



PATIENT SELF-MANAGEMENT CREDENTIALING AND VALUE-BASED HEALTH BENEFIT DESIGN CONSIDERATIONS IN PATIENT-CENTERED, TEAM-BASED CARE

DECEMBER 1, 2016

with Support from
SANOFI

APhA Foundation Contact:

Benjamin M. Bluml, RPh
Senior Vice President, Research and Innovation
American Pharmacists Association Foundation
(202) 429-7571
bbluml@aphanet.org

Introduction

The health care system in the United States is expected to deliver high quality services that result in positive patient outcomes while minimizing costs. This expectation is difficult to achieve or evaluate because the health care delivery system is complex and involves numerous stakeholders (e.g., patients, providers, payors, policymakers, and others) that each have a different, but vested, interest in the system. In addition, the U.S. health care delivery system is extremely fragmented and difficult for both patients and providers to navigate. Patients experience issues related to health care access, quality of care, and rising costs. Health benefit design, formularies, prior authorizations, and other restrictive requirements within the system often create barriers that interfere with the treatment for individual patients.

Medications are the primary treatment modality for chronic health conditions in our health care delivery system today. As such, optimizing medication use is essential for improving health. Health care providers need the flexibility to customize treatment plans to optimize the care delivered to individual patients and improve patient outcomes.

Patient credentialing is a unique concept where the patient's knowledge, skills, and performance associated with their chronic disease, lifestyle requirements, and therapy adherence strategies are assessed so health care providers can tailor education, support and care that effectively meets the specific needs of individual patients. The Patient Self-Management Credential (PSMC) is a psychometrically validated care resource that empowers health care providers and patients to work together in meaningful and efficient ways to identify and address areas for improvement in the self-management of health. With a progressive evidence-base that has evolved over the past 14 years, use of the PSMC has consistently produced patients that are more engaged and empowered to manage their own health care. The results of PSMC assessments have consistently provided a solution that has helped pharmacists and other providers identify the strengths and challenges of individual patients, allowing providers to tailor care plans to meet those specific needs.

Convening a Consortium of Key Stakeholders

The APhA Foundation convened a Consensus Consortium on Patient Self-Management Credentialing and Value-Based Health Benefit Design Considerations in Patient-Centered, Team-Based Care to facilitate an in-depth, thoughtful discussion among diverse perspectives to inform stakeholder thinking about the challenges within the current health care system and opportunities for potential system changes. The Consortium was convened on December 1, 2016, at the APhA headquarters in Washington, DC. Perspectives from four key constituencies were considered: 1) patients who have been empowered by their providers through use of the PSMC, 2) practitioners who have utilized the PSMC in their practices to customize care, 3) payors who make data-driven decisions to inform their coverage, and 4) value-based health decision makers from benefit managers and health systems.

Best practices and experiences from health care professionals with 472 years of collective experiences in 15-plus settings were represented at the Consortium (see table below).

| SETTING | COLLECTIVE YEARS |
|--|------------------|
| Community (chain, independent, food/pharmacy, ambulatory care, FQHC) | 169 |
| Pharmacy and Therapeutics Committee | 74 |
| Research/Analytics | 73 |
| Acute Care (hospital, health system) | 41 |
| Integrated Service Delivery Network | 26 |
| Health Plan | 23 |
| Pharmacy Benefit Management | 9 |
| Accountable Care Organization) | 8 |
| Patient Centered Medical Home | 6 |
| Other | 43 |

The Consortium participants identified a myriad of issues, with the most notable being associated with medication use access, adherence, and self-management of chronic conditions. Information collected from participants included experiences about optimal care and specific examples of approaches that facilitate successful patient outcomes. Participants also identified potential barriers to the implementation of innovative practice models on a local level and brainstormed key components and strategies to facilitate successful resolution to these barriers. Within the Consortium, patient and provider experiences associated with care delivery and achievement within the PSMC were shared in an effort to inform rational, value-based health benefit decision-making.

The Consortium dialogue was robust and resulted in the development of valuable insights that the APhA Foundation used to create a set of principles to guide health care system stakeholders in making value-based health benefit design decisions, particularly for people with challenging and complex chronic conditions. The APhA Foundation anticipates that these principles will guide system stakeholders toward meaningful change in health-system design that will optimize the way that care is delivered, improve patient health outcomes, and decrease health care costs.

