Objectives

- Discuss opportunities for pharmacists in ambulatory care environments.
- Describe staff training necessary to adapt to ambulatory patient care demands.
- Examine the integration of ambulatory patient care environments with the pharmacy enterprise.

Definitions
Ambulatory Care Pharmacy
A Specialty in Medication Use for Preventive and Chronic Care

Ambulatory care pharmacy practice is the provision of integrated, accessible healthcare services by pharmacists who are ACCOUNTABLE for addressing medication needs, developing sustained PARTNERSHIPS with patients, and practicing in the context of family and COMMUNITY. This is accomplished through direct patient care and medication management for ambulatory patients, long-term relationships, coordination of care, patient advocacy, wellness and health promotion, triage and referral, and patient education and self-management.

-ACCP/APhA/ASHP Joint Working Group

Patient-Centered Medical Home (PCMH)

AHRQ defines a medical home not simply as a place but as a model of the organization of primary care that delivers the core functions of primary health care.
- Patient Centered
- Comprehensive Care
- Coordinated Care
- Superb access to care
- Systems based approach to quality and safety

Accountable Care Organization

"The accountable care organization is like a unicorn, a fantastic creature that is vested with mythical powers. But no one has actually seen one."

*Mark Smith, M.D., M.B.A., President and CEO of the California Healthcare Foundation
Accountable Care Organization, Take 2

Camel: A horse designed by a committee.

Accountable Care Organization, Take 3

- A network of doctors and hospitals sharing responsibility for providing coordinated care to patients in hopes of limiting unnecessary spending
- At the heart of each patient's care is a primary care physician
- Differs from an HMO
  - ACO patients are not required to stay in network
  - must meet quality measures to ensure they are not saving money by stinting on necessary care.

Bad News AND Good News
Drug Spend

- 2012: $325.7 billion
  - 84% Rx dispensed as generics
  - Generic Rx may reach 86 – 87%
  - Specialty drugs, account for ~ ¼ of all prescription drug costs, increased by 18.4% in 2012
  - drug sales will rise by more than 4% in 2014, due to fewer brand-name drugs losing patent protection and an influx of newly insured patients

Healthcare Costs by Age

See enlargement p. 34

Physician and Nursing Shortage

Systematic underpayment of primary care and overpayment of specialty care
  - In 2000, 14% of medical graduates opted for family medicine residencies
  - In 2005, 8% opted for family medicine residencies
  - Since 1998, half of family medicine residency slots have been unfilled

Nursing supply peaked in 2010
  - 80% actively employed; only 59% work in hospitals
  - Average age 48 and growing
  - Educational output need to increase by 90% to meet demand in 2025, when there will be a shortage of 500,000 RNs
  - Shortage of instructors - critical
A Spoonful of Sugar Helps the Medicine Go Down….

- Non-adherence
  - $290 billion annually\(^1\)
  - Predictor of adherence: presence of a personal connection with a pharmacist\(^2\)


Here’s the Good News: Opportunities!

- We are truly needed to fill the gap of physicians and nurses
- It is legally within our scope of practice to do so
- We have the vision, training, skills to affect
  - Adherence
  - Drug Spend
  - Drug Morbidity Costs

Our $200,000,000,000 Opportunity

Key findings:

- Medication non-adherence drives the largest avoidable cost ($105 billion)
- Delays in applying evidence-based treatment to patients lead to $40 billion in annual avoidable costs
- Some signs of improvement are evident in the responsible use of antibiotics ($35 billion)
- Many efforts are underway to address the underlying causes of avoidable spending and to improve medication use

\(^1\) IMS Health. Avoidable costs in U.S. healthcare: the $200 billion opportunity from using medicines more responsibly. http://www.imshealth.com/portal/site/imshealth/menuitem.18c196991f79283fddc0ddc01ad8c22a/?vgnextoid=7c14d5026dd3f310VgnVCM1000076192ca2RCRD (accessed 2013 September 25).
Opportunities Provide Us with Challenges We Can Meet

- Improve access to care
- Provide quality care
- Contain costs
- Afford safe use of medications
- Manage other medication-related issues

We must educate patients about the importance and advantage of a pharmacist involved in the delivery of health care.

