

November 29, 2019

Ways and Means Committee
U.S. House of Representatives
1102 Longworth House Office Building
Washington D.C. 20515
Via Email to rural_urban@mail.house.gov

Re: Rural and Underserved Communities Health Task Force Request for Information

Dear Chairman Neal and Ranking Member Brady,

The National Association of Chain Drug Stores (NACDS) applauds the Committee's interest and commitment to advance healthcare delivery and address social determinants of health across urban and rural underserved communities throughout the country. To meaningfully address challenges that contribute to health inequities, the entire healthcare continuum must be explored for opportunities to innovate and advance care, especially via members of the healthcare team that frequently provide care to underserved and vulnerable populations. Community pharmacies, for example, provide clinical healthcare services in most neighborhoods across the country, sometimes as the only healthcare provider within walking or driving distance, offering solutions to address unmet needs related to health inequality and social determinants of health. NACDS appreciates the opportunity to provide ideas and strategies to advance healthcare delivery models that improve care, value, and better serve all communities across the country, including those that are underserved by leveraging the most accessible healthcare professionals – community pharmacists.

NACDS represents traditional drug stores, supermarkets and mass merchants with pharmacies. Chains operate over 40,000 pharmacies, and NACDS' over 80 chain member companies include regional chains, with a minimum of four stores, and national companies. Chains employ nearly 3 million individuals, including 157,000 pharmacists. They fill over 3 billion prescriptions yearly, and help patients use medicines correctly and safely, while offering innovative services that improve patient health and healthcare affordability. NACDS members also include more than 900 supplier partners and over 70 international members representing 21 countries. Please visit nacds.org.

INFORMATION REQUESTS

1. What are the main health care-related factors that influence patient outcomes in rural and/or urban underserved areas? Are there additional, systems or factors outside of the health care industry that influence health outcomes within these communities?

Access to care is a critical factor, strongly influencing patient outcomes and especially important in underserved communities. Physician shortages and unnecessary restrictions on other care providers, such as pharmacists, prevent patients from receiving the most accessible and timely care. Approximately 65 million people live in regions without adequate primary care¹ and experts estimate a shortage of providers: up to 122,000 physicians by 2032 within the United States.² Better leverage of the skills and expertise of all

¹ State and Federal Efforts to Enhance Access to Basic Health Care. The Commonwealth Fund. <https://www.commonwealthfund.org/publications/newsletter-article/state-and-federal-efforts-enhance-access-basic-health-care>

² Association of American Medical Colleges. New Findings Confirm Predictions on Physician Shortage. April 2019. <https://www.aamc.org/newsinsights/press-releases/new-findings-confirm-predictions-physician-shortage>

healthcare professionals, practicing within the community, would support physicians in bridging gaps in care and reduce undue strain across the whole healthcare continuum resulting in better care for the underserved.

Compelling and longstanding evidence demonstrates that pharmacist-provided care is a fundamental component to the vitality and sustainability of providing high-quality and accessible healthcare to Americans.^{3,4,5,6} In fact, national and federal agencies, such as the CDC and the U.S. Surgeon General, have encouraged and recognized the value of pharmacists in efforts to collaboratively improve quality and healthcare outcomes.⁷ Additionally, federal programs like the Public Health Service and the Veterans Health Administration have proven that greater inclusion of pharmacists in direct patient care leads to less administrative burden on other healthcare providers, improved cost efficiency, more cohesive healthcare teams, and most importantly, improved patient outcomes.⁸ Community pharmacists, as the most accessible and frequently visited member of the healthcare team,⁹ complement the care provided by others by facilitating convenient access to affordable and high-quality preventive, chronic and acute care and the role of community pharmacists has evolved rapidly over the last two decades to include immunizations, screenings, health and wellness, treatment for minor illnesses, medication optimization and adherence, chronic care management, and more. And importantly, it was recently estimated that up to \$21.9 billion could be saved within the US healthcare system by optimizing medication use.¹⁰ Further, it has been estimated that lack of medication adherence causes 125,000 deaths, at least 10% of hospitalizations, and hundreds of billions of preventable healthcare spending.¹¹ Pharmacists stand ready to address such issues, especially in underserved communities.

However, outside of the Veteran Administration, Department of Defense, and Public Health Service programs, pharmacists are not federally- recognized providers, which impedes their ability to bill for and sustain clinical care services, limiting their ability to expand the reach of healthcare delivery. Thus, NACDS strongly recommends the Committee leverage the accessibility and clinical expertise of community pharmacists as a core prong within a future strategy on advancing healthcare in underserved communities by duly recognizing pharmacists as healthcare providers.

³ Dalton K, Byrne S. Role of the pharmacist in reducing healthcare costs: current insights. *Integr Pharm Res Pract*. 2017;6:37–46. Published 2017 Jan 25. doi:10.2147/IPRP.S108047. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5774321/>

⁴ Newman TV, Hernandez I, et al. Optimizing the Role of Community Pharmacists in Managing the Health of Populations: Barriers, Facilitators, and Policy Recommendations. *J Manag Care Spec Pharm*. 2019 Sep;25(9):995-1000. doi: 10.18553/jmcp.2019.25.9.995. <https://www.ncbi.nlm.nih.gov/pubmed/31456493>

⁵ Armistead LT, Ferreri SP. Improving Value Through Community Pharmacy Partnerships. *Population Health Management*. 2018. <https://www.liebertpub.com/doi/abs/10.1089/pop.2018.0040?journalCode=pop>

⁶ Milosavljevic A, et al. Community pharmacist-led interventions and their impact on patients' medication adherence and other health outcomes: a systematic review. *International Journal of Pharmacy Practice*. June 2018. <https://onlinelibrary.wiley.com/doi/full/10.1111/ijpp.12462>

⁷ A Program Guide for Public Health: Partnering with Pharmacists in the Prevention and Control of Chronic Diseases. CDC. August 2012. https://www.cdc.gov/dhdsp/programs/spba/docs/pharmacist_guide.pdf

⁸ 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. Dec 2011. https://www.accp.com/docs/positions/misc/improving_patient_and_health_system_outcomes.pdf
Surgeon General supports USPHS report on pharmacists as providers. APhA. January 2012. https://www.pharmacist.com/CEOBlog/surgeon-general-supports-usphs-report-pharmacists-providers?is_sso_called=1

⁹ See Appendix 1

¹⁰ Hemberg N, Huggins D, et al. Innovative Community Pharmacy Practice Models in North Carolina. *North Carolina Medical Journal*. June 2017. <http://www.ncmedicaljournal.com/content/78/3/198.full>

¹¹ Shrank WH, Rogstad TL, Parekh N. Waste in the US Health Care System: Estimated Costs and Potential for Savings. *JAMA*. Published online October 07, 2019;322(15):1501–1509. doi:10.1001/jama.2019.13978

¹² Viswanathan M, Golin CE, et al. Interventions to Improve Adherence to Self-Administered Medications for Chronic Diseases in the United States: A Systematic Review. *Ann Intern Med*. 2012. <https://annals.org/aim/fullarticle/1357338/interventions-improve-adherence-self-administered-medications-chronic-diseases-united-states>

2. What successful models show a demonstrable, positive impact on health outcomes within rural or underserved communities, for example initiatives that address: a) social determinants of health (particularly transportation, housing instability, food insecurity); b) multiple chronic conditions; c) broadband access; or d) the use of telehealth/telemedicine/telemonitoring?

