MSHP Ambulatory Care Survival Guide

Updated March 2024

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I. Introduction (Return to: Table of Contents)

This "Survival Guide" has been created to provide an overview of foundational ambulatory care practice items as well as state specific examples of best practices to meet your needs in the development of your site and services. Despite the variability in ambulatory practice models there are several fundamental components to ambulatory care practice which are addressed in this guide.

Ambulatory care pharmacy is a growing and dynamic field of pharmacy inclusive of a variety of practice settings. The role of the ambulatory care pharmacist is diverse, varying from generalist to specialist in practice settings ranging from primary to specialty care.

Across Michigan ambulatory care pharmacists commonly work in outpatient, primary care, and specialty practice-based settings providing disease state management, medication access/prior authorization/patient assistance, medication therapy management/comprehensive medication management, and transition of care services. Ambulatory pharmacists in Michigan may perform these services supported by collaborative practice agreements and/or as part of a multidisciplinary team. Identification of practice opportunity areas and development of clinical services will vary based on practice setting, but as a foundation the following items should be considered for a new ambulatory pharmacy program:

- Stakeholder identification and buy-in
- Strategic plan development to explain the service and benefits to the organization
- Clinical model infrastructure design including pharmacist location, tool and equipment needs and optimal schedule
- Documentation and clinical communication expectations and procedure
- Development and use of collaborative practice agreements
- Program sustainability and return on investment (ROI)
- Reporting tools to assist in patient identification and clinic workflow
- Identification and tracking of metrics appropriate to measure success of the program

II. Legal Implications[1] (Return to: Table of Contents)

In Michigan, the Department of Licensing and Regulatory Affairs (LARA) regulates pharmacists and the Public Health Code (PHC) defines the practice of pharmacy. While Michigan has not yet recognized pharmacists as providers under state law pharmacists can still participate in many clinical activities that fall within the pharmacist's scope of practice. Michigan laws focus primarily on dispensing and are somewhat vague when it comes to ambulatory care practice outside of a retail pharmacy.

Public Health Code Act 368 contains the laws related to pharmacy practice. Within this document, there are some key definitions and sections that relate to the ambulatory care setting. The definition of "Practice of Pharmacy" includes the following:

(a) The interpretation and evaluation of the prescription.
(b) Drug product selection.
(c) The compounding, dispensing, safe storage, and distribution of drugs and devices.
(d) The maintenance of legally required records.
(e) Advising the prescriber and the patient as required as to contents, therapeutic action, utilization, and possible adverse reactions or interactions of drugs.

Collaborative practice agreements (CPAs) or collaborative drug therapy management is not explicitly authorized within the Public Health Code. However, a pharmacist may act as a "prescriber" under the delegation of a licensed doctor of medicine or doctor of osteopathic medicine, and in this way are able to enter into collaborative practice agreements for their ambulatory practice.

The Public Health Code also allows the pharmacist to delegate tasks or functions to others. This can apply to pharmacy technicians, interns, and students working with the ambulatory care pharmacist. Prior to any delegation, the pharmacist must do all of the following:

(a) Determine the knowledge and skill required to safely and competently complete the specific act, task, or function to be delegated.
(b) Before delegating an act, task, or function, make a determination that the delegatee has the necessary knowledge and skills to safely and competently complete the act, task, or function.
(c) Provide written procedures or protocols, or both, to be followed by the delegatee in the performance of the delegated act, task, or function.
(d) Supervise and evaluate the performance of the delegatee.

(e) Provide remediation of the performance of the delegatee if indicated.
(f) A delegating pharmacist shall bear the ultimate responsibility for the performance of delegated acts, tasks, and functions performed by the delegate within the scope of the delegation.

Given the Public Health Code does not limit disease states or patient populations an ambulatory care pharmacist can manage the development of their own practice in collaboration with physicians to identify areas of opportunity.

III. Credentialing & Privileging[2-6] (Return to: Table of Contents)

The terms "credentialing and privileging," while often completed in succession, are two specific processes. These processes are needed when the individual is licensed to provide care independently (The Joint Commission)[2]. The Center for Medicare and Medicaid Services' expanded definition of "medical staff" includes clinical pharmacists as being eligible to undergo the credentialing and privileging process in a healthcare system[3].