Case Study:
University of Michigan Health System

Patient Centered Medical Home: University of Michigan Health System
PCMH Team Members

- Physicians
- Pharmacists
- Nurses
- Medical Assistants
- Panel Managers
- Office Assistants
- Social Workers
- Nutritionists

PCMH Financial Support

- Developed a systematic and standardized pharmacy-practice model to provide comprehensive patient care
- Established collaborative practice agreements with physicians
- Obtained special clinical privileges endorsed by credentialing committee
- Developed new billing structure and process for service reimbursement
PCMH Pharmacist Practice Model

• 10 embedded pharmacists in all primary care clinics
  – 4.0 clinical FTE
  – 9 internal medicine and 5 family medicine sites
• Pharmacist’s time at PCMH sites varies depending on patient volume (range: 1 – 6 half-days/week)
• Provide disease management service (diabetes, hypertension, and hyperlipidemia), poly-pharmacy consultations (MTM services)

Pharmacist’s Scope of Services Per Collaborative Practice Agreement

• Evaluate and optimize therapeutic regimen
• Provide medication management to achieve treatment goals
• Assess and address barriers to medication adherence
• Provide education on chronic medical conditions and medications
• Assist in limited physical assessment (i.e. BP, foot exam)
• Order labs and medical equipment (i.e. glucometer)
• Facilitate referrals to other health care providers
• Set goals for self management using motivational interviewing

Challenges in Establishing Collaborative Practice Agreement

• Legal Issues
• Credentialing/Privileging Process
• Institutional Standards and Policies
• Trusting Relationship with Providers
• Clinical Protocols
Patient Recruitment and Appointments

- Proactive patient recruitment in addition to physician referrals
  - Screening disease specific registries
  - Reviewing clinic lab results and addressing abnormal values
  - Identifying patients coming in for physician appointments
- Scheduled patient appointments
  - Clinic visits (30 minutes)
  - Phone consults (15 – 30 minutes)

Clinic Productivity

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of Patients</th>
<th>Number of Visits</th>
</tr>
</thead>
<tbody>
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<td>6193</td>
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<tr>
<td>Year 3</td>
<td>1294</td>
<td>6294</td>
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Future Plans

- Expansion from Primary Care to Specialty Clinics
  - Cardiology/Anticoagulation
  - Psychiatry
  - Chronic Kidney Disease Clinic
- Telemedicine Opportunities
- Employer-based CMR
- Explore new reimbursement opportunities and partnerships
Case Study:
Harborview
Medical Center

• 5 pharmacies, filling > 600,000 Rx
annually
• 15,000+ Patient Visits annually
• 17,000+ Refill requests annually

Harborview Medical Center

• 10,000+ Clinical Interventions annually
• 23 clinical specialists
• 1 PGY2 Ambulatory Care Pharmacy Resident

39 Years of Ambulatory
Clinical Pharmacy Services

Community Mental Health
Clinic (1974)

• Dispensing medication
• Intensive patient education
• Consultative service for physicians related to medication therapy
• Collaborative practice developed to initiate, adjust, discontinue
asthma medications
• Refill authorization

Asthma Clinic (1985)
39 Years of Ambulatory Clinical Pharmacy Services

- Expansion to clinics of greatest need
  - International Medicine Clinic (1987)
  - Geriatric Clinic (1988)
  - HIV/AIDS Clinic (1990)
  - Adult Medicine Clinic (1993)
  - Pediatric and Women’s Clinics (1995)

Adult Medicine Clinic: 1995

- Quality improvement initiative around care of patients with hypertension
  - Team 1: Usual care
  - Team 2: Education from clinical pharmacist regarding hypertension management
  - Team 3: Referral to clinical pharmacist for medication management under collaborative agreement
    - Improved SBP/DBP
    - Improved adherence
    - Reduced medication and overall health care costs

CLINICAL PHARMACISTS: 2013

- Family Medicine
- Adult Medicine
- International Medicine
- Senior Care
- Renal
- Liver/Hepatitis
- Anticoagulation
- Orthopedics
- Aftercare
- Cardiology
- HIV/AIDS
- Pioneer Square
- Pediatrics
- HIV/HCV
Privileging and Credentialing