Consortium Recommendations

A synthesis of the information, opinions, and expertise that emerged from the Consortium discussion produced six key themes that provided the basis for developing a principle-centered approach that will contribute to optimizing health and costs of care. The *Key Principles for Transforming the Delivery of Patient Care* that could **IMPACT** effective health care system changes and improve patient outcomes are to:



Key Principles for Transforming the Delivery of Patient Care

I **INSPIRE** Patients, Providers and Payors to Transform the Health Care System

The goal of delivering high quality health care services that result in positive patient outcomes while minimizing health care costs is difficult to achieve or evaluate because the health care system is complex and involves numerous stakeholders that each have their own vested interests in the system.

Patients have an interest in accessing affordable, quality patient care services that enable them to manage their health conditions. Appropriate management requires patients to work with their providers to optimize therapy and reach treatment goals. Once the treatment plan is optimized, ongoing management is a delicate balance that requires patient adherence to the plan, potential adjustment of the plan, and consistent monitoring and follow-up to maintain control of the health condition. Obstacles within the system that can interfere with patient self-management may include high costs of care, formulary restrictions (such as prior authorizations), or lack of benefits/coverage for recommended treatments. In addition, disruptions in care, such as nonadherence, formulary changes, or annual changes in health benefits/coverage, can substantially interfere with the patient's ability to maintain control of chronic health conditions. To optimize care for patients, unnecessary barriers and disruptions in care need to be eliminated or minimized so patients can be consistent with their treatment plans and achieve the best possible outcomes.

Ideally, the U.S. health care system provides resources designed to improve the health and well-being of

the population. However, in order for the system's resources to have a positive impact on an individual patient's outcomes, the delivery of care must be individualized and patient-centered. According to the Institute of Medicine (IOM), patient-centered care is: "Providing care that is respectful of, and responsive to, individual patient preferences, needs and values, and ensuring that patient values guide all clinical decisions."¹ What may be best for one patient may not be best for all patients. The best interest of each individual patient should be the driver for all health care decisions. Patients should feel empowered to demand health care services that enable them to successfully manage their health conditions. Inspiring patients to assume an active role in their health care can be a driving force that positively transforms how health care is delivered. As consumers of health care, patients must feel empowered to advocate for their interests if the health care system creates unnecessary barriers that impede their ability to manage their health.

Providers have a vested interest in delivering high quality health care. With the shift toward value-based benefit designs, the system places emphasis on the quality of care provided and the outcomes achieved. Unfortunately, in the current health care system, providers are often being asked to do more for patients with fewer resources. This can present a significant challenge for providers and requires them to maximize limited resources to have a positive impact on patient care. One way to optimize care is to utilize an interdisciplinary team of health care providers. The value of using a team-based approach is that each provider brings different training, skills, knowledge bases, and patient care experience to the team. Unfortunately, the current health care system is fragmented, and individual health care providers often work and communicate within isolated silos. These barriers interfere

with the ability of health care providers to coordinate care and seamlessly communicate with other health care providers involved in treating a mutual patient. It is vital to remove these silos, or at the very least connect the silos, and facilitate a culture of team-based care. The team-based approach presents opportunities to work collaboratively to maximize the resources each provider brings to the table and eliminate unnecessary overlap. Maximizing every provider's level of expertise and allowing each provider to practice at the top of their respective skill set and license will facilitate a system where the patient has an opportunity to achieve the best possible outcomes. Patients will achieve the greatest benefit when their team of health care providers collaborate with one another and coordinate their care.

As health care costs continue to rise, payors within the health care system have an interest in curbing rising costs. While the need to minimize health care costs is widely acknowledged, it is vital to recognize that cost should not be the only consideration when making health care decisions. When payors make decisions that affect a patient's benefits or coverage, these decisions should be made based on evidence and with the best interest of the patient in mind. From a historical perspective, formularies were originally initiated in health-system settings operating under the guidance of local Pharmacy and Therapeutics Committees through participating pharmacists, physicians, and other stakeholders interested in optimizing medication use. Under these circumstances, health care professionals and administrators were locally responsible and accountable for the entire medication use process (prescribing, dispensing, administering, monitoring, and systems management), and the stakeholders were involved in making formulary decisions. Decisions that created resource utilization changes for patients, providers and payors were thus carefully

considered, principled and made by representative stakeholders participating in the process. They also typically include a balanced and informed approach to therapeutics, safety, efficacy, access and cost. In the current system, stakeholders involved in making formulary decisions may not be actively involved in the patient care process and may be engaged in a "national" approach to formulary management, moving away from local/regional decision making. This can cause a potential negative impact on patient care. Any decision that is made regarding the health and well-being of an individual patient (e.g., which medication should be prescribed to treat a chronic health condition) should be made by stakeholders (e.g., patients, providers) who are making patient-centered decisions based on the evidence.