The Council on Credentialing in Pharmacy (CCP) defines a credential as "documented evidence of professional qualifications"[4]. Basic credentialing is a standard for pharmacist employment in the healthcare system. Some examples of credentials include: an academic degree, a state pharmacist license, a valid liability insurance policy, specialty board certification, etc. CCP further defines credentialing as "a process by which an organization or institution obtains, verifies, and assesses an individual's qualifications to provide patient care services." The credentialing process can vary depending on the institution. Once an individual's credentials are confirmed, a decision is made regarding their eligibility. In developing a credentialing process the following factors should be taken into consideration[3]:

- The type of care being provided
- The pharmacist's scope of practice defined by state law
- The scope of practice for clinical pharmacists within the organization
- The qualifications necessary to provide care

Privileging of pharmacists may not occur in all institutions. A privilege is defined by CCP as "permission or authorization granted by a hospital or other healthcare institution or facility to a health professional (e.g., physician, pharmacist, nurse practitioner) to render specific diagnostic, procedural, or therapeutic services"[4]. Privileging of pharmacists who provide care in advanced practice models is prudent to ensure patient safety. Once granted, individuals may undergo periodic review to maintain privileges. There are several standardized tools available to evaluate professional performance for the maintenance of privileges. Some of these tools include the: ACCP Template for Evaluating a Clinical Pharmacist, Ongoing Professional Practice Evaluation, and Focused Professional Practice Evaluation[3] and the ASHP practice resources on Credentialing and Privileging[6].

IV. Collaborative Practice Agreements[7-11] (Return to: Table of Contents)

A collaborative practice agreement (CPA) is a formal relationship between pharmacists and prescribers. CPAs allow pharmacists to assume professional responsibility for patient care within the context of a defined disease or patient specific protocol. CPAs authorize the delegation of tasks on behalf of a prescriber, such as initiating, monitoring or adjusting patient medications, ordering lab tests, and administering specified medications. It is a partnership utilized to expand team-based health care.

"The role of pharmacists in providing patient care services is compatible and synergistic with the patient-centered medical home model and other innovative models of team-based care. Pharmacists extend the health care team to the local community, providing patients with the resources and care they need. In addition, pharmacists are some of the most accessible health care professionals and have a broader knowledge of medicines (prescription and over-the-counter) than any other member of the health care team."[7]

CPAs must be written documents that specify:

- Which disease states pharmacists can help manage
- Which drugs or drug categories pharmacists can utilize
- What protocols/guidelines pharmacists must follow when carrying out delegated tasks
- How pharmacists and physicians will communicate

Several additional components may be specified, including but not limited to:

- Scope of agreement (parties in agreement, patient care scope specified, etc.)
- Administrative components (training and education, documentation, communication, etc.)
- Legal components (purpose, liability insurance, period of validity, etc.)

Although most CPAs will include similar sections as listed above pharmacists practicing in different settings may need to include additional relevant components. For example, ambulatory care pharmacists practicing in a clinic setting may need to specify who will order relevant lab tests, in addition to who (provider, pharmacist, etc.) will be responsible for appropriate follow up on these laboratory tests. Conversely, pharmacists practicing in the community setting may not need to include information related to laboratory parameters, rather, they may include a section related to the approval of refills, dispensing of over-the-counter medications, or renewal of diabetic testing supplies. Given the distinction between these practice settings and the need for additional guidance, the Michigan Pharmacists Association has created a CPA template for community pharmacists. Although the template is aimed towards cardiovascular disease, it could be modified for other disease states.[8]

V. Billing Practices[12-20] (Return to: Table of Contents)

Vi. Billing Overview:[12-14]

Creating sustainable payment models for pharmacy services is essential to expanding pharmacist's scope-of-practice. Many healthcare payers are moving away from a Fee for Service (FFS) payment model and acquiring a value-based reimbursement model to promote quality outcomes. This may result in more cost savings or cost avoidance initiatives in addition to traditional revenue generation activities which are commonly used to justify return on investment (ROI).

