

St. Vincent  
de Paul  
**charitable  
pharmacy**

**Business Plan:  
Implementing Collaborative Practice Agreement in  
Community Pharmacy**

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## **Executive Summary**

St. Vincent de Paul Charitable Pharmacy (SVDP) in Cincinnati, OH is a dispensing community pharmacy that has implemented a multitude of clinical services into their workflow. These clinical services not only augment the quality of patient care and result in financial sustainability but also reflect the progressive nature of the profession of pharmacy.

The proposed business plan will focus on the implementation of a collaborative practice agreement (CPA) into a traditional community pharmacy workflow with an emphasis on financial viability. This business plan will build upon already established Medication Therapy Management (MTM) services and serve as an adjunct service to streamline the workflow of MTM services.

Collaboration between local community pharmacies and physician practices serves to meet the needs of all three parties involved: the pharmacy, the physician, and the patient. The implementation of a CPA requires careful consideration of state law, pharmacist skill level, and development of trust between all participants.

With consideration to state pharmacy laws, the CPA may be designed to pilot certain disease state management services. At the core of this business model is the use of an MTM platform that allows billing and tracking of interventions made by pharmacists under a CPA. In addition to an augmented revenue stream for clinical care, the introduction of "Symptomatic Relief Consultation Prescriptions" under a CPA will allow for billing of pharmacist dispensing and consultation for OTC products, services which currently have no reimbursement strategy at most traditional community pharmacies.

The goal in allowing pharmacists to collaborate with physicians to manage chronic disease states is to improve patient adherence; to increase loyalty and trust between patients, pharmacists, and collaborating physicians; and to formulate a financially sustainable plan for collaboration of pharmacists and physicians in a traditional community pharmacy setting.

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## **Introduction**

### 1.0 Background on Ohio Law

On March 23, 2016 Ohio House Bill 188 authorized one or more pharmacists to practice under a collaborative practice agreement (CPA) with one or more physicians. A collaborative practice agreement in Ohio (termed “consult agreement” in Ohio Law) allows a pharmacist to manage a patient’s drug therapy for specific diagnoses or diseases and to order and evaluate blood and urine tests. This law has allowed for the expansion of pharmacists’ services, increased access to medical care, and a step forward in the progress toward provider status for pharmacists. Currently all states, except Alabama, have a law allowing for collaborative practice with specific logistic variations.<sup>1</sup>

Justification for medication therapy management (MTM) services provided by pharmacists is well documented in the literature from both a positive patient outcomes standpoint and financial standpoint. The same interventions resolved through prescriber contact via MTM platforms may be resolved in a more streamlined fashion through the use of a CPA. This potentially allows for increased patient satisfaction, improved adherence, and reduced healthcare costs.

### 1.2. Background on St. Vincent de Paul Charitable Pharmacy

The St. Vincent de Paul Charitable Pharmacy (SVDP) in Cincinnati established a CPA with a local free health center (Good Samaritan Free Health Center) in April 2017. This agreement allows the pharmacists at SVDP to interchange, initiate, and discontinue medication as described in the agreement. At present, this agreement is limited to diabetes management and tobacco cessation. From April 2017 to August 2017, a pilot program has provided promising outcomes that will lead to expansion of this agreement to encompass the management of more disease states.

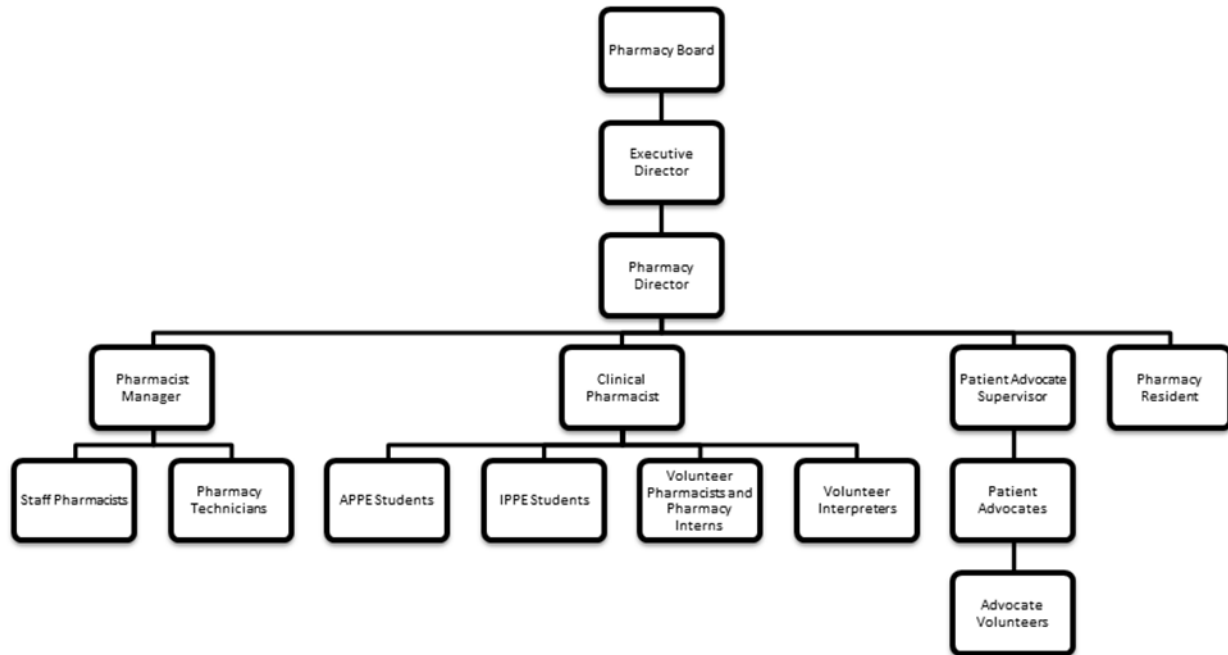
St. Vincent de Paul Charitable Pharmacy is located at:

