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Geoffrey A. Twigg

Apple Discount Drugs, geoff@appleldrugs.com

John Motsko

Apple Discount Drugs, john@appleldrugs.com

Jeff Sherr

Apple Discount Drugs, jeff@appleldrugs.com

Sara El-Baff

UMES School of Pharmacy, selaff@umes.edu

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Interprofessional Approach to Increase Billable Care-Events in a Rural Community

Geoffrey Twigg, PharmD, BCACP, CDE¹; John Mostsko, RPh, CDE¹; Jeffrey Sherr, RPh, FACA¹; Sara El-Baff, BPharm (PharmD Candidate)²

¹Apple Drugs, Salisbury, MD; ²University of Maryland Eastern Shore

ABSTRACT

Objectives: The study was designed to build a financially stable, replicable, and interprofessional program around a Center of Excellence (COE) model exclusively in a community pharmacy setting. This involved creating a separate pharmacy-based clinic within the community pharmacy with recognized rendering providers by payers allowing pharmacists to bill incident to for services and increase the quality of patient clinical outcomes. **Setting:** Apple Discount drugs in Salisbury, MD is a multi-site independent community pharmacy setting offering traditional pharmacy services along with several pharmacist run clinical programs. **Practice Innovation:** The pharmacy developed an interprofessional team around a Center of Excellence (COE) model as a separate medical clinic within the community pharmacy as a subsidiary of the parent company that was staffed with healthcare providers that are recognized by payers to bill for services. **Main Outcome Measures:** Outcomes of the study included analysis of the number of patients seen, the ability to obtain reimbursement for the clinical services offered, and changes in A1C and BMI to support the clinical value of pharmacist intervention. **Results:** A total of 309 patients with diabetes were seen over a 16 month period, including 120 patients who completed the 10 hour diabetes training program. Clinical outcomes showed an improvement in A1C from 9.1 pre enrollment to 7.5 post intervention, and a drop in BMI from 35.7 pre enrollment to 32.4 post intervention. The pharmacy was also able to increase the amount of reimbursement for services provided. **Conclusions:** The development of a pharmacy based clinic business model inside of a community pharmacy has increased the amount of clinically billed services for the pharmacy. Improvements in clinical outcomes led to an acceptance of the pharmacist as a member of the patient's care team by patients, local physician's offices, and third party payers.

Background

Pharmacists are amongst the most trusted healthcare professionals who are regularly approached by patients for expert advice¹. Unfortunately, pharmacists are often overlooked as a member of the patient's healthcare team. The value of clinical services that pharmacists can provide between primary care provider visits cannot be overstated. However, without methods to obtain reimbursement for clinical services, these services become a value added benefit that the pharmacy either gives away or are not allocated appropriate time for. Consequently, there is an absence in comprehensive patient therapy where pharmacists cannot innovatively expand upon and provide quality patient centered clinical continuation of care. A barrier to reimbursement is in part due to the inability of a pharmacist to be recognized with provider status and hence, this becomes a disadvantage because pharmacists are not reimbursed for clinical services that they routinely offer to their patients. Pharmacists are put in a position to search for unique solutions to reimbursement issues in order to keep clinical programs viable for their patients.

Diabetes affects 9.3% of all Americans and is the 7th leading cause of death in the United States². A recent study supports that the involvement of pharmacists in the continuity of care of patients with type 2 diabetes is associated with significantly better glycemic control³. Pharmacy is currently limited to billing Medicare Part B for 10 hours of diabetes self-management education and training (DSME/T) initially and only 2 hours each calendar year after the initial training takes place. This benefit does not recognize the pharmacist as a provider. The benefit is submitted under the durable medical equipment (DME) portion of the patient's Medicare benefit⁴. Attributable to the lack of provider status, many commercial insurance companies will recognize DSME/T as a covered benefit for their patients; however, they will not recognize the pharmacist as a rendering provider to this service when the practice site is the community pharmacy.

Diabetes education has been especially challenging in the tri-county area of the lower Eastern Shore of Maryland⁵. Apple Discount Drugs, located in Salisbury Maryland, has endeavored to focus on expanding the role of the pharmacist outside of traditional dispensing. Due to the need for care of the geographical area surrounding the pharmacy and the desire of the pharmacy to provide these services, the pharmacy needed to develop a mechanism to increase revenue for its diabetes disease state education program. A pharmacy-based clinic model was created to put pharmacists in a position to help alleviate this gap in care by functioning as an extension to primary and specialty care.

