FAQ: Basics of Ambulatory Care Pharmacy Practice
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Contact:
Melanie R. Smith, Pharm.D., BCACP, DPLA
Director, Section of Ambulatory Care Practitioners
sections@ashp.org

Purpose: This document aims to answer frequently asked questions about ambulatory care pharmacy practice encountered by pharmacists interested in beginning a career in ambulatory care pharmacy. Although it is not all inclusive, it is a summary of various reliable and current sources for the aspiring ambulatory care pharmacy practitioner.

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I. Definition:

A. What is ambulatory care pharmacy practice?

In November 2008, the American College of Clinical Pharmacy (ACCP), the American Society of Health-System Pharmacists (ASHP), and the American Pharmacists Association (APhA) petitioned the Board of Pharmacy Specialties (BPS) to recognize ambulatory care pharmacists through specialty certification[1]. In their petition, the ACCP/APhA/ASHP Joint Working Group proposed a definition for ambulatory care pharmacy practice; that definition is now endorsed by BPS[1,2,3]. According to the Joint Working Group and BPS, "Ambulatory care pharmacy practice is the provision of **integrated**, **accessible health care services *by* pharmacists** who are accountable for **addressing medication needs, developing sustained partnerships with patients**, and **practicing in the context of family and community**…"[1,2,3] It involves being an integral part of an outpatient, multidisciplinary healthcare team to improve quality and patient outcomes by focusing on medication management.

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B. Where do ambulatory care pharmacists work?

BPS states, "The ambulatory care pharmacists may work in both an institutional and community-based clinic involved in direct care of a diverse patient population"[1].

Ambulatory care pharmacists may work in the following settings[2,3]:

- Accountable care organizations (ACO)
- Community based or free clinics
- Community pharmacies
- Federally Qualified Health Centers (FQHC)
- Hospital-based outpatient clinics
- Indian Health Service Clinics
- Managed care integrated system
- Outpatient clinics associated with academic medical centers
- Patient-Centered Medical Homes (PCMH)
- Private practice physician clinics
- Rural Health Clinics
- Self-insured employee clinics
- Veterans Affairs (VA) Medical Centers
- Others

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C. What services do ambulatory care pharmacists provide?

Ambulatory-care pharmacists provide, "...***direct patient care*** and **medication management** for **ambulatory patients, long-term relationships, coordination of care, patient advocacy, wellness and health promotion, triage and referral**, and **patient education and self-management**".[1]

Services delivered by ambulatory care pharmacists include, but are not limited to[1,2,3,4,5]:

- Access services or care coordination
- Chronic disease state management
- Comprehensive medication management
- Drug information
- Healthcare provider education
- Immunization screenings and administration
- Medication reconciliation
- Medication Therapy Management (MTM)
- National Committee for Quality Assurance (NCQA) reporting
- Ordering, interpreting, and monitoring laboratory tests
- Participate in transitions of care, annual wellness visits, and group visits
- Participate in Physician Quality Reporting System (PQRS)
- Patient education and counseling
- Preventative care or wellness screenings
- Prospective or retrospective chart reviews
- Refill authorization
- Research & clinical trials
- Shared visits with other healthcare providers (i.e. physicians, nurses, behavioral health specialists)

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II. Developing Ambulatory Care Pharmacy Services:

A. How do I become an ambulatory care pharmacist?

Although there are no set requirements to become an ambulatory care pharmacist, ASHP considers an ASHP-accredited Post Graduate Year One (PGY-1) training as a minimal competency, with a Post Graduate Year Two (PGY-2) training as optimal[1]. In addition, specialty board certification, clinical experience, and continuing-education certification programs should be obtained by all ambulatory care pharmacists involved in direct patient care[1]. The minimum requirements to be an ambulatory care pharmacist also vary by state; therefore, check with your state board of pharmacy to make sure you are in compliance[1,2,3]. Healthcare organizations and payors may also require certain credentials to grant direct patient care privileges[2,3]. While many credentialing boards require residency training (i.e. PGY-1 and/or PGY-2) and/or equivalent years of experience, and/or board certification (i.e. BCACP), some may request additional credentials not unique to pharmacists such as Certified Diabetes Educator (CDE)[2].