- 1125 Bank Street, Cincinnati, OH 45214
- 3015 Glenhills Way, Cincinnati, OH 45238

Good Samaritan Free Health Center is located at:

- 3727 St. Lawrence Avenue, Cincinnati, OH 45205

## Organization and Structure of SVDP:



### 1.3 Mission and Goals

#### MISSION:

To improve the health and welfare of community residents by collaborating with local physicians ensuring quality and streamlined care for patients as well as financial sustainability for pharmacist(s) and physician(s).

#### GOAL:

The goal of this business plan is to provide a guide for the successful implementation of a CPA between physician practices and traditional community pharmacies that is not only beneficial to all parties involved but also financially sustainable.

#### OBJECTIVES:

- Improvement in patient adherence
  - Reduction of time a patient experiences between receiving a prescription to receiving medications (out of stock, waiting on prior authorization, etc.)
- Formulation of a financially sustainable plan for pharmacist and physician collaboration.
  - Enhanced MTM workflow
- Investigation of a new revenue stream for OTC recommendations and counseling
  - Initiation of symptomatic relief consultation prescriptions

- Increased loyalty and trust between patients, pharmacists and collaborating physicians.
  - Pharmacy loyalty could lead to less use of multiple pharmacies given the patient understands a pharmacy with a CPA is the most convenient and efficient way to ensure their pharmaceutical needs are met.
- Identification of targeted interventions that provide maximal financial reimbursement in a fast-paced traditional community pharmacy workflow.

## 2.0 Description of the Service

### 2.1 Collaborative Practice Agreement Description and Workflow For Traditional Community Pharmacies

In pursuit of the organization mission, the Charitable Pharmacy provides comprehensive medication reviews (CMRs), health screenings, and extensive follow-up support to patients. This is not unlike the services provided by traditional community pharmacies who provide CMRs annually seeking to resolve medication-related problems with prescribers.

When completing a CMR with a patient, pharmacists identify medication-related problems. In a traditional community pharmacy (as well as at SVDP Charitable Pharmacy) these problems are often documented in MTM software, such as OutcomesMTM. The problems identified by the pharmacist are communicated to the physician, and resolved by physician authorization of a new, changed, or discontinued medication. The time to response to the proposed intervention can vary from provider to provider, but it inevitably results in delayed treatment.

When an intervention is resolved in OutcomesMTM, traditional community pharmacies can submit a claim for reimbursement. For example, if a pharmacist identifies that a patient's hemoglobin A1c (A1c) is not well controlled as a result of sub-therapeutic doses of insulin, the pharmacist can then submit a "dose too low" claim for the patient's insulin and contact the prescriber asking for an increased dose. When/if the prescriber responds with an increased dose of insulin, the pharmacist can close the claim as successful and bill for this intervention. The same process is completed for other medication-related problems as well as CMRs.

When the pharmacist(s) and physician(s) enter into a CPA, the medication-related problems identified are documented similarly in the OutcomesMTM system. However, the workflow is slightly abbreviated resulting in benefit to the patient, pharmacist, and physician. Using the same example as above, a pharmacist who has entered into a CPA with a physician office could immediately increase the insulin without contacting the physician provided

this intervention is specified in the CPA. By eliminating the communication delay, pharmacists are able to provide effective, efficient care by the expansion of prescriptive rights by CPA. Subsequently, the pharmacist would create the OutcomesMTM claim, resolve as successful, and bill for the claim in one seamless step. With interventions resolved by the CPA, the pharmacy may experience increased MTM revenue while the physician has more time to focus on patient appointments rather than responding to pharmacist recommendations.