When identifying payment strategies for a pharmacy service, there are many things to consider including the location of the service, billing provider, need for supervision, and reimbursement amount. Prior to billing any service, the requirements for billing and documentation should be reviewed with appropriate parties which may include medical billing, supervising provider, and third-party payers. These requirements may include specific courses/trainings (ex. care management) that may need to be completed prior to initiation of billing, as well as on an annual basis. See list below for state specific requirements:

- Location of service: Depending on the requirements for billing, the service may have stipulations on the specific location in which it is provided. This is typically within a provider office, a health system office, or a pharmacy. Telehealth options also exist.
    - Face-to-Face Billing Opportunities: Billing codes for face-to-face incident-to-physician billing include evaluation and management (E&M) billing codes 99211-99215, with the code selected based on the complexity of the visit and time spent with the patient. However, pharmacists are limited to billing 99211 regardless of time spent or complexity of the visit. In a hospital-based clinic, both 99211 and G0463 (the facility fee) may be submitted. In a physician-based clinic, only 99211 is billed for government payors such as Medicaid, Medicare, and TriCare. For both hospital and physician-based clinics, the commercial payers are only billed 99211, while G0463 does not apply. Other face-to-face billing opportunities reimbursed by Medicare include Transitional Care Management, Chronic Care Management (for non-face-to-face care coordination efforts), Annual Wellness Visits, and Diabetes Self-Management Training (see table below). It is important to note that some of these billing codes only require general supervision (under provider direction, but the billing provider does not need to be onsite or immediately available). Other billing codes require direct supervision (provider must be present in the same location and immediately available while the service is delivered).

- Telehealth Billing Opportunities: In response to the COVID-19 pandemic, the Coronavirus Preparedness and Response Supplemental Appropriations Act became law on March 6, 2020. This legislation allowed CMS to expand access to care and telehealth billing codes. While the use of telehealth codes was originally planned to be used temporarily, the Consolidated Appropriations Act of 2023 extended telehealth flexibilities through December 31, 2024. See table below for the existing opportunities.

- Supervision: Codes may require the rendering provider to provide oversight of the performed service.
  - None: No supervision required for billing of service.
  - Direct: Requires a physician to be immediately available during the performance of the service. The physician does not need to be in the room while the service is provided but must be available within the location of service to provide assistance and guidance if needed. A co-signature may be required on documentation of services requiring direct supervision.
  - General: The service is performed under the direction and control of the physician, but their physical presence is not required.
- Reimbursement: When billing, it is important to understand how appropriate funds are received and recognized by the organization from the third party.
  - Direct: The pharmacy and/or pharmacist can bill the third party independently and receive payment for services from the payer.
  - Indirect: The pharmacy and/or pharmacist is required to work under an agreement with an eligible provider to receive reimbursement from a payer. The provider submits the claim and receives the payment. Typically, the pharmacy and/or pharmacist may have a financial agreement with the provider or is employed by the same entity (healthcare system).

  - Pharmacists can check the approximate reimbursement for a particular code via the Medicare Physician Fee Schedule: https://www.cms.gov/apps/physician-fee-schedule/search/search-results.aspx?Y=0&T=4&HT=0&CT=2&H1=99605&C=76&M=5.

Examples of Michigan specific opportunities:

- Provider delivered care management (PDCM):[12,13]
    - Insurance providers have noticed the value of interdisciplinary teams and their ability to improve patient outcomes. Some payers have begun reimbursing for non-physician services through PDCM services. Eligible providers of PDCM services include registered nurses, social workers, dietitians, and **pharmacists** as well as other licensed and unlicensed healthcare team members.
    - In addition to receiving reimbursement as FFS through billing codes, PDCM is typically tied to value-based reimbursement through an uplift or incentive payment for participating. Services that may be reimbursed through PDCM include face-to-face encounters, telephone encounters, and care coordination between community resources and/or other healthcare providers.
    - Requirements for billing and document can vary by payer.
- Michigan Medicaid:[14]
    - In April 2017, Michigan Medicaid began covering Medication Therapy Management (MTM) to all beneficiaries who are on at least one chronic medication.
    - Through this program, using the existing MTM CPT codes, a pharmacist may bill for an initial visit and up to seven follow up visits in a calendar year.
    - Specific training is required prior to performing services and billing must occur through the CHAMPS platform.
    - Pharmacists can deliver MTM services to beneficiaries enrolled in FFS or any other Michigan Medicaid health plan (including managed care programs) from ambulatory care outpatient clinics, community pharmacies, or the beneficiary's home. Provision of services is excluded in inpatient settings. Reimbursement for these services is issued directly to the facility billing under a Type 2 National Provider Identifier (NPI); reimbursement is not issued directly to a pharmacist.