Changes to health care benefits and coverage may be inevitable, but there must be a consistent and predictable approach to the decision-making process that ensures support for patients and reinforces efforts to treat and manage chronic health conditions. Payors must commit to minimizing disruptions in care. If an evidence-based decision drives a change in the plan parameters or coverage, patients and the patient's health care providers should be informed in advance to facilitate a smooth transition to an alternative therapy. Justification for changes being made in benefits or coverage should be communicated to the patient and the patient's health care providers to manage the transition and minimize any negative impact. When patients and health care providers are uninformed about benefits or coverage changes, resulting disruptions in care are detrimental to the patient, negatively impacting the process for patients to achieve or even maintain treatment goals.



MAKE the Patient the Center of All Health Care Decisions

Often patients feel that they have lost control within the health care system, and this lack of empowerment can be overwhelming and may affect self-management of their condition. Disruptions in care, such as a new insurance plan or coverage changes on an existing plan, can have a ripple effect on altering treatment outcomes. Out-of-pocket expenses may increase or medication coverage rules may change, leading to a patient's decision to discontinue prescribed medications that had been effective in managing their chronic health care condition. Access to health care providers that patients have built rapport with may no longer be available. Even access to valuable patient care tools, such as medication adherence packaging, may not be available when the patient is required to access a new pharmacy provider. These care disruptions can occur annually or more frequently in some coverage arrangements, and without patient or provider awareness, thus disturbing care relationships and negatively impacting health and well-being.

These modifications in therapy are often driven by financial considerations rather than the patient's health care needs. Health care providers, especially pharmacists, are often faced with managing and facilitating communications about adjustments to therapy when benefits change, and it can be challenging for health care providers to explain to patients the rationale for a change in medication coverage. There is an identified need to minimize disruptions in patient care and to have effective processes in place to manage care disruptions when they do occur. A patient-centered approach to health care system decisions, rather than purely financially driven decisions, may prove to be both clinically and economically advantageous.

There is a distinct opportunity to maximize patient care outcomes by focusing on ensuring continuity of care and improving the patient care experience. Generally, the focus is on improving the care provided to patients, rather than improving care by including patients in the decision-making process. There is value in establishing a patient-centered approach as the foundation to all aspects of designing health care systems that utilize highly functioning team-based care. Including patients in the decision-making process enables the patient to take an active role in their care, having shared accountability in improving their total health. Patients are more likely to adhere to a plan they helped to create.

A health care provider's approach to caring for patients can also make a difference. Pharmacists are in a position to foster patient empowerment by engaging them directly in their own care, exploring and identifying their motivations and specific needs. Activating the patient as an informed participant in their care, at the center of the decision-making process, may prove instrumental to achieving goals of therapy. While a patient-centered approach is important, the system also needs to empower and engage patients in self-care management to obtain optimal results.

Tools such as the PSMC, developed by the APhA Foundation, can be helpful in efficiently assessing patient knowledge, skills, and performance related to self-management of their health care condition. In order to maintain desired health outcomes, it is crucial to focus on the patient, understanding his or her individual needs.

P **PROMOTE** Access to Evidence and Information that Elevates Clinical Decision-Making

Ideally, health care providers should have access to quality evidence and patient information that will support clinical decision-making. Information sharing among providers that are trying to maximize the care for a mutual patient will ensure that providers are making the best decisions they can by improving the information they have access to. For example, physicians would be better positioned to make well-informed treatment decisions with access to an accurate and up-to-date medication list and patient specific adherence data. Pharmacists would benefit from having access to a patient's laboratory data and physician progress notes that can help them determine if a patient's medication therapy is helping them achieve their treatment goal.

In the current fragmented health care system, barriers exist that interfere with the ability of health care providers to access critical patient information, coordinate care and communicate with other health care providers involved in treating a mutual patient. Expecting health care providers to make treatment decisions with limited patient information does not serve the patient's or the health care system's best interests. As health care providers work together to help a patient manage a health condition, it is important to facilitate regular communication and establish a consistent flow of information between and among providers. All health care providers involved in the patient's care should have access to the patient's treatment plan, be able to consistently assess the patient's progress toward his or her goals, and seamlessly communicate with other providers about changes being made to the care plan. Ideally, all health care providers would have shared read-write access to the mutual patient's medical record, which would facilitate information

sharing that is essential for all providers to optimize patient care.