Corresponding author: Geoffrey Twigg, PharmD, BCACP, CDE
Clinical Pharmacist, Apple Drugs
404A N. Fruitland Blvd, Salisbury, MD 21801
geoff@appledrugs.com

OBJECTIVES

The study was designed to build a financially stable, replicable, and interprofessional program around a Center of Excellence (COE)⁶ model exclusively in a community pharmacy setting. This involved creating a separate pharmacy-based medical clinic within the community pharmacy where pharmacists could have a mechanism to obtain reimbursement from third party payers to bill for services. The researchers also wanted to determine if the increase in quality patient centered clinical offerings would lead to an increase in patient loyalty to the retail areas of the community pharmacy.

SETTING

This study took place on the rural lower Eastern Shore of Maryland. The 2014 Census data estimates show that 16.7% of residents, in the pharmacy's service area, live in poverty (Maryland overall average is 10.1%) and only 26% have a bachelor's degree or higher. This leads to a lower standard of living with an average per capita income of \$27,327, which is only 75% of the Maryland average⁴. Compounding the issues of low socioeconomic status, the Tri-County area on the lower eastern shore of Maryland rank first, second, and fourth in terms of unemployment rate in the state⁵. The rural nature of the tri-county area also makes access to providers more difficult for patients as the population density is one-quarter that of the Maryland average. To further exacerbate the need in this patient population the incidence of diabetes estimates at 12%^{7,8}.

Uninsured patients is at 15%⁹ with many more patients considered underinsured and lacking access to care. This means the number of actual patients with diabetes is likely much higher than estimates due to lack of access to needed care. The resources available for managing diabetes in this area are limited. There is only one other diabetes education center in the area, however, it does not perform any clinical interventions. Many individuals needing immediate care for complex diabetes issues are forced to travel to surrounding metropolitan areas for endocrinology services, a distance of 120-150 miles.

Practice Description

Apple Discount Drugs is an independent, community pharmacy that serves the study area. Over the past several years, the pharmacy has explored increasing the clinical role of the pharmacist in serving the community outside of the traditional role of dispensing. The Apple Diabetes Center began offering individualized patient care services in 2009 and received American Association of Diabetes Educators (AADE) recognition as a DSME program in January 2011¹⁰. Apple Discount Drugs began focusing on MTM in 2010 and has been

recognized on both the state and national levels for the quality of clinical services provided to patients^{11,12}.

PRACTICE INNOVATION

In order to increase the amount of clinical services that the pharmacy offered, the researchers created a separate pharmacy-based medical clinic as a subsidiary of the parent company that was staffed with healthcare providers that are recognized by payers to bill for services. The pharmacists, in collaboration with rendering providers for billable services, could increase the number of patients seen, the quality of the patient clinical outcomes, and the number of billable clinical services that the pharmacy offers.

The interprofessional team that the clinic utilized consisted of clinical pharmacists, a dietician, a nurse practitioner, and a physician medical director. The retail business of the pharmacy was able to share some ancillary staff with the COE that included the billing specialist to submit claims to third party insurance and collect copayments.

The researchers implemented this model by targeting an unmet need in diabetes care to increase reimbursement for DSME services since the pharmacy already had the infrastructure in place to provide this service, however, this is an initial step in creating a mechanism for reimbursement that will work across any disease state.

Methods**Legal Consultation for creation of the Center of Excellence Model**

In August 2014, the pharmacy administrators first retained a lawyer who specializes in medical and pharmacy legal issues to address any legal obligations for the community pharmacy and new clinic. The legal team looked at potential barriers and assessed the overall need to use this approach of building a separate entity, such as the center for excellence, as opposed to billing third party payers as a traditional pharmacy. However, there were no mechanisms for credentialing a pharmacist working out of a community pharmacy setting. It was also determined that the practitioners that could be credentialed for billing purposes, such as nurse practitioners or dieticians, could not assign benefits to the pharmacy-based diabetes center.

The legal team identified that many of the potential commercial payers would recognize a pharmacy-based medical clinic if the clinic were licensed as a medical clinic as opposed to a pharmacy. Therefore, creating a center for excellence 'clinic' model operating under the community pharmacy business was the best approach for the expansion of clinical services. Once the decision was made, a new company

was incorporated into Apple Discount Drugs to house the clinic, the Apple Core Clinical Care. A new tax ID and NPI were obtained for the new business and determination of the staffing model began.