Community pharmacists are well-positioned to positively impact health outcomes for those living in rural, medically underserved areas. However, it is necessary to promote models of care that allow pharmacists to play a role in clinical care through management of patients' medications and chronic conditions, especially for those living in rural areas who may not have access to a primary care provider on a regular basis. Pharmacist interventions have been proven to improve therapeutic and safety outcomes and the results of various meta-analyses conducted for hemoglobin A1c, cholesterol, and blood pressure demonstrated the significant benefits of pharmacist care—favoring pharmacists' direct patient care impact over comparative services.¹²

- One example of a pharmacy-led chronic care management initiative designed to serve an underserved population includes a CMMI grant to the University of Southern California and AltaMed. This initiative aimed to optimize patient health and reduce avoidable hospitalizations and emergency visits for high risk patients by integrating pharmacists into safety net clinics.
- This collaborative program resulted in reduced rates of uncontrolled blood sugar by nearly a quarter (23%), improvements in LDL with 14% more patients controlled, and improvements in blood pressure with 9% more patients controlled at 6 months in the intervention group (collaborative care model with pharmacists as leads) versus the control group (primary care physicians only). Through this project, pharmacists identified 67,169 medication-related problem in 5,775 patients which resulted in a 33% reduction in readmissions per patient per year. This initiative illustrates how pharmacists can significantly impact underserved communities by providing a convenient location for patients to receive healthcare services.¹³ **See Appendix A for additional examples.**

3. What should the Committee consider with respect to patient volume adequacy in rural areas?

Rural areas generally face a shortage of physicians and healthcare providers to provide the necessary services to the surrounding community. It is crucial for the Committee to consider the inclusion of other healthcare professionals as recognized providers in order to dispense high quality and accessible care. While healthcare services have traditionally been provided by primary care physicians, nurse practitioners, and physician assistants, the role of community pharmacists has broadened in the last decade to encompass immunizations, screenings, health and wellness care, treatment for minor illnesses, medication optimization, and chronic care management programs, etc. Thus, community pharmacists stand ready to address challenges to health inequality and social determinants of health in coordination with the rest of the care continuum, especially as they are well-integrated into their communities and in tune with regional, socioeconomic challenges. Currently, some individual states recognize pharmacists as providers and authorize the provision of certain

¹² Chisholm-Burns AM, et al. US Pharmacists' Effect as Team Members on Patient Care: Systematic Review and Meta-Analyses. Medical Care: October 2010 - Volume 48 - Issue 10 - p 923-933. https://journals.lww.com/lww-medicalcare/Fulltext/2010/10000/US_Pharmacists_Effect_as_Team_Members_on_Patient.10.aspx

¹³ Chen SW. Comprehensive Medication Management (CMM) for Hypertension Patients: Driving Value and Sustainability. University of Southern California. <http://betheresandiego.org/storage/files/cmm-for-htn-usc-steven-chen-condensed-slide-deck.pdf>; Chen SW. Integration of Pharmacy Teams into Primary Care. The Center for Excellence in Primary Care and the Center for Care Innovations. May 2015. https://www.careinnovations.org/wp-content/uploads/2017/10/USC.CEPC_pharm_webinar_FinalV.pdf

patient care services; however, the nation overall lags behind in providing federal recognition and reimbursement¹⁴ for pharmacists to broadly provide and sustain clinical care.

Additionally, pharmacists' ability to provide comprehensive patient care is dependent on how expansive or restrictive their scope of practice authority is authorized within the states. Expanding pharmacists' authority to provide clinical care broadly across all states, would go a long way to increase access to high quality clinical care across the country, especially impactful in underserved areas. For example, the ability for pharmacists to prescribe medications—also known as autonomous prescribing—for certain disease states and conditions, that do not require a physician diagnosis, allows the healthcare community to expand their reach to vulnerable patients and provide the necessary care, while reducing overall strain on the care continuum. Ultimately, modernization of the current scope of practice for pharmacists is vital for pharmacists to practice to their full abilities and help other healthcare professionals answer the call to provide patients in rural areas with the patient-centered, accessible, and timely care they deserve.

4. What lessons can we glean from service line reduction or elimination in hospitals that serve underserved communities where — a. patients have the option to transition to alternative care sites, including community health centers and federally qualified health centers? b. there is broader investment in primary care or public health? c. the cause is related to a lack of flexibility in health care delivery or payment?

As hospitals and other care sites continue to close, especially in underserved areas, it is necessary for patients to have alternative locations to receive coordinated, high quality care including chronic care management, preventive care, and more. Community pharmacies are well-positioned to serve as an alternative care site to support the rest of the care continuum.¹⁵ Notable agencies within the healthcare system, such as the VA, DoD, PHS, CDC¹⁶ and the U.S. Surgeon General,¹⁷ recognize the value of pharmacists in improving quality and healthcare outcomes through services such as transitions of care, chronic disease management, and more. By providing these important services in a convenient, easily accessible location, patients in rural areas will benefit from expanded access to health and improved health outcomes. Additionally, pharmacists have the ability to intervene, via preventive care services and transitions-of-care,¹⁸ in order to prevent hospitalizations and reduce readmissions. Pharmacists are also uniquely qualified to provide patient care services through synergistic efforts that complement other provider services in a variety of ways, for example, through medication therapy optimization and promotion of medication adherence.^{19,20} Thus, care collaboration across the healthcare team provides patients with higher quality, safer, and more comprehensive care.²¹ Further,

¹⁴ Heath S. Bill Targets Patient Access to Pharmacy Care in Rural Areas. Patient Engagement HIT. <https://patientengagementhit.com/news/bill-targets-patient-access-to-pharmacy-care-in-rural-areas>

¹⁵ Heath S. How Pharmacists Can Drive Patient Engagement, Value-Based Care. March 2019. <https://patientengagementhit.com/news/how-pharmacists-can-drive-patient-engagement-value-based-care>

¹⁶ A Program Guide for Public Health: Partnering with Pharmacists in the Prevention and Control of Chronic Diseases. CDC. August 2012. https://www.cdc.gov/dhdp/programs/spha/docs/pharmacist_guide.pdf

¹⁷ 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. Dec 2011. https://www.accp.com/docs/positions/misc/improving_patient_and_health_system_outcomes.pdf
Surgeon General supports USPHS report on pharmacists as providers. APhA. January 2012. https://www.pharmacist.com/CEOBlog/surgeon-general-supports-usphs-report-pharmacists-providers?is_sso_called=1