A CPA creates a formal practice relationship between a pharmacist and prescriber. The agreement specifically spells out the functions of all parties involved. Laws dictating the degree of pharmacists' involvement in a CPA vary from state to state, but most states have some version of a law indicating roles for a collaborative practice agreement. Most CPAs are used in the context of physicians authorizing the pharmacist to initiate, modify, or discontinue medication therapy. The pharmacist may also be authorized to order and interpret medical laboratory tests. The pharmacist does not assume a diagnosing function, but instead uses the results of lab testing and patient reports as data to optimize the medication regimen.

## 2.2 Physician Role

The role of the physician(s) in a CPA is to ensure that the pharmacist(s) abide by the conditions defined in the CPA. In most jurisdictions, the disease states pharmacists are authorized to manage are not restricted or specifically designated. The functions of the pharmacist (outside the normal scope of practice) under a CPA are decided by collaboration between the physician and pharmacist to determine which disease states and interventions would best help their mutual patient population.

## 2.3 Pharmacist Role

The function of the pharmacist(s) within a CPA is specified by the agreement itself. The pharmacist(s) has the responsibility of adhering to the functions described in the CPA and not stepping beyond irsscope of practice agreed upon with the physician(s). The pharmacist is responsible for documenting the use of CPA appropriately and communicating changes to the physician. The pharmacist must meet periodically with the physician(s) for review of the CPA and the implementation of any quality improvement measures.

## 2.4 Description of Services Included

The services included in a CPA vary depending on the functions that state law will allow and on physician preference. These services will be specifically

detailed in the CPA document that is signed by all parties. The most beneficial services to include within a CPA for a traditional community pharmacy are those that provide maximal benefit for all parties involved and integrate easily into a fast-paced pharmacy workflow. Potential services for implementation will include disease state management for chronic disease states such as diabetes, hypertension, asthma, and COPD. The CPA will also specify if a pharmacist can order specific lab tests specifically related to disease state management. Targeted interventions within each of the managed disease states are critical to ensuring integration of CPAs in a fast paced workflow. The targeted pharmacist-initiated interventions are detailed below.

- Quantity Adjustments
  - A recent law change in Ohio has allowed pharmacists to authorize a 90-day supply of medication for patients if the prescription meets certain criteria. This is helpful in the case of medications used for chronic conditions; however, there are many instances when a patient presents a prescription with an invalid quantity written in error or that would not last the intended amount of time. An example of this would be a prescription written for one vial of Levemir insulin, 60 units at bedtime. This prescription would only last the patient 16 days. Under a CPA, the pharmacist can avoid the delay of contacting the physician to change the quantity of the prescription to two vials.
  
- Formulation Interchanges
  - A community pharmacy will carry a variety of medication dosage forms. After patient consultation, change to an extended-release product of the same medication may be beneficial to mediate unpleasant side effects or improve adherence with once daily dosing. Additionally, a pharmacy may carry only one dosage form of a medication (i.e. capsule) but the prescription is written for a different formulation that is not interchangeable (i.e. liquid). Under a CPA, the pharmacist could change the dosage form on the prescription to facilitate streamlined pharmacy workflow and efficient patient care.
  
- Therapeutic Interchanges
  - Drug “classes” exist because there are several with the same mechanism of action in the body from multiple manufacturers. Under a CPA, medications within a drug class could be interchangeable. Some drug classes such as inhaled corticosteroids and statin-cholesterol medications have many options within the same drug class and not every pharmacy will



carry every variety. When presented a prescription for one inhaled corticosteroid that the pharmacy does not carry, under a CPA the pharmacist would immediately be able to interchange this medication for a therapeutically equivalent dose of the inhaler the pharmacy carries. Additionally, the ability to change interchange medications within classes allows immediate patient access to life sustaining medications that may be delayed by insurance company prior authorizations. The timely access to certain classes of medications (i.e. antibiotics) may mean the difference between a successful recovery or hospital readmittance.

- Drug Optimization
  - Community pharmacists are in a unique and accessible role for patients. Patients will have more contact with their community pharmacist than their primary care physician in 6 months' time. Medications that are adjusted based on evidence-based guidelines are limited to titrations performed at a physician appointment. However, patients may experience limited physician appointment availability increasing time between titration and thereby time to disease state control. Dose titrations may be based on point-of-care (POC) testing such as blood glucose monitoring, hemoglobin A1c, and blood pressure readings that can be performed in a traditional community pharmacy. As POC testing becomes more common-place in community pharmacies, under a CPA the pharmacist could increase, or decrease the dose of medications used for chronic disease management.
  
- Drug Initiation
  - Many medications require a physician examination or specialized lab monitoring. Some medications, however, are prescribed based on age and patient-reported risk factors. For example, the initiation of Aspirin 81mg in a patient >50 years old with cardiac risk factors would be possible in community pharmacy with a pharmacist under a CPA.
  
