



November 9, 2022

RE: Judith Steinberg, Senior Advisor, Office of the Assistant Secretary of Health, Department of Health and Human Services (HHS): HHS Initiative to Strengthen Primary Health Care

Dear Dr. Steinberg,

The American Pharmacists Association (APhA) appreciated the opportunity to meet with you and your colleagues to discuss the Health and Human Services (HHS) Initiative to Strengthen Primary Health Care and how pharmacists can contribute to improving primary health care. This letter contains the follow-up information requested during the meeting.

APhA is the largest association of pharmacists in the United States advancing the entire pharmacy profession. APhA represents pharmacists in all practice settings, including but not limited to community pharmacies, hospitals, long-term care facilities, specialty pharmacies, community health centers, physician offices, ambulatory clinics, managed care organizations, hospice settings, and government facilities. Our members strive to improve medication use, advance patient care, and enhance public health.

Like other health care professionals, pharmacists have a standard process of care, the [Pharmacists' Patient Care Process](#) (PPCP), which is approved by the Joint Committee of Pharmacy Practitioners and supported by thirteen national pharmacy organizations. This team-based, patient-centered care approach has the foundational elements of collaboration, coordination, and documentation, and is required training for all student pharmacists and pharmacy residents, and an expectation of practicing pharmacists.

APhA and its members are aligned with HHS' "goal state of the practice of primary health care.". We offer the following selected evidence on pharmacists' services that contribute to improved primary care.

Impact of pharmacists on patients receiving primary care services

Pharmacists contribute to primary health care by providing a variety of health and wellness, medication management, and acute and chronic care management services. Pharmacists also increase access to care, especially in underserved areas. There is significant opportunity for enhanced utilization of pharmacists in primary health care to address unmet care needs and improve patient health outcomes and experiences. Per your request, we are submitting the following information that highlights selected examples of evidence for pharmacists' contributions to primary health care. We would also welcome the opportunity to connect you with pharmacists in various practice settings to discuss how they are addressing primary care needs in their communities.

- **Primary Care:** “Optimizing the primary care clinical pharmacy specialist: Increasing patient access and quality of care within the Veterans Health Administration”

The Department of Veterans Affairs (VA) has integrated more than 1,850 Clinical Pharmacy Specialists (CPS) providers into their patient-centered medical home (PCMH) model for comprehensive medication management (CMM). VA has demonstrated that 27% of primary care return appointments could be averted by integrating a CPS, thus increasing access to care. Multiple VA studies show improvement in quality of care: significant reduction in median A1c values to 7.7% from an A1c baseline of 10%, significant reductions in median systolic blood pressure and diastolic blood pressure from a baseline of 142/83 to 134/79.

<https://accpjournals.onlinelibrary.wiley.com/doi/abs/10.1002/jac5.1177>

- **Medication Optimization:** “Primary Care Clinical Pharmacy Specialist Practice” (*Appendix A*)

The Department of Veterans Affairs uses a team-based care model in primary care that incorporates the clinical pharmacist providing CMM services. As of 2020, there are 4,566 CPPs functioning as advanced practice providers system-wide with 2,171 providing direct patient care. The impact of pharmacist services showed achievements in the quadruple aim outcomes.

- **Patient Experience:** “Evaluation of Patient Experience with Veterans Affairs Clinical Pharmacists Practitioners (CPP) Providing Comprehensive Medication Management”

As patient experience is playing a larger role in assessing high quality health care, the VA’s CPP providers received a rating of 4 or 5 on a scale of 1 to 5 for CMM services in its first year. This high rating was demonstrated with scores ranging from the low to high 90th percentile across all patient experience domains.

<https://journals.sagepub.com/doi/abs/10.1177/08971900221117892>

Case examples of pharmacists working in team-based care models

As our health care system transitions from the Fee for Service (FFS) model to Value-Based Payment (VBP) models, patient-centered medical homes (PCMH) and accountable care organizations (ACO) are two common forms of VBP that offer numerous opportunities for pharmacist involvement. Many pharmacists across the country are part of innovative practices within these models. Pharmacists often work in population health management, direct patient care services, or both. The peer-reviewed APhA resource, *Successful Integration of Pharmacists in Accountable Care Organizations and Medical Home Models: Case Studies*, contains ten in-depth examples of pharmacist integration into team-based models in a variety of settings, including pharmacists’ roles, types of services delivered, metrics pharmacists are impacting, and information on the financial models for supporting their work on the team. The ten practices highlighted in this resource are listed below.

https://pharmacist.com/Portals/0/PDFS/Practice/APhA_Medical_Home_ACO_Report_Final.pdf

- *Advocate Medical Group, Chicago, IL*

Health-system PCMH, ACO model with pharmacists performing chronic disease management.

