Wisconsin Council on Medical Education and Workforce

Primary Care Pharmacy Practice

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October 30, 2023

Today's Objectives

- Envision collaborative models of care that deliver enhanced clinical, patient and economic outcomes that involves pharmacists.

- Recognize the importance of aligning incentives, given the healthcare ecosystem(s) and emerging models of care by various healthcare providers, including pharmacists.

MEDICAL COLLEGE OF WISCONSIN

Healthcare workforce: Example Wisconsin

FINDINGS

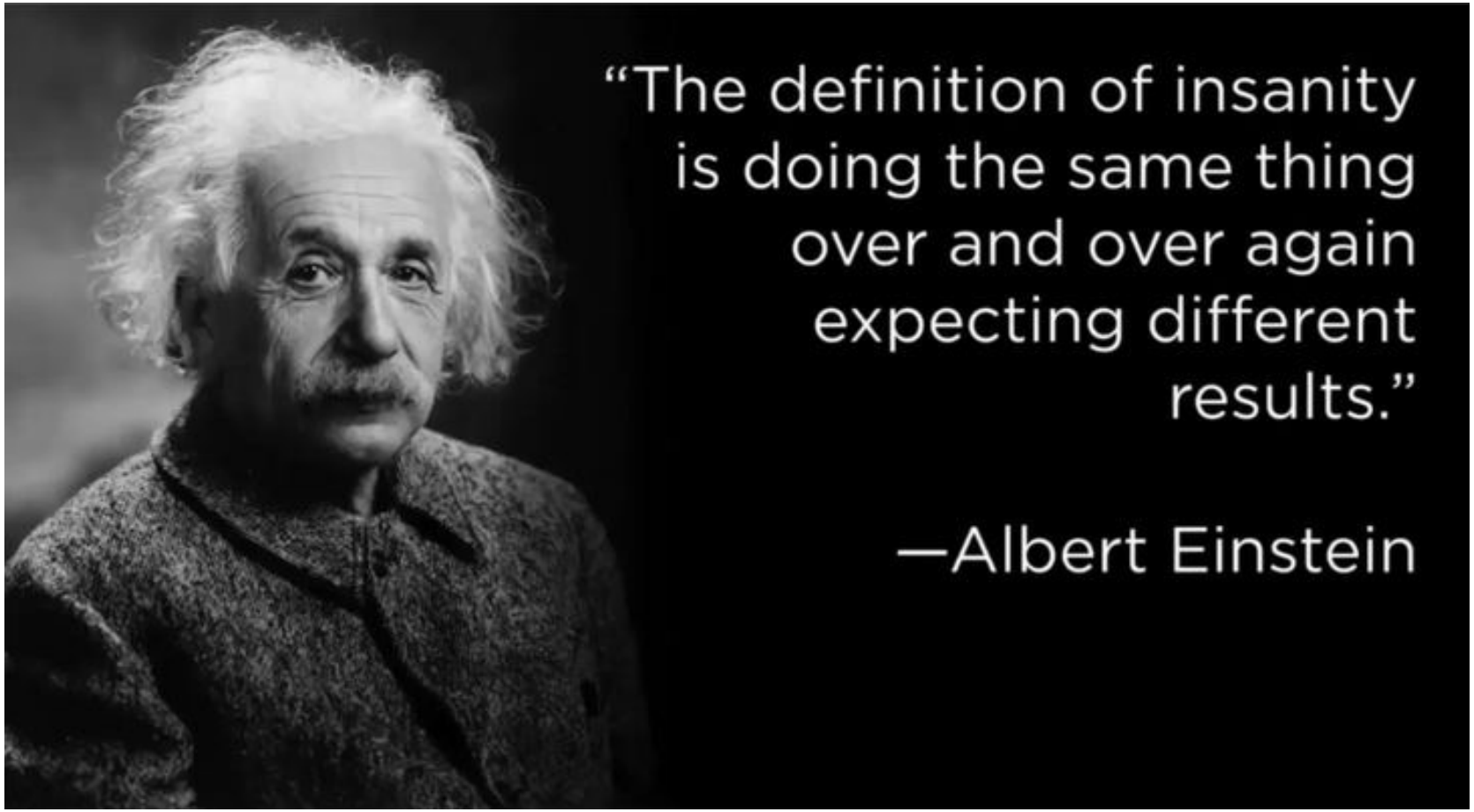
1. Initial findings show shortages across a number of disciplines, including registered nurses, licensed practical nurses, and physicians. Our current pipelines for these professions is not sufficient to fill the shortages.
2. Further analysis suggests that there will be no surplus of APNs, PAs, and pharmacists. They will be incorporated into the workforce, provided that there will be capacity in the education and training pipeline, and continued movement of APNS, PAs, and pharmacists into new roles.
3. The projected static working age population, at the state and national levels, will diminish the number of potential students in Wisconsin and available workers from other states.
4. *There will be a significant shortage of nurses unless the pipeline is dramatically expanded.* While shortages for any of the healthcare professions will have an adverse impact, the projected nursing shortage will have a far-reaching effect on healthcare delivery.
5. Workforce data sources are inconsistent and often lack timeliness.

January 2022 Newsletter

WCMEW PRESENTS 2021 WORKFORCE REPORT TO RWHC

At the January 7 Rural Wisconsin Health Cooperative (RWHC) Board meeting, George Quinn, WCMEW Executive Director presented WCMEW's 2021 Workforce Report **"THE FUTURE OF WISCONSIN'S HEALTHCARE WORKFORCE"**. The goals of the report were to take more comprehensive look at Wisconsin's healthcare workforce. It is the first from WCMEW to include physicians, physician assistants, pharmacists, and nursing professionals.

Will "the doctor" see you now?
Maybe not amid the changing health care landscape in the US.



2004, the physician search firm Merritt Hawkins first issued their Survey of *Physician Appointment Wait Times*….to see a new physician was 21 days. In their 2022 survey, the new patient appointment increased to an average of 26 days.

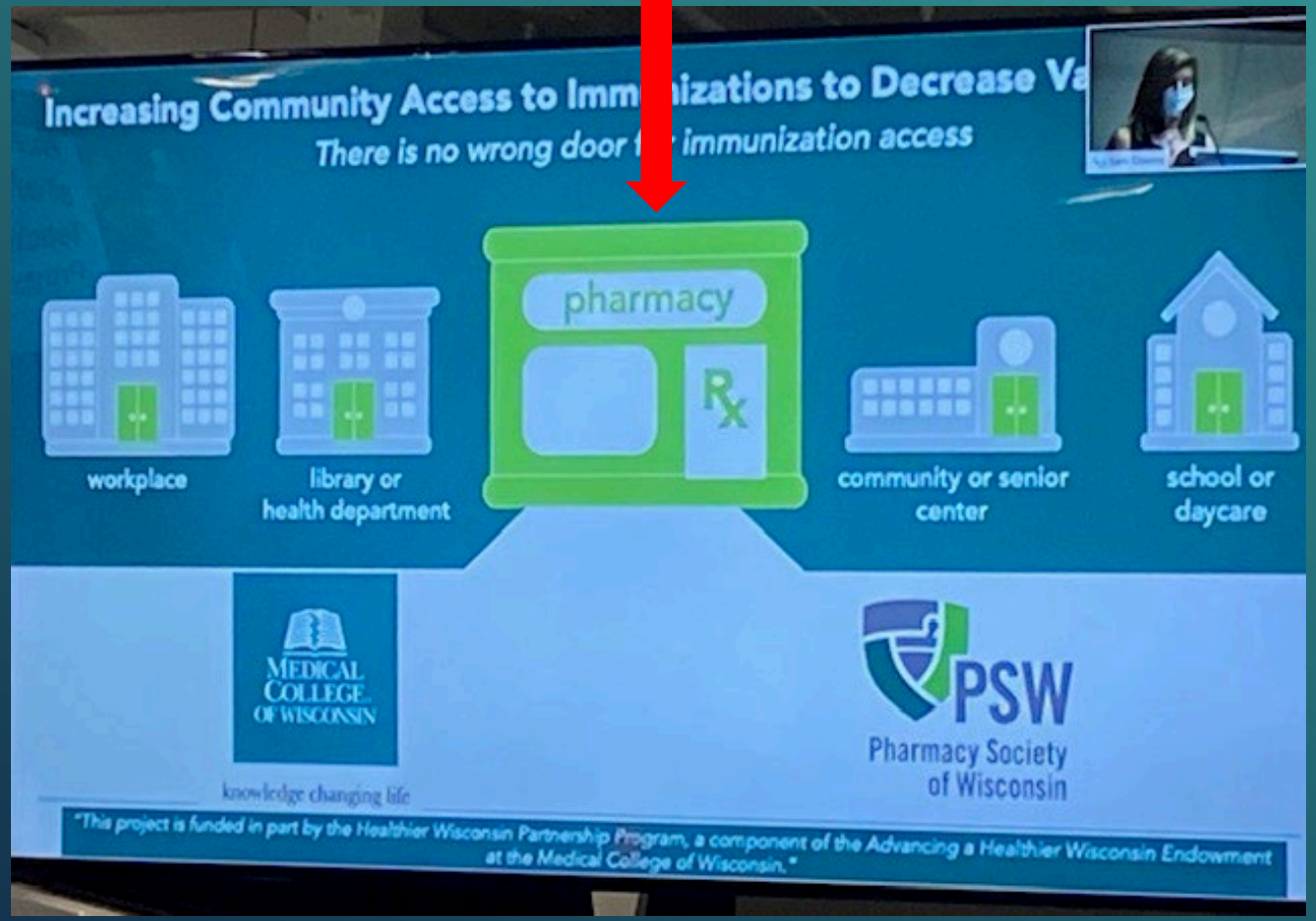
“This is a problem that has been simmering and now beginning to erupt in some communities at a boil. It’s hard to find that front door of the health system,” said Ann Greiner, president/CEO of the Primary Care Collaborative.

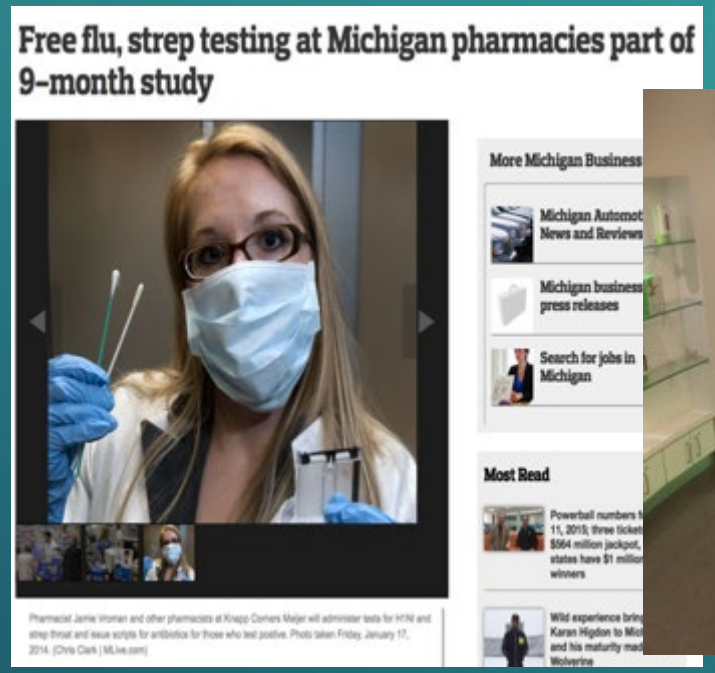
The Overlooked Front Door to Healthcare…expanding access via Primary Care Pharmacy Practice