- Symptomatic Relief Consultation Prescriptions
  - In a traditional community pharmacy, the "consultation" window is often used for the patient to ask the pharmacist for an over-the-counter (OTC) drug recommendation. The patient describes their symptoms to the pharmacist and the pharmacist recommends a drug product. In the last decade many prescription only medications used for symptom management have become OTC products. Under a CPA the pharmacist would be able to create a prescription for an OTC medication allowing for a complete

medication profile for the patient when verifying any medication interactions. Creating a “symptomatic relief consultation prescription” will allow the patient to have the therapy monitored by the pharmacist, reimbursement for the pharmacist’s consultation services via a dispensing fee and a possibly a lower cost for the patient depending on the co-pay.

### 3.0 Description of Sustainability (Market Analysis Summary)

#### 3.1 Market Needs and Wants

3.1.1 There is no shortage of patients dealing with chronic disease and management of these diseases is not outside a pharmacist’s scope of practice especially with clinical experience and specialized training. In addition to this, the demand of an expanding, aging, and increasingly insured population has created concern about the sufficiency of our health care. More than 44,000 primary care physicians will be needed by 2035, and at the current production rate a shortage of about 33,000 primary care physicians<sup>2,3</sup> With this shortage, pharmacists are in an ideal position to help manage patients with chronic diseases alongside physicians.

#### 3.2 Patient Needs and Wants

3.2.1 Patients desire the interactions with their healthcare providers to be both meaningful and efficient. Much of the patient frustration in community pharmacies arises from miscommunication between the physician, pharmacist, and patient resulting in inefficient care.

For patients specifically in the Cincinnati area served by SVDP Charitable Pharmacy, the need for affordable healthcare and prescription services is in high demand.

For patients served by traditional community/independent pharmacies, the need for convenient chronic care management and health check-ins may drive patient needs and wants.

Establishment of a CPA agreement will allow for a more efficient and patient-centered pharmacy workflow.

#### 3.3 Potential Market

3.3.1 The prevalence of established CPAs expanded to traditional, independent, and charitable community pharmacies in the state of Ohio and eventually in all states nationwide.

### 3.4 Target Market

3.4.1 The target market for this business plan is both independent and traditional community pharmacies who would be interested in collaborating with local physicians to streamline their workflow and provide effective and efficient patient care.

### 3.5 Pharmacist Perspective

3.5.1 In a traditional community pharmacy, the role of a dispensing pharmacist is often integrated with clinical roles such as offering MTM services. The incorporation of a CPA into the pharmacy workflow will take additional time commitment initially, but with full implementation will improve the quality and quantity of the pharmacy workflow as pharmacists will spend less time contacting prescribers for medication related problems that can be immediately resolved.

### 3.6 Physician Perspective

3.6.1 As the demand for primary care services increase and the number prescribers able to meet this demand decreases, prescribers will need to delegate certain activities to other healthcare professionals or turn away patients who need chronic care management services. Prescribers interact daily with pharmacists who call to clarify prescriptions or who send refill requests on behalf of patients. Prescribers who already have a certain level of trust with certain community pharmacists will view the collaboration and delegation of workload to pharmacists as advantageous.

### 3.7 Market Segmentation

#### 3.7.1 Target Market Segment Strategy

A concentration strategy will be utilized to identify the target market. For the purposes of this business plan the target market is traditional, independent, and charitable community pharmacies that operate within jurisdictions that allow for collaborative practice agreements between physicians and pharmacists.

## 4.0 Strategy and Implementation Summary

### 4.1 Competitive Edge (SWOT Analysis)

#### 4.1.1 Internal Strengths

4.1.1.1 The charitable pharmacy (or a traditional community/independent pharmacy) is frequented by patients with chronic diseases needing life sustaining medication.

Pharmacists who work in community pharmacies are one of the most accessible healthcare professionals. Because of the knowledge level, clinical skill, and unique community positions pharmacists possess, they are able to interact with patients more frequently than a physician would and are qualified to manage medications related to chronic conditions by conducting POC testing and following clinical guidelines.

#### 4.1.2 Internal Weaknesses

4.1.2.1 Pharmacists in traditional community pharmacies have varying clinical skill levels. Not all pharmacists in a traditional community setting may feel comfortable operating under collaborative practice agreement managing medications for chronic care patients.

4.1.2.2 Corporate community pharmacies may be more resistant to adopting a CPA as this may increase liability for the organization as a whole.

#### 4.1.3 External Opportunities

4.1.3.1 Physician offices that are willing to work with community pharmacists to manage chronic care patients are necessary for the establishment of collaborative proactive agreements.

4.1.3.2 Patients who come to a community pharmacy seeking quality and efficient care.

4.1.3.3 Pharmacy students and interns in academic rotations with the pharmacy can be taught the process for documenting use of the CPA. This experience will provide the student with a valuable learning experience at no financial cost to the pharmacy.