¹⁸ Shaver A. Impact of a community pharmacy transitions-of-care program on 30-day readmission. Journal of the American Pharmacists Association Volume 59, Issue 2, March–April 2019, Pages 202–209. <https://www.sciencedirect.com/science/article/pii/S1544319118304412?via%3Dihub>
Shull MT, Braitman LE, Stites SD, DeLuca A, Hauser D. Effects of a pharmacist-driven intervention program on hospital readmissions. Am J Health Syst Pharm. 2018 May 1;75(9):e221-e230. doi: 10.2146/ajhp170287. <https://www.ncbi.nlm.nih.gov/pubmed/29691265>

¹⁹ 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. December 2011. https://www.accp.com/docs/positions/misc/improving_patient_and_health_system_outcomes.pdf

²⁰ Manolakis PG, Skelton JB. Pharmacists' contributions to primary care in the United States collaborating to address unmet patient care needs: the emerging role for pharmacists to address the shortage of primary care providers. Am J Pharm Educ. 2010;74(10):S7. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3058447/>

²¹ Isasi F. The Expanding Role of Pharmacists in Transformed Health Care System. National Governors Association. 2015. <https://icpp.net/wp-content/uploads/2015/09/NGA-TheExpandingRoleOfPharmacists.pdf>

pharmacists have been shown to improve healthcare quality, including the ability to influence a variety of endorsed quality metrics as part of value-based and alternative payment models, specifically related to transitions of care, medication optimization, chronic care, preventive care, and more.²²

However, such benefits cannot be sustained or scaled if pharmacists lack opportunity to be reimbursed for clinical care.

5. If states or health systems have formed regional networks of care, leveraging for example systems of transport or the use of telehealth/telemedicine, what states or entities are these, what approaches did they use to form these networks, what challenges did they overcome, and what challenges persist?

Pharmacy Networks of Care. Value-based care networks are designed and implemented to provide greater patient care coordination and utilize pharmacists to their full ability, which would be of value within medically underserved areas. For example, the Community Care of North Carolina (CCNC) created the Community Pharmacy Enhanced Services Network (CPESN) via CMMI-funded grant to test new reimbursement models for community pharmacies serving Medicaid, Medicare, and dually eligible beneficiaries. This allowed pharmacies to support and provide enhanced services in order to improve access and quality of care for patients. Through the provision of a wide variety of clinical services, improved healthcare outcomes have been observed, such as decreased A1c and blood pressure levels, increased medication adherence, and ultimately, decreased downstream healthcare costs.²³ Unfortunately, barriers to sustainability continue to challenge the scalability of these models of care throughout the nation, especially in underserved areas, due to lack of provider recognition for pharmacists and subsequent inability to sustain clinical service delivery. ***See Appendix B for Examples of Value-based Pharmacy Care.***

Telehealth. Chain pharmacies and retail health clinics are accessible, cost effective healthcare destinations.²⁴ Increasingly, pharmacies and retail health clinics are expanding their accessibility to patients by offering telehealth services.²⁵ Examples of telehealth services and partnerships are included in the Appendix for a handful of pharmacies, some of which initiate telehealth services through their clinics. Telehealth services have been proven as a cost effective, quality way to deliver accessible healthcare to patients. However, telehealth is underutilized and increased access to these services through myriad healthcare destinations, including pharmacies, could help improve uptake.²⁶ Further, expanding the ability for pharmacists to bill Medicare “incident-to” by leveraging telemedicine instead of requiring pharmacists to be onsite with physicians could improve the scalability of such initiatives to improve access to care. ***See Appendix C for Examples of Pharmacy Telehealth Engagement.***

²² Bonner L. A Whirlwind Tour of Value-Based Payment Models- with Pharmacists as your guide. Pharmacy Today. June 2018.

[https://www.pharmacytoday.org/article/S1042-0991\(18\)30783-7/fulltext](https://www.pharmacytoday.org/article/S1042-0991(18)30783-7/fulltext)

Payment Methods in Outpatient Team-based Clinical Pharmacy Practice, Part 2: MACRA for Pharmacists. American College of Clinical Pharmacy. August 2018.

https://www.accp.com/docs/positions/misc/Practice_Advancement_Issue_Brief.pdf

²³ Community Pharmacy Enhanced Services Network. <https://www.cpesn.com/>

²⁴Knapp K, Yoshizuka K, et al. Co-located Retail Clinics and Pharmacies: An Opportunity to Provide More Primary Care. June 2019. MDPI.

<https://www.mdpi.com/2226-4787/7/3/74/pdf>

Bachrach D, Frohlich J, et al. Building a Culture of Health: The Value Proposition of Retail Clinics. Robert Wood Johnson Foundation/Manatt. April 2015.

http://www.manatt.com/uploadedFiles/Content/5_Insights/White_Papers/Retail_Clinic_RWJF.pdf

²⁵Livingston S. Storefront clinics expanded telehealth gaining ground. Modern Healthcare. February 2017.

<https://www.modernhealthcare.com/article/20170218/TRANSFORMATION02/170219900/storefront-clinics-expanded-telehealth-gaining-ground>

²⁶Barnett ML, Ray KN, Souza J. Trends in Telemedicine Use in a Large Commercially Insured Population, 2005-2017. Journal of the American Medical Association. November 2018. <https://jamanetwork.com/journals/jama/fullarticle/2716547>

6. What successful models show a demonstrable, positive impact on addressing workforce shortages in rural and underserved areas? What makes these models successful?

As the most accessible healthcare provider, pharmacists are well-positioned to fill workforce shortages in rural and underserved areas. The number of pharmacists in the United States continues to grow, with an excess of around 50,000 pharmacists expected in 2030 if the healthcare system does not allow for expanded pharmacist roles.²⁷ Patients are already visiting their pharmacies more than other healthcare providers – with data from a high-risk Medicaid population showing that patients visit pharmacies ten times more frequently than they see other healthcare providers²⁸ – so it is critical to leverage the untapped potential of pharmacists to provide care for patients, especially in rural areas. Multiple studies have also shown that when patients visit pharmacists for chronic disease management, vaccinations, or minor ailments care, they often do so outside of normal clinic hours, and many of these patients do not have a primary care provider.^{29,30,31,32,33} Therefore, by promoting models of care that expand pharmacists' authority and support pharmacist reimbursement for clinical care services and delivery, patients living in rural areas will have increased opportunities and options to access quality healthcare services that best meet their unique needs.

NACDS urges the Committee to promote models of care that expand pharmacists' authority to provide direct patient care services and corresponding reimbursement, so patients living in rural and urban underserved areas are not left behind in the transformation of healthcare.

7. Access to providers that address oral, behavioral, and substance use needs in rural and underserved communities can be particularly limited. What approaches have communities or states taken to address such gaps in care delivery?

States across the nation have modernized their statutes and policies to authorize pharmacists to help improve access to care related to substance misuse. Currently, all 50 states give pharmacists the ability to furnish naloxone. Approximately 28 states have expanded pharmacist authority to allow pharmacists to prescribe naloxone via statewide protocol or statewide standing order.³⁴ Additionally, pharmacists are well-positioned and capable of providing Screening, Brief Intervention, and Referral to Treatment (SBIRT) services within the community. Deemed as one of the most trusted and accessible members of the healthcare team, pharmacists are able to identify and assess the risk and/or severity of substance use and provide the appropriate intervention or linkage to care necessary. In Virginia, pharmacists are recognized as providers of SBIRT services to improve access to evidence-based treatment for Medicaid and CHIP members and can administer the screening tool and provide the necessary counseling, intervention and follow-up in an effort to help improve care.³⁵ Pharmacists have also been shown to advance access to care for mental health including this example:

²⁷ HRSA. National Center for Health Workforce Analysis. Allied Health Workforce Projections, 2016-2030: Pharmacists. 2016.