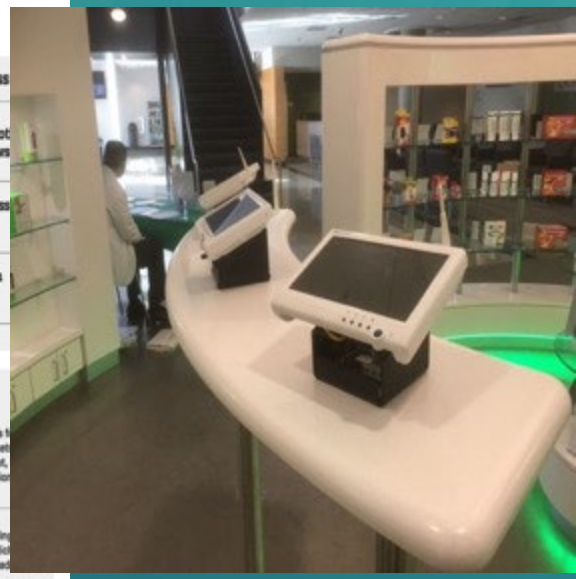
https://www.usatoday.com/story/news/nation/2023/06/27/primary-care-doctor-shortages-on-the-rise-in-the-us-as-wait-times-grow/70352744007/

Pharmacies and Pharmacists

- "Front Door" to Healthcare, 60,000 locations
- 95% US population live within 5 miles of a Pharmacy
- Doctorly educated past 25+ years





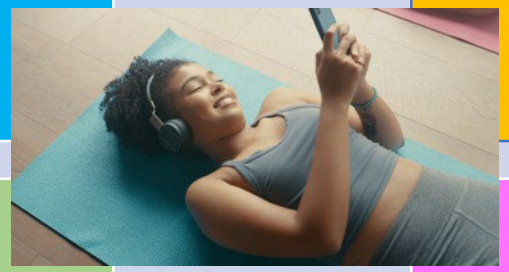


Challenges to the Healthcare Team…

- Addresses Shortages of Physicians
- Practitioners at TOP of License & Education
- Lower Healthcare Costs & Increased Quality >> Satisfaction
- Advancing Triple to Quadruple Aim (improving work-life providers

Care where

They desire



Commonwealth Fund International Surveys

The U.S. remains the only high-income country lacking universal health insurance coverage. With nearly 30 million people still uninsured and some 40 million with health plans that leave them potentially underinsured, out-of-pocket health care costs continue to mar U.S. health care performance

Top-performing countries: Norway, Netherlands, and Australia.

https://www.commonwealthfund.org/publications/fund-reports/2021/aug/mirror-mirror-2021-reflecting-poorly?gclid=EAIaIQobChMIu8HI77-C9gIVWcmUCR2OoQhREAAYAiAAEgLsP_D_BwE

Health Care System Performance Rankings

	AUS	CAN	FRA	GER	NETH	NZ	NOR	SWE	SWIZ	UK	US
OVERALL RANKING	**3**	**10**	**8**	**5**	**2**	**6**	**1**	**7**	**9**	**4**	**11**
Access to Care	8	9	7	3	1	5	2	6	10	4	11
Care Process	6	4	10	9	3	1	8	11	7	5	2
Administrative Efficiency	2	7	6	9	8	3	1	5	10	4	11
Equity	1	10	7	2	5	9	8	6	3	4	11
Health Care Outcomes	1	10	6	7	4	8	2	5	3	9	11

Peterson-KFF Health System Tracker reporting only 12% of U.S. doctors are generalists, compared with 23% in Germany and as many as 45% in the Netherlands. **That means it's often hard to find a doctor and make an appointment that's not weeks or months away.**

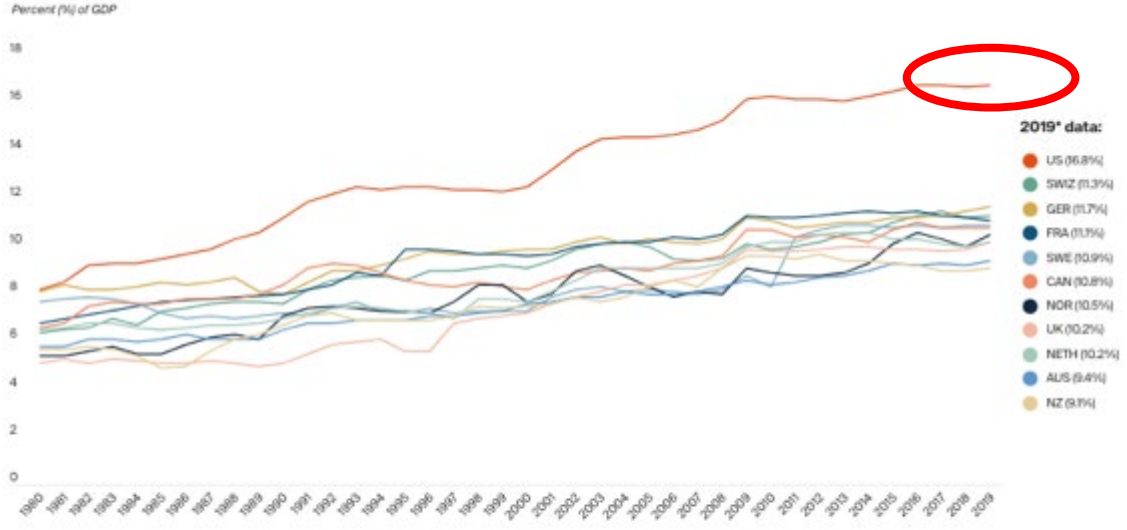
Comparative Health Care System Performance Scores

Note: To normalize performance scores across countries, each score is the calculated standard deviation from a 10-country average that excludes the US. See How We Conducted This Study for more detail.

Data: Commonwealth Fund analysis.

Source: Eric C. Schneider et al., *Mirror, Mirror 2021 — Reflecting Poorly: Health Care in the U.S. Compared to Other High-Income Countries* (Commonwealth Fund, Aug. 2021). https://doi.org/10.26099/010V-H208

Health Care Spending as a Percentage of GDP, 1980–2019



Notes: Current expenditures on health. Based on System of Health Accounts methodology, with some differences between country methodologies. GDP refers to gross domestic product. * 2019 data are provisional or estimated for Australia, Canada, and New Zealand.

Data: OECD Health Data, July 2021.

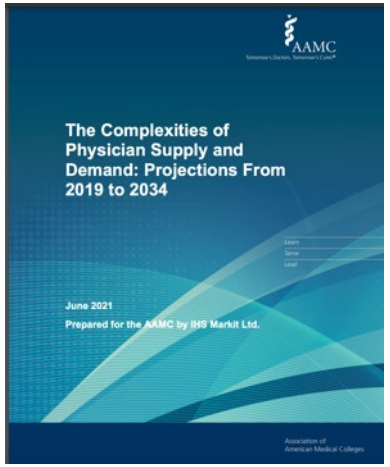
Source: Eric C. Schneider et al., *Mirror, Mirror 2021 — Reflecting Poorly: Health Care in the U.S. Compared to Other High-Income Countries* (Commonwealth Fund, Aug. 2021). https://doi.org/10.26099/010V-H208

Primary Care…

- **Primary care** is the day-to-day healthcare given by a health care provider. Typically this provider acts as the first contact and principal point of continuing care for patients within a healthcare system, and coordinates other specialist care that the patient may need.[1][2][3] Patients commonly receive primary care from professionals such as a primary care physician (general practitioner or family physician), a physician assistant, or a nurse practitioner. In some localities, such a professional may be a registered nurse, a pharmacist, a clinical officer (as in parts of Africa), or an Ayurvedic or other traditional medicine professional (as in parts of Asia). Depending on the nature of the health condition, patients may then be referred for secondary or tertiary care.

https://en.wikipedia.org/wiki/Primary_care

US 2019-2034 Physician Supply & Demand: Primary Care

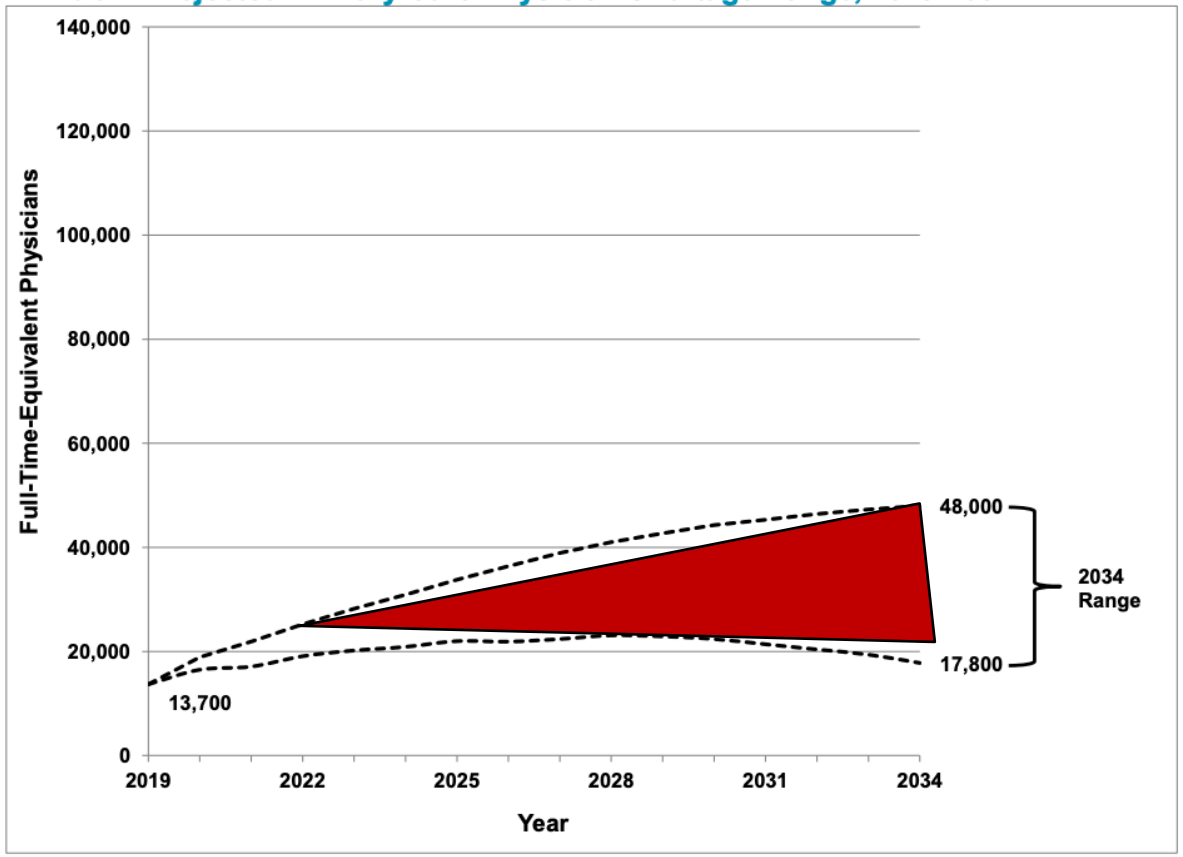


- **Short falls in primary care range between 17,800 - 48,000 physicians by 2034**
- **Achieving population health goals may raise demand for physicians**
  - **reduce excess body weight; improve control of blood pressure, cholesterol, and blood glucose levels; & smoking cessation**
- **Population growth & aging drive increasing demand**
- **Underserved populations could rise demand substantially**

Point to Ponder:

- "Pharmacists" not mentioned once
- "Pharmacy" mentioned once

Exhibit 4: Projected Primary Care Physician Shortage Range, 2019-2034



IHS Markit, *The Complexities of Physician Supply and Demand 2021 Update: Projections from 2019 to 2034.*

Primary Care "Pharmacists Practitioners"

Team-Focused Collaborators in Patient-Centered Care

Partners in Primary & Chronic Care

Care Providers at the top of their Education and Licenses

Engage in Preventive Care & Public Health

Manage Medications - Personalized Outcomes

PRIMARY CARE

PHARMACY PRACTICE

"MCW's School of Pharmacy addresses rapid changes in the pharmacy profession, including an increase in the aging population and the continuing demand for primary care and health services in rural and underserved urban areas. It will be transformative in reshaping how pharmacists contribute to healthcare through our emphasis on interprofessional, team-based practice experiences."