A **ALIGN** the Incentives for Patients, Providers and Payors

For over 14 years, the APhA Foundation has been successfully implementing its structure and process models coupled with the PSMC to demonstrate the impact of health care collaborations that include pharmacists empowering patients, improving people's health, and lowering total costs for care. The challenges of program implementation vary across diverse communities, but the outcomes appear to remain consistent. When integrated health care teams utilize knowledge, skill, and performance assessments that help providers identify patient strengths and weaknesses, the team is able to create consistency, reinforce messaging, and give patients the tools and information they need to manage their health between visits with a health care provider. One component that has been consistent and emphasized in the successful APhA Foundation's structure and process models is encouraging incentives to be properly aligned for patients, providers, and payors.

Within published examples such as the Asheville Project, Patient Self-Management Program (PSMP), and the Diabetes Ten City Challenge (DTCC), patients received financial incentives to attend visits with the pharmacist and remain engaged in their own health care. In Project IMPACT: Diabetes, some patients received financial incentives, but many patients within these disproportionately affected populations who had access to low-cost or free services already recognized the access to high quality health care as the incentive. This trend illustrates that patients' access to health care may play an important role in determining the types of incentives that will effectively engage them in their own health care. When patients are beneficiaries

of a traditional, self-insured employer, they tend to engage most actively when there are financial incentives (or disincentives) provided. However, when patients are un- or under-insured, they often engage with their pharmacist because it provides them access to care they may not otherwise have received. Regardless of the type of incentive provided, properly aligning incentives is a cornerstone to engaging patients in self-management.

Incentives also need to be properly aligned for health care providers to effectively provide services that support health education, self-management, and patient empowerment within the health care system. From a historical perspective, provider incentives have most often been directly linked to payment for services. An additional incentive that could facilitate implementation of collaborative interdisciplinary care is additional payment to health care providers who participate in team-based care to achieve better health outcomes and greater efficiencies for their patients.

A trend is emerging in the federally qualified health centers and free clinics, as demonstrated within Project IMPACT: Diabetes, indicating that resource-scarce organizations actively embrace pharmacists as essential members of the health care team due to the efficiencies and cost savings they create. These organizations seek every opportunity to keep each member of the health care team working at the top of their respective skill set and license to foster cost-effective outcome improvements.

For payors, the ultimate incentive is lowering total health care costs while maintaining or improving the care that beneficiaries receive. The self-insured employer models of The Asheville Project, PSMP, and DTCC have shown that payors can consistently achieve net savings of approximately \$1,000 per

patient with diabetes per year when the pharmacist is involved in patient-centered, team-based care. These cost savings take into account patient incentives, payment for health care provider services (including pharmacists), and increased medication spend due to elevated adherence levels. The lower total cost for care makes this a sustainable model that enlightened payors, who are at-risk for all health care costs, are inclined to implement and maintain.

Properly aligning the incentives requires a change in the way money is invested in health care, particularly for government payors and large health plans. Costs are often viewed in two silos: medical claims and pharmacy claims. By segmenting these costs and not evaluating the per-beneficiary spend in total, the full value of the patient care services is rarely recognized. The increase in pharmacy claims due to increased medication adherence does not typically get linked to the decrease in medical claims from reduced hospitalizations and emergent care issues. As demonstrated in the Project IMPACT: Diabetes safety net communities, the government's investment provides resources for un- or under-insured people to receive care before their health care needs reach an emergent level. This type of investment begins to create a goal-oriented environment where providers work together to achieve better health. In order for payors to be successful and fully incentivized to implement patient-centered, team-based care services, they will need to invest significantly in ongoing health management and patient empowerment while evaluating health care costs in total.





CULTIVATE Quality Improvement and Practice Enhancement

The national focus on a value-based health system has shifted the marketplace from paying providers a fee for each service delivered toward paying providers for the quality of the care they provide as assessed by outcomes achieved. Value-based programs are focused around three aims – better care for individuals, better health for populations, and lower health care costs that directly link performance of quality measures to provider payment².