Vii. Billing Codes:[15-21]

Before initiation of billing codes listed in the table, below be sure to work with your institution's billing department as reimbursement may vary based on specific plan and practice site requirements.

***Given the evolving role of ambulatory care pharmacists, billing codes are subject to change at any time. Please consult references for up to date information. Of note, codes payable by Medicare benefits may also be payable by select Medicaid and private insurers.**

Description	Current Procedural Terminology (CPT) Code	Service Description	Location	Supervision	Reimbursement
Evaluation and Management (E/M)- "Incident to"					
Face-to-face office visit of an established patient. Codes are based on patient complexity. *Pharmacists currently limited to use of 99211.	**99211***	Nurse/Pharmacist	Provider office	Direct	Indirect
	99212	Problem focused, minimal medical decision making			
	99213	Expanded problem focused; low medical decision making			
	99214	Detailed problem; moderate decision making			
	99215	Comprehensive problem; high decision making			
	G0463	Used with Medicare	Hospital outpatient clinic		
Medicare Annual Wellness Visits (AWV) - Medicare Part B Benefit					

Description	Current Procedural Terminology (CPT) Code	Service Description	Location	Supervision	Reimbursement
AWV consists of reviewing health history with patient and developing or updating a prevention plan. Cost is covered by Medicare, no co-pay.	G0439	Initial visit (Pharmacists CANNOT bill for initial visit, defer to providers)	Provider office	Direct	Indirect
	G0439	Subsequent visits (Pharmacists CAN bill for subsequent visits)			
Chronic Care Management (CCM) - Medicare Part B Benefit					
Non-face-to-face visit for coordination of care for patients with Medicare and multiple chronic conditions. Must receive verbal consent from patient. Additional requirements for CCM billing can be found in references.[22]	99487	60 minutes	Provider office	General	Indirect
	99489	Each additional 30 minutes			
	99490	≥20 minutes			
Transitional Care Management (TCM) - Medicare Part B Benefit					
Bundle payment for additional patient support following care transition. Phone call must take place within 2 days of discharge and a face-to-face visit within 7-14 days of discharge.	99495	Within 7 days of discharge	Provider office	General	Indirect
	99496	Within 14 days of discharge			

Description	Current Procedural Terminology (CPT) Code	Service Description	Location	Supervision	Reimbursement
Null if readmitted within 30 days.					
Continuous Glucose Monitor (CGM)					
Requires documented ambulatory CGM data for a minimum of 72 hours. 95249 or 95250 can be billed at the same time as 95251.	95249	Placement of CGM device (personal)	Pharmacy/ Provider office	None	Direct or Indirect
	95250	Placement of CGM device (professional)			
	95251	CGM interpretation	Provider office	General	Indirect
Medication Therapy Management (MTM)^					
MTM services provided by a pharmacist, individual, face-to-face with patient, with assessment and intervention if provided.	99605	New patient, individual face-to-face encounter. Initial 15 minutes	Community Pharmacy, employer groups, provider office	None	Direct
	99606	Established patient, individual face-to-face encounter Initial 15 minutes			

Description	Current Procedural Terminology (CPT) Code	Service Description	Location	Supervision	Reimbursement
	99607	Each additional 15 minutes (following 99605 or 99606)			
Provider Delivered Care Management (PDCM)					
PDCM delivered care allows physician-lead health care teams to deliver services that are billed by qualified practitioners. Due to the COVID pandemic, BCBSM allows all 12 PDCM codes to be conducted via telephone or virtual (via secure video conferencing).[23] *Specific requirements for G9001 may not apply to pharmacist visits	G9001*	Initiation of care management services (Comprehensive Assessment) and comprehensive (focused) care plan	Provider office, physician organization	General	Indirect
	G9002	Individual, face-to-face visit with care manager, <45 minutes			
	G9007	Team conference between care manager and primary care provider to discuss care plan.			
	G9008	Physician directed coordination of care			