There are various credentials available for ambulatory care pharmacists[2,3]:

- Unique to pharmacists
    - BCACP – Board Certified Ambulatory Care Pharmacist
    - BCPS – Board Certified Pharmacotherapy Specialist
    - BCOP – Board Certified Oncology Pharmacist
    - BCGP – Board Certified Geriatric Pharmacist
    - BCPP – Board Certified Psychiatric Pharmacist

- Applicable to pharmacists and other healthcare professionals
    - BC-ADM – Board Certified – Advanced Diabetes Management[4]
    - CDE – Certified Diabetes Educator[5]
    - CAE - Certified Asthma Educator[6]
    - CTTS - Certified Tobacco Treatment Specialist (CTTS)[7]
    - CLS - Clinical Lipid Specialist[8]
    - CACP - Certified Anticoagulation Care Provider[9]

For more information, please refer to the document developed by ASHP's Section of Ambulatory Care Practitioners titled "Entry-Level Competencies Needed for Ambulatory Care Practice,"[10]and ASHP's Section Advisory Group on Clinical Practice Advancement document titled "Ambulatory Care Career Tool"[11]. If you are interested in pursuing pharmacy residency training, please refer to ASHP's website on residency information[12].

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B. How do I start ambulatory care pharmacy services?

There are various factors to consider when starting ambulatory care pharmacy services[1,2]:

- Overall factors to consider
  - Be a cooperative team member (identify practice needs and help fill those voids)
  - Document services and outcomes (specific to your institution; shows value)
  - Have open communication (share your interventions and outcomes with stakeholders)
  - Have patience and perseverance (may take months to years)
  - Identify and collaborate with a physician champion (especially those in leadership positions at your institution or those who have a positive working experience with ambulatory care pharmacists)
  - Obtaining "buy-in" from stakeholders (clinicians and administrators)

- Technical factors to consider before patient care
  - Documentation and data tracking
  - Fee for service *vs* value-based reimbursements
  - Institutional priorities and goals
  - Payer mix (private *vs* Medicare *vs* Medicaid *vs* commercial insurance)
  - Space (both office and clinic)
  - Staff support (scheduling, handling no-shows, etc.)
  - Workflow (will you share a medical assistant, nurse, or won't receive help)

There are a variety of tools that cover this topic in depth. You are encouraged to visit and read those sources for more guidance on how to get started[3-11].

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C. What is a collaborative practice agreement and how do I create one?

According to the Centers for Disease Control and Prevention (CDC) and their document *Advancing Team-Based Care through Collaborative Practice Agreements*, a Collaborative Practice Agreement (CPA) is "...a formal agreement in which a licensed provider makes a diagnosis, supervises patient care, and refers patients to a pharmacist under a protocol that allows the pharmacist to perform specific patient care functions"[1,2].

Collaborative drug therapy management (CDTM) with physicians and other health care providers via CPAs allow qualified ambulatory care pharmacists with an advanced scope of practice to initiate, adjust, and discontinue medications, order and monitor laboratory studies, and perform limited physical assessments[3] for various conditions (e.g. diabetes, hypertension, hyperlipidemia, chronic obstructive pulmonary disease, asthma, heart failure, anticoagulation, etc.)[1]. The privileges of ambulatory care pharmacists vary by state, practice site, and payor. For example, in some states they are recognized as Advanced Practice Pharmacist (APP), Clinical Pharmacist Practitioner (CPP), or Pharmacist Clinician (PhC)[2].

The CPA you create must be approved by your collaborating colleague(s), state board of pharmacy, healthcare institution(s), and credentialing body (refer to your state laws for specifics). As you create your CPA, be sure to seek advice from all stakeholders, including payors. Once created, the CPA should be reviewed annually or more often (if required by state law). With each review, you should update the document as needed with input from all stakeholders. For an example of a CPA, please refer to Figure 2: Sample Collaborative Practice Agreement for Hypertension/Cardiovascular Disease, pages 15-16 in the "Advancing Team-Based Care Through Collaborative Practice Agreements"[1]. For more on the various types CPAs across the country, please refer to Adams and Weaver's "The Continuum of Pharmacist Prescriptive Authority"[4].