Pharmacists are well positioned to be part of value-based solutions to improve care and decrease health care costs. Quality standards and measures that focus on medication safety, medication adherence and appropriateness of medication therapy are all areas where the pharmacist is best positioned to improve quality of care for patients. In a value-based health system, pharmacists must establish consistency and predictability in the quality of the services they provide and demonstrate they can meet established quality measures that seek to drive quality of care around medication use such as the Centers for Medicare and Medicaid's (CMS) Star Ratings, the Pharmacy Quality Alliances' (PQA) Performance Measures, and The Joint Commission Standards.

As the health care system evolves, numerous stakeholders will have incentives to measure and benchmark the outcomes of health care providers, including pharmacists. Consumers will have access to information that will drive decisions on individual providers, health-systems, and pharmacy practices. There are numerous ways that pharmacists, both individually and at a practice level, can demonstrate competency and ensure quality.

All providers can work to improve quality within their own practice sites and use tools and resources that drive positive outcomes for their patients. Providers must continue to promote continuous quality improvement and practice enhancement through the adoption of quality standards and engage in established processes to ensure continued competency. For some pharmacists, pursuing additional credentialing and privileging opportunities may be of value. Certification through the Board of Pharmacy Specialties (BPS) in one of eight recognized specialties is a way to formally demonstrate continued competence in an area of specialization. As the scope of pharmacy practice evolves to meet the complex medication-related needs of patients, board certification assures stakeholders of the level of knowledge and skills of pharmacists who provide direct patient care.³

Pharmacy practices can choose to be accredited as a way to demonstrate their commitment to quality and adherence to established practice standards. For example, the Center for Pharmacy Practice Accreditation (CPPA), a partnership established by the APhA, the National Association of Boards of Pharmacy (NABP), and the American Society of Health-System Pharmacists (ASHP), develops and implements comprehensive programs of pharmacy practice site accreditation and manages the process leading to the use of consensus-based standards for pharmacy practice accreditation. CPPA accredits those pharmacy practices that meet the accreditation criteria. Additional groups such as URAC, the Accreditation Commission for Health Care (ACHC), and the Compliance Team, among others, provide accreditation programs. Health plans, employers, regulators and other providers increasingly recognize site level accreditation as a measure of the quality of care provided.

There are also opportunities for individual practices to demonstrate that they meet quality standards through participation in enhanced service networks. These networks, such as Community Care of North Carolina and the Iowa Community Pharmacy Network, establish criteria to ensure their participating pharmacies work closely with other stakeholders to provide quality services to patients, improve clinical outcomes, and decrease the costs of care. The roles and responsibilities of these sites go beyond traditional dispensing services to provide a suite of services that ensure medication optimization. Pharmacies that are accepted to participate must demonstrate the ability to deliver high quality, patient-centered care through an active, team-based approach. These types of service networks are rapidly expanding and offer additional opportunities for pharmacies to be included in value-based networks.

As evidenced through the published improvements associated with the use of the PSMC, patient credentialing is an innovative and consistently effective way to recognize and encourage patients to be self-motivated and take a personal interest in improving their health. When pharmacists and other health care providers utilize PSMC in their practices, they can ensure that health care resources are utilized most efficiently during each patient interaction and can tailor the encounter to meet the needs of the individual patient based on results from the credentialing process.



TAKE Accountability for the Financial, Clinical and Humanistic Outcomes of Patient Medication Use

Medications are the primary treatment modality for many chronic conditions, and when patients are well managed on their prescribed medications, outcomes can improve. Pharmacists are uniquely trained, within

the health care team, to manage these medication outcomes. There is significant evidence over the last several decades that demonstrate the impact pharmacists can have in improving patient outcomes (e.g., adherence, alzheimer's, depression, diabetes, hyperlipidemia, hypertension, osteoporosis, adverse drug events, quality of life).^{4, 5, 6} As medications account for more of the health care spend, pharmacists can take direct accountability for ensuring positive financial, clinical and humanistic outcomes for their patients.

Critically, the health care system must have appropriate metrics and consistent ways to collect and report outcomes to accurately measure the impact of pharmacists. These system designs must consider both process and outcomes measures. The system should not only be able to collect and report how pharmacists impact positive outcomes but also be able to assess the value of poor outcomes that were avoided through the patient care services provided by the pharmacists. It is critical that pharmacists, both individually and collectively, demonstrate the clinical, humanistic and financial evidence of medication-related interventions.