<https://bhw.hrsa.gov/sites/default/files/bhw/nchwa/projections/pharmacists-2016-2030.pdf>

²⁸ Hemberg N, Huggins D, et al. Innovative Community Pharmacy Practice Models in North Carolina. North Carolina Medical Journal. June 2017.

<http://www.ncmedicaljournal.com/content/78/3/198.full>

²⁹ Klepser ME, Adams AJ, Klepser DG. Antimicrobial Stewardship in Outpatient Settings: Leveraging Innovative Physician-Pharmacist Collaborations to Reduce Antibiotic Resistance. Health Security. 2015;13(3):166-173. doi:10.1089/hs.2014.0083

³⁰ Klepser DG, Klepser ME, Smith JK, Dering-Anderson AM, Nelson M, Pohren LE. Utilization of influenza and streptococcal pharyngitis point-of-care testing in the community pharmacy practice setting. Research in Social and Administrative Pharmacy. 2018;14(4):356-359. doi:10.1016/j.sapharm.2017.04.012

³¹ Klepser DG, Klepser ME, Dering-Anderson AM, Morse JA, Smith JK, Klepser SA. Community pharmacist-physician collaborative streptococcal pharyngitis management program. Journal of the American Pharmacists Association. 2016;56(3):323-329.e1. doi:10.1016/j.japh.2015.11.013

³² Klepser ME, Klepser DG, Dering-Anderson AM, Morse JA, Smith JK, Klepser SA. Effectiveness of a pharmacist-physician collaborative program to manage influenza-like illness. Journal of the American Pharmacists Association. 2016;56(1):14-21. doi:10.1016/j.japh.2015.11.008

³³ Goad JA, Taitel MS, Fensterheim LE, Cannon AE. Vaccinations administered during off-clinic hours at a national community pharmacy: implications for increasing patient access and convenience. Ann Fam Med. 2013 Sep-Oct;11(5):429-36. doi: 10.1370/afm.1542. <https://www.ncbi.nlm.nih.gov/pubmed/24019274>

³⁴ NASPA 2019. <https://naspa.us/resource/naloxone-access-community-pharmacies/>

³⁵ Virginia Administrative Code. <https://law.lis.virginia.gov/admincode/title12/agency30/chapter130/section5070/>

- 3,726 patients were screened for depression by pharmacists during the study period. A total of 67 (1.8%) patients screened positive on the PHQ-2. Of the patients who completed the PHQ-9, approximately 25% met the criteria for consideration of diagnosis and were referred to their physician. Five patients presented with suicidal thoughts and were referred for urgent treatment. Approximately 60% of patients with a positive PHQ-9 had initiated or modified treatment at the time of follow-up.
- Authors conclude that a screening program for depression was successfully developed and implemented in the community pharmacy setting. Using the PHQ, pharmacists were able to quickly identify undiagnosed patients with symptoms of depression. The majority of patients with a positive screening had initiated or modified treatment at the time of follow-up.³⁶

However, the ability of pharmacists to broadly improve access to and sustain mental and behavioral health interventions is limited due to lack of recognition as federal healthcare providers. NACDS strongly recommends the Committee urgently and imperatively take legislative action and work with CMS to recognize pharmacists as healthcare providers as a core strategy within the larger initiative to improve health in underserved areas of the nation.

8. The availability of post-acute care and long-term services and supports is limited across the nation, but can be particularly challenging in rural and underserved areas facing disproportionately large burdens of chronic and disabling conditions. What approaches have communities taken to address these gaps in care delivery and the associated challenges of social isolation?

To address gaps in care delivery, pharmacists can be utilized both to manage chronic conditions as well as prevent them. Pharmacists have a proven ability to improve clinical outcomes associated with chronic conditions, and they are also well-positioned to provide preventive services. By supporting pharmacists to provide these preventive services, primary care physicians, nurse practitioners, and physicians assistants are able to provide care where it's needed most - on extremely complex and challenging patients. This care approach has been studied extensively. Research demonstrates that primary care physicians are more efficient when they delegate preventive care and chronic care management to other care-team members, like pharmacists.³⁷ This is especially important when you consider workload and time constraints of primary care physicians. Notably, it has been observed that general practitioners have about 2 minutes per clinic visit to properly implement preventive care, leading to a care deficit of over 5 hours per day for preventive care.³⁸ To buttress this point, it's been estimated that 1,773 hours of a physician's annual time, or 7.4 hours per working day would be needed to fully satisfy the United States Preventive Services Task Force (USPSTF) recommendations for these preventive services.³⁹ These unmet national and state preventative care needs can be lessened by supporting pharmacists to provide evidence-based, low-risk, high-value interventions, such as preventive care screenings and chronic disease management.

10. Are there two or three institutional, policy, or programmatic efforts needed to further strengthen patient safety and care quality in health systems that provide care to rural and underserved populations?

To further strengthen patient safety and care quality across the country for underserved populations, it is crucial that the Committee explore all opportunities for untapped potential, leveraging expertise across the

³⁶ Rosser S, Frede S, et al. Development, Implementation, and Evaluation of Pharmacist-Conducted Screening Program for Depression. Journal of the American Pharmacists Association. Feb 2013. <https://www.sciencedirect.com/science/article/pii/S1544319115302831?via%3Dihub>

³⁷ Altschuler J, Margolius D, Bodenheimer T, Grumbach K. Estimating a reasonable patient panel size for primary care physicians with team-based task delegation. Ann Fam Med. 2012 Sep-Oct;10(5):396-400. doi:10.1370/afm.1400. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3438206/>

³⁸ Caverly TJ et al. Much to do with nothing: microsimulation study on time management in primary care. 2018. BMJ. 2018;363 <https://www.bmj.com/content/363/bmj.k4983>

³⁹ Yarnall, Kimberly S H et al. "Primary care: is there enough time for prevention?" American journal of public health vol. 93,4 (2003): 635-41. doi:10.2105/ajph.93.4.635 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1447803/>

entire care continuum. Especially given the proven ability for pharmacists to improve access to care, quality, and reduce downstream costs, despite lacking reimbursement models for providing clinical care to date, NACDS strongly urges the Committee to support and implement the following:

- Federal recognition of pharmacists as healthcare providers;
- Expansion of pharmacist authority to broadly provide all clinical care which they are qualified to provide, especially all facets of medication management, chronic care management, and preventive care;
- Include pharmacists as eligible providers in future and existing value-based healthcare models;
- As an alternative to direct and immediate inclusion of pharmacy in CMS programs, consider testing a pharmacy value-based payment program to increase access to evidence-based community pharmacy care through CMMI.