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III. Sustaining Ambulatory Care Pharmacy Services:

A. How do I bill for my ambulatory care pharmacy services?

Critical questions from stakeholders will deal with billing and compensation for ambulatory care pharmacy services.

Process

1. Before an initiative is undertaken, you will need to verify the service being proposed is sustainable, with a respectable return on investment, and aligns with the mission and vision of your institution[1,2]. There are various sources available to guide you and the stakeholders through this complicated topic[1-9].
2. Identify the decision-makers that may impact any portion of the billing process. Key personnel in the billing team may include, but not limited to, the clinic manager, clinic scheduler, director of pharmacy, billing department and coding specialist(s), marketing, information technology (IT), chief compliance officer, and others.
3. Schedule individual meetings with each of them. Be prepared to present your proposed services. Ask their perspective and what they believe will be barriers to the proposed initiatives.
4. If you do not already have one, with the help of the credentialing department, apply for a national provider identifier (NPI)[10].
5. Once you have met with all of them individually, and have a list of their challenges, find evidence-based solutions to those perceived barriers.
6. Form a committee and schedule a meeting with all of the billing stakeholders where you will present them with a summary of your plan, including solutions to their challenges.
7. Create an action-plan from the meeting (SMART[11] goals or another similar format is recommended) and schedule recurring meetings to keep the momentum in your favor.
8. Once billing is occurring for your services, follow up with stakeholders through committee and/or individual meetings to assure quality and accuracy.

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The amount of information on billing for ambulatory care pharmacy services can be overwhelming and all information may not be applicable to your situation. For example, the billing capabilities of ambulatory care pharmacists differ by state[1], and it may skew the stakeholders' understanding of your proposed services. If a stakeholder has practiced in other states, where the scope of practice and billing capabilities for ambulatory care pharmacists are different than your current region, he/she may attempt to incorrectly apply them at your practice site[2]. A quick way lose support from key personnel is to present information that is not aligned with state and local laws and regulations; therefore, cite only pertinent billing information.

As you research and prepare for the ambulatory care pharmacy services billing meeting, remember pharmacists are *not recognized* Medicare Part B healthcare providers (except as immunizers), so be prepared to give your view on this matter[1]. Nonetheless, Centers for Medicare and Medicaid Services (CMS) has confirmed physicians may bill using "incident to" for services provided by pharmacists, if all requirements of the statute and regulations are met[3].

The location of your practice is not the only variable to keep in mind when billing for ambulatory care pharmacy services. The type of practice where you are employed, the payor, documentation requirements, the NPI number that is tied to the bill, supervision requirements, and other factors are also important. For example, differences exist when billing for ambulatory care pharmacy services in a non-facility (physician-based) clinic versus a hospital-based (facility) clinic, and when billing CMS or private payers[1].

Within non-facility (physician-based) ambulatory care pharmacy clinics, there are various methods to generate revenue such as 1) Current procedural terminology (CPT) "incident-to" codes; 2) Diabetes Self- Management Training/Education (DSMT/E); 3) Insulin pump training; 4) Medicare Annual Wellness Visits[4]; 5) Chronic Care Management (CCM)[5]; 6) Transitional Care Management (TCM)[6]; 7) Immunizations[2,7]. In contrast, if you bill for ambulatory care pharmacy services in hospital-owned facilities, your revenue may rely on the use of facility fees[1].

For more on pharmacists billing and coding for services provided in physician-based clinics refer to "Pharmacist billing/coding quick reference sheet for services provided in physician-based clinics"[8]. Billing for ambulatory care pharmacy services in Federally Qualified Health Centers (FQHCs) has its own nuances. For more on this topic, please review the "Opportunities for Sustainable Pharmacy Services in Federally Qualified Health Centers (FQHCs)" document[9].

Alternative payment models include value-based payment programs, or capitated-risk models, and these are gaining traction as payors attempt to move away from the traditional fee-for-service healthcare payment models[10-16]. Most recently, "U.S. Department of Health and Human Services (HHS) Secretary Alex Azar and Centers for Medicare & Medicaid Services (CMS) Administrator Seema Verma [announced] the CMS Primary Cares Initiative, a new set of payment models that will transform primary care to deliver better value for patients throughout the healthcare system"[11]. (see section "How do I show value for my services" in this document).

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B. How do I show value for my services?