John R. Raymond, Sr., MD, President and CEO, Medical College of Wisconsin

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Exploring Pharmacists' Role in a Changing Healthcare Environment 1

"Collaborative care models that include a pharmacist can help alleviate some of the demand for physician-provided care, and also facilitate access to primary care services, especially those related to medication management."

- Collaborative team-based care, facilitated by agreements and protocols, has been shown to improve therapeutic outcomes in areas such as diabetes, hypertension, dyslipidemia, and anticoagulation.

- Recent evidence suggests that the addition of a pharmacist in a collaborative, team-based setting can improve performance against quality indicators and national health goals."

Implementing High-Quality Primary Care Rebuilding the Foundation of Health Care (2021)

449 pages

National Academies of Sciences, Engineering, and Medicine. 2021. *Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care*. Washington, DC: The National Academies Press.https://doi.org/10.17226/25983.

Pharmacists

Pharmacists working in primary care assume responsibility as members of the interprofessional care team to optimize medication therapy to ensure that it is safe, effective, affordable, and convenient (PCPCC, 2012; Ramalho de Oliveira et al., 2010). With the increasing prevalence of chronic disease and the resultant use of more medications, helping individuals and the health care team manage medication complexities is essential (Buttorff and Bauman, 2017; Qato et al., 2008). Fragmented care may increase the risk of medication mismanagement, as prescribing happens across many care settings and the lack of interoperability of EHRs further limits the accuracy of medication lists. Illness and death resulting from non-optimized medication therapy led to an estimated 275,000 avoidable deaths in 2016, with a cost of nearly $528.4 billion (Watanabe et al., 2018).

Pharmacist expertise is critical in guiding the team, person, and family in effectively assessing, planning, and managing medication use. The pharmacist works with them to develop an individualized plan that achieves the intended goals of therapy with appropriate follow-up to ensure optimal medication use and outcomes (CMM in Primary Care Research Team, 2018). Pharmacists can also collaborate as members of interprofessional primary care teams to deliver preventive care and chronic disease management in a variety of models, including as embedded practitioners in a primary care practice, through collaborative relationships between medical and community pharmacy practices, or via telehealth.

Research has shown that pharmacists contribute positively to the health of people and communities by delivering services aimed at improving medication use, with impact noticed across all areas of the quadruple aim (McFarland and Buck, 2020; PCPCC, 2012). Pharmacists have also been shown

National Academies of Sciences, Engineering, and Medicine. 2021. *Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care*. Washington, DC: The National Academies Press.https://doi.org/10.17226/25983.

Pharmacists in primary care

The greatest challenge to integrating the role of the pharmacist in primary care relates to financing barriers, with payment for clinical pharmacy services not systematically covered by Medicare and Medicaid and payment strategies varying widely state to state. Increasingly, health plans and clinical organizations engaged in risk-based contracting are recognizing pharmacists' important contributions to chronic care management through direct payment strategies or inclusion in value-based payment arrangements (Cothran et al., 2019; Cowart and Olson, 2019; Patwardhan et al., 2012). Expanding awareness of the beneficial effects of integrating pharmacists into primary care teams on clinical, economic, and humanistic outcomes is needed to support the scale and sustainability of the positive collaborations emerging nationwide.

Payments

1. Cash
2. Commercial Insurers
3. Medicare
4. Medicaid

Embedded Pharmacists in Physician Offices

Open Access Article

How a State Measures Up: Ambulatory Care Pharmacists' Perception of Practice Management Systems for Comprehensive Medication Management in Utah

by Kyle Turner, Alan Abbinanti, Bradly Winter, Benjamin Berrett, Jeff Olson and Nicholas Cox
Pharmacy 2020, *8*(3), 136; https://doi.org/10.3390/pharmacy8030136 - 01 Aug 2020

Abstract Comprehensive medication management (CMM) is a patient-centered standard of care that ensures a patient's medications are optimized. The CMM Practice Management Assessment Tool (PMAT) is a tool to assess areas of CMM practice management. The purpose of this project was to assess the [...] Read more.
(This article belongs to the Special Issue Embedded Pharmacists in Primary Care)

Open Access Article

Expansion and Evaluation of Pharmacist Services in Primary Care

by Katherine J. Hartkopf, Kristina M. Heimerl, Kayla M. McGowan and Brian G. Arndt
Pharmacy 2020, *8*(3), 124; https://doi.org/10.3390/pharmacy8030124 - 22 Jul 2020

Abstract Challenges with primary care access and overextended providers present opportunities for pharmacists as patient care extenders for chronic disease management. The primary objective was to align primary care pharmacist services with organizational priorities and improve patient clinical outcomes. The secondary objective was to [...] Read more.
(This article belongs to the Special Issue Embedded Pharmacists in Primary Care)

Open Access Article

Practice Transformation Driven through Academic Partnerships

by Renee Robinson, Cara Liday, Anushka Burde, Tracy Pettinger, Amy Paul, Elaine Nguyen, John Holmes, Megan Penner, Angela Jaglowicz, Nathan Spann, Julia Boyle, Michael Biddle, Brooke Buffat, Kevin Cleveland, Brecon Powell and Christopher Owens
Pharmacy 2020, *8*(3), 120; https://doi.org/10.3390/pharmacy8030120 - 14 Jul 2020

Abstract Evidence-based interventions have been shown to improve the quality of patient care, reduce costs, and improve overall health outcomes; however, adopting new published research and knowledge into practice has historically been slow, and requires an active, systematic approach to engage clinicians and healthcare [...] Read more.
(This article belongs to the Special Issue Embedded Pharmacists in Primary Care)

► Show Figures

Open Access Article

Diabetes-Related Patient Outcomes through Comprehensive Medication Management Delivered by Clinical Pharmacists in a Rural Family Medicine Clinic

by Jarred Prudencio and Michelle Kim
Pharmacy 2020, *8*(3), 115; https://doi.org/10.3390/pharmacy8030115 - 09 Jul 2020

Abstract Two clinical pharmacy faculty members from a college of pharmacy provide comprehensive medication management in a rural family medicine clinic. The data was assessed for patients with diabetes managed by the pharmacists from 1 January 2017 through to 31 December 2019 to determine [...] Read more.
(This article belongs to the Special Issue Embedded Pharmacists in Primary Care)

► Show Figures

Other

Jump to: Research

Open Access Case Report

Pilot Study: Evaluating the Impact of Pharmacist Patient-Specific Medication Recommendations for Diabetes Mellitus Therapy to Family Medicine Residents

by Camlyn Masuda, Rachel Randall and Marina Ortiz
Pharmacy 2020, *8*(3), 158; https://doi.org/10.3390/pharmacy8030158 - 31 Aug 2020

Abstract Pharmacists have demonstrated effectiveness in managing diabetes mellitus (DM) and lowering hemoglobin A1C (A1C) through direct patient management. Often patients with diabetes and elevated A1C may not be able to come into the clinic for separate appointments with a pharmacist or for diabetes [...] Read more.
(This article belongs to the Special Issue Embedded Pharmacists in Primary Care)

Open Access Case Report

From Pilot to Scale, the 5 Year Growth of a Primary Care Pharmacist Model

by Jordan Spillane and Erika Smith
Pharmacy 2020, *8*(3), 132; https://doi.org/10.3390/pharmacy8030132 - 30 Jul 2020

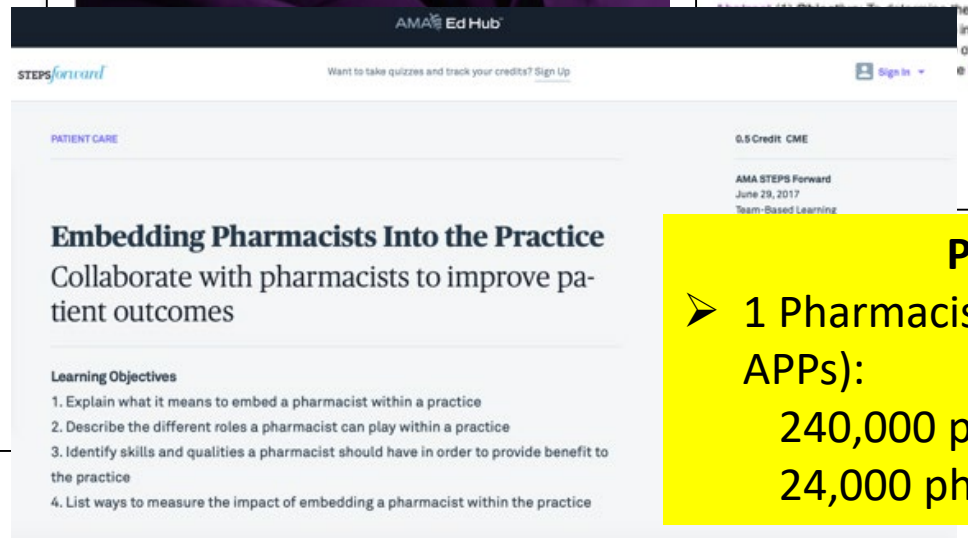
Abstract This case report details the five year journey of implementing, growing and optimizing a primary care pharmacist model in the ambulatory clinic setting within a health system. There is published evidence supporting the numerous benefits of including pharmacists in the primary care medical [...] Read more.
(This article belongs to the Special Issue Embedded Pharmacists in Primary Care)

Open Access Case Report

Trends in Clinical Pharmacist Integration in Family Medicine Residency Programs in North America

by Jennie B. Jarrett and Jody L. Lounsbery
Pharmacy 2020, *8*(3), 126; https://doi.org/10.3390/pharmacy8030126 - 24 Jul 2020

...he change in prevalence of clinical pharmacists as clinician educators within family ...in North America and to describe their clinical, educational and administrative scope over ...of the [...] Read more.
...e Embedded Pharmacists in Primary Care)



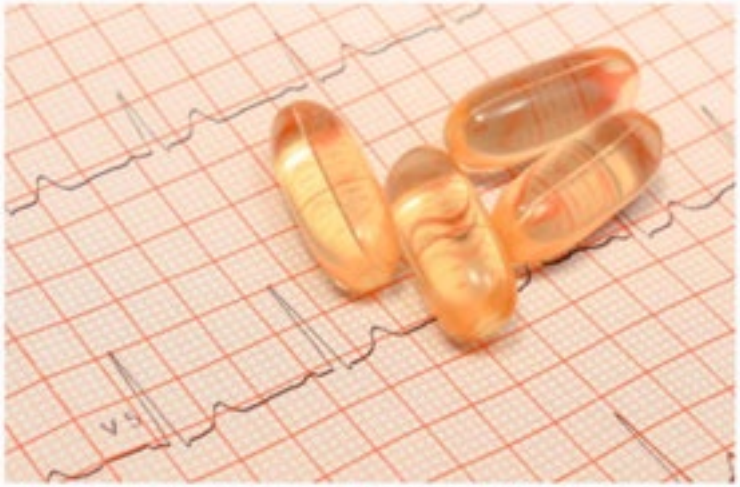
Point to Ponder:

- 1 Pharmacists to 10 Physicians (or APPs):
  240,000 primary care physicians = 24,000 pharmacists

52,766 views | Oct 10, 2018, 12:00pm

Can Pharmacists Help Reinvent Primary Care in the United States?

Sachin H. Jain Contributor ⓘ
Healthcare
I cover transformation and innovation across the health care industry.