#### 4.1.4 External Threats

4.1.4.1 Physician resistance to allowing pharmacists expansion of their scope of practice.

### 4.2 Marketing/Operating Strategy For Pharmacists

#### 4.2.1 Site Selection

4.2.1.1 The sites for implementation of CPA include Saint Vincent De Paul Charitable Pharmacies at both the 1125 Bank Street, Cincinnati OH and 3015 Glenhills Way, Cincinnati, OH 45238. Both of these locations are located

conveniently along bus routes for easy patient accessibility and have ample parking for patients as well. The Bank Street location is located in the underserved West End of Cincinnati, and the Glenhills location is minutes from the Good Samaritan Free Health Center with whom the CPA is established. Having a pharmacy so closely located to the physician site with which the CPA is established allows additional convenience to patients who may need to visit both locations.

#### 4.2.2 Work Flow

4.2.2.1 Below are examples of ideal pharmacy workflow in a traditional community pharmacy under a CPA agreement. The first example will be utilizing one of the targeted interventions and the second example will be using a “symptomatic relief consultation prescription” model.

4.2.2.1.1 A patient comes to the pharmacy with a prescription for Advair 100/50mcg 1 puff BID. The pharmacy technician looks at the prescription and notes that pharmacy does not have any Advair 100/50mcg inhalers on the shelf. The pharmacy technician has been trained for this type of medication to place the prescription in the “CPA basket” for the pharmacist to review. The pharmacy technician informs the patient that the pharmacist will need to take an additional look at the prescription to ensure it can be filled in a timely manner. The pharmacist looks at the prescription and recognizes that she can interchange the ICS/LABA inhaler prescribed to one the pharmacy has in stock currently under an active CPA with the prescriber. The pharmacist opens a “suboptimal drug” intervention in OutcomesMTM and documents the out-of-stock situation. The pharmacist documents the interchange of the medication under the CPA and can then close the claim as “successful” immediately. The revenue from this interchange is 20 dollars. The pharmacist then documents on the original that “per CPA” the medication was exchanged for Breo Ellipta 100/25mcg 1 puff daily. When the patient picks up the medication the patient must consent to the

change in medication by signing a CPA consent document. The interventions made under the CPA will be provided to the prescriber at the end of each month (or more often depending on state jurisdiction/prescriber preference).

4.2.2.1.2 A patient comes to the pharmacy and approaches the consultation window. The pharmacist assess the patient's symptoms, history of symptoms, onset, location. aggravating/remitting factors, current medications, allergies, and medical diagnoses. All of the patient symptoms and complaints are typical for seasonal allergies and the pharmacist recommends Loratadine 1 tablet by mouth daily for the duration of the allergy season. With patient consent signed, and if specified under the CPA the pharmacist will initiate a prescription for the medication with no refills. The patient will have their insurance billed for this medication and the pharmacy will receive the revenue from both the dispensing fee and the resolved OutcomesMTM claim of "Needs Drug Therapy." The information regarding the initiated prescription will be reported to the physician office with whom the CPA is signed.

#### 4.2.3 Facility Design

4.2.3.1 Each of the pharmacy sites will have 2-3 private consultation rooms for patient evaluation. After the evaluation/consultation the patient can walk a short distance to the pharmacy counter. Each site is equipped with a balance (scale), blood pressure cuffs, stethoscopes, blood glucose monitors, test strips, alcohol swabs, lancets and POC A1c testing supplies.

4.2.3.2 Each pharmacy will have a traditional dispensing area where patients can pick up/drop off prescriptions.

#### 4.2.4 Staff Training

4.2.4.1 Staff training for pharmacy personnel is essential for implementation of a CPA. The pharmacy technicians and interns will need to be trained to identify medication problems covered under the CPA efficiently at the window and then triage these problems to the pharmacist who can