Credentialing
- Validation process
  - Degrees
  - Licensure
  - Certificates, Awards, Post-Graduate training

Privileging
- Process used to grant a specific practitioner the authorization to provide specific patient care services, scope of practice

Coordinated and Integrated Care Begins With...
Dispensing pharmacies - the bridge between the specialists and the pharmacists in the outpatient pharmacies

Access to physicians
Access to medication
- Charity
- Insurance issues
- Copays
- Patient assistance
- Prior authorizations
Quick response to requests
- Information
- Medication
- Consultation

What Do These Pharmacists Do?
Workstation in the provider room of the clinic
- Consult on medication therapy for individual patients to optimize treatment
- Educate attendings, fellows, residents and medical students on global medication and prescribing issues, based on current literature
- Strong influence on prescribing practices
- Immediately available to meet with patient being seen if there are medication therapy issues
- On referral from physician, will manage medication therapy for chronic disease
- Provide interdisciplinary care coordination

Enabling the true intent of the PCMH:
- Facilitating partnership with individual patients to assure indicated care is provided when and where it is needed
How Do They Improve Care?

• Increase access to care (especially the medically underserved and vulnerable)
• Act as a physician extender to allow physician-based care to be provided to more critically ill patients
• Partner with physicians to optimize medication therapy
• Continuity: consistently available
• Improve patient and provider satisfaction
• Enhance cost effectiveness
• Assure patient safety

Methods of Funding the Model

• Physician group employs pharmacists
• Pharmacy employs pharmacist, but clinic/physician group funds FTE
• Pharmacy employs pharmacists and funds FTEs

Do You Currently Have Ambulatory Clinical Services?

1. Where is your practice site?
2. What services do you provide?
   ▪ Describe model of care
3. Is your organization part of Patient Centered Medical Home (PCMH) and/or Accountable Care Organization (ACO)
What Are Your Greatest Challenges?

• Administration buy-in?
• Medical Staff acceptance?
• Staffing?
• Training?
• Expansion?
• Reimbursement?

Determine Your Philosophy

Creation of Vision Statement

Created in 1996:

Set the national standard for provision of care. Achieve recognition as leaders in providing fully integrated, patient-centered, pharmaceutical care through innovative, safe, cost-effective, and accessible pharmacy services. Provide excellence in research and training.
Creation of Service Goals

Service and program excellence (12)
- Optimize adherence of medication regimen
- Provide patient care and education within an interdisciplinary care framework

Human Resources (2)
- Invest in highly qualified staff with demonstrated professional, technical, and interpersonal competencies

Financial Viability (2)

Administration (1)

Creation of Standards of Practice

• With existing pharmacist team, exploration of standards of practice and care
  – Leverage the PPMI
    • Drug therapy management should be available from a pharmacist for each outpatient (B9)
    • Medication reconciliation in the ED, discharge and ambulatory care setting (B22)
    • Establish processes to ensure medication related continuity of care for discharged patients (B23)
    • Responsible for outcomes (B7)
    • Patient safety and ADRs (B17, 21)
    • Quality of care and financial health (A5, 7, 8)

Creation of Standards of Practice (15)

  Commonalities and Absolutes
  – A progress note shall be written at each visit
  – Appropriate recommendations and drug regimen changes shall be made and documented in the plan
  – Nationally recognized treatment guidelines/clinic-specific standards of practice shall be utilized for the chronic and acute illnesses, which clinic-based pharmacists manage
Determining Your Philosophy

* Primary Care +
* Specialty Clinics
  - Oncology
  - Transplant
  - Hepatitis/Liver
  - Renal
  - Pain
  - Clinical Chronic Disease Manager
* Disease State Specific
  - Hypertension
  - Diabetes
  - Anticoagulation
  - Heart Failure
  - Dyslipidemia
  - Tobacco Cessation
  - Asthma

How Do You Envision Your Practice?

* Disease state based clinics?
  - Diabetes
  - Hypertension
  - Lipids
  - Anticoagulation
* Primary care?
* Specialty care?
* Part of a national demonstration project?