All healthcare providers should be recognized for their unique expertise within the healthcare team and utilized to their full abilities, especially as issues with access to care are observed throughout the nation. Unfortunately, pharmacists have been long excluded from opportunities to be reimbursed for the clinical care they provide, depriving patients, especially seniors and those in rural and underserved areas, from necessary transformation in community healthcare delivery. Unlike physicians, nurse practitioners, physician assistants, clinical nurse specialists, physical therapists, clinical psychologists, speech-language pathologists, audiologists, and nutrition professionals, pharmacists have been totally restricted in their ability to sustain clinical patient care services due to lack of recognition as healthcare providers by CMS, despite robust evidence that pharmacists improve quality of care, health outcomes, patient experience, and reduce downstream healthcare costs.⁴⁰ Additionally, as observed within federal programs, pharmacists are capable of providing direct patient care that would result in improved access and reduced burden for physicians to focus on more complex cases. Thus, recognition and expansion of pharmacists' role within the community is vital to bridging the observed gaps in care seen throughout the nation.

By implementing the above through legislative action or collaboration with HHS and CMS, NACDS strongly believes our recommendations will expand access and improve quality of care across the country, with the greatest benefit to vulnerable populations in underserved areas.

Thank you for consideration of our comments. We look forward to any future opportunities to engage with the Committee on these critical issues.

STEVEN C. ANDERSON, IOM, CAE
President & Chief Executive Officer
National Association of Chain Drug Stores

⁴⁰ Krumme A, Glynn, R., Schneeweiss, S. et al. (2018). Medication Synchronization Programs Improve Adherence to Cardiovascular Medications and Health Care Use. *Health Affairs* 37(1)125-133.

Government Accountability Office. (July 2019). [Limited Information Exists on the Effects of Synchronizing Medication Refills.](#)

Pringle JL, et al. (2013). The Pennsylvania Project: Pharmacist Intervention Improved Medication Adherence and Reduced Health Care Costs. *Health Affairs*, 33(8), 1444-1452.

Vegter S, et al; "Improving Adherence to Lipid-Lowering Therapy in a Community Pharmacy Intervention Program: A Cost-Effectiveness Analysis;" *Journal of Managed Care & Specialty Pharmacy*; July 2014. <https://www.jmcp.org/doi/10.18553/jmcp.2014.20.7.722>

Spence MM, et al; "Evaluation of an Outpatient Pharmacy Clinical Services Program on Adherence and Clinical Outcomes Among Patients with Diabetes and/or Coronary Artery Disease;" *Journal of Managed Care & Specialty Pharmacy*; October 2014. <https://www.jmcp.org/doi/10.18553/jmcp.2014.20.10.1036>

APPENDIX

Appendix A. Examples of Pharmacist Impacts on Underserved Communities	
Pharmacy-based immunization services increased the likelihood of immunization for influenza and pneumococcal diseases, resulting in millions of additional immunizations in the United States. Five years after national implementation, it is estimated that 6.2 million additional influenza immunizations and 3.5 million additional pneumococcal immunizations are attributable to pharmacy-delivered immunization services each year	Patel AR, Breck AB, Law MR. The impact of pharmacy-based immunization services on the likelihood of immunization in the United States. Journal of the American Pharmacists Association. August 2018. https://www.japha.org/article/S1544-3191(18)30231-0/pdf
Pharmacist-provided MTM can improve chronic disease intermediate outcomes for medically underserved patients in FQHCs. This pilot study displayed improvement in diabetes and hypertension clinical markers associated with pharmacist provision of MTM . A1c goal achievement occurred in 52.84% of patients and hypertension control was reported in 65.21%. Pharmacists identified and resolved more than 1400 medication-related problems and addressed multiple adverse drug event issues.	Rodis JL, et al. Improving Chronic Disease Outcomes Through Medication Therapy Management in Federally Qualified Health Centers. Journal of Primary Care & Community Health. 2017. https://www.ncbi.nlm.nih.gov/pubmed/28381095
A large proportion of adults being vaccinated receive their vaccines during evening, weekend, and holiday hours at the pharmacy, when traditional vaccine providers are likely unavailable. Younger, working-aged, healthy adults, in particular, a variety of immunizations during off-clinic hours. With the low rates of adult and adolescent vaccination in the United States, community pharmacies are creating new opportunities for vaccination that expand access and convenience .	Goad JA, et al. Vaccinations Administered During Off-Clinic Hours at a National Community Pharmacy: Implications for Increasing Patient Access and Convenience. Annals of Family Medicine. September 2013. https://www.ncbi.nlm.nih.gov/pubmed/24019274
This retrospective analysis studied community pharmacies providing flu and group A streptococcus (GAS) testing. Participating pharmacies reported 661 visits for adult (age 18 and over) patients tested for influenza and for GAS pharyngitis. For the GAS patients, 91 (16.9%) tested positive. For the Influenza patients, 22.9% tested positive and 64 (77.1%) tested negative. Access to care was improved as patients presented to the visit outside normal clinic hours for 38% of the pharmacy visits, and 53.7% did not have a primary care provider .	Klepser D, et al. Utilization of influenza and streptococcal pharyngitis point-of-care testing in the community pharmacy practice setting. Research in Social Administrative Pharmacy. 2018. https://www.ncbi.nlm.nih.gov/pubmed/28479019
This survey analyzes Oregon pharmacy practices in the provision of hormonal contraception (HC) and evaluates if pharmacists' motivation to prescribe HC changed after 6 and 12 months of experience. The survey results demonstrated that pharmacist prescribing of HC continues to grow with almost 50% of pharmacists billing insurance for the visit. Visits take <30 minutes and the top 3 motivators continue to be enhanced access to care , reducing unintended pregnancy, and expanding pharmacists' scope of practice.	Rodriguez MI et al. Pharmacists' experience with prescribing hormonal contraception in Oregon. Journal of the American Pharmacists Association. December 2018. https://www.sciencedirect.com/science/article/pii/S154431911830339X
This umbrella review included 13 research syntheses, finding that the provision of preventive services at community pharmacies is shown to be effective at increasing immunization rates, supporting smoking	San-Juan-Rodriguez A, Newman TV, Hernandez I, et al. Impact of community pharmacist-provided preventive services