Description	Current Procedural Terminology (CPT) Code	Service Description	Location	Supervision	Reimbursement
	98966	Phone services 5-10 minutes in medical discussion			
	98967	Phone services 11-20 minutes in medical discussion			
	98968	Phone services 21-30 minutes in medical discussion			
	99487	Coordination of care 31-75 minutes			
	99489	Coordination of care, every 30 minutes over 75			
Telehealth Services					
Video Audio and video capabilities for two-way, real-time interactive communication (Facetime, Skype, Zoom)	99201-99205	New patients†	Provider office	General	Indirect
	99211-99215	Established patients			

Description	Current Procedural Terminology (CPT) Code	Service Description	Location	Supervision	Reimbursement
Telephone Evaluation and management billing code for telephonic outreach	99441	5-10 minutes of medical discussion			
	99442	11-20 minutes of medical discussion			
	99443	21-30 minutes of medical discussion			
Virtual Check-In‡ Brief check in via telephone or other telecommunication Cannot be related to an E/M code provided in the last 7 days nor leading to an E/M code in the next 24 hours. Medicare: No additional reimbursement codes beyond 5-10 minutes verbal consent must be obtained.	G2012	5-10 minutes			
	G2010	Remote evaluation of recorded video and/or images submitted by an established patient			
E-Visit‡	G2061	5-10 minutes			

Description	Current Procedural Terminology (CPT) Code	Service Description	Location	Supervision	Reimbursement
Discussion through an online patient portal. Billed as cumulative time over 7 days.	G2062	11-20 minutes			
	G2063	21 or more minutes			

^MTM billing may require the use of a Third Party platform such as OutcomesMTM
†Pharmacists must adhere to incident-to billing rules which requires that the patient has an established relationship with the provider.
‡ Established patients only

VI. Pharmacist Extender Utilization[24,25] (Return to: Table of Contents)

Pharmacy practice has changed drastically over the last several decades. It has transitioned from primarily a process-based to a more clinical-based profession. Additional clinical responsibilities and services provided by ambulatory care pharmacists, such as those outlined in this guide, lend themselves to the use of pharmacist extenders to allow the ambulatory care pharmacist to provide care to a broader population of patients, streamline workflows and practice at the top of their license.

Pharmacist extenders most commonly include pharmacy technicians, students, residents and medical assistants. All extender types can be leveraged for both direct and indirect patient care activities to expand the reach of the ambulatory care pharmacist. A number of the goals/objectives found in the Practice Advancement Initiative (PAI) 2030 also support the use of extenders to advance the role of pharmacists.

Examples of the types of activities a pharmacist extender could be leveraged for and the roles each extender might have can be found in the following table:

Type of Activity	**Pharmacy Technician**	**Student**	**Resident**	**Medical Assistant / Other Clinical Staff**
Transitions of Care	Pre-visit medication history Calls to pharmacies to verify fill history	Patient interview/ Medication history Recommendations on medication changes	Completion of medication reconciliation process Supervision of student and/or technician using the Layer Learning Practice Model (LLPM)	Pre-visit medication history
Disease State Management/ Medication Management Visits	Scheduling visit Collection of self-monitoring data Simple follow-up for newly started medications	Patient interview Medication history Medication Recommendations Medication/device patient education	Up to full responsibility for patient visit Supervision of student utilizing LLPM	Taking vitals Medication history Scheduling visit
Type of Activity	**Pharmacy Technician**	**Student**	**Resident**	**Medical Assistant/ Other Clinical stuff**

Indirect Tasks	Data collection activities Insurance formulary navigation Prior authorization requests	Drug information questions Education to office staff	Electronic medical record (EMR) in-basket management Drug information questions Education to office staff	EMR in-basket management Answering phone calls Scheduling appointments Authorization of prescription refills Billing Prior authorization requests

VII. Quality Metrics and Dashboard Development[26,27] (Return to: Table of Contents)

Regardless of the type or scope of ambulatory practice, it is paramount to develop, obtain, and manage quality and outcome metrics. Continuous metric evaluation can achieve multiple goals including:

- Development and/or sustainability of practice model
- Identification of service opportunities that would improve clinical endpoints, enhance safety outcomes, and/or achieve neutral or favorable return on investment
- Rationale and implementation of service line expansion

The development and selection of quality and outcome metrics should focus on those that are meaningful, feasible, and actionable. Inclusion of quality elements should be driven by national and institutional performance metrics and rating systems, such as HEDIS, NCQA, and other relevant payor models. A standardized documentation system is critical to gather complete and unbiased information, using discrete data elements. Ideally, this information would translate into a meaningful dashboard to track quality outcomes for ambulatory care practices.

