolled in medication synchronization programs at 10 independent community pharmacies across the country

Average enrolled patient was taking 5.9 synchronized medications

Patients enrolled in a medication synchronization program received an average of 3.4 more refills per prescription over a 12-months;

Participating pharmacies filled 20 more prescriptions per patient per year, on average, for these patients

First-fill abandonment was reduced more than 90% for patients enrolled in the synchronization program.

90% of patients on synchronized refills were considered adherent; as compared with 56% of patients not receiving synchronized refills
Impact of Medication Synchronization on Adherence (Measured as PDC) by Therapy

- Cardiovascular: 92.4%
- Diabetes: 88.6%
- Hyperlipidemia: 89.1%
- Hypertension: 89.9%
- Mental Health: 89.8%
- Other: 88.6%
- Respiratory: 81.3%
- Ulcer: 88.1%

Proportion of Patient Prescriptions that are Adherent (PDC>80%)

- Synchronized
- Non-Synchronized
Ontario Drug Benefit Expansion - MedsCheck

- Annual appointments to review medications to ensure their safe and effective use.
  - Maintain accurate medication history
  - “Right medication, right dose, right time”

- 1:1 consultations with patients chronic diseases:
  - Diabetes, asthma, HTN (use of monitoring devices)
  - Long-term home residents, and those having difficulty traveling to a pharmacy.

- Consultations with prescribers about:
  - ADRs’, duplicative therapies, dosage adjustment

Ontario Drug Benefit - MedsCheck

Objectives (effective April 1, 2011):

1. Promote healthier patient outcomes
2. Improve and optimize drug therapy
3. Ensure benefits are used appropriately
4. Reduce inappropriate drug use and drug wastage

- Reimbursement to a community pharmacy for a pharmaceutical opinion is $15 per prescription.
- Pharmacist must document and make a recommendation to prescriber regarding medication.
- Payment is claimed through the Ontario Drug Benefit (ODB) Health Network System (HNS).
Reasons for a clinical intervention:

1. Therapeutic Duplication; drug may not be necessary
2. Requires drug; patient needs additional drug therapy
3. Sub-optimal response to a drug; drug is not working as intended
4. Dosage too low
5. Adverse drug reaction; possibly related to an allergy or a conflict with another medication or food
6. Dangerously high dose; patient may, either accidentally or on purpose, be taking too much of the medication
7. Non-compliance; patient is refusing to take the drug, or not taking it properly
Ontario Drug Benefit - MedsCheck

Conducting a pharmaceutical opinion:

- Occurs in an accredited community pharmacy as a result of receiving a new or repeat prescription request from the patient;
- Pharmacist identifies the issue and/or potential drug related problem;
- Pharmacist contacts the prescriber regarding the issue and makes a recommendation;
- Pharmacist documents outcome of clinical intervention / pharmaceutical opinion;
- Pharmacist communicates with patient regarding the drug therapy issue and outcome.
A claim for payment is made after the prescription intervention has occurred, the patient has been informed, the prescriber has been contacted and documentation is completed and signed by the pharmacist.

<table>
<thead>
<tr>
<th>PIN:</th>
<th>NAME FOR PIN</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>93899991</td>
<td>Forgery confirmed Not Filled</td>
<td>Prescription not filled as prescribed due to a clinical issue or confirmed as a falsified Prescription.</td>
</tr>
<tr>
<td>93899992</td>
<td>No Change to Rx</td>
<td>Pharmacist's recommendation made to prescriber resulting in no change to the prescription; filled as originally prescribed.</td>
</tr>
<tr>
<td>93899993</td>
<td>Change to Rx</td>
<td>Pharmacist's recommendation made to prescriber resulting in a change to the prescription which was subsequently filled</td>
</tr>
</tbody>
</table>

✓ All claim documentation must be cross-referenced to the prescription and include the reason for the pharmaceutical opinion.
✓ All claims will be monitored by the ministry and any claims submitted for non-ODB recipients will be automatically recovered from a future ODB payment.
Pharmacists Trained To Vaccinate

Location, Location, Location
In 2010, 18.4 percent of adults received their vaccine in a pharmacy, 39.8% doctor’s office, 17.4% workplace. MMWR-CDC 2011

Demographics
Patients 65 years and older were more likely than younger patients to receive influenza in a supermarket/pharmacy. NPR 2011

Influenza vaccination #
Number of doses administered in supermarkets and pharmacies increased from 6 million in 2006–07 to 17 million in 2010–11. MMWR-CDC 2011

What is next?
**Consumer Interest in Services Offered at the Community Pharmacy**