- *Family Health Services of Darke County, Greenville, OH*

Federally Qualified Health Center (FQHC) PCMH model with pharmacists focusing on diabetes, smoking cessation, and medication management.

- *Geisinger Ambulatory Clinical Pharmacy Program, Danville, PA*

FQHC, rural, primary care, specialty care, pharmacy tele-management setting in an ACO, PCMH model with pharmacist services focusing on disease state management.

- *Jefferson Health Population Health Pharmacy Team, Philadelphia, PA*

Health-system Comprehensive Primary Care Plus (CPC+) and Delaware Valley ACO with pharmacist services focusing on comprehensive medication management and targeted medication reviews.

- *Michigan Medicine, Ann Arbor, MI*

Primary care health centers, community pharmacy PCMH with pharmacist services focusing on comprehensive medication management and chronic disease state management.

- *The Ohio State University General Internal Medicine Clinics, Columbus, OH*

Health-system general internal medicine clinics in a network of 6 PCMHs within an ACO with pharmacist services focusing on chronic disease state management (diabetes, hypertension, and smoking cessation), transitional care management, population health management, polypharmacy and deprescribing.

- *Park Nicollet Health Services, Minneapolis, MN*

Integrated delivery network, ACO and PCMH model, with pharmacist services focused on comprehensive medication management.

- *Providence St. Joseph Heritage Healthcare, Fullerton, CA*

Medical group ACO, PCMH model with pharmacist services focusing on chronic disease state management.

- *Think Whole Person Healthcare, Omaha, NE*

Primary care center, community pharmacy ACO model with pharmacist services focused on comprehensive medication management and chronic disease state management.

- *University of Washington Medicine, Seattle, WA*

Health-system ACO, PCMH model with pharmacist services focused on comprehensive medication management and chronic disease state management.

Chronic Condition Management

The impact of pharmacists on outcomes for patients with chronic conditions is demonstrated in numerous studies. Pharmacists are increasingly reaching out into their communities to provide services in locations such as churches, community centers, and salons and barbershops to meet patients where they live, work, and play.

- **Hypertension:** “A Cluster-Randomized Trial of Blood Pressure Reduction in Black Barbershops”

This cluster-randomized trial in 52 Black-owned barbershops found that uncontrolled hypertension among non-Hispanic Black men can be significantly reduced when coupling medication management by specialty-trained pharmacists with health promotion by barbers. At baseline, the mean systolic blood pressure (SBP) was >152 mmHg, and six months post-intervention the mean SBP fell by 27 mmHg. A blood pressure level of less than 130/80 mmHg was achieved in 63.6% of barbershop patrons in the intervention group versus 11.7% in the control group. (<https://www.nejm.org/doi/full/10.1056/NEJMoa1717250>)

- **Hypertension:** “Cluster-randomized trial of a physician/pharmacist collaborative model to improve blood pressure control”

In this large (625 patients), multi-site (32 clinics), prospective (up to 24 months), cluster-randomization trial of collaboration between a physician and a pharmacist to improve short- and long-term blood pressure control, patients treated by pharmacists were more likely to have a meaningful reduction in blood pressure at 9 months and this reduction continued 13 months after the patient’s intervention with the pharmacist stopped. The adjusted difference in mean systolic/diastolic blood pressure between the intervention and control groups for all subjects at 9-months was -6.1/-2.9 mmHg, and it was -6.4/-2.9 mmHg in subjects from racial or ethnic minorities. In addition, BP control and mean BP were significantly improved from minorities in intervention offices at 18 and 24 months ($P = 0.048$ to $P < 0.001$) compared with the control group. (<https://www.ahajournals.org/doi/full/10.1161/CIRCOUTCOMES.114.001283>)

- **Hypertension:** CDC evaluation of Michigan Medicine Hypertension Program

The Michigan Medicine Hypertension Pharmacist’s Program was evaluated by the Centers for Disease Control and Prevention (CDC) and resulted in an implementation guide for public health practitioners to engage pharmacists in hypertension management. This guide has shown improvement in long-term blood pressure control and to decrease racial and socioeconomic disparities. Pharmacists provision of disease state management services for patients with hypertension using the PPCP process has benefited patient outcomes. In

partnership with Meijer, a regional American supercenter chain store and retail pharmacy, the Michigan Medicine Program was able to expand its hypertension services to patients living near community pharmacies. (https://www.cdc.gov/dhdsp/pubs/docs/PCCP_Guide_June2021-508.pdf)
(https://www.cdc.gov/dhdsp/evaluation_resources/guides/pharmacists_patient_care.htm)