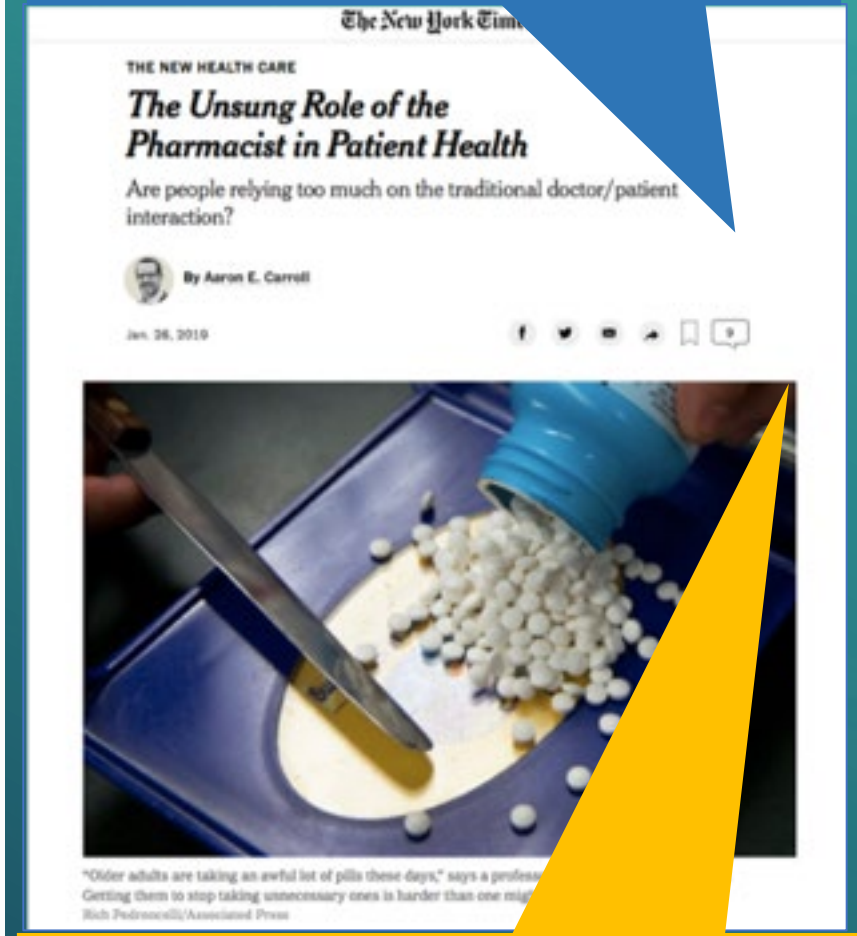


Pharmacists may be the key to improving quality and access of primary care and chronic disease management in the United States. (Getty Royalty Free)

There's a shortage of primary care physicians in the United States. The Association of American Medical Colleges (AAMC) recently reported that by the year 2030, we may be short more than 104,000 doctors, making it difficult for patients to get the care they need.

Knowing this, medical schools are scrambling to steer students away from specialty care; health care systems and hospitals are on a recruitment binge, offering salary bonuses and other incentives to primary care physicians; and technologists are developing new and innovative ways for patients to connect with far-away doctors - for instance, through telemedicine and other video technologies.

"...people end up with a risky pileup of prescribed medications. Many efforts have been made....Yet we've usually focused on physician behavior, when there's another powerful lever: pharmacists."



The New York Times

THE NEW HEALTH CARE

The Unsung Role of the Pharmacist in Patient Health

Are people relying too much on the traditional doctor/patient interaction?

By Aaron E. Carroll

Jan. 28, 2019

"Older adults are taking an awful lot of pills these days," says a profes
Getting them to stop taking unnecessary ones is harder than one mig
Rich Pedroncelli/Associated Press

POST: Ideally, I would like to see a pharmacist working for our multi-specialty medical practice, and available to consult when we need to talk, as they often are at the ICU, but since there is no obvious "revenue stream" associated with that...

"This should allow us to shift from 'imprecision medicine' to precision treatments, but it will likely change the role of the pharmacist and the delivery channels we know today."

The future of pharmacy: Disruption creates transformative opportunities and challenges (2020)

Future of the pharmacist

In today's health care ecosystem, the pharmacist is a trusted, critical, and —often—underutilized resource. As the pharmacy industry increases its use of enabling technologies, pharmacists may find themselves at a professional crossroads: either grow their role's scope and value or face potential disintermediation.

After all, in a not-so-distant future, robots will likely dispense medications to patients, 3D printers may print combination therapies, and algorithms may address most clinical edits. When combined with technology like smart contact lenses that use augmented reality (AR), it's possible that lower-skilled staff, such as pharmacy technicians, may be able to conduct basic tasks like visual verification.

Fortunately, an increasing demand for physicians,[11] combined with projections about people living longer, should create opportunities for pharmacists to evolve and expand their role—perhaps even to become the next

generation of primary care providers (PCPs) who treat patients with acute illnesses and manage chronic conditions like diabetes, hypertension, and asthma. That will require regulatory changes, but pharmacists are increasingly being recognized as providers in the United States,[12] building on global discussions about pharmacist prescribing.[13]

www.deloitte.com

Figure 3. Acute diagnosis | Strep Throat Sam

- Data convener
- Science and insights
- Health products
- Specialty care
- Consumer-centric
- Localized health destination
- Connectors and intermediaries
- Individualized financier

1. Sam enters the bathroom and brushes his teeth with his **smart toothbrush**, which detects the first signs of a strep throat strain from his mouth bacteria
2. His smart toothbrush sends a **digital bacteria sample** off to the lab, which confirms an early strep throat **diagnosis within seconds**, long before symptoms are shown
3. Sam is notified of the lab results and early diagnosis via his **voice-enabled AI avatar**, which directs him to the kitchen to retrieve the tea automatically prepared by his **smart kettle**, and **his smart fridge** nudges him to eat yogurt with probiotic cultures
4. Sam's diagnosis **automatically triggers** an alert to his local health destination, where a treatment plan is developed. The local health destination's avatar connects with Sam to ask if he has any questions or concerns
5. Leveraging his data, the local health destination **3D prints** a single pill tailored to attack the exact bacteria strain and which can be easily metabolized by Sam's enzymes
6. Once 3D printed, a **drone flies the pill** from the health destination to Sam's home so he can take his medication before he leaves for work
7. In the background, the cost of the 3D printed pill is calculated based on Sam's risk profile and **automatically deducted** from his financial account
8. A few hours later, the **avatar follows up** to check how he's feeling and assess any symptoms
9. Sam confirms verbally that he is not feeling any strep symptoms, and his smart toothbrush later validates that the **strain has been eliminated**

Note: This represents a hypothetical future journey.

The pharmacist of the future: Unlocking the profession's potential to improve patient care (2021)

Deloitte. Insights

Article

30 minute read · 01 December 2021

The pharmacist of the future

Unlocking the profession's potential to improve patient care


George Van Antwerp
United States


Vipul Bhatt
United States


Greg Myers
United States


Natasha Eisner
United States

See more

In Deloitte's Future of Health vision, the focus will be on prevention over treatment, and care will happen in the home or community. As accessible and trusted health care personnel, pharmacists can play a big role.

FIGURE 1

Opportunities for pharmacists to contribute to public and population health abound

Primary care

Pharmacists can supplement or extend primary care services in chronic condition management, prevention and wellness, diagnosing and treating minor acute illnesses, supporting mental health, and aging in place.

Specialty care

As therapies become more complex, pharmacists' pharmacotherapy expertise will be in even greater demand in specialty areas, such as oncology, cell and gene, and rare diseases.

Digital health

Pharmacists could provide access to point-in-care diagnostics, prescribe digital therapeutics, and help customers identify digital health tools for their needs. They might even help with setup and configuration of medical devices and health apps, as well as interpreting the data from these tools.

Population health analytics

Besides clinical activities, pharmacists can move into analytical roles to identify health improvement opportunities, develop algorithms for clinical decision support and population health analytics, and design programs that improve population health.

Source: Deloitte analysis.

"10–15 years from now, as I look at this time I would say 'Oh my gosh, I can't believe we dispensed medications without actually doing a cheek swab.' I think that's going to be a very antiquated way of looking at how we prescribe."

—EVP, pharmacist provider division, technology provider

"Medication is the one way that we've got to treat chronic diseases and keep patients productive, having good quality of life, continuing to go to work, and staying out of the hospital. So, we have to get the pharmacist much more in the forefront of doing real-time medication management."

—VP, pharmacy business services, health care system

"Today, pharmacists can only dispense what the patient has on the record. But if I took my Lasix and my ankles are still three times as large as they should be, and I can't walk across the room, do I need to go to the emergency room? Or maybe, a good bolus of Lasix could do the trick. This is something pharmacists should be able to do."

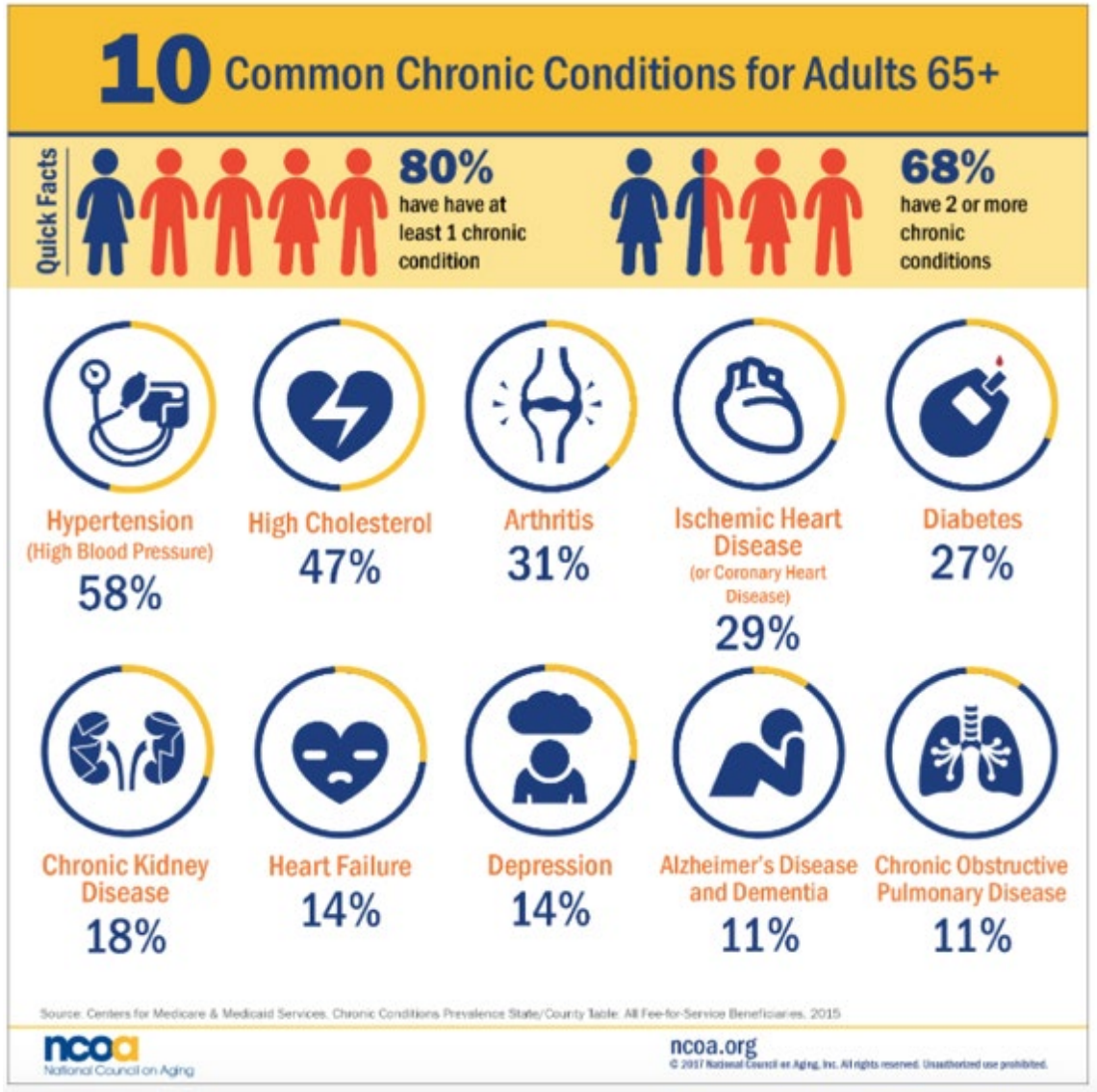
—Pharmacy contracts and operations manager, health care system

"Not being able to manage their medications is one of the reasons [older adults] are unable to stay in the home that they love. And pharmacists can help them stay there longer, intervene, even if we have to send nurses out."