Tools and resources:

- The timeline and comparison for each metric will depend on the service provided or disease state assessed. The data should be continually evaluated at predefined time points. Metrics may be compared to a baseline, a control group not exposed to the intervention, internal standards, or external standards (guideline or benchmark data)
- The first step to ensuring a meaningful dashboard is to identify an IT contact within the institution. This individual should be familiar with the use of dashboards but should also understand the ambulatory care pharmacist's workflow
- Other tools to investigate include assessing existing reporting and benchmarking metrics and reports within the institution, in addition to other reports that may be available through the EMR

Prior to implementation of a dashboard it is important to determine key stakeholders who may influence which metrics and outcomes may be most relevant. These key stakeholders will vary depending on the institution and practice site, but may include the following:

- Medical/institutional leadership: CEO, quality workgroup, physician leaders
- Pharmacy personnel: supervisors, colleagues
- Interprofessional team: nurses, support staff

Patient identification:

- The next step in the development of a meaningful dashboard is for pharmacists to accurately identify patients assigned to their service.
- For example, if a pharmacist practices in a primary care setting managing patients with diabetes and is interested in assessing glycemic outcomes, patients assigned to the pharmacist's care will need to be identified appropriately to track baseline A1c and improvements over time.
- This may be accomplished through generation of EMR reports. If this is not easily attainable, other possibilities include (dependent on EMR software):

    - Utilization of patient lists/flagging within EMR
    - Flowsheets within EMR
    - Inclusion of pharmacist on patient care team list in EMR

- Manual creation of list of patients outside of EMR to track (eg. Microsoft Excel log)
- Intervention tracking through EMR reports (i.e. iVents in Epic)

Outcomes

- Outcomes of interestand clinical benchmarks that are important to the institution or applicable local/national organizations will vary by practice setting
- These outcomes may be relevant based on particular incentive payments to a clinic or clinic designation (i.e. Patient Centered Medical Home designation, Accountable Care Organization). The table below lists common outcomes tracked in the outpatient ambulatory care setting
- It is also important to report outcomes in a meaningful way, using graphics or tables/charts to view changes in outcomes most efficiently
- Lastly, it is important to keep in mind the potential audience and their accessibility to this dashboard. For example, determine if the dashboard should be a public page accessible to anyone within the institution, or if certain access must be granted to specific individuals. If there are currently other dashboards used at your practice site it would be best to incorporate your pharmacy specific outcomes into that platform, if possible.

Type of Outcome	**Examples**
Clinical	- Primary care: A1c, BP, LDL, UACR, INR, weight, vaccinations - Specialty: viral load with HIV medications, ADR with oncology medications - Payer based quality metrics: Antidepressant persistence, asthma medication ratio, avoidance of antibiotics in acute bronchitis, BP (<140/90), HgbA1c (<8 vs <9%), post-discharge medication reconciliation, pharmacotherapy for COPD, proportion of days covered for DM medications, statin therapy - Other: 30-day mortality rates, comprehensive medication reviews
Humanistic	- Patient experience ratings - Quality of life/functioning scores - Provider/other health care professional satisfaction
Productivity	- # pharmacist hours - # patients - # encounters (phone vs face to face) - # and type of interventions (eg. medication additions, discontinuations, changes)

	- # of vaccinations - # non-visit patient care hours - # direct patient care hours - # chart reviews - # non-patient care activities - # prior authorizations, financial assistance, medication interchange - Indirect impact (i.e. changes to provider productivity or prescribing trends)
Health Care Utilization	- ED utilization - Prevention of hospitalization/emergency room visits - Hospitalizations (i.e. HF hospitalizations for cardiology clinics, COPD/asthma exacerbations requiring acute care visit) - 30-day readmission rates