- **Mental Health, Substance Use Disorders:** *“Pharmacist medication reviews to improve safety monitoring in primary care patients”*

Pharmacists impacted patient safety in patients prescribed psychotropic agents with known sub-optimal safety monitoring who were exclusively followed by their primary care providers. Over a 1-year project period, pharmacists’ reviews and subsequent accepted recommendations resulted in an 18% improvement in patients being up to date in psychotropic medication safety monitoring as well as a 20% reduction in risk for drug interaction-based adverse events. Notably, the provider survey regarding the service was overall positive, with some feedback that it would be helpful if pharmacists would take a more active role in ordering and completing laboratory monitoring or personally seeing the patients.
(<https://psycnet.apa.org/doiLanding?doi=10.1037%2Fsh0000185>)

- **Mental Health, Substance Use Disorders:** *“Assessing the impact of medication management review service for females diagnosed with depression and anxiety”*

This single-blind, parallel randomized control trial showed medication management review services by pharmacists reduced treatment-related problems (TRPs), including adherence, in females with depression and anxiety. At baseline, the study population (n = 73, mean age 41.8) had 177 total TRPs identified, with 2.42 per patient, and 54.8% reported adherence. At follow-up, a significant decline in the number of TRPs was found in the intervention group versus the control group (0.58 versus 1.13, $P < 0.001$). Adherence was more likely in the intervention group, 88.9% vs 51.4% ($P < 0.001$). In addition, significant improvements in depression ($P < 0.001$) and anxiety ($P = 0.003$) were found in the intervention group.
(<https://onlinelibrary.wiley.com/doi/10.1111/jep.13314>)

- **Diabetes:** *“The Impact of a pharmacist-driven, collaborative practice on diabetes management in an urban underserved population”*

This mixed method assessment of a pharmacist-driven, collaborative practice on patients with Type II diabetes in a federally qualified health center showed significant improvement in A1C < 9%, ACE inhibitor/angiotensin receptor and status use, and tobacco cessation at follow-up. Pharmacists were authorized to optimize medications and order laboratory tests and referrals in a team-based care model. Satisfaction from both providers and patients were also satisfactory. Pharmacists’ services were rated by patients consistently >90% and were rated 9/10 or 10/10 97.4% of the time. Additionally, provider satisfaction was also high at 96% of the overall program. (<https://www.tandfonline.com/doi/abs/10.1080/13561820.2019.1633289>)

- **Cardiovascular Disease:** *“Best Practices Guide for Cardiovascular Disease Prevention Programs”*

The CDC offered this evaluation which showed the integration of pharmacists into team-based care can bring improvements in quality of patient care. Pharmacists can play key roles in reducing the modifiable risk factors for CVD through prevention, management, and treatment. Pharmacists operate in team-based care models, facilitated by collaborative practice agreements, and provide patient self-management and education, medication therapy management, and disease management services to optimize patient care and health outcomes. (<https://www.cdc.gov/dhbsp/pubs/docs/Best-Practices-Guide-508.pdf>)

- **Transitions of care:** *“Effect of Postdismissal Pharmacist Visits for Patients Using High-risk Medications”*

This retrospective study included 502 patients taking at least ten medications, including one high risk medication, who were seen at one of 6 primary care clinics by a pharmacist for 30 minutes prior to seeing their primary care provider post discharge from the hospital. A random cohort of 502 patients who met study inclusion criteria but only saw their primary care provider post discharge served as the comparison group. Pharmacists provided medication management services including medication reconciliation, identification of drug-related problems, and medication adherence services. Patients seen by a pharmacist and clinician post-discharge had a significantly lower 30-day post-discharge readmission rate than the clinician only group. This effect persisted for up to 180 days after hospitalization. ([https://www.mcpiqojournal.org/article/S2542-4548\(17\)30134-0/fulltext](https://www.mcpiqojournal.org/article/S2542-4548(17)30134-0/fulltext)).

Pharmacists’ roles in prevention and wellness

Pharmacists, especially in community pharmacy settings have an active role in providing prevention and wellness services, including assessment and administration of vaccines, conducting point of care testing, including CLIA-waived tests for screening and test to treat services, and prescribing medications to meet public health needs under expanded scopes of practice such as naloxone for opioid overdose reversal and oral contraceptives. Pharmacists also triage and refer patients to primary care providers based on screening and assessment services, when needed.