After you start billing for ambulatory care pharmacy services, the next task is to track metrics, demonstrate *value,* and adjust your practice based on the results. In some practice sites, tracking metrics is more streamlined, while at other practices, keeping track of outcomes can be more labor-intensive and daunting. For example, if you are a new to a practice site with minimal or nonexistent exposure to ambulatory care pharmacists, then it may be more challenging to successfully track results. On the other hand, if you work at a practice site with established ambulatory care pharmacy services that readily maintains pharmacist interventions and outcomes via electronic health records, then showing value may be simpler.

For this reason, include IT from the start of your ambulatory care pharmacy services. IT facilitates the collection and interpretation of data, so you may apply the metrics in the process of quality improvement. If your practice site does not have the capabilities to track ambulatory care pharmacy metrics, you may have to rely on tracking them yourself through a HIPAA protected

platform. Finally, the literature shows many examples of successful ambulatory care pharmacy services that demonstrate value[1-9]. You are encouraged to reach out and find successful models in your area, as well reviewing successful models across the country.

If you are not certain on the type of metrics you will track, start by asking stakeholders what matters to them and the patients. Some examples of tracked quality metrics include CMS Quality Measures[10], Healthcare Effectiveness Data and Information Set (HEDIS)[11], National Quality Forum (NQF)[12], patient experience, and improving transitions of care. Although difference may exist in the type of metrics you select to follow, the importance behind keeping track of outcomes is similar: to show the value of ambulatory care pharmacists.

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C. How much will I be reimbursed for my ambulatory care services?

This can vary based on the level of service (i.e. CPT code), the payor, and your local, state, and national reimbursement agreements[1]. You can find the current reimbursement for each CPT code using the CMS Physician Fee Schedule Look-up Tool[2]. Overall, as you establish and maintain your ambulatory care pharmacy services, you will need: 1) an extensive team of billing experts; 2) continuous quality metrics to be monitored; 3) feedback to adjust your billing practices based on reimbursement rates; 4) mentorship from ambulatory care pharmacy colleagues (see section on "Mentorship" in this document).

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IV. What are some barriers to expect?[1]

As you work to establish your clinical practice, there are a number of barriers that should be expected and worked to proactively address. *First*, challenges exist with defining the pharmacist's role within the clinic. While ambulatory care practice is becoming more common, each practice setting is unique, and therefore the role the pharmacist will play in each setting is slightly different. To address this: 1) Start by discussing the workflow of the clinic with the healthcare providers and staff; 2) Identify issues in the practice, such as gaps in care, and determine if those voids can be filled through ambulatory care pharmacy services; 3) Through this process, focus on developing relationships with the clinic staff and your healthcare colleagues to ensure an open dialogue. Once again, it is paramount during this process to utilize colleagues across the country to understand different models and develop a model that works for your site. (see section on "Mentorship" in this document).

A *second* barrier to be considered is compensation for your time, both as it relates to reimbursement but also in terms of salary. Many institutions are now utilizing a salary sharing model between the department of pharmacy and the medical group or department in which the pharmacist is providing services. Salary may further be offset by reimbursement for services provided. It is important to clearly establish the funding source from the outset. Pharmacists entering these rolls must become well versed in the opportunities for billing and meet with appropriate stakeholders in the organization to establish reimbursement strategies. This ties to sustainability of the ambulatory care pharmacist's position. Because pharmacists are well-compensated health care providers, it is essential to establish metrics and goals and continually track this information to justify the pharmacist's salary. This data is will also be valuable in the future to validate the request of additional resources. Some examples of metrics include readmission rates, provider time savings, and prescription capture. (see section on "Sustaining Ambulatory Care Pharmacy Services" in this document).

Another challenge that may be encountered is related to the documentation of services provided. The ambulatory healthcare record is often different from the inpatient record and it may take time to learn the new system, perhaps requiring extra training courses in order to receive access. When documenting services rendered by you, using a documentation template may increase efficiency and ensure comprehensive documentation. It is important to understand requirements for documentation as it relates to reimbursement and ensure those are met.

Lastly, as your practice and responsibilities grow, time management will become essential. Once established and the value of ambulatory care pharmacy services has spread, you may be asked to expand the scope and/or availability of your services. While this is a great opportunity, you must reflect on the goals of the service and the ability to provide the range of services, without negatively impacting your wellness and the quality of the ambulatory care pharmacy services.