—EVP, independent pharmacy chain

Chronic Conditions in US Adults age 65≥

- 80% of adults 65 ≥ have at least one chronic condition
- 68% have two or more



Which conditions use medications?

The Surgeon General's Call to Action to Control Hypertension

- *These activities support referral of individuals to resources outside of the primary care setting for blood pressure management services, as well as to physical activity, nutrition, and pharmacist-based interventions, including medication therapy management.*
- *Where allowed by law, medication change protocols for nurses, pharmacists, and other team members are recommended to ensure that each team member's activities within his or her scope of practice are being maximized.*
- *Nurses, pharmacists, and community health workers can also play unique and important roles in care delivery, and strong evidence supports their use for hypertension control in particular.*
- *One challenge to establishing care teams, however, is that reimbursement models are not always in place to support their use, especially when teams include nontraditional members such as pharmacists and community health workers.*

U.S. Department of Health and Human Services. *The Surgeon General's Call to Action to Control Hypertension.* Washington, DC: U.S. Department of Health and Human Services, Office of the Surgeon General; 2020.

2011 US Surgeon General Report:

Improving Patient and Health System Outcomes through Advanced Pharmacy Practice

HC Savings

$1,123 per patient on medication claims and $472 per patient on medical, hospital, and emergency department expenses at five primary care sites in Connecticut

More than $1,600 in direct health care costs per patient at a pharmacist-run anticoagulation clinic, compared with usual medical costs

$1,200 to $1,872 per patient in direct health care costs for patients with diabetes enrolled in the Asheville Project for up to five years

$918 per patient in direct health care costs for patients with diabetes enrolled in the Patient Self-Management Program for Diabetes for one year

$1,230 per patient in indirect costs for those with asthma and direct cost savings of $725average/patient.

$3.5 billion in hospital costs by coordinating medications from multiple providers

SAVED

≠

EARNED

John G. Gums, Pharm.D., FCCP
Professor of Pharmacy and Medicine
Associate Dean for Clinical and Administrative Affairs
College of Pharmacy
University of Florida

Pharmacist Provider Status: Medicaid

2021

HEALTH

New laws help pharmacists care for underserved communities

BY MEGAN CARPENTER | MILWAUKEE
PUBLISHED 8:00 PM ET JAN. 05, 2022

WAUWATOSA, Wis.—Wisconsin is now the eighth state in the country to recognize pharmacists as non-physician providers under a Medicaid system. With the passage of three pro-pharmacy bills last month, including Act 98, pharmacists can help close the healthcare gap for Wisconsinites in underserved areas of the state.

"Roughly 90% of Americans are within five miles of a pharmacy, so that's access right there," said Dr. George MacKinnon, founding dean and professor of the Medical College of Wisconsin's School of Pharmacy.

MacKinnon added that two out of three Wisconsin counties are considered medically underserved, the majority of which are within the state's extreme urban and rural populations.

"The system we have right now is very cumbersome because it requires a patient to see a provider after they receive a test more than likely at a pharmacy," he said. "Why not simplify that and test and treat at the pharmacy?"

Act 98 mandates gives Wisconsin pharmacists "provider status" and reimburses them for services to Medicaid patients.

2014

450.033 Services delegated by physician. A pharmacist may perform any patient care service delegated to the pharmacist by a physician, as defined in s. 448.01 (5).

TEAMING UP FOR BETTER PATIENT CARE
Pharmacist Provider Status

2021 Act 98: Pharmacist Provider Status

This bill requires the Wisconsin Medicaid Program reimburse pharmacists for any clinical care service covered under the program that is within a pharmacist's scope of practice or delegated to a pharmacist by a physician.

This bill was championed by Senator Julian Bradley and Representative David Murphy.

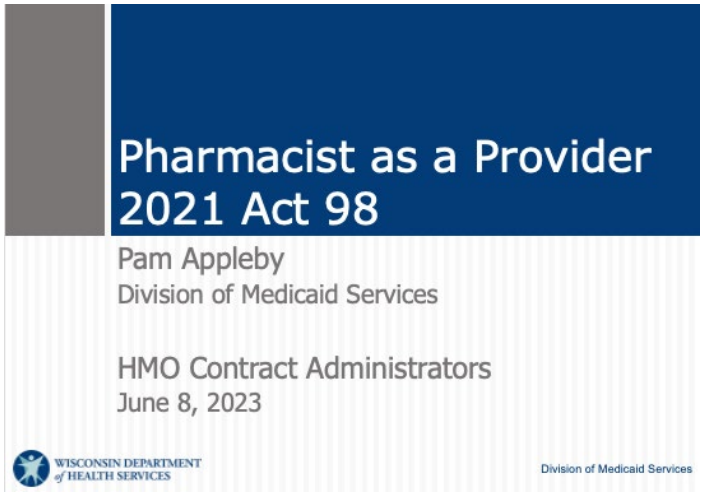
This Department of Health Services will work toward implementing this legislation, including necessary rule and policy changes. We anticipate pharmacists will begin billing for services in late-2022.

ACT 98 is not expanding the Scope of practice of pharmacy, but rather affirming our scope and Aligning Reimbursement.

Pharmacist Provider Status: Medicaid Enrollment

Pharmacists will enroll with the Medicaid program as a provider.

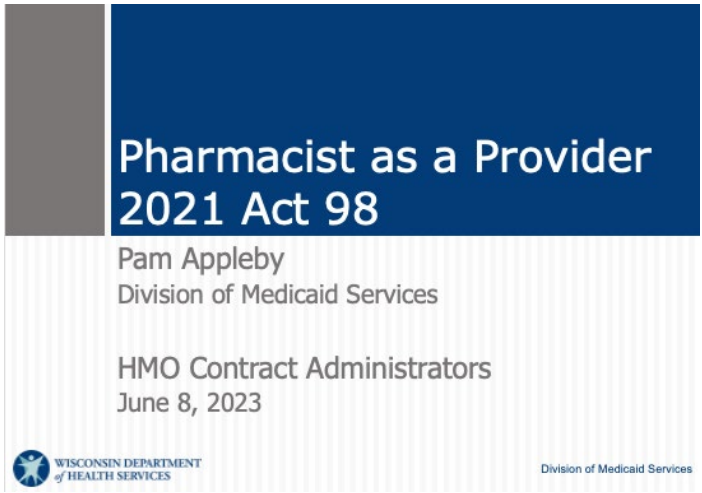
- DMS is creating a new enrollment pathway for pharmacists.
- Pharmacists will complete the enrollment process through the ForwardHealth Portal.
  - Application
  - Include appropriate documentation
    - Attest if practice with a collaborative practice agreement
  - No enrollment fee for pharmacists
  - Every three years pharmacists will need to reenroll



Pharmacist Provider Status: Medicaid

Tentative Timeline

- Q2 2023
  - Defining service package and reimbursement methodology
- Q3 2023
  - Provider enrollment pathway built
  - Train and enroll providers
- Q4 2023
  - Service package built
  - Train providers on policy and billing for services



Federal Pharmacist Provider Status

The Pharmacy and Medically Underserved Areas Enhancement Act, H.R. 2759/S. 1362

U.S. House of Representatives on April 22, 2021 & the U.S. Senate on April 26, 2021

- Bill would add pharmacists to the list of providers whose patient care services, when delivered to patients in medically underserved communities, are covered by Medicare Part B (i.e., grant them "provider status").
- The legislation would ensure that pharmacists are fairly compensated for the valuable patient care they provide to beneficiaries who struggle to access basic health care services.

"the following healthcare professionals are recognized as healthcare providers as defined by the Social Security Act (and **<u>can bill</u>**) Medicare:

- ✓ Physicians
- ✓ Physician Assistants
- ✓ Nurse Practitioner/Clinical Nurse Specialist
- ✓ Certified Nurse Midwife
- ✓ Psychologist/Clinical Psychologist
- ✓ Clinical Social Worker
- ✓ Dietician
- ✓ Occupational Therapist
- ✓ Physical Therapist"

TAMMY BALDWIN
WISCONSIN

United States Senate

WASHINGTON, DC 20510

COMMITTEES:
APPROPRIATIONS
COMMERCE
HEALTH, EDUCATION, LABOR, AND PENSIONS

Dear George:
Thank you for contacting me about the role of pharmacists in our health care system. I appreciate hearing your thoughts on this important issue.

Pharmacists provide valuable services and health education to individuals in their communities. Families in Wisconsin and around the country rely on community pharmacists to provide access to and information on their medicines; to help manage and monitor their drug regimens; and to customize certain medicines to help fit their unique health needs. It is important that patients continue to have access to a reliable, affordable source of health care advice and counsel at their neighborhood pharmacy.

On April 25, 2021, Senator Chuck Grassley (R-IA) introduced the Pharmacy and Medically Underserved Areas Enhancement Act (S.1362). I was proud to cosponsor this bill, which would expand access to pharmacists' services for Medicare beneficiaries by recognizing licensed pharmacists practicing in medically underserved areas as providers under Medicare and establishing a payment mechanism for such services. Rest assured I will continue my work in the Senate to ensure that all Americans have access to quality, affordable health care that meets their needs.
Once again, thank you for contacting my office. It is important for me to hear from the people of Wisconsin on the issues, thoughts and concerns that matter most to you. If I can be of further assistance, please visit my website at www.baldwin.senate.gov for information on how to contact my office.

Sincerely,

Tammy Baldwin
United States Senator

Medicare "Incident-to Billing"

There 3 different levels of supervision:

1) **General** supervision - requires physician to provide overall supervision of the service, but the physician is not mandated to be at the place of service;

2) **Direct** supervision - requires physician to be at the place of service and be immediately available to assist but is not required to be in the room where service is provided;

3) **Immediate** supervision – requires physician to be physically present in the room where the service is being provided.

Direct supervision allows the pharmacist to work independently of a physician allowing the physician to continue conducting other clinic visits….

TABLE 1 Number of Visits Required to Break Even[a]

Visit Frequency	Level of Service, $		
	Level 1	Level 3	Level 4
Average Medicare reimbursement	21.96	74.16	109.44
Visits per year[b]	6,374.00	1,997.00	1,355.00
Visits per week	122.60	38.40	26.10
Visits per day	24.50	7.70	5.22

Source: Medicare Physician Fee Schedule Look-up tool (https://www.cms.gov/apps/physician-fee-schedule/license-agreement.aspx).

[a]Assumes $0 overhead costs and a salary plus fringe of $125,000.