Staffing Models
### Staffing Models

**Your Own Staff:**
- Continuity
- Standards

**Pharmacy Residents:**
- General Practice
- Specialty

**Pharmacy School Faculty:**
- Transformation of education
- Research vs. Teaching
- Recruitment and retention
- Publish

### Staff Training

- Board Certification
- Residency training (PGY1 vs PGY2)
- Evidence-based Clinical Care Guidelines (example)
- Shadow program
- Collaborative practice agreement
- Experience
- In-house disease state training
- Mini-residency (3mo for staff)
- Senior person on call for extended training

### Staff Training

- Contact local college of pharmacy
- Selected classes
- ASHP Core Therapeutic Module series
Leadership Support

Pharmacy Leadership Support

**Pharmacy Department**
- Chief Pharmacy Officer
- Director of Pharmacy
- Clinical Supervisor
- Residency Director

**College of Pharmacy**
- Dean
- Department Chair

Medical Leadership Support

- Identify key leaders in the health system
- Set up standing meetings
- Create awareness and visibility
- Actively engage in institution's committees
Physician Champions

- Identify local physician champions
- Develop trusting relationships
  - Frequent communications
  - Exceed expectations
  - Need to be visible
- Collaborate on projects

Patient-Centered Medical Home Clinical Outcomes

Impact on Glycemic Control

- Patients with baseline A1c > 7.0% (n = 543) had a mean decrease in A1c by 0.85% (p<0.0001)
- Patients with baseline A1c > 8.0% (n = 373) had a mean decrease in A1c by 1.20% (p<0.0001)
- Patients with baseline A1c > 9.0% (n = 231) had a mean decrease in A1c by 1.75% (p<0.0001)
Therapeutic Interventions by PCMH Pharmacist

- Increased dose
- Added medication
- Decreased dose
- Deleted medication
- Optimized regimen

Diabetes Registry QI Report

UMHS TARGET GOAL: 90% 90% 90% 90% 90% 90%

Non-PharmD Patients (N = 6329; 89%)

- No. of Patients Met Goal: 6057
- % of Patients Met Goal: 96%
- UMHS Goal Met? Yes

PharmD Patients (N = 816; 11%)

- No. of Patients Met Goal: 810
- % of Patients Met Goal: 99%
- UMHS Goal Met? Yes

* Eligible patients: 4908
** Eligible patients: 656

Reporting Period (07/01/2011 - 06/30/2012)

See enlargement p. 34
Quality Improvement Projects

Strategies to Improve BP Control in Patients with Diabetes

- Developed patient care and treatment protocols to standardize hypertension care
- Implemented sticker system to flag elevated BP
- Scheduled follow up appointments for patients with elevated BP in 2 - 4 weeks with a pharmacist
- Intensified treatment regimen by pharmacists with collaborative practice agreement
- Developed and implemented Home BP Machine Loaning Program

Sticker System Trigger Follow-Up Scheduling

*Follow-Up Appointment in Patients with Elevated Blood Pressure*

- No appointment
- 1 - 4 months
- > 1 month

- [Graph showing follow-up appointments over time]
Improve Statin Use in Patients with Diabetes

- UMHS Goal: 96%
  - Exclusion: <40 years old and LDL < 100
- Quality Indicator
  - Pioneer ACO
  - Meaningful Use
  - Medicare Advantage Program
  - MyCareCompare.org
- Total number of targeted patients: 515

Statin Project Timeline

Chronic Care Huddle Team

- Brief weekly huddles (15 minutes) to discuss quality improvement initiatives/projects
- Huddle team members include one representative from each discipline:
  - Physician
  - Pharmacist
  - Nurse
  - Medical assistant
  - Clerical staff
  - Panel manager
  - Health center manager
Charge for the Chronic Care Huddle

- Review disease specific registries and identify areas of improvement
- Brainstorm together to prioritize areas of need
- Develop a systematic approach to improve process of care
- Implement changes in rapid cycles and monitor for challenges and successes
- Evaluate outcomes and actively engage in continuous improvement of care