- **Vaccines, testing, treating:** *“Essential Services: Quantifying the contribution of America’s pharmacists in COVID-19 clinical interventions”*

From February 2020 through September 2022, this review found that pharmacists and their teammates conducted >42 million COVID-19 tests, provided >270 million vaccinations within community pharmacy programs alone, and provided >50 million influenza and other vaccinations per year. Pharmacists accounted for >50% of COVID-19 vaccinations in the United States. Pharmacists prescribed, dispensed, and administered an uncounted number of antibody products and antiviral medications. Using conservative estimates, pandemic interventions by pharmacists and teammates averted >1 million deaths, >8 million hospitalizations, and \$450 billion in health care costs. HHS pandemic-related temporary expanded scope of practice authorities for pharmacists, pharmacy interns, and pharmacy

technicians helped to facilitate pharmacy team abilities to provide these services and contribute to these outcomes.

(<https://www.sciencedirect.com/science/article/pii/S1544319122002795?dgcid=author>.)

- **Screenings and Referrals:** “Comparison of pharmacists’ scoring of fall risk to other fall risk assessments”

This cross-sectional study compared pharmacist measured drug-associated fall risk versus different risk assessment measurements and found no significant difference between the Pharmacist Risk Score (PRS) and other fall risk assessments. Each fall risk assessment was highly correlated ($P < 0.001$) with the number of reported falls and demonstrated that pharmacists’ risk assessment is comparable to other assessments in distinguishing fallers from nonfallers. ([https://www.japha.org/article/S1544-3191\(21\)00467-2/fulltext](https://www.japha.org/article/S1544-3191(21)00467-2/fulltext)) The Centers for Disease Control and Prevention (CDC) has developed the *Steady-Rx Older Adult Falls Prevention Guide for Community Pharmacists* to promote pharmacists’ involvement in screening, assessing and coordinating care with other providers to prevent falls.

(<https://www.cdc.gov/steady/pdf/Steady-Implementation-Plan-508.pdf>)

Importance of payment & health information and technology to pharmacist patient care delivery in primary health care models

Payment: A sufficient financial model for pharmacists’ patient care services is needed across payer types in order to fully realize their expertise and contributions to improved patient health. Currently, pharmacists’ services are not covered for payment in Medicare Part B, and coverage is variable in state Medicaid and commercial health plans. Lack of a financial model to support pharmacists’ work as part of primary care teams is a significant barrier to uptake, despite the desires of many physicians to include pharmacists as part of the team. In the Part B program, pharmacists are considered auxiliary personnel or clinical staff, and some of their services can be billed by physicians and nonphysician practitioner (NPPs), under incident to physician services arrangements. However, CMS policy restricts the use of Evaluation and Management (E/M) CPT codes for auxiliary personnel/clinical staff to CPT code 99211 for incident to arrangements. This code is insufficient to cover pharmacists’ work managing complex medication regimens and chronic conditions. Efforts by CMS to close this gap would greatly enhance pharmacist uptake as part of primary care teams.

Some states have enacted legislation and regulations to cover some pharmacists’ services in state Medicaid programs and commercial health plans (Appendix B). Some commercial health plans are voluntarily opting to cover pharmacists as credentialed providers for some services in their provider networks. This progress is encouraging, but further expansion, directed by guidance from CMS to Medicaid programs, is needed across the states to fully optimize use of pharmacists, and coverage in Medicare Part B continues to be a significant barrier, including in value-based models where fee-for-service payment is a component of the model.

Health information technology: Pharmacists need access to clinical and other relevant data to optimally care for their patients, and the ability to electronically exchange information for care coordination is a foundational need for pharmacists’ service delivery. Pharmacists in embedded

primary care practices usually can access information through the practice's electronic medical record and exchange information via the practice's interoperable electronic health record (EHR) system. Pharmacists in community pharmacies and other practices outside of the primary care practice need interoperable EHR systems and the ability to exchange electronic data.

Pharmacists are recognized as health care providers by the Office of the National Coordinator (ONC) for Health IT, and as such, are [actors](#) under the Cures Act information blocking final rule. This means that pharmacists cannot be blocked from exchanging information by other actors. The pharmacy profession is working diligently to leverage various options such as Health Information Exchanges (HIEs) and the information blocking rule that facilitate pharmacists' participation in electronic information exchange so that pharmacists have the information they need for patient assessments and care plans for primary care services.

Congressional directives to CMS to enhance pharmacist participation in primary health care

Congress emphasized the following pharmacist-related intentions for federal funding at the Centers for Medicare and Medicaid Services (CMS) in the Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations bill, 2023 (H. Rept. 117-403.): (<https://www.congress.gov/117/crpt/hrpt403/CRPT-117hrpt403.pdf>)

“Pharmacists and Patient Care Services. — The Committee is aware that certain Medicare Part B services and care frameworks have provisions to include pharmacists and their patient care services. However, CMS has few mechanisms to identify and evaluate the contributions of pharmacists to patient care and outcomes or to identify barriers within current service requirements that prevent scalable involvement of pharmacists. The Committee encourages CMS to create a mechanism to provide greater visibility into the scope and outcomes of the Medicare services currently provided by pharmacists [emphasis added].”