Value-based contracting, where providers are paid based on the attainment of medication-related health outcomes, is evolving. Pharmacists must engage in these specific programs and deliver predictable and measurable clinical results that demonstrate decreased costs. Engagement in value-based contracting rewards the efforts of high performers and allows these pharmacists to make themselves indispensable to patients, providers and payors. Providers that deliver high quality care that contributes to positive patient outcomes should seek appropriate attribution for the care they provide.

Conclusion

The Consortium identified a principle-centered approach for “what” needs to happen to optimize the delivery of patient care. If we: 1) Inspire patients, providers and payors to transform the health care system; 2) Make the patient the center of all health care decisions; 3) Promote access to evidence and information that elevates clinical decision-making; 4) Align the incentives for patients, providers and payors; 5) Cultivate quality improvement and practice enhancement; and 6) Take accountability for the financial, clinical and humanistic outcomes of patient medication use, we can optimize the way health care is delivered.

The APhA Foundation will continue to work with system stakeholders to develop tools and resources that will guide stakeholders on “how” to translate these principles into practice and invent a preferred future for our health care delivery system.

About the APhA Foundation

The APhA Foundation recognizes that innovation is the key to breakthrough thinking that leads to dramatic system improvements. The APhA Foundation continuously searches for and evaluates the next innovation that will improve people’s health through pharmacists’ patient care services. The APhA Foundation has convened and collaborated with top thought leaders to discuss future practice innovation and created practice resources for the following topics: Medication Therapy Management⁷, Depression⁸, Chronic Obstructive Pulmonary Disease⁹, Appointment Based Model¹⁰, Collaborative Practice Agreements¹¹, and Pharmacogenomics¹². From these discussions, ideas for new tools and innovative practice models have been successfully developed and implemented.

The APhA Foundation is a 501(c)(3) charitable nonprofit organization recognized as a national leader in pharmacy practice-based research and has a history of producing innovative programs that improve the quality of consumer health outcomes. Much of the APhA Foundation’s research has been focused on chronic disease management that helps prevent serious complications, increased medical spending, and hospitalizations. Key outcomes typically evaluated include clinical, process, humanistic, and economic measures. Through the APhA Foundation’s extensive experience in designing and implementing innovative care models, it has developed a vault of resources that empower communities to collect and analyze meaningful data in an organized and efficient way. Key information and outcomes of our research projects can be found at APhAFoundation.org.^{13, 14, 15, 16, 17, 18, 19, 20, 21, 22}

Participants in the Consortium Conference

**Amanda Applegate,
PharmD, BCACP**

Pharmacy Clinical
Services Coordinator
Balls Food Stores
Kansas City, KS

Tery Baskin, PharmD

President and CEO
RxResults
Little Rock, AR

John Beckner, BSP Pharm

Senior Director,
Strategic Initiatives
National Community
Pharmacists Association
Alexandria, VA