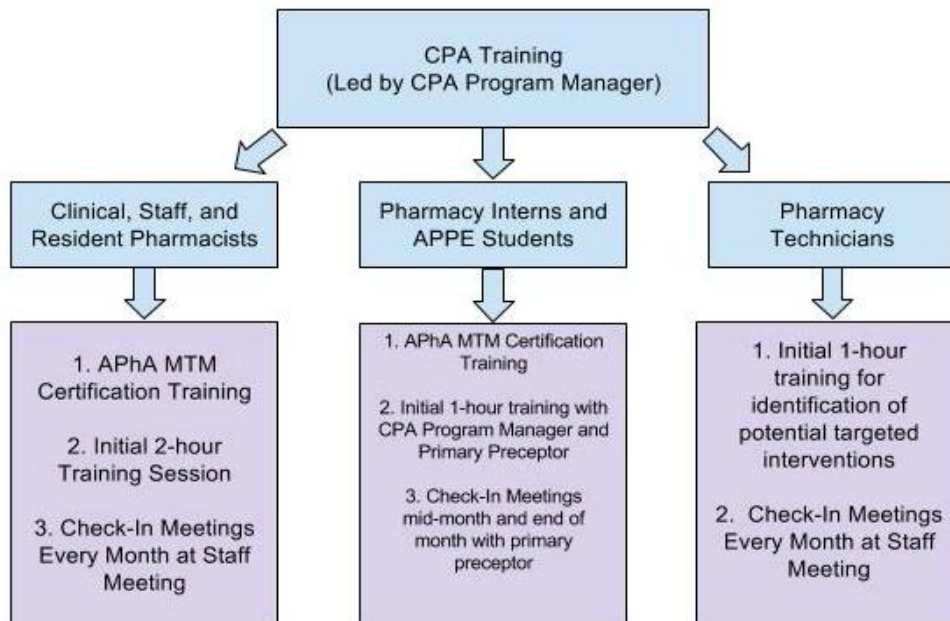
make the intervention. Each of the pharmacy personnel will also need to be trained on the enhanced OutcomesMTM workflow as well as documentation and follow-up.

4.2.4.2 An initial two hour training for clinical pharmacists, staff pharmacists and the providers participating in the CPA will be provided by the CPA Program Manager. This training will include an introduction to the enhanced workflow and the documentation process for targeted interventions under the CPA.

4.2.4.3 An initial one hour training will be conducted for pharmacy technicians. This training will emphasize identifying the targeted interventions, educating patients about the CPA process, and obtaining consent from patients who are eligible for targeted interventions under the CPA.

4.2.4.4 Pharmacy Interns and APPE students will also have an initial one hour training for identification of targeted interventions, documentation of these interventions in OutcomesMTM and explanation of the CPA process to the patients.

4.2.4.5 At monthly staff meetings 20 minutes of the meeting will be led by the CPA Program Manager. This time will be used for updating the staff about progress made with the CPA, any changes to the program, and/or additional training.



#### 4.2.5 Legal Information

4.2.5.1 Ohio House Bill 188 authorized one or more pharmacists to practice under a collaborative practice agreement (CPA) with one or more physicians. A collaborative practice agreement in Ohio allows a pharmacist to manage a patient’s drug therapy for specific diagnoses or diseases and to order and evaluate blood and urine tests. This law has allowed for the expansion of pharmacists’ services, increased access to medical care, and a step forward in the progress toward provider status for pharmacists. Most states have variations of these laws that allow for variations of collaborative practice between physicians and pharmacists.

4.2.6 Insurance

4.2.6.1 The Society of St. Vincent de Paul has a general liability policy provided by Cincinnati Insurance Company (Fairfield, OH).

4.2.6.2 The Charitable Pharmacy has a liability policy provided by Health Providers Service Organization (Hartboro, PA).

4.2.7 Security

4.2.7.1 Pharmacy services are provided at the private dispensing window and in separate appointment rooms.

4.2.7.2 Communication with patients is carried out on secure telephone lines.

4.2.7.3 All volunteers are required to sign a volunteer waiver indicating they will safeguard client information and abide by HIPAA.

4.2.7.4 The pharmacy area is occupied by staff during open hours, and closed with door locks and digital locks during closed hours.

5.0 Management Team and Personnel

5.1 The essential team members for implementation of the CPA agreement in a traditional community pharmacy include a CPA Program Manager, at least one to two staff pharmacists who have signed the CPA and with whom the physician(s) feel comfortable working with, and pharmacy technicians/interns for CPA triage and documentation. Below is a table with each team member role and responsibilities.

Pharmacy	Role/Responsibilities	Number of	Training/Certification
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Team Member		Personnel Needed	Needed
CPA Program Manager	<p>Trains personnel on CPA and is responsible for documentation and reporting of CPA interventions to the physician. This team member meets with the physicians involved in the CPA and reviews interventions for quality improvement purposes and to allow physicians to change/amend parts of the CPA.</p> <p>Reports to Pharmacy Manager</p>	One	<ol style="list-style-type: none"> <li>1. Doctor of Pharmacy Degree from an ACPE accredited program</li> <li>2. State pharmacy licensure</li> <li>3. APhA MTM Certification</li> <li>4. At least 2 years experience with OutcomesMTM platform</li> <li>5. At least two years working in a traditional community setting</li> <li>6. Community Pharmacy Residency Trained (optional)</li> </ol>
Clinical/Staff/ Resident Pharmacist	<p>The clinical and staff pharmacists working in the pharmacy that are included in the CPA will be responsible for adhering to the scope of practice detailed by the CPA and implementing the appropriate interventions in a timely manner.</p> <p>Reports to CPA Program Manager</p>	Initially: 2-3 Depending on success of initial CPA can train other pharmacists with whom the collaborating physician is comfortable with.	<ol style="list-style-type: none"> <li>7. Doctor of Pharmacy Degree from an ACPE accredited program</li> <li>8. State pharmacy licensure</li> <li>9. APhA MTM Certification</li> </ol>
Pharmacy Interns (APPE Students)	Under the supervision of a pharmacist practicing under a CPA, pharmacy interns and APPE students can document and close intervention claims in OutcomesMTM. This can be helpful to pharmacy workflow, as	Initially: At least 1-2	<ol style="list-style-type: none"> <li>1. State Pharmacy Intern License</li> <li>2. APhA MTM Certification (preferred)</li> </ol>