“Pharmacist-Provided Incident to Physician Services. — The Committee is pleased with CMS's recognition in the calendar year 2021 physician fee schedule (PFS) final rule (FR 84583) that “pharmacists could be considered QHPs [qualified health care professionals] or clinical staff, depending on their role in a given service,” and that “new coding might be useful to specifically identify these particular models of care.” However, the Committee remains concerned with current CMS PFS requirements restricting physicians' and nonphysician practitioners' (NPPs) utilizing pharmacists under incident to models to bill at the lowest E/M code (99211), with an estimated time commitment of 7 minutes. The Committee understands this restriction has diminished providers' engagement with pharmacists in team-based care models across the country. CMS should consider how to ensure physicians and NPPs can optimize the use of pharmacists. The Committee encourages CMS identify mechanisms to attribute, report, and sustain pharmacists' patient care contributions to beneficiaries in the Medicare Part B program [emphasis added].”

Conclusion

Thank you for the opportunity to provide these examples of evidence of the impact of pharmacist services to support the HHS's Initiative to Strengthen Primary Health Care. Pharmacists play a vital role in providing primary health care services, and through removal of barriers and HHS action, they can be further optimized to contribute to primary health care services. If you have any questions or

require additional information, please contact Michael Baxter, Acting Head of Government Affairs, at mbaxter@aphanet.org.

Sincerely,

A handwritten signature in black ink that reads "Anne Burns". The signature is written in a cursive style with a large, stylized initial "A".

Anne L. Burns, RPh
Vice President, Professional Affairs

DEPARTMENT OF VETERANS AFFAIRS (VA)—Primary Care Clinical Pharmacy Specialist (CPS) Practice	
Focus Area	Team-based care model, with comprehensive medication management (CMM) practice in primary care that incorporates the clinical pharmacist providing CMM services. This model is found across the VA and implemented across VA facilities with outcomes ranging from quality to humanistic outcomes.
At-a-Glance	<ul style="list-style-type: none"> ■ Organization Type: Government, Accountable Care Organization ■ Launch Date: In 2010, the VA implemented a Primary Care Medical Home (PCMH) model known as Patient-Aligned Care Teams (PACTs). Each PCMH team followed a panel of veterans and included core team members as well as the clinical pharmacist known as the clinical pharmacist practitioner (CPP). ■ Payment and Funding Sources: Government funded, each facility is funded based on their patient population and complexity of the services provided at that organization. Budget is allocated across the facility to ensure care is provided for the patient population. VA care includes ambulatory, acute and long-term care services provided to the patient population. <ul style="list-style-type: none"> ■ In 2019, there were nearly 2.6 million CMM interventions captured across over 1.2 million clinical pharmacist face-to-face and virtual visits.¹
Organization Details	The VA provides care across 145 VA medical facilities and 1,283 outpatient sites of care. The veteran population has over 9 million patients, 10% of which are female veterans.
Brief History of CMM Program	<ul style="list-style-type: none"> ■ In 2010, the VA implemented their PCMH, which incorporated a team to care for each veteran, consisting of a primary care provider, registered nurse, licensed professional nurse (LPN) and medical support administration (MSA). The clinical pharmacist practitioner (CPP) is assigned to the PCMH team at a ratio of 1 CPP per 3,600 primary care patients. As of March 2020, there are 4,566 CPPs (49.2% of the total of 9,285 VA pharmacists) functioning as advanced practice providers system-wide with 2,171 providing direct patient care services in primary care.
Results & Achievements Focus on the Quadruple Aim* <ul style="list-style-type: none"> ■ <i>Better Outcomes</i> ■ <i>Cost Savings</i> ■ <i>Patient Satisfaction & Engagement</i> ■ <i>Clinician Satisfaction</i> 	<p>Better Outcomes¹:</p> <ul style="list-style-type: none"> ■ 27% of return appointments were avoided as a result of CMM interventions by the CPP, freeing PCPs to see other patients.¹ ■ 111 CPPs served 133,270 veterans during 429,460 visits, with approximately 67% of the care provided to rural veterans.⁵ ■ On average, each CPP cared for 564 veterans during 1,255 visits annually.⁵ <p>Cost savings:</p> <ul style="list-style-type: none"> ■ The 27% avoided return appointments at one site (noted above), projected a cost avoidance that would result in nearly \$3.8 million in cost savings per year for the VA.¹ ■ Rural veterans receiving CMM resulted in \$2.1 million savings annually by alleviating the need for the PCP to see them.^{1,5} <p style="text-align: right;"><i>continued</i></p>