Diabetes Registry

*Other sites include 3 clinics with comparable diabetic patient totals

Controlled Substance Registry
PCMH Reimbursement Summary

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<tr>
<th>T-code Billing</th>
<th>Medical Home Funding</th>
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<td>185,000</td>
<td>196,000</td>
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<tr>
<td>Year 2</td>
<td>Year 2</td>
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<td>104,954</td>
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<td>Year 3</td>
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<td>76,554</td>
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<th>Practice Setting</th>
<th>Reimbursement</th>
<th>CPT Codes</th>
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<td>Cash</td>
<td>All settings</td>
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<tr>
<td>MTM</td>
<td>Pharmacy Self Insured employers</td>
<td>C or D Plan Self-insured Third parties/health plans, intermediaries</td>
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<tr>
<td>Facility Only</td>
<td>Physician and Hospital Based Outpatient Clinics</td>
<td>Medicare: Varies regionally Commercial</td>
</tr>
<tr>
<td>Diabetes self management training (DSME/T)</td>
<td>All (accredited program and CDE or DASPA required)</td>
<td>Medicare: Varies regionally</td>
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<tr>
<td>Transitional Care Management</td>
<td>Physician and Hospital Based Outpatient Clinics</td>
<td>Medicare: Varies regionally</td>
</tr>
<tr>
<td>Annual Wellness Visit</td>
<td>All</td>
<td>Medicare: Varies regionally</td>
</tr>
</tbody>
</table>

See enlargement p. 35
CMS Star Ratings

• CMS initiative to improve quality, safety and efficiency of services beneficiaries receive
  – Rating of 1 to 5 stars on various measures for Medicare Part C and D
    • 20 operational measures and 27 clinical measures
• Star ratings impact:
  – Reimbursement/Capitation
  – Ability to share in quality bonuses with stakeholders
    • hospitals, clinics, pharmacies
  – Retention and attraction of beneficiaries

CMS Star Initiative
Medication Focused Part D Measures

• Drug Plan Members 65+ Who Receive Prescriptions for Certain Drugs with a High Risk of Side Effects, When There May be Safer Drug Choices
• Using the Kind of Blood Pressure Medication that is Recommended for People with Diabetes
• Medication Adherence for Oral Diabetes Medications
• Medication Adherence for Hypertension (ACE/ARB)
• Medication Adherence for Cholesterol (Statins) Quality Improvement

All of the above measures are triple weighted

New 2015 Star Measure: Comprehensive Medication Review

• Comprehensive medication review (CMR)
  – Evaluate medication regimen for efficacy, safety, and costs
  – Recommend treatment alternatives to providers
  – Provide patient education
• Measures % eligible patients receiving CMR
  – Patients who opt-out or do not respond to offers will not be excluded
• Challenges in providing CMR
  – High patient and physician refusal rates
MTM Reimbursement

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<td>Prescriber Consultation</td>
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<td>Patient Compliance Consultation</td>
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<td>Patient Education/Monitoring</td>
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<td>Prescriber Refusal</td>
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<tr>
<td>Patient Refusal</td>
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CMR fee based on Priority Health Plan. Other plans may be less.

ROI

“Clinical pharmacists are the most underutilized members of the health care team.”

– George Halvorson, Chairman and CEO of Kaiser Foundation Health Plan (2009 HIMSS)

Return on Investment

- Reduction in overall healthcare costs
- Reduction in readmissions
- Reduction in ED visits
- Cost offsets, physicians doing more, able to charge more, treat more patients
- Allow physicians to see more/more complicated patients throughout the day, which means increased health care access and increased revenue
- Improved patient outcomes
- Decreased number of drug related adverse events
- Improved access to primary care services
- Increased patient, provider, and pharmacist satisfaction
Surgeon General’s Report

- Don’t reinvent the wheel
- Decades of data (inclusive of meta-analyses and systematic reviews)
- Roughly 1:4 or better

Soft Dollars

- Relationships with physicians, nursing, social work, dieticians, financial counseling
- Access to medications: charity care, copay waivers, patient assistance
- Satisfaction
  - Physicians
  - Patients
  - Pharmacists