The study was institutional review board (IRB) exempt. This study only changed the way the way the pharmacy presented itself for billing and marketing purposes. Informed consent to provide education and clinical services was obtained from the patient at the first encounter in the same manner that was traditionally used prior to this study.

Interprofessional Team

The interprofessional team recruited by the pharmacy clinic comprised of the clinical pharmacists, a dietician, a nurse practitioner, and a physician medical director. A billing specialist was also recruited to submit claims to third party insurance and collect copayments from patients. During the duration of the study, the State of Maryland introduced a law that allows a nurse practitioner the ability to practice independent of physician oversight. This opportunity allowed the pharmacy to reach out to nurse practitioners to function as rendering providers, creating an added benefit where the pharmacy could save money by hiring a nurse practitioner for less rather than a medical doctor.

Given that the rendering provider may have had a relationship with outside provider offices that could potentially be referring patients into the clinic. To avoid possible Stark law violations and the possible perception that the clinic may be paying providers or rendering the provider something of value in exchange for referrals, it was agreed that hiring a rendering provider, regardless of the level of license, as an hourly employee rather than paying the provider a per diem per patient was the best way to avoid a potential Stark violation. An appropriate hourly figure was determined according to the average salaries for healthcare practitioners based on the level of licensure in the area. The salary was negotiated with the provider based on experience or other intangible qualities that the clinician brought to the clinic.

Commercial Payers and Billing

The pharmacy's legal team was involved in credentialing and contacting commercial payers in order to credential clinical pharmacists with available payers. The rendering providers of medical services also made sure that they were credentialed with the same payer groups. The pharmacy's liability insurance was notified of the new clinic and coverage was adjusted so that all licensed personnel had appropriate coverage.

Third party payers contracted directly with the pharmacy clinic utilized a contract language that was typically similar to that

used with traditional medical office clinic sites. Due to this, the legal team would typically ask for an addendum to be added to contracts to specify that the Center for Excellence pharmacy-based clinic was mainly focused on disease state education and not in the practice of medical diagnosis, prescribing, or dealing with controlled substances.

Clinical Diabetes Program

The clinic program was marketed through local media and referral sources. The patients who took part in the program were mainly referred by local prescribers, self-referred, and from other members of the pharmacy's staff working with patients in traditional pharmacy services. The referring prescriber faxed results of study patients' most recent lab work, history and physical, and medication reconciliation. If the patient had been self-referred, that clinic contacted the patient's healthcare provider directly for patient medical records. The State of Maryland health information exchange, CRISP, authorized the pharmacy on-line access to health information⁸, allowing access to lab results and some baseline history for some of the patients managed by Apple Discount Drugs.

A total of 309 patients were enrolled in the program with 11 prediabetes patients, 6 Type 1 Diabetes Mellitus (T1DM) patients, and 284 type 2 Diabetes Mellitus (T2DM) patients. The group included 165 female and 144 male patients. The age group included 16 patients who were between 19 to 44 years, 143 patients between 45 to 64 years and 150 patients who were greater than the age of 64 years.

The formal diabetes education program was transferred from the traditional main community pharmacy to the Apple Core Clinical Care, the Center for Excellence clinic. The transfer kept the revenue generated from the clinical care program and the traditional services separated, making it easier to track the results of this study.

In September 2014 the DSME/T program was initiated at the pharmacy and was based off of the AADE7¹³ curriculum and core components of MTM; however, the program was structured and adjusted to meet the individual needs of the patient where a combination of group and individual counseling sessions were developed based on patient specific needs. For instance, special needs patients who were not deemed candidates for group participation were offered classes as one-on-one learning sessions with a CDE that was based on similar content as the group classes tailored to their required special needs.

Initially, patients underwent a counseling session whereby a pharmacist CDE worked one-on-one with the patient. The

initial meeting with the patient enabled the pharmacist to gain an understanding and identify any knowledge deficit that the patient may have towards their current health status. It also allowed the pharmacist to set patient specific goals, and recommend medication and lifestyle interventions that catered to the individual when indicated. Patient education included detailed instruction in healthy eating, staying active, monitoring their disease, taking medications, problem solving, reducing risks, and developing healthy coping skills. These educational methods provided tools to set individualized, realistic, and obtainable goals with the intent of the patient taking ownership of their own care. Once classes were completed, patients scheduled follow-up appointments with the clinic to go over their progress toward meeting their treatment goals. The pharmacist then provided education, coaching, or made suggested medical interventions back to the patient's prescriber. Many of the interventions that the pharmacist would suggest were based on managing side effects, pharmacoconomics, adherence, and guideline based therapy omissions. A interprofessional healthcare team approach was encouraged through the clinic where clinicians, pharmacists, nurse practitioners, and dieticians worked collaboratively with patients to bring their expertise and alternative perspectives into the diabetes education experience.