<p><i>continued</i></p> <p>Results & Achievements</p> <p><i>*Aims chosen to align with examples from “The Outcomes of Implementing and Integrating Comprehensive Medication Management in Team-Based Care: A Review of the Evidence on Quality, Access and Costs”</i></p>	<p>Patient Satisfaction & Engagement:</p> <ul style="list-style-type: none"> ■ 627 patients took a patient satisfaction survey, with a mean overall score of 90.6% (SD = 10%). Mean scores within the service, knowledge and self-management domains were 92.0% (SD = 10.8%), 89.7% (SD = 11.35%) and 89.2% (SD = 12.0%).³ ■ CMM telehealth services were evaluated, with a median patient satisfaction score demonstrated of 39.5 (IQR = 36-40) out of a maximum score of 40.⁴ <p>Clinician Satisfaction²:</p> <ul style="list-style-type: none"> ■ In evaluating team member perceptions (PCPs, medical support assistants and RNs, N=91) to how the CPP decreased the time patients had to wait for primary care services, it was noted the CPP had a moderate impact (average score of 4 out of 5) by all team members.⁶ ■ In evaluating the CPP integration and how their contribution to the team improves job satisfaction, it was noted the CPP had a significant impact (average score of 4.5 out of 5) by all team members.⁶
<p>Patient Success Story</p>	<p>Kansas City VA Medical Center, Kansas City, Missouri:</p> <p>An 82-year-old male was initially referred to the CPP by the patient’s geriatrician for CMM. The patient’s past medical history included type 2 diabetes, hypertension, hyperlipemia, diabetic retinopathy, coronary artery disease, peripheral vascular disease, congestive heart failure and chronic kidney disease. His labs upon initial review included A1c 8.5%, Serum Creatinine (Scr) 2.43 and eGFR 25.7. His diabetes medications included insulin detemir 2-3 units Subcut QHS (Noted if bedtime reading <150mg/dL would inject 2 units) and insulin aspart 6-13 units Subcut TID AC meals.</p> <p>Upon initial CPP video visit, the patient expressed concerns of frequent distressing hypoglycemic episodes before dinner and bedtime (blood sugars in the 60s to 70s) and elevated morning readings (blood sugars in the 190s). The CPP increased his insulin detemir, reduced his insulin aspart and provided patient education on his insulin therapy and blood sugar goals (e.g., monitoring for hypoglycemia, avoiding insulin self-adjustment).</p> <p>Two weeks later, the CPP followed up with the patient by video. The patient reported 1 mild hypoglycemic event and average blood sugars of 160-190mg/dL. The CPP determined that based on cardiac history and chronic kidney disease, he would be a good candidate for a GLP 1 agonist prescribing dulaglutide 0.75mg Subcut weekly. As blood sugars were anticipated to improve with addition of GLP 1 agonist, insulin aspart was discontinued to avoid hypoglycemia, and his insulin detemir was continued. In conjunction with the physician, the CPP ordered a repeat Scr in 4 weeks to assess patient renal function and scheduled video follow up.</p> <p>At the next follow up, the patient denied hypoglycemic events and ADRs from recent regimen changes; however, he did notice his evening and bedtime readings had trended upward. The CPP noticed his Scr was stable and discussed further dose increase of dulaglutide to 1.5mg Subcut weekly. The patient agreed and the CPP scheduled follow up labs and video visit in 4 weeks.</p> <p style="text-align: right;"><i>continued</i></p>