[b]Assumes 52 weeks per year. J Manag Care Spec Pharm. 2018;24(12):1273-76

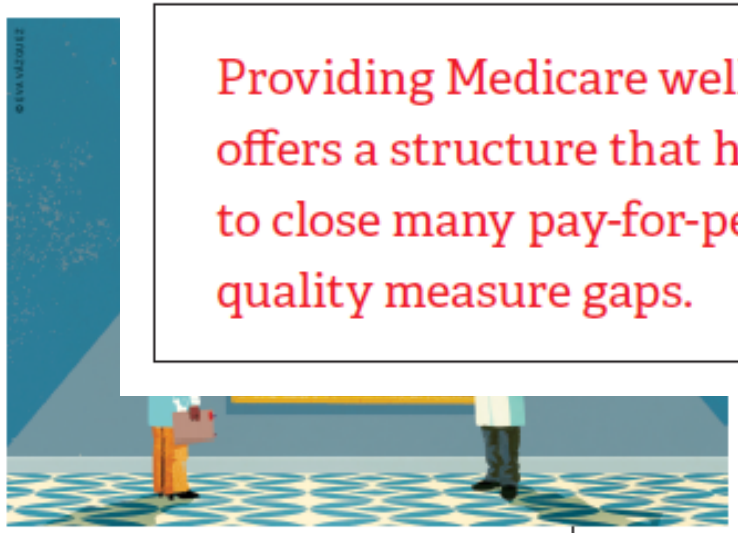
"Incident To"	Fee	RVU
99211	$23.53	0.18
99212	$57.45	0.70
99213	$92.05	1.30
99214	$129.77	1.92
99215	$183.07	2.80

ARNOLD E. CUENCA, DO, CAQSM, FAAFP, AND SUSAN KAPSNER, CCS

Medicare Wellness Visits: Reassessing Their Value to Your Patients and Your Practice

Providing Medicare wellness visits can be challenging but can improve quality and practice revenue.

Providing Medicare wellness visits also offers a structure that helps physicians to close many pay-for-performance quality measure gaps.



The Affordable Care Act of 2010 created the Medicare annual wellness visit (AWV) as a way to provide patients with comprehensive preventive care services at no cost. Yet many practices have been slow to provide substantial numbers of these visits. Only 15.6 percent of eligible patients received an AWV through 2014.[1] In addition to finding lackluster overall participation, researchers have found AWV rates are lower among practices caring for underserved populations, such as racial minorities, rural residents, or those dually enrolled in Medicaid.[2]

Physicians and other health care providers do not offer AWVs to their Medicare patients for numerous reasons. Providing and documenting all of the required AWV elements efficiently can be

ABOUT THE AUTHORS
Dr. Cuenca is a board-certified family medicine and sports medicine physician with MemorialCare Medical Group in Mission Viejo, Calif. He is also a member of *FPM*'s Editorial Advisory Board. Susan Kapsner is a certified coding specialist and a coding compliance supervisor for the MemorialCare Medical Foundation. Author disclosure: no relevant financial affiliations disclosed.

AWV

The **IPPE** is a one-time physical exam performed within the first 12 months of a patient's enrollment under Part B Medicare. The **initial AWV** can be provided 12 months after the patient first enrolled or 12 months after he or she received the IPPE. A **subsequent AWV** can then be provided annually.

KEY POINTS

- The Medicare annual wellness visit (AWV) and the initial preventive physical examination (IPPE) provide a number of benefits to patients and physicians, but many physicians still do not provide them.
- Medicare wellness visits can help physicians address care gaps and report quality measures important in pay-for-performance systems.
- When billed correctly and delivered efficiently along with other covered Medicare preventive services, AWVs can boost practice revenue.

Cuenca AE, Kapsner S. Medicare Wellness Visits: Reassessing Their Value to Your Patients and Your Practice. Fam Pract Manag. 2019 Mar/Apr;26(2):25-30. PMID:

Medicare Part B: Annual Wellness Visits (AWV) = *Brown Bag*

1. Conducted once every 12 months
   - ✓ Develop (update) a personalized prevention plan
   - ✓ Help prevent disease and disability based on health and risk factors
   - ✓ May include a cognitive impairment assessment
2. Personalized prevention plan
   - ✓ A review of medical and family history
   - ✓ Developing (updating) a list of current providers and prescriptions
   - ✓ Height, weight, blood pressure, and other routine measurements
   - ✓ Detection of any cognitive impairment
   - ✓ Personalized health advice
   - ✓ A list of risk factors and treatment options
   - ✓ A screening schedule for appropriate preventive service
   - ✓ Advanced Care Planning
3. AWV benefit and national utilization rates remain low (<25%)

AWV Case study: North Carolina (financial modeling)

Financial implications of pharmacist-led Medicare annual wellness visits

Irene Park, Susan E. Sutherland, Lisa Ray, and Courtenay Gilmore Wilson

Abstract

Objective: To determine if pharmacist-led Medicare Annual Wellness Visits (AWVs) are a feasible mechanism to financially support a pharmacist position in physicians' offices.

Setting: Large, teaching, ambulatory clinic in North Carolina.

Practice description: The Mountain Area Health Education Family Health Center is a family medicine practice that houses a large medical residency program. The Department of Pharmacotherapy comprises five pharmacists and two pharmacy residents providing direct patient care.

Practice innovation: In April 2012, pharmacists began conducting Medicare AWVs for patients referred by their primary care physicians within the practice.

Main Outcome Measures: Visit reimbursement, annual revenue, number of patients who must be seen to cover the cost of a pharmacist's salary.

Results: A small practice requires all eligible Medicare patients to complete an AWV to generate enough revenue to support a new pharmacist position. A medium-sized practice requires a 54% utilization rate, and a large practice requires an 18% utilization rate. Two additional AWVs per half-day of clinic are needed to support an existing pharmacotherapy clinic. A total of 1,070 AWVs per year are required to support a pharmacist's salary, regardless of practice size.

Conclusions: AWV reimbursement may significantly contribute to supporting the cost of a pharmacist, particularly in medium- to large-sized practices. In larger practices, enough revenue can be generated to support the cost of multiple pharmacists.

Keywords: Ambulatory care services, preventive health services, physicians' offices, reimbursement mechanisms, medical coding

J Am Pharm Assoc. 2014;54:435–440.
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Correspondence: Courtenay Gilmore Wilson, PharmD, CDE, BCPS, CPP, 123 Hendersonville Road Asheville, NC 28803

Table 1. Assumptions used in financial analysis.

Characteristic	Assumption
Patient volume of established pharmacotherapy clinic	2,000 visits/y[14]
Pharmacist salary/benefits	$120,000/y[14]
Time allocation	376 clinic half-d/y
Clinic capacity	seven 30-min visits/clinic half-d
Clinic size	2,000 patients/physician[24]
Clinic population	20% Medicare beneficiaries

Table 3. Charge for pharmacist-led visit types[23]

HCPCS code	Code descriptor	2013 North Carolina Medicare rates
G0438	Annual Wellness Visit, includes PPPS, initial visit	$162.15
G0439	Annual Wellness Visit, includes PPPS, subsequent visit	$107.25
99211	Office/outpatient visit, established	$19.29

Abbreviations used: HCPCS, Healthcare Common Procedure Coding System; PPPS, Personalized Prevention Plan of Services

Financial implications of pharmacist-led Medicare annual wellness visits. Park I, Sutherland SE, Ray L, et al. J Am Pharm Assoc. 2014;54:435–440.

Case study: north Carolina (financial modeling)

Table 2. Number of visits per half-day needed to generate pharmacist salary for various practice sizes, assuming 10% initial, 90% subsequent AWVs

No. physicians (practice size)	AWV utilization rate	No. AWVs	Revenue from AWVs	No. 99211 visits	Revenue from 99211	No. visits/ half-d	Total revenue
	9%[a]	72	$8,118	5,800	$111,882	15.6	$120,000
	50%	400	$45,096	3,884	$74,922	11.4	$120,018
2 (small)	100%	800	$90,192	1,546	$29,822	6.2	$120,014
	9%[a]	180	$20,293	5,169	$99,710	14.2	$120,003
	50%	1,000	$112,740	377	$7,272	3.7	$120,012
5 (medium)	100%	2,000	$225,480	0	$0	5.3	$225,480
	9%[a]	540	$60,879	3,065	$59,124	9.6	$120,003
	50%	3,000	$338,220	0	$0	8.0	$338,220
15 (large)	100%	6,000	$676,440	0	$0	16.0	$676,440

Abbreviation used: AWV, Medicare Annual Wellness Visit
[a]2012 National AWV utilization rate[26]

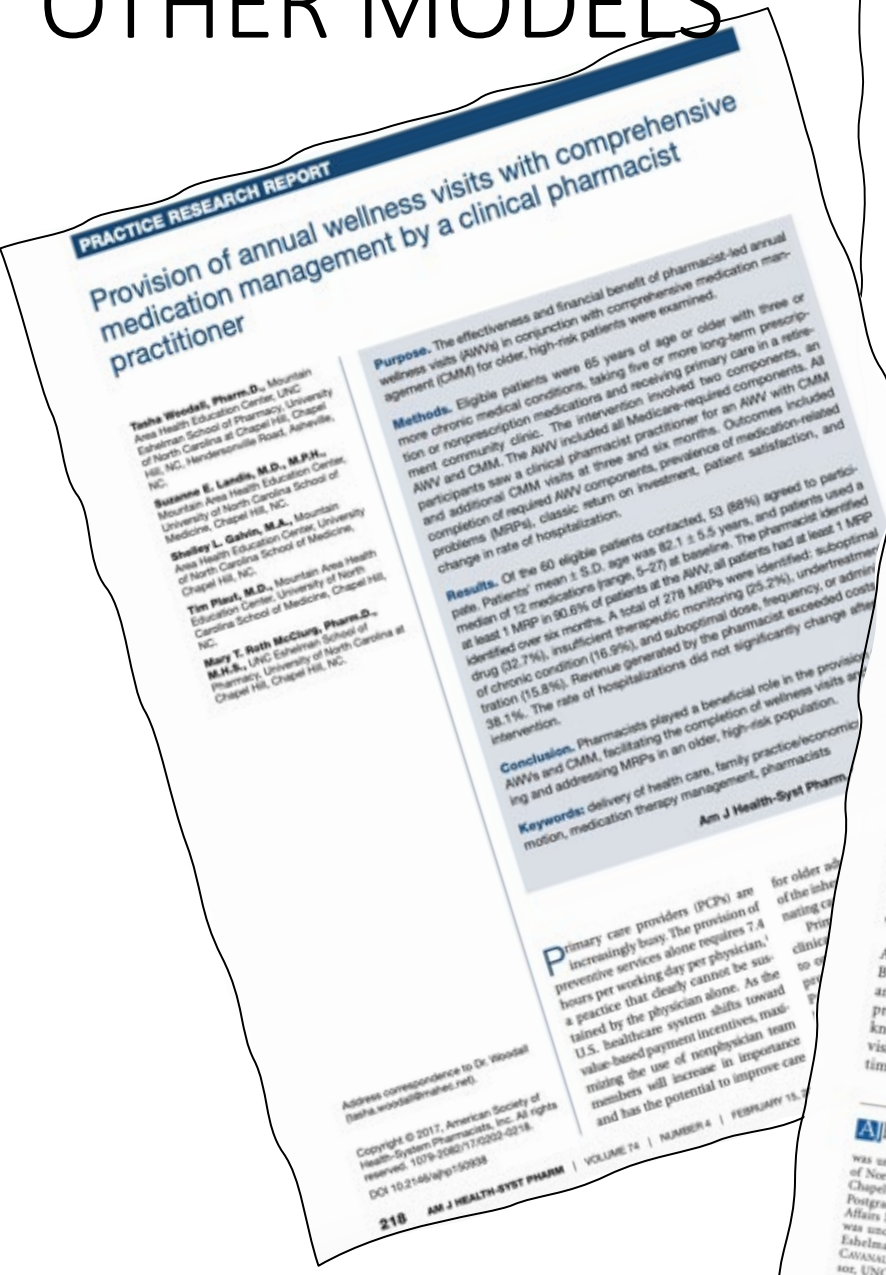
Financial implications of pharmacist-led Medicare annual wellness visits. Park I, Sutherland SE, Ray L, et al. J Am Pharm Assoc. 2014;54:435–440.