	<p>a pharmacist in a traditional community pharmacy may not have time to document the intervention during typical dispensing hours.</p> <p>Pharmacy Interns and APPE students may also be trained to triage CPA interventions at the pharmacy counter and make recommendations about drug interchanges before the pharmacist gives the final sign-off.</p> <p>Projects related to QI for the CPA could be assigned to the pharmacy interns or APPE students to facilitate improvements in the CPA process.</p>		
Pharmacy Technicians	<p>Pharmacy technicians working at the prescription drop-off or order-entry windows will be the “first-line” of defense for initiating CPA interventions. If the trained technician encounters an opportunity for one or more of the targeted interventions at the pharmacy window, he/she can place the prescription (or note) into a CPA basket near the pharmacist and alert the pharmacist that possible CPA intervention is present. Pharmacy technicians may also be</p>	Initially: 1-2	

	responsible for explaining to patients their choice to consent in the CPA process and what that means for their medication management.		
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## 6.0 Financial Implications

### 6.1 Projected Revenue

#### 6.1.1 Targeted Interventions

The targeted interventions described previously in conjunction with the enhanced workflow will generate additional revenue for the pharmacy and a more streamlined patient care process for all parties. Below are the potential monthly income benefits from each of the targeted interventions using the OutcomesMTM billing platform. Using this platform for each of the targeted interventions will result in **100% “acceptance” rate** of the interventions and a \$20 reimbursement for each.

Quantity Adjustments: One of the fundamental responsibilities of a pharmacist is to ensure the accuracy of prescriptions presented at the pharmacy. Consider for a moment a prescription that is written for Amoxicillin 500mg, take one tablet by mouth twice daily for 10 days with a quantity of #10. With only 10 tablets the patient will run out of medication 5 days into their course of therapy. This could potentially lead to additional Urgent Care/Emergency Care Visits resulting from unresolved infection that will lead to more healthcare costs to the patient and the healthcare system as a whole. Under a CPA the pharmacist could potentially submit a claim to OutcomesMTM for the medication-related problem of insufficient quantity and simultaneously close the claim as successful. Using this workflow process the pharmacist will increase pharmacy revenue and streamline pharmacy workflow. So in this intervention example the financial revenue is coming both from **cost avoidance** and **an enhanced OutcomesMTM workflow**.

Formulation Interchanges: The ability to change drug dosage form/formulation without contacting a physician and enabling a seamless workflow from patient presentation of prescription to patient counseling on the medication. If a prescription is written for a certain medication dosage form that the pharmacy does not ordinarily keep in stock the patient may go without the medication for a period of time while the pharmacist is contacting the doctor. Under a CPA this formulation interchange can happen immediately so that the patient does not go without care.

Therapeutic Interchanges: The interchange of medications within a certain drug class is a routinely accepted by providers at comparable dosage strengths. When a pharmacy does not carry a certain medication from a particular drug class, the prescription may need to be transferred to a competing store for the patient to fill. This takes revenue away from the pharmacy. Under a CPA, it is possible that the pharmacist can interchange the medication within the drug class at a comparable dose. This allows the pharmacy to reap the benefit of dispensing the prescription and receiving a dispensing fee, and billing for the intervention in OutcomesMTM. The patient also benefits from no lapses in therapy and efficient service.

Drug Optimization: This targeted intervention will rely heavily on the clinical services offered at the pharmacy. With a well-established MTM program POC testing for blood glucose, A1c and blood pressure may already be present. If these programs are not currently robust, APPE pharmacy students and interns can be used to perform these activities. With the results of POC testing, based on clinical guidelines the pharmacist can initiate a prescription for a dose increase of medications for multiple chronic disease states. The new prescription can be immediately filled by the pharmacy generating a successful “dose too low/high” claim billing in OutcomesMTM and revenue for the pharmacy through a dispensing fee.

Drug Initiation: Medications that are prescribed based on age and patient reported risk factors can easily be implemented by pharmacist following clinical guidelines. The pharmacist (or pharmacy intern/APPE student) can calculate a patient’s 10-year ASCVD risk score using information reported for the patient. This score along with the patient’s age and other risk factors may indicate that the patient is a candidate for statin (cholesterol lowering) medication therapy. This allows the pharmacy to reap the benefit of receiving the dispensing fee from the prescription and billing for the successful intervention in OutcomesMTM.