Financial	- Revenue Generation
	  - Utilization of face-to-face and telephonic billing codes
	  - Percent of billable/reimbursable encounters
	- Cost Savings
	  - Incentive codes (i.e. PDCM)
	  - Payor/reimbursement specific outcomes (ex # patient "touches" for BCBS)

VIII. Evolving & Expansion of Pharmacy Practice **(Return to: Table of Contents)**

Pharmacist role in the ambulatory setting has quickly evolved from primarily safely distributing medications to working side-by-side with a multidisciplinary team. Evolving and expanding pharmacy practices are growing across the nation to help optimize healthcare needs. In addition to chronic disease management in primary and specialty clinics there are other examples of pharmacy expansion opportunities, including but not limited to, hematology, rheumatology, smoking cessation, substance use disorder, and vaccine management. Additional opportunities are detailed below.

Antimicrobial stewardship:

- MSHP antimicrobial stewardship subcommittee encourages ambulatory care and community pharmacist involvement in educating and following up with patients on symptom improvement and/or worsening along with coordination of next steps for patients as deemed necessary.

- Monitoring of outpatient antimicrobial use provides an opportunity to justify use of ambulatory care pharmacists in the area of antimicrobial stewardship efforts. A statewide initiative has been established that quantifies and assesses outpatient prescribing practices:
    - The Collaboration to Harmonize Antimicrobial Registry Measures (CHARM) is a collaborative effort to utilize existing data from partner institution's EMR data to quantify and assess local antimicrobial prescribing practices. The registry also allows participating clinics to benchmark their usage patterns against compiled data for other clinics. To get started/gather more information you may contact one of the core CHARM team members: Minji Sohn (MinjiSohn@ferris.edu) or Michael Klepser (MichaelKlepser@ferris.edu).
- The Core Elements of Outpatient Antibiotic Stewardship provides a framework for antimicrobial stewardship in outpatient settings that routinely provide antibiotic treatment.[28] It also serves as an excellent guide for institutions eager to incorporate more stewardship into their practice settings.

Comprehensive medication management:

- Although ambulatory care pharmacists can be highly effective focusing on the management of patients with specific disease states, there is increasing demand for "comprehensive medication management" (CMM).
- CMM is defined as a patient-centered approach to optimizing all of a patient's medications.
- CMM can be implemented initially in a practice setting or used as an opportunity to expand your reach.
- Optimizingmeds.org is a resource that can be used to identify areas for growth and improvement.

Virtual health:

- A way to manage care through the comfort of your own home. Many physician offices are offering this as an option.
- COVID-19 led to more patients staying at home instead of attending routine physician appointments. Physician offices and health-systems had to adapt to the new recommendations, which led to more virtual and telehealth visits being set up.
- Virtual health is a new way to see a physician in a quick manner and has led more practices (including ambulatory care pharmacists) to adapt to new technology available to our patients.