AWV Example Projections

No Physicians (#400 pts/MD)	AWV utlilization rate (%)	No AWVs	Initial AWV 10%	Follow Up AWV 90%	Initial AWV (G0438)	Follow Up AWV (G0438)	Revenue AWVs	Initial AWV (G0438) RVU	Follow Up (G0438) RVU	Total RVUs
6,000 pts					$ 174.00	$ 110.00		2.43	1.5	
15	20	1200	120	1080	$ 20,880	$ 118,800	$ 139,680	292	1620	1912
	33	1980	198	1782	$ 34,452	$ 196,020	$ 230,472	481	2673	3154
	67	4020	402	3618	$ 69,948	$ 397,980	$ 467,928	977	5427	6404
12,000 pts										
30	20	2400	240	2160	$ 41,760	$ 237,600	$ 279,360	583	3240	3823
	33	3960	396	3564	$ 68,904	$ 392,040	$ 460,944	962	5346	6308
	67	8040	804	7236	$ 139,896	$ 795,960	$ 935,856	1954	10854	12808

2019 est rates

OTHER MODELS



PRACTICE RESEARCH REPORT

Provision of annual wellness visits with comprehensive medication management by a clinical pharmacist

Tasha Woodell, Pharm.D., Mountain Area Health Education Center, UNC Eshelman School of Pharmacy, University of North Carolina at Chapel Hill, Chapel Hill, NC; Hendersonville Road, Asheville, NC.

Suzanne E. Landis, M.D., M.P.H., Mountain Area Health Education Center, University of North Carolina School of Medicine, Chapel Hill, NC.

Shelley L. Galvin, M.A., Mountain Area Health Education Center, University of North Carolina School of Medicine, Chapel Hill, NC.

Tim Pleuss, M.D., Mountain Area Health Education Center, University of North Carolina School of Medicine, Chapel Hill, NC.

Mary T. Roth McClurg, Pharm.D., M.H.S., UNC Eshelman School of Pharmacy, University of North Carolina at Chapel Hill, Chapel Hill, NC.

Purpose. The effectiveness and financial benefit of pharmacist-led annual wellness visits (AWVs) in conjunction with comprehensive medication management (CMM) for older, high-risk patients were examined.

Methods. Eligible patients were 65 years of age or older with three or more chronic medical conditions, taking five or more long-term prescription or nonprescription medications and receiving primary care in a retirement community clinic. The intervention involved two components, an AWV and CMM. The AWV included all Medicare-required components. All participants saw a clinical pharmacist practitioner for an AWV with CMM and additional CMM visits at three and six months. Outcomes included completion of required AWV components, prevalence of medication-related problems (MRPs), classic return on investment, patient satisfaction, and change in rate of hospitalization.

Results. Of the 60 eligible patients contacted, 53 (88%) agreed to participate. Patients' mean ± S.D. age was 82.1 ± 5.5 years, and patients used a median of 12 medications (range, 5–27) at baseline. The pharmacist identified at least 1 MRP in 90.6% of patients at the AWV; all patients had at least 1 MRP identified over six months. A total of 278 MRPs were identified: suboptimal drug (32.7%), insufficient therapeutic monitoring (25.2%), undertreatment of chronic condition (16.9%), and suboptimal dose, frequency, or administration (15.8%). Revenue generated by the pharmacist exceeded costs by 38.1%. The rate of hospitalizations did not significantly change after intervention.

Conclusion. Pharmacists played a beneficial role in the provision of AWVs and CMM, facilitating the completion of wellness visits and identifying and addressing MRPs in an older, high-risk population.

Keywords: delivery of health care, family practice/economic motion, medication therapy management, pharmacists

Am J Health-Syst Pharm.

Primary care providers (PCPs) are increasingly busy. The provision of preventive services alone requires 7.4 hours per working day per physician,[1] a practice that clearly cannot be sustained by the physician alone. As the U.S. healthcare system shifts toward value-based payment incentives, maximizing the use of nonphysician team members will increase in importance and has the potential to improve care

Address correspondence to Dr. Woodell (tasha.woodell@mahec.net).

DOI 10.2146/ajhp150938

EXPERIENCE

Financial implications of pharmacist-led Medicare annual wellness visits

Irene Park, Susan E. Sutherland, Lisa Ray, and Courtenay Gilmore Wilson

Abstract

...determine if pharmacist-led Medicare Annual Wellness Vis... financially support a pharmacist po...

Received November 18, 2013, and in revised form February 7, 2014. Accepted for publication March 10, 2014.

Irene Park, PharmD, CPP, is Assistant Professor of Clinical Education, Eshelman School of Pharmacy; and clinical pharmacist at Mountain Area Health Education ... Asheville, NC. **Susan E. Suther...** ... Mission Hos...

PRACTICE REPORTS

Medicare annual wellness visits conducted by a pharmacist in an internal medicine clinic

KEITH WARSHANY, CHRISTINA H. SHERRILL, JAMIE CAVANAUGH, TIMOTHY J. IVES, AND BETSY BRYANT SHILLIDAY

An audio interview that supplements the information in this article is available on AJHP's website at www.ajhp.org/site/misc/podcasts.xhtml.

Scan to access AJHP podcasts

Purpose. The clinical and financial outcomes of an initial Medicare annual wellness visit (AWV) administered by a clinical pharmacist practitioner (CPP) in an academic internal medicine clinic are described.

Summary. As a result of the Patient Protection and Affordable Care Act, Medicare Part B allows for coverage of an AWV at no cost to eligible beneficiaries. The AWV is directed at health prevention, disease detection, and coordination of screening available to beneficiaries. CPPs are pharmacists who are recognized as advanced practice providers in the state of North Carolina and are authorized to administer AWVs. Eligible Medicare beneficiaries at least 65 years of age in an academic internal medicine clinic were mailed invitations to schedule an AWV. Patients who scheduled an AWV were mailed a packet to complete before the visit. During the visit, the packet was reviewed and interventions were made based on prespecified criteria derived from evidence-based medicine recommendations. After completion of the AWV, patients were provided with a detailed and individualized prevention plan. Between August 2011 and May 2012, 98 patients attended an AWV, all performed by the same CPP. The average time from check in to checkout for all patients was 73 minutes. The CPP made 441 interventions during these 98 visits, averaging 4.5 interventions per AWV completed. All initial AWVs were reimbursable up to a maximum of $159.38 per visit.

Conclusion. A Medicare AWV administered by a CPP resulted in a wide variety of patient interventions and reimbursement for services provided.

Am J Health-Syst Pharm. 2014; 71:44-9

The Patient Protection and Affordable Care Act (PPACA) established Medicare Part B coverage of an annual wellness visit (AWV) at no cost to eligible beneficiaries. Coverage for the AWV took effect on January 1, 2011, and is consistent with the PPACA's emphasis on preventive health care measures, including health promotion and disease detection.

Beneficiaries are eligible for an AWV if they have had Medicare Part B coverage for at least 12 months and have not completed an initial preventive physical examination, also known as the "Welcome to Medicare" visit.[1] The benefit provides for a one-time initial AWV and subsequent AWVs if at least 12 months have passed since the previous AWV. The AWV does not include a physical examination, as the goal is to build on the "Welcome to Medicare" visit by providing screening and preventive services for which the beneficiaries are eligible. Components for initial and subsequent AWVs based on 2011 requirements are listed in Table 1.

AJHP LT KEITH WARSHANY, PHARM.D., is Staff Pharmacist, Northern Navajo Medical Center, Indian Health Service, Shiprock, NM; when the project described in this article was undertaken, he was doctor of pharmacy candidate, University of North Carolina (UNC) Eshelman School of Pharmacy, UNC at Chapel Hill, Chapel Hill. CHRISTINA H. SHERRILL, PHARM.D., is Postgraduate Year 1 Pharmacy Resident, Charles George Veterans Affairs Medical Center, Asheville, NC; when the project described was undertaken, she was doctor of pharmacy candidate, UNC Eshelman School of Pharmacy, UNC at Chapel Hill. JAMIE CAVANAUGH, PHARM.D., BCPS, CPP, is Clinical Assistant Professor, UNC School of Medicine, and Assistant Professor of Clinical Education, UNC Eshelman School of Pharmacy; TIMOTHY J. IVES, PHARM.D., M.P.H., BCPS, FCCP, CPP, is Professor, UNC Eshelman School of Pharmacy, and Adjunct Professor, UNC School of Medicine; and BETSY BRYANT SHILLIDAY, PHARM.D., CDE, CPP, BCACP, is Associate Professor of Clinical Education, UNC Eshelman School of Pharmacy, and Clinical Associate Professor, UNC School of Medicine, UNC at Chapel Hill.

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The authors have declared no potential conflicts of interest.

DOI 10.2146/ajhp130202

NOTES

Outcomes of annual wellness visits provided by pharmacists in an accountable care organization associated with a federally qualified health center

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Amy Kennedy, Pharm.D., BCACP, Department of Pharmacy Practice and Science, College of Pharmacy, University of Arizona, Tucson, AZ, and El Rio Health Center, Tucson AZ.

Sandra Leal, Pharm.D., M.P.H., CDE, FCCP, Sanford Rx, Tucson, AZ.

Background. The clinical and financial outcomes of annual wellness visits (AWVs) conducted by clinical pharmacists working as part of an accountable care organization (ACO) in a federally qualified health center were evaluated.

Methods. In this retrospective, single-center, chart review study, patients seen for AWVs at El Rio Health Center between October and December 2013 were eligible for study inclusion. Data collected from patient charts included patient demographics, preventive screenings ordered by clinical pharmacists during the AWV and completed within one month after the visit, other screenings completed by clinical pharmacists during the visit, medication changes by clinical pharmacists, and revenues collected from the AWV and preventive screenings. Descriptive statistics were calculated and variables compared; *p* values were calculated using single-sample Student's *t* tests.

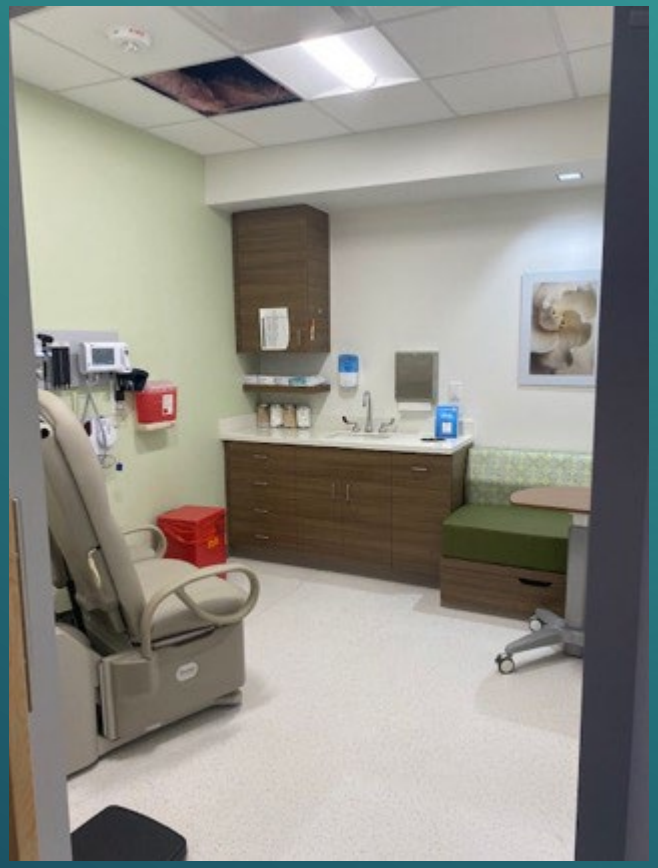
Results. Three hundred patient records were reviewed. Clinical pharmacists completed 1608 interventions, with a mean of 5.4 interventions per patient. A total of 272 referrals were made, 120 (45%) of which were completed within one month of the visit. Of the 183 laboratory tests ordered for diabetes and lipid screening, 152 (83%) were completed within one month of the AWV ($p < 0.001$). Of the 370 vaccinations offered during the visits, 182 (49%) were administered ($p < 0.001$). Twenty-four medication and dosage changes were made by clinical pharmacists during AWVs, and the total revenue for the AWVs conducted by pharmacists and services completed during the visits exceeded $22,000.