#### 6.1.2 Enhanced Workflow

The enhanced OutcomesMTM workflow will produce multiple opportunities for potential revenue. The identification of targeted interventions for patients of the physician with whom the CPA is established will potentially lead to billable MTM claim. The convenience of opening targeted interventions when identified at the pharmacy window and immediately closing those claim under the authority of the CPA allows for immediate submission of the successful interventions. Each successful targeted intervention, and initiation of a symptomatic consultation prescription results in \$20 per closed intervention. If a pharmacy was able to sustain a constant flow of at least 1 completed CMR billed through OutcomesMTM (a \$75 dollar reimbursement) and 5 successful targeted interventions each day (\$20 dollars each). The pharmacy could expect a revenue of at least \$63,700 dollars annually. Most traditional community pharmacies have established MTM programs that will result in far above this minimum revenue.

The dispensing fee (variable) collected by the pharmacy from each symptomatic relief consultation prescription would also need to be added to this dollar figure to create an expected annual revenue. This revenue stream could be accomplished by utilizing existing pharmacy staff but would also enable the possibility of creating a position for a full time “CPA Program Manager.” The individual in this position would be responsible for training staff, carrying out the targeted interventions, documenting interventions, interacting with the providers listed in the CPA and participating in continuous quality improvement of the CPA process.

#### 6.1.2 Initiation of “Symptomatic Relief Consultation Prescription”

The process of billing for consultation services by the pharmacist may be foreign concept to patients who are accustomed to receiving this service for free. If a patient were to visit a doctor's office complaining of constipation and the doctor wrote a prescription for docusate 100mg (an over-the-counter product) the patient would pay for that visit, and not necessarily come to your pharmacy to get the medication. The establishment SRCPs will allow pharmacists to continue counseling patients in OTC medications, but will create the additional benefit of initiating and dispensing a prescription for this product, both of which bring additional revenue to the pharmacy.

### 6.2 Projected Expenses

6.2.1 The initial expenses for implementing a CPA in a traditional community pharmacy are minimal if the pharmacy have previously engaged in offering MTM clinical services. It may be possible to implement the change in workflow with no additional staff, but at least one individual must be responsible for the training of the team, documentation of CPA, and follow-up with the collaborating providers. Below is an estimate of start-up costs (for one month) for CPA implementation in a traditional community pharmacy not currently engaged in any clinical MTM work.

Item	Quantity	Cost
Siemens Diagnostics 5075US DCA Vantage Diabetes Analyzer (POC A1c)	1 Machine	\$2,978.75 each
DCA Vantage Reagent Kit (for A1c Machine)	3 Packages/month	\$80.95 each x 3 = \$242.85/month
DCA A1C Normal & Abnormal Control Combination Kit	1 Kit/Year	\$87.00/year
Sphygmomanometer -	2	\$50.00

Professional Blood Pressure Monitor		
Blood Glucose Monitor, and Testing Supplies	2	\$200 initially; \$50 per month thereafter
APhA MTM Training	Number will vary based on the number of pharmacists needing certification	Per person: \$255 APhA Member / \$515 Nonmember
OutcomesMTM Pharmacy Subscription	N/A	N/A
OutcomesMTM Premium Subscription	1 Subscription per pharmacy	\$95/month = \$1,140

## 7.0 Implications of CPA

### 7.1 Steps toward provider status

The success of CPA implementation is instrumental to the eventual acceptance of pharmacist provider status by providers. As pharmacists continue to step into roles that allow for expanded clinical services, this may prompt continued and progressive law changes. Pharmacists must prove that they can practice safely and effectively under the current legislation before more expansive legislation is considered and approved.

## 8.0 References

- Centers for Disease Control and Prevention. *Advancing Team-Based Care Through Collaborative Practice Agreements: A Resource and Implementation Guide for Adding Pharmacists to the Care Team*. Atlanta, GA: Centers for Disease Control and Prevention, U.S. Department of Health and Human Services; 2017.
- Jun JK. Establishing Clinical Pharmacy Services With Prescribing Privileges in a Federally Qualified Health Center Primary Care Clinic. *Journal of Pharmacy Practice*. 2017;089719001771875. doi:10.1177/0897190017718752.
- Ohio State Board of Pharmacy. *Pharmacist Consult Agreements with Physicians*. ORC 4729.39
- Petterson SM, Liaw WR, Tran C, Bazemore AW. Estimating the Residency Expansion Required to Avoid Projected Primary Care Physician Shortages by 2035. *The Annals of Family Medicine*. 2015;13(2):107-114. doi:10.1370/afm.1760.
- OutcomesMTM. *2015 MTM Trend Report*.