To document the number of patients that attended each class, the pharmacy developed a sign in sheet where patients logged their attendance to each group session. The ability to prove attendance was important due to the fact that, unlike Medicare, some of our third party commercial payers paid at a different rate based on the size of the group class.

Evaluation

Data was collected using the AADE7 software system. This allowed the researchers to store encounter notes and run reports that compared clinical outcomes of patients. Economic outcomes were compiled using the CPR+ software system.

RESULTS

Clinical Implications

A total of 309 patients with prediabetes patients, Type 1 Diabetes Mellitus (T1DM) patients, and type 2 Diabetes Mellitus (T2DM) patients were seen between the months of September 2014 to December 2015, who had at least one visit within the clinic model. Of the patients enrolled, 120 patients graduated the DSME/T 10 hour training course. The average drop in A1C was from an A1C of 9.1 (pre-enrollment) to 7.5 (1.6 average drop in A1C) in those patients that completed the entire course cycle and graduated the DSME/T class. Patients who completed the class cycle also experienced a drop in body mass index (BMI) from an average of 35.7 (pre-intervention)

down to 32.4 (3.3 average drop in BMI) at 6 months-post graduation (Table 1).

New Approaches – Billable Pharmacist Services

The pharmacy successfully presented its outcome data and the interprofessional model of care to the commercial third party payers to support the effectiveness of the clinics pharmacy rendered services at providing direct patient care. As a result of the beginning successes of the study, the largest commercial payer in the pharmacy's service area formed a pilot program that granted the pharmacist/CDEs a limited provider status to offer DSME/T. During the study, a positive reputation of the clinic was relayed by the patients enrolled in the study to their healthcare providers. The newly found respect of healthcare providers towards the benefits of the innovative services provided by the pharmacists in the study encouraged third party payers to become a large referral source to the program. With healthcare providers support and our persistent contact with third party payers, the patient centered medical home (PCMH), in association with third party payers, comprised a large referral source into the pharmacy and granted the clinical pharmacists access to view patients' clinical portal that contained all documentation relevant to clinical care, including nursing notes, medication refill history, and laboratory results.

Due to the clinical successes that pharmacists had with patients, one large third party insurer is attempting to remodel their patient portal to allow the pharmacist to leave clinical notes back to care coordinators. Having healthcare professionals on staff that are recognized by third party payers as providers increased the ability of the pharmacy to directly bill for more of the clinical services. Third party payers did not require any additional training or certifications such as a PharmD degree or MTM training, however, they did ask pharmacists providing the services to be a Certified Diabetes Educator (CDE)¹⁴.

Economic Outcome

The largest source of revenue and billable patient subset that the pharmacy serviced came as a result of gaining a direct provider status granted by a specific third party payer who enabled the pharmacy to directly bill for services the clinical pharmacist provided to the patient. Billing in this manner meant the pharmacy was able to collect payment and did not have split reimbursements with any other credentialed practitioners. With the help of the credentialed rendering providers within the clinic model, the pharmacy was able to increase the amount of 'incident to' billing opportunities. However, as the pharmacy clinic obtained direct limited provider status allowing for direct billing, the billing incident to rendering providers represented a reduced number of claims.

While the pharmacy did incur expenses for additional employees. This led to additional revenue coming into the pharmacy for a service that was traditionally limited to a smaller group of patients and given away free of charge. In the first year of the clinic model, the pharmacy was able to generate 2 times the amount of revenue when compared to previous year's revenue where the pharmacy only billed for DSME/T as part of the Medicare Part B benefit through the DME department.