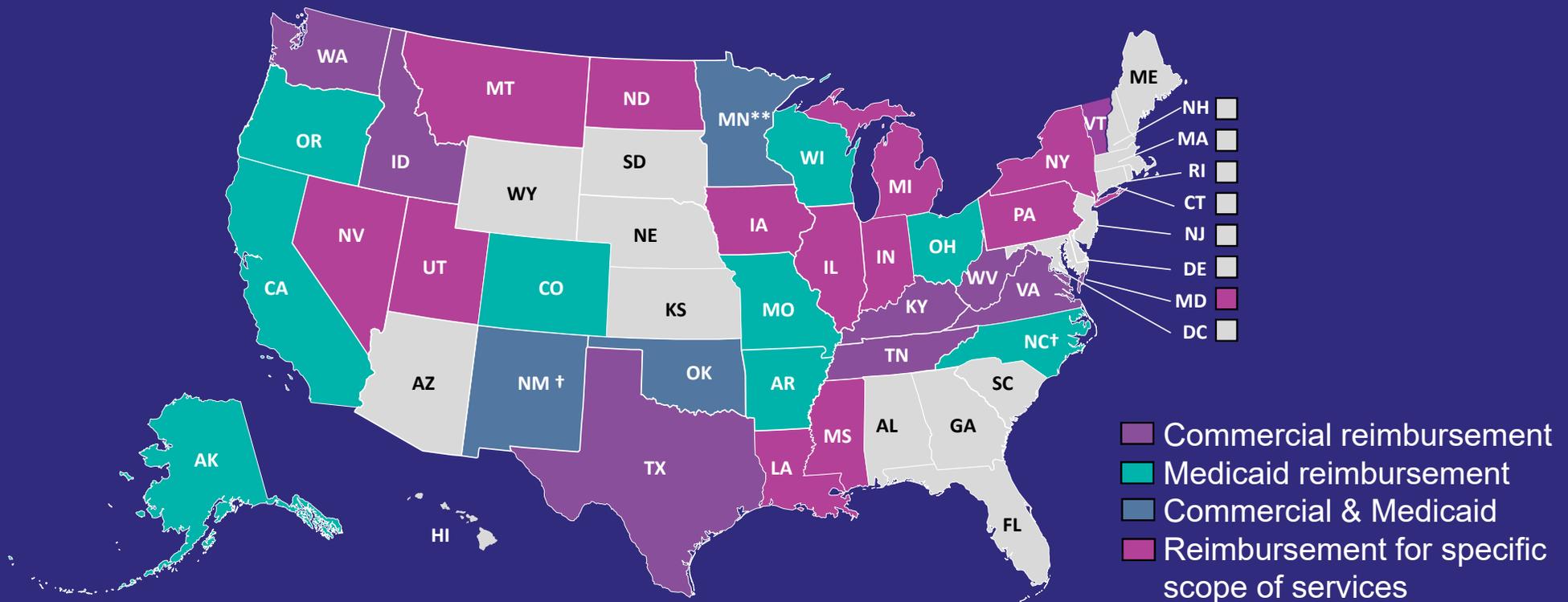
<p><i>continued</i> Patient Success Story</p>	<p>At subsequent visits, the patient’s renal function stayed stable, and his blood sugar continued to improve with the majority of his readings within 140–160mg/dL. He continued to deny hypoglycemic events or ADRs. At his next visit, the patients A1c improved from 8.5% to 7.8%, meeting the patients adjusted A1c goal of less than 8%. The CPP continued to work closely with the patient in conjunction with his primary care provider and CMM team.</p>
<p>Team-Based Care Strategy</p>	<ul style="list-style-type: none"> ■ Interprofessional Team Roles: <ul style="list-style-type: none"> ▪ CMM is a core concept of veteran care. The CPP provides CMM in between PACT provider visits to initiate, modify or discontinue medications, as well as in foundational or high-volume areas. The CPP, co-located with the primary care team, sees patients face to face and with virtual modalities. Patients are referred to CPPs via direct provider referral, team referral (e.g., nurse) and population health management activities. ▪ The interprofessional primary care team includes 1 CPP, 1 PACT provider, 1 RN care manager, 1 LPN and 1 medical support staff. The team also has additional team members to include registered dietitians, social workers and primary care mental health integration team members. ■ Role of the CPP: <ul style="list-style-type: none"> ▪ Scope of Advanced Practice: VHA policy’s VHA Handbook 1108.11 Clinical Pharmacy Services outlines core activities and authority for clinical pharmacist scope of practice. CPPs have had prescriptive authority set forth in VA national policy since 1985. The CPP functions with independent clinical decision-making to perform CMM services included in their scope of practice with credentialing consistent with the medical staff process serving as an advanced practice provider. ■ Visit Structure: <ul style="list-style-type: none"> ▪ Visits can be any form including in-person, telephone, home care or telehealth (e.g., VA Video Connect and Clinical Video Telehealth). CPPs also provide team support (e.g., chart consultation, secure messaging and curbside and e-consults). ▪ Typical time allotted for each visit type: 30 min
<p>Patient Referral Criteria</p>	<ul style="list-style-type: none"> ■ Eligibility: <ul style="list-style-type: none"> ▪ Any patient requiring CMM services is eligible for care. The goal is for 15–20% of patients from the PCP panel to be seen by the CPP for CMM. In addition to quality improvements, this creates an addition of 3 weeks of appointments for the PCP. ■ CMM Populations of Focus: <ul style="list-style-type: none"> ▪ CPPs focus on the provision of CMM services and are referred patients through a variety of means including patient self-referral, physician and team member handoff and population health management dashboards. Patients are seen for multiple common primary care conditions and managed by the CPP.