<p>cessation, managing hormonal contraceptive therapies, and identifying patients at high risk for certain diseases. Community pharmacies offer an ideal venue for the provision of preventive services due to their convenient location and extended hours of operation.</p>	<p>on clinical, utilization, and economic outcomes: An umbrella review. Preventive Medicine. 2018. https://www.ncbi.nlm.nih.gov/pubmed/30145351</p>
<p>Among black male barbershop patrons with uncontrolled hypertension, health promotion by barbers resulted in larger blood-pressure reduction when coupled with medication management in barbershops by specialty-trained pharmacists. The mean reductions in systolic and diastolic blood pressure were 21.6 and 14.9 mmHg greater, respectively, in participants assigned to the pharmacist-led intervention than in those assigned to the active control. In the intervention group, the rate of cohort retention was 95%, there were few adverse events, and self-rated health and patient engagement increased.</p>	<p>Victor RG, et al. A Cluster-Randomized Trial of Blood-Pressure Reduction in Black Barbershops. The New England Journal of Medicine. April 2018. https://www.nejm.org/doi/full/10.1056/NEJMoa1717250</p>
<p>This study describes the result of a pharmacist-driven, type 2 diabetes targeted, collaborative practice within an urban, underserved federally qualified health center. Pharmacists within a primary care team managed patients with chronic illnesses utilizing a collaborative practice agreement. Pharmacists had a significant impact on improving the health outcomes of patients with Type 2 diabetes, with significant improvements in patient attainment of A1c <9%, ACE inhibitor/angiotensin receptor blocker and statin use, and tobacco cessation at follow-up</p>	<p>Lokken J, et al. The impact of a pharmacist-driven, collaborative practice on diabetes management in an Urban underserved population: a mixed method assessment. Journal of Interprofessional Care. August 2019. https://www.tandfonline.com/doi/abs/10.1080/13561820.2019.1633289?journalCode=ijic20&</p>
<p>This article highlights three health systems – Yale-New Haven Health, Ascension, and the University of Illinois Hospital and Health Sciences System – that are utilizing pharmacists to provide healthcare services to underserved patients.</p>	<p>https://www.ashpintersections.org/2018/06/underserved-patients-rely-on-pharmacists-to-fill-care-gap/</p>

Appendix B. Examples of Value-based Models in Pharmacy

1. Wellmark Blue Cross Blue Shield Value Based Pharmacy Program (VBPP)

Payor: Medicare, Medicaid, and Commercial

Background: In July 2016, Wellmark identified high performing independent and chain pharmacies in Iowa and South Dakota to participate in a new value-based model, focused on better serving patients with asthma, diabetes, hyperlipidemia, and depression. Goals of this program include ensuring that the patient is on the right drug and is adherent, and in the longer-term, to reduce emergency department visits, hospital readmissions, and total cost of care.

Program Details: For inclusion in the network, participating pharmacies must offer multiple clinical services (e.g. year-round immunization program, comprehensive medication reviews, health screenings, and medication synchronization appointments). Participating pharmacies are also required to formally document services delivered and actively communicate information to patients' providers, provide adequate space for private or semi-private consultations, develop a service plan based on community-specific needs, establish formal immunization protocol and/or collaborative practice agreement(s), and ongoing pharmacist training. Eligible members for the program include those with ≥ 1 chronic medication or diagnosed with a chronic condition. Example metrics to evaluate pharmacy performance vary by disease state and include:

- Diabetes – blood sugar control and blood pressure control
- Depression - readmissions
- Cardiovascular risk - cholesterol goals, is patient on correct statin intensity?
- Asthma - assess how often patient is utilizing rescue inhaler

Payment Structure: Wellmark's VBPP network is structured outside of the Pharmacy Benefit Manager (PBM) relationship. VBPP payment structure is per member per month (PMPM) with bonuses. Bonus from shared savings is received based on Wellmark's evaluation of costs.

Preliminary Results: As of July 2018, researchers are collecting and analyzing VBPP data to determine the impacts of this program. However, the **Continuous Medication Monitoring (CoMM) pharmacy pilot**, which informed the creation of the ongoing Wellmark VBPP model, had significant results. Specifically, the CoMM pilot was designed to assess the effects of continuous medication monitoring (CoMM) on total costs of care, proportion of days covered (PDC) rates and the use of high-risk medications by elderly patients. The pilot results demonstrated lower total costs of care and meaningfully better medication adherence. *Per member per month (PMPM) costs were approximately \$300 lower for patients who received medications only from the pharmacy offering the CoMM program as compared to patients receiving medications from other pharmacies.* This pilot validated that paying pharmacists to proactively address the safety, effectiveness, and adherence of medications at the time of dispensing can support optimization of medication therapy and decrease costs.⁴¹

2. Wisconsin Pharmacy Quality Collaborative (WPQC)⁴²

Payors: Medicaid, Medicare Part D, Medicare, Commercial, and SeniorCare

Background: Established in 2008, the WPQC is an initiative of the Pharmacy Society of Wisconsin (PSW), which connects community pharmacists with patients, physicians, and health plans to improve the quality and reduce the cost of medication use across Wisconsin. In 2012 the PSW received a \$4.1 million Health Care Innovation

⁴¹ Pilot: While some of the pharmacy services promoted and measured are different between the current Wellmark Blue Cross Blue Shield VBPP and the CoMM pilot, in the CoMM, pharmacists assessed each of the medications being dispensed, identified, and resolved any medication-related problems, and then documented their actions. Examples of drug therapy problems include doses too high or low, duplicate therapy, omissions in drug therapy, etc. Doucette, William R, et al.; "Pharmacy performance while providing continuous medication monitoring."; *Journal of the American Pharmacists Association*; Volume 57, Issue 6, 692-697.

[https://www.iapha.org/article/S1544-3191\(17\)30788-4/fulltext](https://www.iapha.org/article/S1544-3191(17)30788-4/fulltext)

⁴² <http://www.pswi.org/wpqc>

<http://www.pswi.org/WPQC/About-WPQC/About-WPQC>

<https://www.dhs.wisconsin.gov/publications/p01558.pdf>

<http://www.pswi.org/WPQC/WPQC-Payers/Benefits-to-Payers>

Award from the Centers for Medicare & Medicaid Services (CMS) to expand the WPQC statewide. Currently, over 500 pharmacists are actively certified through WPQC. Current health plan partners include the Wisconsin Medicaid and SeniorCare programs and the United Way of Dane County, representing approximately 20% of the state population, or over 1 million Wisconsin lives.

Program Details: WPQC is a network of pharmacies with pharmacists who provide medication therapy management (MTM) services, such as comprehensive medication reviews (CMRs) to complex, high-risk patients. This model leverages pharmacists to reduce medication complexity and errors, improve adherence, and empower patients to safely manage their medication regimens. WPQC and its health plan partners facilitate the provision of MTM services for patients taking multiple medications to treat chronic conditions, those at risk of falls and adverse drug events (ADEs), and those recently discharged from the hospital. The UWDC CMR program supports community and senior center case managers to identify older adults at risk of falls and ADEs and intervene by scheduling WPQC- provided CMRs and offering home falls safety assessments. Services can also be provided at the pharmacy or the patient's residence. Similarly, a partnership in Milwaukee between WPQC pharmacies and UniteMKE trains community health workers in medication adherence screening. The community health workers then make CMR referrals to WPQC pharmacies.

Eligible patients must meet at least one of the following criteria to receive WPQC CMR services: take four or more prescription medications to treat/prevent two or more chronic conditions, diagnosis of diabetes, have multiple prescribers, or low health literacy. Patients also qualify for a CMR in the 14 days following discharge from a hospital or long-term care facility to prevent a readmission to the hospital. Additionally, a referral from a prescriber automatically qualifies any patient covered by a participating health plan for WPQC services.