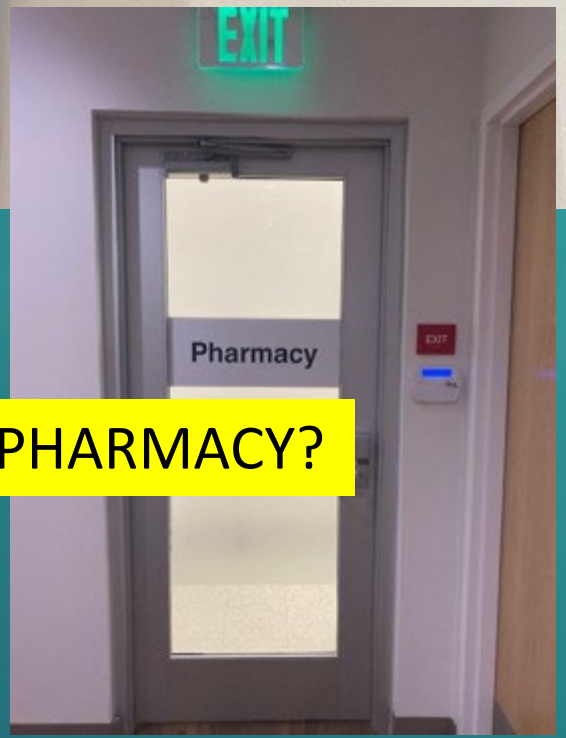
Conclusion. Recommendations made by pharmacists during AWVs in an ACO associated with a federally qualified health center had a high acceptance rate and generated substantial revenue.

Am J Health-Syst Pharm. 2016; 73:225-8

Annual wellness visits (AWVs) were introduced in January 2011 by the Patient Protection and Affordable Care Act with the goal of providing comprehensive preventive care to Medicare Part B beneficiaries.[1] Thus far, more than 4 million people have taken advantage of these services,[2] which provide personalized education about lifesaving preventive examinations and screenings.[3] Beneficiaries can take advantage of this service if they have been covered by Medicare Part B for at least 12 months and have not completed the "Welcome to Medicare" visit (an initial preventive physical examination) within the first year.[1]

AWVs can be conducted by licensed healthcare professionals, including physicians, qualified nonphysician practitioners, and teams of medical professionals working under the direct supervision of a physician. Despite not being recognized as healthcare providers, clini-





PRIMARY CARE?

RETAIL PHARMACY?

Emerging collaborative care models

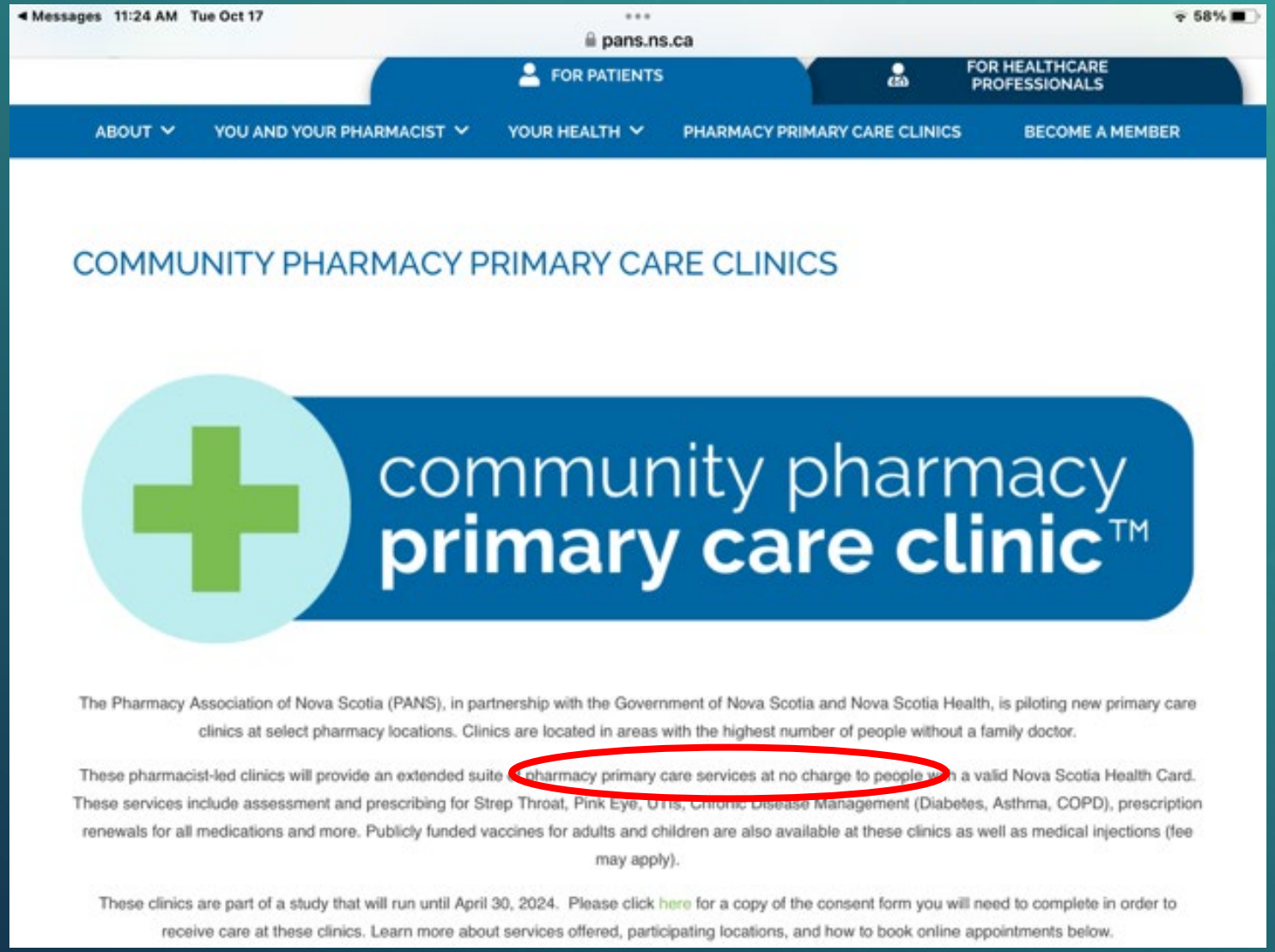
I envision new models of care where it will be common and expected to have embedded pharmacists in hospitals & ambulatory clinics managing high cost-complex medication therapies.

This sentiment was echoed by Dr. Anthony Fauci, in a presentation I attended this April, rereferring to pharmacy: *"One stop shopping for personal and family health."*

The capabilities of pharmacists became apparent in the pandemic. In May 2023, the Former FDA Commissioner, Dr. Scott Gottlieb on the essential role of pharmacists: "I think that's really going to be a cultural change that going forward more people will look to the pharmacy to get more routine health care."

I see the emergence of the ***community-located, primary care pharmacy practice.***

Let‘s look to the North… Nova Scotia



PARTICIPATING PHARMACIES

Central Zone

City	Pharmacy Name	Clinic Address	Clinic Phone Number	Online Appointment Booking Link
Bedford	Brookline Pharmasave	105 - 6 Bloom Lane	902-835-9111, ext 2	Click Here to Book
Bedford/Halifax	Guardian Bedford	535 Larry Uteck Blvd	902-407-4373, ext 0	Click Here to Book
Dartmouth	Shoppers Drug Mart	118 Wyse Rd	902-464-9644, ext 3, then 4	Click Here to Book
Dartmouth	The Medicine Shoppe	105-133 Baker Dr	902-461-2244	Click Here to Book
Halifax	Shoppers Drug Mart	6025 Almon St	902-453-3723, ext 3, then 4	Click Here to Book
Halifax	Shoppers Drug Mart	3430 Joseph Howe Dr	902-443-6084, ext 3, then 4	Click Here to Book
Lower Sackville	Shoppers Drug Mart	766 Sackville Dr	902-864-4631, ext 3, then 4	Click Here to Book
Windsor	Windsor Pharmasave	30 Gerrish St	902-798-2216, ext 8	Click Here to Book

Eastern Zone

City	Pharmacy Name	Clinic Address	Clinic Phone Number	Online Appointment Booking Link
Antigonish	Teasdale Apothecary	65 Beech Hill Rd	902-735-2696, ext 2	Click Here to Book
Glace Bay	Shoppers Drug Mart	255 Commercial St	902-849-2920, ext 3 then 4	Click Here to Book
North Sydney	PharmaChoice	107 King St	902-794-4444	Click Here to Book
Port Hawkesbury	The Medicine Shoppe	708B Reeves St	902-631-0806	Click Here to Book
Sydney	Shoppers Drug Mart	254 Prince St, Unit A015	902-562-1144, option 3 then 4	Click Here to Book

Northern Zone

City	Pharamcy Name	Clinic Address	Clinic Phone Number	Online Appointment Booking Link
Elmsdale	Guardian - Elmsdale Pharmacy	269 Hwy 214	902-883-2228, ext 0	Click Here to Book
New Glasgow	Shoppers Drug Mart	912 East River Rd	902-752-0280, ext 3 then 4	Click Here to Book
Pictou	Pictou Pharmasave	33 Water St	902-485-4339	Click Here to Book
Truro	The Medicine Shoppe	1B-664 Prince St	902-814-2679	Click Here to Book

Western Zone

City	Pharmacy Name	Clinic Address	Clinic Phone Number	Online Appointment Booking Link
Aylesford	Chisholm's Pharmacy	2710 Hwy 1	902- 847-3465	Click Here to Book
Berwick	Wilsons Pharmasave	213 Commercial St	902-538-3185, ext 1 then 2	Click Here to Book
Bridgewater	Bridgewater Guardian	202-42 Glen Allan Dr	902-530-2217	Click Here to Book
Chester	Chester Pharmasave	3785 NS Trunk 3	902-275-3518, ext 2	Click Here to Book
Digby	Balser's Pharmachoice	83 Warwick St	902-247-3108	Click Here to Book
Greenwood	Shoppers Drug Mart	1124 Bridge St	902-765-3060, ext 3 then 4	Click Here to Book
Shelburne	TLC Pharmasave	157 Water St	902-875-4852	Click Here to Book
Yarmouth	City Drug Store	369 Main St	902-742-3579, ext 3	Click Here to Book

- Chronic Disease Care - Heart Disease
- Chronic Disease Care - Lung Conditions (Asthma and COPD)
- Chronic Disease Care - Diabetes
- Common & Minor Ailments
- Anticoagulation Management for Warfarin Patients (CPAMS)
- Assessment for Prescribing Birth Control
- Shingles Treatment
- Lyme Disease Prevention
- Uncomplicated Bladder Infections
- Sore Throat including Strep Throat
- Mental Health and Addiction Services

SERVICES OFFERED

CLICK TO VIEW THE DESCRIPTION OF EACH SERVICE:

- **Assessing and Prescribing for Prescription Renewals**

  The pharmacist will do an assessment to determine if it is safe and effective for you to continue to take the medication(s). If appropriate, the pharmacist will prescribe renewals (refills) for your medication(s). The pharmacist may also at this time recommend dosage adjustments or other changes to ensure your medication is doing what is expected.

  This service is covered with your NS Health card up to 4 times per year.

  Note: Pharmacists may assess and renew for narcotic and controlled drugs and substances, however there are limitations on the amounts that can be prescribed. The pharmacist will do an assessment to determine if it is appropriate to renew and in what quantity.

- Chronic Disease Care - Heart Disease
- Chronic Disease Care - Lung Conditions (Asthma and COPD)

Thank you….
Let's keep the discussion going!

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