Critical Element: Physician Champion

- Know the most complex patients and often the first to quickly identify when something isn’t right
- Another pair of keen eyes looking out for the well being of our chronically ill patients
- Interpret DI pop-ups, educate about safety warnings, new medications
- Leadership in QI initiatives

“Clinic without our pharmacists would be unthinkable! Our patients would suffer, and my work would be far more difficult…”
Stories Have Power

• 7/21 presented with N/V and had "food poisoning"
• 7/23 admitted for chest pain from clinic, PharmD triaged him immediately as "he looked bad and this wasn't run of the mill "food poisoning." CK: 1940. DC’d 7/24 with "musculoskeletal pain."
• Readmitted 7/25 for nausea/abdominal pain, still with unaddressed high CK. DC’d a few days later without intervention, dx: small bowel obstruction/ work-up as OP Appointment with PharmD 7/30, stopped the statin
• ER 7/31 for "foot pain", dx: cellulitis
• Appointment with PharmD 8/6 and his CK had come down to 200 and he was feeling much better

Pitfalls

• Difficulty obtaining physician acceptance
• Lack of support from hospital administration
• Slow process for credentialing status
• Inadequate understanding of pharmacist practice by finance/billing
• Inadequate training of pharmacists
• Indifferent attitude of pharmacists
• Lack of practice model vision
• Space
• Outcomes failing to meet expectations

Prepare for Possible Pitfalls
Where Do We Begin?

• Choose your focus
  – High risk patients
  – High risk drugs
  – High cost drugs

• What are you willing to be held accountable for?
  – Safety
  – Drug costs
  – Patient outcomes
  – Overall medical costs (waste, readmissions, etc.)
Healthcare Costs by Age

![Image of Healthcare Costs by Age graph]


Diabetes Registry QI Report (cont’d)

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<tr>
<th>Total N = 7145</th>
<th>A1c Tests</th>
<th>LDL C Test</th>
<th>LDL C &lt; 100</th>
<th>On Statin</th>
<th>Monitor for Nephropathy</th>
<th>Eye Exam</th>
<th>Foot Exam</th>
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<td>93%</td>
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<td>56%</td>
<td>96%</td>
<td>90%</td>
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<td>PharmD Patients (N = 816; 11%)</td>
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<td>551</td>
<td>628**</td>
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* Eligible patients: 4908  ** Eligible patients: 656

Reporting Period (07/01/2011 - 06/30/2012)
### Billing Opportunity

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### Statin Project Timeline

- **Student Pharmacist Chart Review Training**: March 18-24
- **Standardization of Chart Review**: March 25-31
- **Initial Chart Review by Students**: April 1 - June 23
- **PCMH Pharmacist Assessment/Plan**: April 8 - June 30
- **Collect Outcomes Data**: To be determined

Contact Patients to Implement Plan
Discuss Plan with Providers if Needed
RESOURCES AND REFERENCES

Accountable Care


Health Care Reform


Patient Centered Medical Home


Ambulatory Clinical Practice


5. IMS Health. Avoidable costs in U.S. healthcare: the $200 billion opportunity from using medicines more responsibly, [http://www.imshealth.com/portal/site/imshealth/menuitem.18c196991f79283fddc0ddc01ad8c22a/?vgnextoid=7c14d5026dd3f310VqnVCM1000076192ca2RCRD](http://www.imshealth.com/portal/site/imshealth/menuitem.18c196991f79283fddc0ddc01ad8c22a/?vgnextoid=7c14d5026dd3f310VqnVCM1000076192ca2RCRD) (accessed 2013 September 25).


**Other Resources**


## Integrating With and Establishing Ambulatory Patient Care Services

### Planning Worksheet

#### Philosophy

**Model of Care**
- Specialty
- Primary Care

**Notes:**

#### Leadership Support

- FTEs
- Fully Leveraging Skills of Pharmacists
- Medical Staff

**Notes:**

#### Staffing

- Model
- Hiring
- Credentialing
- Training

**Notes:**

#### Demonstrating Value

- Clinical Outcomes
- Patient Satisfaction
- Provider Satisfaction
- Reimbursement
- Cost Avoidance

**Notes:**