Preliminary Results: In 2016, the Wisconsin Department of Health Services Division of Health Care Access and Accountability completed an evaluation of the project work. The evaluation showed that patients who received a CMR at some point prior to hospitalization exhibited a decrease of \$524 in inpatient costs per hospitalized patient in comparison with a control group that had not received a CMR. [This finding](#) suggests that CMRs provided through WPQC may have been impacting health care utilization between 2012-15. Results from the pilot phase of WPQC (2008-2010), which included Unity Health Insurance and Group Health Cooperative of South-Central Wisconsin showed:

- 1) 10:1 Return on Investment (ROI) for services which directly impacted medication cost;
- 2) ROI was maintained at 2.5:1 when combining services which directly impacted medication cost and comprehensive medication reviews; and
- 3) Facilitating the use of health plan formularies to ensure the least expensive equivalent medication, pharmacists can save payers and patients 3-4 times the cost of medications.

Payment Structure: Compensation for the CMR service is provided by participating health plans on a fee-for-service basis and includes one initial visit and three follow-up visits with the pharmacist annually at no cost to the patient.

3. Community Care of North Carolina – Enhanced Pharmacy Services Network⁴³

Payor: Medicare and Medicaid Innovation Grant

Background: The following \$15.6 million CMMI project led by North Carolina Community Care Networks, Inc. (CCNC), Optimizing the Medical Neighborhood: Transforming Care Coordination through the North Carolina

⁴³ <https://www.communitycarenc.org/>
<https://www.cpesn.com/>
https://issuu.com/iowapharmacyassociation/docs/2016q2_jo
[urnal_web https://cpesn.com/payors](https://cpesn.com/payors)

Community Pharmacy Enhanced Services Network, tested a model focused on community-based pharmacists who delivered medication management services to Medicaid, Medicare, and dually eligible Medicare-Medicaid and NC Health Choice beneficiaries with at least one chronic condition and had over 80% of their medications filled within the last 100 days at one of 275 participating pharmacies. This project was one of 39 awardees for a 3-year cooperative agreement known as Round Two of the Healthcare Innovation Awards (HCIA R2). While the impact analysis for the CCNC project is still underway, the project reached 92% of its enrollment goal – more than 70% of enrolled patients were Medicare-Medicaid dual eligible – as they tested the use of a value-based approach to incentivize pharmacists to move from filling prescriptions to providing enhanced services that address gaps in patient care for the most at-risk patients. Of the 39 awardees – only two reported their program had been replicated by others - with 15 other pharmacy networks replicating the CCNC project and another 25 or more requesting technical assistance to do so. This model has garnered substantial interest across the pharmacy community and payers, and more demonstration work needs to be done to further refine the quality program tested and press toward larger scale sustainability and replicability across Medicare and state Medicaid programs. Further, CCNC reported working closely with the North Carolina Division of Medical Assistance to incorporate the program into a Medicaid reform effort.

Program Details: Participating pharmacies are given access to CCNC information that allows pharmacists to review prescription claims data, adherence data, and population management tools. Pharmacies are allowed to participate in the CPESN-NC framework as long as they deliver enhanced services, document interventions, and meet minimum established criteria. CPESN-NC pharmacies must provide a proactive waste management program that prevents medication waste by verifying patient need prior to each fill, patient counseling and adherence coaching, and assistance with medication reconciliation especially after hospital discharge.

Preliminary Results: Outcomes from this grant have not been published yet. Based upon preliminary results, high-risk Medicaid patients supported by CPESN pharmacies are:

- 45% less likely to have an inpatient hospitalization admission,
- 35% less likely to have a preventable hospital admission or readmission,
- 15% less likely to experience an emergency department visit,
- 25% more likely to engage their primary care provider (PCP), and
- 20% more adherent to their medications.

Primary goals of this grant were to improve quality and reduce costs while enhancing the ability of the primary care provider (PCP) to improve care outcomes for patients with chronic diseases.

Payment Structure: The payment structure is per member per month (PMPM) based on the patient risk or complexity and pharmacy performance score. Pharmacy performance score is based upon the following metrics: risk-adjusted total cost of care, risk-adjusted inpatient hospitalizations, risk-adjusted emergency department visits, adherence to antihypertensive medications, adherence to statins, adherences to DM medications, and patients' adherence to multiple chronic medications. Payment is based on current Medicare Chronic Care Management codes.

Patients must have high preventable risks. For example, a patient with high preventable risk is a 55-year-old with diabetes and high cholesterol who has a history of two previous ER visits and is nonadherent to their cholesterol medication. A pharmacist can help this patient become more adherent to the cholesterol medication and reduce the likelihood of a \$3,000 or significantly higher ER visit.

4. Inland Empire Health Plan (IEHP) Pharmacy P4P Program⁴⁴

Payors: Medi-Cal and Medicare

Background: In 2013, IEHP, a Medi-Cal and Medicare health plan that provides managed care for more than 1.2 million California residents, developed the IEHP Pharmacy Pay-For-Performance (P4P) Program – one of the first programs of its kind – designed to improve pharmacy services through IEHP’s 450 community pharmacy providers. The main focus of the program aimed to validate the roles of community pharmacies in promoting healthcare quality and define a pharmacy payment model for outcome-based services while improving members’ health, reducing costs, and increasing the plan’s star rating. IEHP has a Pharmacy Quality Star Ratings system created to help IEHP members locate high-quality pharmacies based on data collected. The searchable system displays the rating of each participating pharmacy. The ratings range from 1 to 5 stars, with 5 stars being the best.

Program Details: The initiative began with a focus on pharmacist review of member’s Proportion of Days Covered (PDC), which is a measure of medication adherence. Pharmacists worked to achieve members’ adherence goal of PDC ≥ 80%. In a later phase, the Pharmacy Home Program began, which provided reimbursement for pharmacies that reached PDC member adherence goals and included medication therapy management (MTM) services to provide care for diabetes, high blood pressure, high cholesterol, and/or asthma. The most recent phase of the program, Safe Rx Network, commenced with a focus on medication safety, and requires pharmacists to review all relevant drug utilization review (DURs) alerts, and determine the most appropriate interventions. DUR alerts and appropriate intervention can mitigate the risk of adverse or medication-related events. There are four DUR alert categories in the program: drug-drug interactions, high dose exceeding maximum recommended dose, therapeutic and ingredient duplication, and high-risk medications for the elderly. To evaluate the program, IEHP measures DUR interventions, percentage (%) of total processed claims with safety DUR alerts, and percentage (%) of overall inappropriate claims avoided. IEHP is preparing to expand their quality-focused initiatives with a Point-of-Care (POC) MTM Pharmacy Program with expected launch date in 2019.

Preliminary Results: Prior to current phase of the DUR program, pharmacists were able to significantly increase medication adherence rates. Likewise, based on current DUR program data collection and calculations, overridden DUR alerts are trending down from baseline. Therefore, pharmacists are intervening on DUR alerts more often: this process helps to optimize medication therapy and ensure that only safe and effective medications reach patients.