Discussion

With dwindling reimbursements to pharmacies for dispensing, it is imperative for community pharmacists to explore other avenues to allow a viable increase in revenue. In return, reimbursement for clinical services rendered by a pharmacist will support better utilization of pharmacist clinical skills in order to advance patient health as part of a interprofessional healthcare team. As the most accessible members of healthcare, pharmacists are well trained and in a prime position to offer patient care that is individualized to various chronic conditions. Although Medication Therapy Management (MTM) offers pharmacists some ability to provide services to patients, the lack of volume and reimbursement schedules are often not robust enough to sustain a clinical program.

Prior to building the clinic model that focused on diabetes education and therapy management in a community pharmacy setting, the pharmacy could only bill DSME/T under the Medicare Part B benefit through the pharmacy DME department. While the pharmacy is still struggling to bill all commercial payers, the clinic model has helped the pharmacy to dramatically increase the number of billable intervention. This has been achieved by the use of incident to billing as well as, a dramatic increase in the number of payers who due to our study, now view our clinical pharmacists as providers. With the success of creating additional revenue sources, the pharmacy was able to dedicate more pharmacist hours to clinical services outside of the traditional roles of dispensing. In accordance with the success of this study, should national provider status for pharmacists pass, pharmacists can further expand this study model to include other chronic conditions. Future goals include that pharmacists gain the ability to directly bill for services without the need to bill incident to another provider. Direct billing should have a profound impact on a pharmacy's ability to keep clinical programs viable.

The billing complexities were carefully evaluated in determining the COE model. Members of the interprofessional team such as the dietician and nurse practitioner, were technically able to bill for services that they rendered before the clinic model was adapted. However, independent billing

would have proved to be a challenging arrangement to this study because it meant the billing would have had to be done by the individual rendering provider and there was no entity for the provider to assign the monetary benefits. This meant that the provider would be paid as an independent contractor and would have to pay the pharmacy for the time and space to work with patients. In return, the rendering provider would also have to pay tax on the income obtained directly and then make deductions based on what was paid back into the pharmacy as well as provide their own billing. This would have been a highly unorganized and cumbersome billing process, the clinic model alleviated these issues where the claim was still billed under the rendering provider's NPI number however, benefits were assigned back to the clinic. This allowed for billing to be completed by the pharmacy's billing department and the rendering provider to be paid as an employee rather than a contractor.

Due to the additional services that were offered by the pharmacy and clinic, a large portion of patients who were referred to the clinic but who had their prescriptions filled at other pharmacies would commonly have prescriptions transferred to the pharmacy, adding additional revenue. The ability of the pharmacy to integrate clinical services and medication management into a patient's pharmacy care has been the decisive factor that has been cited by a large portion of patients in this subset to make this decision. It has been noted by the clinical staff that patients seem more engaged and have better medication adherence after interaction with a clinical pharmacist.

The new traffic into the pharmacy also allowed the clinical pharmacist to increase the number of clinical offerings with the goal of reducing the incidence and progression of various chronic conditions. Patients are now routinely screened for comorbidities during DSME/T. Pharmacist screen patients for obstructive sleep apnea, diabetes depression/distress, hypertension, and the insurance that immunization status is up to date. There has also been an increase in the number of over the counter diabetes supplies sold by the retail pharmacy since the founding of the clinic.

An unexpected barrier to service included patient's unawareness of paying co-payments and deductibles in a pharmacy setting. Even though patients traditionally expect to pay for these services when they are rendered in a physician's office or hospital setting, it was a new experience for many patients to pay a co-payment for pharmacist services. To overcome this barrier, the pharmacy clinic reached out to third party payers to attempt to bundle services such as the diabetes classes, into one service rather than having to bill multiple dates of services and billing the patient for multiple co-

payments. So far there has been little acceptance of this proposal by commercial payers but the pharmacy has been allowed to present the concept to the decision makers at higher levels inside the third party payer. Most payers are still viewing the group classes much like a shared medical appointment¹⁵ that requires co-payment at each service visit rather than a series of classes making up a single product which would have a single co-payment.

In order to insure patients are aware of any co-payments, the clinic created a form for invoicing educational services rendered in the pharmacy. The form contained the date and duration of time spent with the pharmacist, it also explained that the insurance would be billed for the services rendered, the process involved, and any remaining co-payments depending on the benefits of their insurance plan. An intake sheet for newly referred patients was also created that detailed necessary clinical data from prescribers and the billing department so that they can verify benefits prior to a patient coming in for services. Prior to a patient's initial appointment to the clinic, the documents insured that an alert can be sent to the patients' insurance plan's benefit structure in terms of copayment and deductible prior to having services rendered.