Reference:
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V. What is the future of Ambulatory Care Pharmacy?

The future of ambulatory care pharmacy in the United States of America (USA) is positive. As the provision of healthcare transitions into a value-based service[1], more healthcare systems and private physician offices are expected to hire ambulatory care pharmacists to maximize revenue while still achieving high-quality patient care. Most of the hiring will occur in ACO's and Patient Center Medical Homes (PCMH's) who need to demonstrate value by providing cost-effective quality healthcare[1]. Pharmacists, whose salary is less expensive than physicians, can provide many of these services with similar outcomes. According to the Pharmacy Manpower Project, which surveyed hiring managers across the USA, the demand is greater than the supply for clinical pharmacists. The 2018 Q4 report states the Pharmacist Demand Indicator (DPI) is 3.4 for specialized pharmacists[2]. This category includes advanced or specialized qualifications such as Medication-Therapy-Management (MTM), anticoagulation, oncology, or informatics[2]. A DPI of 5 indicates a high demand and very limited supply, while a DPI of 3 indicates supply equals demand, and A DPI of below 3 indicates supply exceeds demand[2]. This data is also supported by the Bureau of Labor Statistics (BLS), which reports between 2016 and 2026, 7200 jobs are expected to be added to pharmacy employment in outpatient care centers, home healthcare and physician offices[3].

The perspective among physicians towards utilizing pharmacists more effectively in their practice sites is also favorable. The American Medical Association (AMA) encourages its members to add pharmacists to their teams in order to see better outcomes.[4] The AMA Education Hub has an online module called "Embedding Pharmacists into the Practice." Among its goals is teaching "how to collaborate with pharmacists to improve patient outcomes," as well coming up with business plans and marketing pharmacists to patients.[5] "We saw that the benefits were enormous. Outcomes improved, patient satisfaction went up, it saved time, and it enhanced the team approach to the patient-centered care model," said Marie T. Brown, MD, FACP, senior physician advisor in AMA's Physician Satisfaction and Practice Sustainability Group in Chicago and module coauthor.[4]

The growing shortage of primary care physicians means that healthcare systems that offer pharmacists on-site may have an advantage over other employers. Paul Lebovitz, MD, vice chair of the Allegheny Health Network Medicine Institute said, "Like all things in healthcare, it is about the dollars." Allegheny recently added pharmacists to 250 practice sites as part of its ACO model. Each pharmacist is being shared by 10 physician and non-physician personnel. Eric Maroyka, Director of the Center on Pharmacist Practice Advancement at ASHP said, "Anything that can be done on an ambulatory care basis will be done that way and that is where the maximum payment will be."[6] Additionally, a 2018 poll by the Managed Healthcare Executive magazine asked the question to healthcare executives: Should pharmacists be compensated under Medicare Part B for prescribing medications and helping assess patients' conditions? Seventy-five (75%) of respondents said, "Yes."[7]

Ambulatory care pharmacy is expected to encounter some challenges. Without provider-status recognition, physician practices that hire pharmacists must do so with the understanding it will require innovative and flexible methods to collect for clinical pharmacy services. It takes a couple of years for clinical pharmacists embedded in the practice to show increased revenue to the clinic. The reason for the delay is the way CMS assesses data. CMS looks at the data from 2 years ago to make a decision on whether the organization met its quality goals for MIPS (Merit-Based Incentive Payment System) and to determine level of payment/loss of payment.[8] The pharmacist is unable to bill under their own name and thus cannot bring in direct revenue to the clinic. This has an impact on decisions made to hire pharmacists since the organization has to demonstrate a return on pharmacist investment. ACO-associated financial incentives alone may not be enough to support clinical pharmacists. Payment reform that leads to appropriate reimbursement is key for the growth and success of ambulatory care pharmacy in the USA.

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VI. What are some Ambulatory Care Pharmacy Practice Examples?