Payment Structure: Pharmacies are paid a certain amount of dollars per prescription claim that is processed with an overridden DUR alert providing that a payable PSC code is included. The P4P payment per claim will be determined based on final paid prescription volume. Furthermore, there is a bonus payment associated with not filling a prescription after receiving a DUR notification or alert. A pharmacy will receive bonus payment if the percentage of paid prescription volume associated with overridden DUR alerts of the total paid prescription is lower than IEHP threshold. Pharmacies can also earn payment for participating in a Text Message Incentive Program. Monetary support will be allocated to encourage pharmacies to implement a text message system to provide notification to IEHP members. For pharmacies to meet the requirement for opt-in, IEHP members much opt-in >50%. Pharmacies may also earn payment based on member satisfaction survey results.

⁴⁴ <https://ww3.iehp.org/en/providers/pharmaceutical-services/pharmacy-p4p-program>

Appendix C. Examples of Chain Pharmacy and Retail Health Clinic Telehealth Programs

Company	Telehealth Offerings/Partnerships	Sources
CVS	(2018/2019) Direct to consumer video visits through CVS app in connection with MinuteClinic for patients aged 2 years and older via the Teladoc Health platform, available in 26 states and DC, for a minor illness, minor injury, or a skin condition. Began in 2018, expanded in July 2019.	https://mhealthintelligence.com/news/cvs-health-expands-direct-to-consumer-telehealth-service-to-26-states
Giant Eagle	(2018) Connected care kiosks in three Pittsburgh supermarkets. The kiosks, located in a separate room in the pharmacy area, enable consumers aged 3 and older to connect on a virtual care platform with a University of Pittsburgh (UPMC) provider for a variety of non-urgent concerns, including colds, infections and allergies. The kiosk is also equipped with mHealth-enabled blood pressure cuffs, thermometers and otoscopes.	https://mhealthintelligence.com/news/upmc-giant-eagle-partnership-puts-telehealth-kiosks-in-markets
H-E-B	(2019) Patients can purchase a single doctor's visit at the store's pharmacy counter and download the MD Box app. The app is marketed to insured and uninsured people as an alternative to urgent care centers, and as over-the-counter assistance for people who may need a prescription medication but can't take the time off work or can't afford a doctor's visit. Once in the app, patients answer some basic questions about their symptoms. Within minutes, they are connected to a licensed medical provider who, through video chat, is able to diagnose their condition and determine an appropriate treatment plan. The doctor visit is complete in less than 30 minutes, according to a news release.	https://www.houstonchronicle.com/lifestyle/renew-houston/health/article/H-E-B-partners-with-an-app-that-lets-you-video-14413837.php
Kroger	At The Little Clinic, telehealth is virtually conducted by their expert staff through telecommunication equipment. Their Licensed Practical Nurse (LPN) facilitates the visit, beginning by taking the patient's vitals and medical history. The LPN then connects the patient to a Provider using telecommunication technology and a camera which transmits live pictures of systems (i.e. ear, nose, throat, eyes). The Provider interviews and assesses the patient to inform diagnosis, order a treatment via the LPN, and/or prescribe medicine.	https://www.thelittleclinic.com/topic/tlc-now-offering-telehealth-visits-3 https://www.thelittleclinic.com/dietitian

	For nutrition advice, patients download “Zoom” on their smart device to meet and be virtually connected with a team of Kroger dietitians.	
Publix	As announced in 2017, Florida's BayCare Health System is opening Publix pharmacies in several of its hospitals, in exchange for mHealth stations and telehealth clinics in Publix supermarkets. “BayCare HealthHubs” offer mHealth devices to measure pulse, weight, body mass index and blood pressure, as well as free health and wellness information, and include a secure channel so that users can send biometric data to their doctor. The health system plans to open roughly 25 telehealth clinics at Publix supermarkets, allowing visitors to connect remotely with a physician for non-emergency care.	https://mhealthintelligence.com/news/florida-hospital-supermarket-chain-launch-telehealth-partnership
Rite Aid	(2019) RediClinic Express kiosks offer direct to consumer telehealth services in Pennsylvania pharmacies for non-urgent health issues through partnership with InTouch Health. Patients can schedule an appointment online or at the kiosk, either through a touchscreen portal or by speaking to a clinical assistant at the site. That assistant gathers vital signs and hands out a questionnaire, after which, the patient is matched with an available clinician for a virtual visit in the kiosk.	https://mhealthintelligence.com/news/rite-aid-eyes-telehealth-kiosks-in-new-deal-with-intouch-health
Walgreens	<p>(2019) In partnership with Microsoft, offering mHealth and telehealth through a connected health platform including telehealth stations and digital health tools. Beginning with a 12-store pilot of “digital health corners” geared toward promoting health devices to better manage preventive, acute, and chronic care.</p> <p>(2018) “Find Care Now” includes an online platform to connect patients with more than 17 healthcare providers, including national telehealth provider MDLive for tele-mental health and non-acute urgent care. The mobile app offers Walgreens’ estimated 5 million active members access to local healthcare services.</p>	https://mhealthintelligence.com/news/newyork-presbyterian-walgreens-announce-telehealth-collaboration https://mhealthintelligence.com/news/walgreens-launches-an-online-marketplace-for-telehealth-mhealth https://news.walgreens.com/press-releases/general-news/providence-st-joseph-health-to-operate-seven-additional-retail-clinics-in-walgreens-stores-in-washington-and-oregon.htm

	<p>(2018) Pacific Northwest-based Providence-St. Joseph Health – Retail clinic operation in Oregon and Washington with telehealth visits included as part of this partnership.</p> <p>(2017) NewYork-Presbyterian - Telehealth kiosks in select New York City pharmacies, offering an on-demand link to a physician through a high-definition video conferencing platform for treatment of non-life-threatening illnesses and injuries. Connected devices used in an examination include a forehead thermometer, blood pressure cuff, pulse oximeter and dermascope.</p>	
Walmart	<p>Offers a telehealth program to nearly all employees through a partnership with Doctor On Demand, Grand Rounds and HealthSCOPE Benefits. In 2019, Walmart expanded telehealth services for employees in Colorado, Wisconsin, and Minnesota for mental health, urgent health, preventive health and chronic care services.</p> <p>Sam’s Club, an affiliate of Walmart, announced in September 2019, they will be offering telehealth to members in Michigan, Pennsylvania and North Carolina under a partnership/program called “Sam’s Club Care Accelerator Together with Humana”. Will offer unlimited telehealth visits for \$1 each in collaboration with a Seattle-based connected health company called 98point6.</p> <p>Announced in 2018, Walmart is establishing telehealth stations at some of its locations in a partnership with the Department of Veterans Affairs as part of their “Anywhere to Anywhere VA Health Care” program.</p>	<p>https://mhealthintelligence.com/news/va-announces-telehealth-partnerships-with-walmart-philips-t-mobile</p> <p>https://corporate.walmart.com/newsroom/2018/12/06/u-s-department-of-veteran-affairs-and-walmart-announce-telehealth-collaboration-to-reach-underserved-veterans</p> <p>https://mhealthintelligence.com/news/walmart-expands-telehealth-services-for-employees-in-3-states</p> <p>https://mhealthintelligence.com/news/sams-club-includes-telehealth-in-new-bundled-health-program</p>