IX. References **(Return to: Table of Contents)**

1. Public Health Code Act 368 of 1978. Part 177. Pharmacy Practice and Drug Control. http://www.legislature.mi.gov/(S(yiy1ct0uefwli4wegkqim4l0))/mileg.aspx?page=getObject&objectName=mcl-368-1978-15. Accessed May 26, 2022.
2. The Joint Commission Accreditation Ambulatory Care. Ambulatory Care Program: The Who, What, When, and Wheres of Credentialing and Privileging. https://www.jointcommission.org/assets/1/18/AHC_who_what_ credentialing_booklet.pdf. Accessed May 26, 2020.
3. Engle JP, Dick TB, Bryant G, et al. Credentialing and privileging for clinical pharmacists. *J Am Coll Clin Pharm*. 2020;3(1):133-144.
4. Rouse MJ, Vlasses PH, Webb CE; Council on Credentialing in Pharmacy. Credentialing and privileging of pharmacists: a resource paper from the Council on Credentialing in Pharmacy. *Am J Health Syst Pharm*. 2014;71(21):1891-1900.
5. Claxton KL, Wojtal P. Design and implementation of a credentialing and privileging model for ambulatory care pharmacists. *Am J Health Syst Pharm*. 2006;63(17):1627-1632.
6. Credentialing and Privileging - ASHP. https://www.ashp.org:443/Pharmacy-Practice/Resource-Centers/Credentialing-and-Privilegin. Accessed May 26, 2022.
7. Emerging Practices in Diabetes Prevention and Control: Working with Pharmacists. National Center for Chronic Disease Prevention and Health Promotion. https://www.cdc.gov/diabetes/pdfs/programs/stateandlocal/emerging_practices-work_with_pharmacists.pdf
8. Community Practice Resources. Michigan Pharmacists Association. https://www.michiganpharmacists.org/PracticeResources/communitypractice
9. Advancing Team-Based Care Through Collaborative Practice Agreements A Resource and Implementation Guide for Adding Pharmacists to the Care Team. National Center for Chronic Disease Prevention and Health Promotion. https://www.cdc.gov/dhdsp/pubs/docs/CPA-Team-Based-Care.pdf
10. Collaborative Practice Agreements (CPA) And Pharmacists' Patient Care Services. APhA Foundation. https://www.aphafoundation.org/collaborative-practice-agreements
11. Collaborative Practice Agreements: Resources and More. National Alliance of State Pharmacy Associations. June 2017. https://naspa.us/resource/cpa/
12. Michigan Institute for Care Management and Transformation. https://micmt-cares.org/
13. Michigan Center for Clinical Systems Improvement. https://www.miccsi.org/
14. Roath E, Malburg D, Jalloul F. Delivery of MTM services for Michigan Medicaid beneficiaries. Michigan Pharmacists Association. 2019 Oct. https://www.michiganpharmacists.org/education/online/2017mtm
15. American Pharmacists Association. Billing Primer: A Pharmacist's Guide to Outpatient Fee-for-Service Billing. Washington, DC: American Pharmacists Association; February 2018.
16. American Pharmacists Association. Pharmacists' Patient Care Services Digest. March 2015. https://www.pharmacist.com/sites/default/files/Pharmacists%20Patient%20Care%20Services%20Digest%202015.pdf
17. American Pharmacists Association. Billing for MTM services: Tips for Pharmacists. 2008. https://www.pharmacist.com/sites/default/files/files/mtm_billing_tips.pdf

18. American Society of Health System Pharmacists. Ambulatory Care Practitioners: Pharmacists billing for ambulatory pharmacy patient care services in a physician-based clinic and other non-hospital-based environments FAQ. May 2014.
19. National Council of Prescription Drug Programs. Billing Guidance for Pharmacists' Professional and Patient Care Services. June 2018.https://ncpdp.org/NCPDP/media/pdf/wp/Billing_Guidance_for_Pharmacists_Professional_and_Patient_Care_Services_White_Paper.pdf
20. American Association of Colleges of Pharmacy. Practice Advancement Issue Brief: Payment Methods in Outpatient Team-based Clinical Pharmacy Practice, Part 1. August 2018. Medicare telemedicine health care provider fact sheet 2020. https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet
21. Physician Fee Schedule (PFS) Proposed Rule CY 2022. ASHP. https://www.ashp.org/advocacy-and-issues/key-issues/other-issues/hospital-reimbursement/physician-fee-schedule-pfs-proposed-rule-cy-2022?loginreturnUrl=SSOCheckOnly
22. Chronic Care Management Services. Medicare Learning Network. CMS. Updated March 2022. https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/chroniccaremanagement.pdf
23. Michigan Institute for Care Management and Transformation (MiCMT) FAQs. Updated November 4, 2021. https://micmt-cares.org/faqs.
24. Practice Advancement Initiative 2030. ASHP. https://www.ashp.org/Pharmacy-Practice/PAI/PAI-Recommendations
25. Pinelli N, Eckel S, et al. The layered learning practice model: Lessons learned from implementation. *American Journal of Health-System Pharmacy*. 2016; 73(24):2077-2082.
26. Harris IM, Baker E, Berry T, et al. Developing a business-practice model for pharmacy services in ambulatory settings. *Pharmacotherapy*. 2008;28:7-34.
27. Umbreit A, Holm E, Gander K, et al. Developing a dashboard for benchmarking the productivity of a medication therapy management program. *JAPhA*. 2017;57:95-101.
28. Sanchez, G.V., Fleming-Dutra, K.E., Roberts, R.M., Hicks, L.A. Core Elements of Outpatient Antibiotic Stewardship. MMWR Recomm Rep 2016;65(No. RR-6):1–12.