<table>
<thead>
<tr>
<th>Service</th>
<th>Offered</th>
<th>Preferred</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immunizations</td>
<td>53%</td>
<td>35%</td>
</tr>
<tr>
<td>Blood Glucose</td>
<td>57%</td>
<td>50%</td>
</tr>
<tr>
<td>Blood Cholesterol</td>
<td>63%</td>
<td>51%</td>
</tr>
<tr>
<td>Private Consults</td>
<td>62%</td>
<td>40%</td>
</tr>
<tr>
<td>Group Education</td>
<td>69%</td>
<td>60%</td>
</tr>
</tbody>
</table>

n=158

Center for the Advancement of Pharmacy Practice (CAPP), presented at NACDS, Aug 1999 - unpublished data, MacKinnon GE, Moffett JM, et al.
Convenient Care Clinics

- The complimentary monitoring service administered by a nurse practitioner or physician assistant includes:
  - Hemoglobin A1c and blood glucose test
  - Blood pressure check
  - Body mass index (BMI)
  - Cholesterol test
  - Comprehensive foot exam
  - Microalbumin test (kidney function check)

- The practitioner will also conduct a review of lifestyle factors and give immediate results and recommendations. With patient permission, [we] will share a copy of the visit record with the patient's primary care provider.

*Today’s PharmD graduates are prepared to do these functions*
Pharmacist recognition as providers in the United States

Source: National Alliance of State Pharmacy Associations. Data are current as of January 2014.

* Payment includes Medicaid, state employee benefits, and network contracts with private payers beyond Medicare Part D, immunizations, and contracts between a single payer and a single provider, incident-to billing, and facility fee billing.
National Alliance of State Pharmacy Associations (NASPA).

- 34 states recognized pharmacists as providers or practitioners,
- Majority States do so through state statute, but a handful also recognize pharmacists within their state Medicaid provider manuals but not within state law.
- 28 states, pharmacists’ patient care services (other than immunization administration) are covered.
  - In 15 states pharmacists can be paid for services by their Medicaid program for at least one specified service, and 6 states with a state employee MTM benefit.
  - Connection between payment and a state’s designation of pharmacists as providers likely due to pharmacists not being federally recognized (SS Act) as providers.
California Pharmacist Provider Status Law effective January 1

Declares pharmacists as health care providers who have the authority to provide health care services. Authorizes all licensed pharmacists to:

- Administer drugs and biologics when ordered by a prescriber. Previously, this was limited to oral and topical administration. SB 493 allows pharmacists to administer drugs via other methods, including by injection.

- Provide consultation, training, and education about drug therapy, disease management, and disease prevention.

- Participate in multidisciplinary review of patient progress, including appropriate access to medical records.
Continued...

- Furnish travel medications recommended by CDC not requiring a diagnosis.

- Independently initiate and administer immunizations to patients 3 years of age and older if certain training, certification, recordkeeping, and reporting requirements are met. If a pharmacist wants to provide immunizations to children younger than 3 years, the pharmacist must have a physician protocol.

- Order and interpret tests for the purpose of monitoring and managing the efficacy and toxicity of drug therapies, in coordination with the patient’s primary care provider or diagnosing prescriber.
Provisions requiring regulations that may be finalized after 2014

Establishes an Advanced Practice Pharmacist (APP) recognition, and authorizes APPs to:

- Perform patient assessments.
- Order and interpret drug therapy–related tests in coordination with the patient’s primary care provider or diagnosing prescriber.
- Refer patients to other health care providers (HCPs).
- Initiate, adjust, and discontinue drug therapy pursuant to an order by a patient’s treating prescriber and in accordance with established protocols.
- Participate in the evaluation and management of diseases and health conditions in collaboration with other HCPs.
Provisions requiring regulations that may be finalized after 2014

Requires pharmacists seeking recognition as APPs to complete any 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 1 year under a collaborative practice agreement or protocol with a physician, APP pharmacist, CDTM pharmacist, or health system.
March 11, 2014, HR 4190 was introduced in the US House of Representatives to recognize pharmacists as providers under Medicare Part B by amending Title XVIII of the Social Security Act.

Introduced by Representatives Brett Guthrie (R-KY), G.K. Butterfield (D-NC), and Todd Young (R-IN), will enable patient access to, and reimbursement for, Medicare Part B services by state-licensed pharmacists in medically underserved communities.

Get ready to send letters, emails and phone calls to your legislators!
Roosevelt University pharmacists will be prepared to meet the universal vision of pharmacy practice, whereby pharmacists will be the health care professionals responsible for overall medication management to ensure optimal patient therapy outcomes.