Dean Benton, BSP Pharm

Clinical Coordinator
Dillons Pharmacy
Hutchinson, KS

Benjamin Bluml, BSP Pharm

Senior Vice President,
Research and Innovation
APhA Foundation
Washington, DC

Kelly A. Brock, PharmD

President
KB Pharmacy Solutions
Tustin, CA

Barry Bunting, PharmD

National Practice Leader,
Health Plan Innovation
Ateb
Raleigh, NC

Mark Cziraky, PharmD

Vice President of Research
HealthCore, Inc., an Anthem
Company
Philadelphia, PA

John Forbes, BSP Pharm

Owner
Medicap Pharmacy
Des Moines, IA

Scott Hamstra, MD

Infectious Disease Specialist
U.S. Indian Health Service
Tuscon, AZ

Elizabeth K. Keyes, BSP Pharm

Executive Director
APhA Foundation
Washington, DC

**Sandra Leal, PharmD, MPH,
CDE, FAPhA**

Vice President for Innovation
SinfoniaRx
Tuscon, AZ

**Thomas Menighan, BSP Pharm,
MBA, ScD, FAPhA**

Executive Vice President and CEO
APhA
Washington, DC

Shannon Peter, PharmD

Clinical Pharmacy Manager
Think Whole Person Healthcare
Omaha, NE

Pete Sheldon

Vice President, Education &
Patient Engagement
Med-IQ
Baltimore, MD

Steve Simenson, BSP Pharm

Managing Partner
Goodrich Pharmacies
Anoka, MN

Jann B. Skelton, BSP Pharm, MBA

President
Silver Pennies Consulting
North Caldwell, NJ

Parisa Vatanka, PharmD, CTTs

Project Development Manager
APhA Foundation
Washington, DC

References

1. Institute of Medicine (IOM). 2001. Crossing the Quality Chasm. Crossing the Quality Chasm: A New Health System for the 21st Century. Washington, D.C: National Academy Press.
2. U.S. Centers for Medicare and Medicare Services. What are value based programs? Accessed at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Value-Based-Programs.html> on December 2, 2016.
3. Board of Pharmacy Specialties. Five-year vision for pharmacy specialties. January 12, 2013. Accessed at <http://www.bpsweb.org/wp-content/uploads/BPS-WHITE-PAPER-FINAL-January-2013.pdf> on December 9, 2016.
4. American Pharmacists Association Foundation. Our Work. Accessed at <http://www.aphafoundation.org/our-work> on December 1, 2016.
5. Giberson S, Yoder S, Lee MP. Improving patient and health system outcomes through advanced pharmacy practice: a report to the U.S. Surgeon General. Office of the Chief Pharmacist. U.S. Public Health Service; 2011.
6. Chisholm-Burns MA, Kim Lee J, Spivey CA, et al. US pharmacists' effect as team members on patient care: systematic review and metaanalyses. *Med Care*. 2010;48(10):923–33.
7. Definition of Medication Therapy Management: Development of Profession-wide Consensus. *J Am Pharm Assoc*. 2005 Sep-Oct;45:566-572.
8. White paper on expanding the role of pharmacists in depression. APhA Foundation. 2009.
9. White paper on expanding the role of pharmacists in chronic obstructive pulmonary disease. *J Am Pharm Assoc*. 2011 Mar-Apr;51:e20-e28.
10. Pharmacy's Appointment Based Model: A Prescription Synchronization Program that Improves Adherence. APhA Foundation 2013. Available at: [http://www.aphafoundation.org/sites/default/files/ckeditor/files/ABMWhitePaper-FINAL-20130923\(3\).pdf](http://www.aphafoundation.org/sites/default/files/ckeditor/files/ABMWhitePaper-FINAL-20130923(3).pdf).
11. Consortium recommendations for advancing pharmacists' patient care services and collaborative practice agreements. *J Am Pharm Assoc*. 2013;53:e132-e141.
12. Advancing Pharmacogenomics in Pharmacy Practice. APhA Foundation. 2013. Available at: [http://www.aphafoundation.org/sites/default/files/ckeditor/files/Advancing%20PGx%20-%20Strategic%20Plan%20-%2020121224\(1\).pdf](http://www.aphafoundation.org/sites/default/files/ckeditor/files/Advancing%20PGx%20-%20Strategic%20Plan%20-%2020121224(1).pdf).
13. Patient Self-Management Program for Diabetes: First-Year Clinical Humanistic and Economic Outcomes. *J Am Pharm Assoc*. 2005 Mar-Apr;45:130-137.
14. The Diabetes Ten City Challenge: Final Economic and Clinical Results. *J Am Pharm Assoc*. 2009 May-Jun;49:e52-e60.
15. Improving outcomes for diverse populations disproportionately affected by diabetes: Final results of Project IMPACT: Diabetes. *J Am Pharm Assoc*. 2014 Sept/Oct;54:477-485.
16. Integrating pharmacists into diverse diabetes care teams: Implementation tactics from Project IMPACT: Diabetes. *J Am Pharm Assoc*. 2014 Sept/Oct;54:538-541.
17. Results in Project ImPACT: Hyperlipidemia. *J Am Pharm Assoc*. 2000 Mar-Apr;40:157–165.
18. Regional Osteoporosis Screening, Referral, and Monitoring Program in Community Pharmacies: Findings from Project ImPACT: Osteoporosis. *J Am Pharm Assoc*. 2004 Mar-Apr;44:152–160.
19. Clinical and economic outcomes of a pilot project examining pharmacist-focused collaborative care treatment for depression. *J Am Pharm Assoc*. 2011;51:40-49.
20. Project ImPACT: Hypertension Outcomes of a Pharmacist-Provided Hypertension Service. *INNOVATIONS in Pharmacy*. 2013. 4(3):126.
21. Cognitive memory screening and referral program in community pharmacies in the United States. *Int J Clin Pharm*. 2013 Dec: Online.
22. ABM for ACO Beneficiaries. Research in progress. www.aphafoundation.org/appointment-based-model.