<p>Size of CMM Program</p>	<p>Staffing:</p> <ul style="list-style-type: none"> ■ As of March 2020, there are 4,566 CPPs (49.2% of the total of 9,285 VA pharmacists) functioning as advanced practice providers with a scope of practice for CMM. <ul style="list-style-type: none"> ▪ 2,171 of these CPPs provide direct patient care services in primary care. During the last 3 years, CPPs have increased by 20%.⁵ ■ Support Staff (e.g., CPhT, MA, RN, etc.): <ul style="list-style-type: none"> ▪ Schedule patients after referral for CMM. ▪ Provided education to patients on what the CPP CMM visit will encompass. ▪ Nursing support for rooming of patients, vitals, patient education (e.g., glucose monitoring). ▪ RN identification of patients for CMM after performing population health management. ▪ Some facilities have implemented Clinical Pharmacy Technicians into the team to directly support the CPP. <p>Program Capacity:</p> <ul style="list-style-type: none"> ■ Preestablished metrics focused on the CPP direct patient care time found 90% of their time was dedicated to CMM services.
<p>Program Success Factors</p>	<ul style="list-style-type: none"> ■ Convenient patient access and simple program entry <ul style="list-style-type: none"> ▪ Improved access to a CMM team member ▪ Focus across a broad range of CMM care ▪ Multiple delivery modalities (e.g., in-person, virtual) ■ Utilizing team members to their fullest capacity eased primary care workload, further helping to achieve the quadruple aim. ■ Demonstrated efficiency and effectiveness of cross-setting team-based care, articulating CMM's value. ■ Organization culture recognizes the CPP as CMM patient care professional. ■ Integrated electronic health record that allows for sharing across disciplines and population management dashboards to identify patients in need of CMM care.
<p>Next Steps, Future Goals</p>	<ul style="list-style-type: none"> ■ Expanded CPP integration into other practice areas where patient care needs are apparent (e.g., substance use disorder, pharmacogenomics, pain management, mental health). ■ Continued CMM model with integrated CPPs in hopes of closing staffing gap by 20% in the next 3 years. ■ Continued focus on veteran experience and CMM impacts that experience over time.

<p>References</p>	<ol style="list-style-type: none"> 1. McFarland MS, Nelson J, Ourth H, et al. Optimizing the primary care clinical pharmacy specialist: increasing patient access and quality of care within the Veterans Health Administration. <i>J Am Coll Clin Pharm</i> 2020;3(2):494-500. https://doi.org/10.1002/jac5.1177. 2. McFarland MS, Lamb K, Hughes J, et al. Perceptions of integration of the clinical pharmacist into the patient care medical home model. <i>J Healthcare Quality</i> 2018;40(5):265-73. https://doi.org/10.1097/jhq.000000000000114. 3. McFarland MS, Wallace J, Parra J, Baker J. Evaluation of patient satisfaction with diabetes management provided by clinical pharmacists in the patient-centered medical home. <i>Patient</i> 2014; 7:115-21. https://link.springer.com/article/10.1007/s40271-013-0039-7. 4. Maxwell LG, McFarland MS, Baker JW, Cassidy RF. Evaluation of the impact of a pharmacist-led telehealth clinic on diabetes-related goals of therapy in a veteran population. <i>Pharmacotherapy</i> 2016;36(3):348-56. https://doi.org/10.1002/phar.1719. 5. Groppi JA, Ourth H, Tran M, et al. Increasing rural patient access using clinical pharmacy specialist providers: Successful practice integration within the Department of Veterans Affairs, <i>American Journal of Health-System Pharmacy</i>, 2021; 78(8):712-19. https://doi.org/10.1093/ajhp/zxab011. 6. Zogas A, Gillespie C, Kleinberg F, et al. Clinical Pharmacist Integration into Veterans' Primary Care: Team Members Perspectives. <i>J Am Board Fam Med</i> 2021; 34(2): 320-27. https://doi.org/10.3122/jabfm.2021.02.200328.
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Appendix B

Payment for Pharmacist Services in the States*



*Examples of states where pharmacists are receiving reimbursement for a broad or narrow scope of their patient care services. Not intended to be a comprehensive representation.

**Reimbursement is for medication therapy management (MTM), however MTM is broadly defined to encompass services within pharmacist state scope of practice

†Pharmacist reimbursement for a broad scope of services is largely tied to the requirement of being an advanced practice pharmacist