When the pharmacy initially began its clinical program, a perception that the pharmacist was competing with the physician for the care of a given patient presented some difficulties and interacting with local physicians proved to be a challenge. However, the program has helped the clinical pharmacists working out of the community pharmacy to gain the acceptance of local physician groups and provide awareness towards the benefits of a pharmacist getting involved in their patients' healthcare. The local providers began to view pharmacists as an extension to primary care rather than competition and a central part to the continuity of patient therapy between doctor visits. Our services also opened up patients to take more of a proactive role in their own care and this in return, made the physician's job a lot easier because they were able to manage their patients' diabetes more effectively. The positive outcomes seen by patients in the clinic have made many of the pharmacist interventions more likely to be accepted.

Our clinical pharmacists have always believed in the benefits of the program, whether the program was considered to be part of the pharmacy or the Center for Excellence. Gaining the acceptance of the local prescribers and some third party payers has helped grow the program exponentially. The pharmacy has been very proactive in marketing the clinic to local service areas¹⁶. However, having a physician actively promote the program and the benefits directly to the patient have proven to be the most beneficial form of program

promotion. Due to the outcomes data produced by the pharmacist led diabetes center, referring physicians also began referring patients not only for diabetes care but also for patients in need of preventative care. In essence, the clinical pharmacists have effectively broadened the clinics services by seeing numerous patients diagnosed with pre-diabetes and managing the multiple co-morbidities that can lead to development of diabetes. The clinical pharmacists, with the help of the billing department are actively determining if these additional services are billable opportunities to help maximize revenue.

The Center for Excellence clinic for diabetes management has been successful in billing DSME/T to commercial payers that prior to this study, would not contract with a pharmacy. The clinic thus far has not billed services other than DSME/T but the model, as designed, can be replicated across any disease state where services of continuity of care can be provided. The clinic will continue to use the increased reimbursement to attempt an expansion in the number of clinical services offered to our patients.

Limitations

There are several limitations that may render this study difficult to replicate. The level of licensure that is required to provide credentialed clinical services may vary from state to state and across health plan payers. Additionally, some of the payers will allow for the practitioner who is providing oversight to solely extend their availability over the phone, while some payers require patients to physically be on site. The level of oversight over the program by the rendering provider required to successfully bill the pharmacist's time incident to may also vary between insurance plans.

CONCLUSION

The development of a pharmacy based clinic business model inside of a community pharmacy has increased the amount of clinically billed service opportunities for the pharmacy both directly from incident-to billing, as well as, a potential to achieve provider status directly from payers. Increases in revenues have allowed pharmacists to dedicate more time to promote patient continuity of care and enforce to patients the importance of taking a more proactive approach to their healthcare. Expansion of the pharmacy's clinical services led to an increased traffic in the pharmacy, additional prescriptions filled, and an increase in the sales of over the counter products.

Patients reported beneficial interactions with their pharmacists in a community pharmacy setting. Even though there was an initial resistance to pharmacist rendered services, the unique healthcare setting was shown to be advantageous

in that unlike a hospital or physician's office, the community pharmacy had a neutral and friendly environment where patients did not perceive it as a place that was predominantly for the sick. Hence, patients took comfort in accessing the service and felt the accessibility of healthcare professionals such as pharmacists and nurse practitioners, beneficial between doctor visits. The study's outcomes have led to an acceptance of the pharmacist as a member of the patient's care team by local physician's office and third party payers. Patients were also able to access pharmacists' expertise for a more effective medication therapy management in order to achieve quality health outcomes that was adjusted to patient lifestyle and tailored to their therapy needs.

While this example was employed with a goal to increase revenue around diabetes education, it was an initial expansion within a community pharmacy with the desire to create a mechanism for future reimbursement of pharmacist based services as part of a interprofessional healthcare team that will work across any disease state.

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Table 1

	Pre-DSME		Post-DSME	
	A1C	BMI	A1C	BMI
Average	9.1 (± 2.1)	35.7 (±7.5)	7.5 (± 1.2)	32.4 (± 7.3)
High	15.8	54.2	10.5	49.7
Low	5.8	19.3	5.5	18.1

Figure #1



This flow chart depicts the order of services as it relates to setting up the Center for Excellence Model Clinic at Core Clinical Care. Geographical location and volume will help to govern the amount of expense and potential revenue that this model may bring in for clinical services.