Example One[1]

Pharmacist DW works in a Seniors Clinic providing chronic-care management (CCM) services. Every month, she screens a list of patients for eligibility to participate in the program. Eligible patients are identified by Medicare as having a life expectancy of greater than 12 months and with two or more chronic medical conditions. After DW screens eligible patients, the primary care provider will recommend the CCM visit to the patient, and the medical assistant will consent the patient if the patient agrees to the visit. DW will be part of the shared-visit with the provider and the patient. If DW has a schedule conflict, she calls the patient later to introduce herself and explain the program. A follow-up appointment with DW is then scheduled for CCM. DW bills for her services using "incident-to" billing code 99487, which means a Medicare-approved provider is her indirect supervisor. DW provides the CCM service either in person or over the phone, and she spends an average of 45 minutes with each patient and typically focuses on one or two chronic conditions each month. She discusses with the patient therapeutic recommendations. A copy of her note is shared with the PCP after each encounter for review. For CPT code 99487 with a combined clinic staff time of 60 minutes per month results in an estimated reimbursement of $93.

Reference:
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Example Two[1]

SB works in a rural free-clinic providing diabetes management services. The clinic receives no federal or state funding, and eligible patients have no insurance of any kind. Candidates for diabetes management have A1Cs greater than 9%. SB educates patients on diabetes, counsels on lifestyle modifications and manages their diabetes, hypertension, and lipid medications under a collaborative practice agreement, which includes insulin initiation and adjustment. The initial patient visit is 90 minutes and follow-up visits are 30 minutes. The follow-up visits are scheduled as often as necessary. All of SB's clinical notes are co-signed by the referring provider. For each patient seen, SB keeps track of the A1C, blood pressure, and lipid levels. He sometimes writes referrals for eye-exams and provides tobacco cessation counseling. Thanks to pharmacists like SB, after two years in this clinic, patients have significant improvements in their A1C, lipid values and blood pressure control.

Reference:
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Example Three[1]

ML works in the internal medicine outpatient clinic established by a university hospital. Her job is to manage patients with chronic nonmalignant pain under a CDTM protocol. Her patients are eligible to participate if they have a pain diagnosis or indication and taking chronic opioids (3 months or more). The pharmacy team screens the patients by reviewing their medical records. If the PCP approves, he/she then refers the patient to the pharmacy-led pain program. The pharmacy team will then contact the patient to set up their appointment with the pharmacist, preferably on a day when both their PCP and pharmacist are in clinic. Under the CDTM, ML has authority to start, stop and adjust medications related to pain, except for Schedule II substances. If the patient is on a controlled medication, ML can only make recommendations to the PCP. This is because, in her state, pharmacists cannot obtain DEA numbers to prescribe any controlled substances. The initial patient visit is scheduled for 60 minutes and follow up visits are 30 minutes. Follow ups can be scheduled every 2-6 weeks as needed with phone calls, as well. The pharmacy team checks the prescription drug monitoring program for each patient at least every 6 months to detect aberrant behavior. The team also administers the Diagnosis, Intractability, Risk, Efficacy (DIRE) tool at the first visit to find out if the patient is at risk for aberrant behavior. During the patient's visit, ML uses the same form for each patient to help her guide the visit, track outcomes and have the same standard of care. For billing, the codes used are G-codes associated with services provided by hospital-based clinics.

Reference:
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Example Four[1]

DL works in an urgent heart failure clinic as part of a health system. His job is to monitor the medications of heart failure patients between their medical appointments through MTM. DL does this by ordering and monitoring lab values for patients on digoxin and spironolactone and making sure they are on therapeutic doses of their medications (e.g. Beta-blockers). In addition, he educates patients on how their medications work, thus boosting adherence and reducing emergency department visits. DL monitors about 10-20 patients a day and spends most of his time on the phone optimizing pharmacotherapy of the established patients in his service.

Reference:
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VII. Mentorship:

The importance of networking and interprofessional practice cannot be overstated when it comes to ambulatory care pharmacy. As an ambulatory care pharmacist, you must rely on others in your profession as well as those specializing in other areas such as business, IT, nursing, medicine, behavioral health, social work, and many more to effectively implement ambulatory care pharmacy services. To succeed, you will also need to find a mentor who has gone through a similar path and apply his/her advice to develop your own practice and professional skills. If possible, search for a champion in a leadership position at your healthcare institution to facilitate the full implementation of your initiatives, ideally a physician. Be persistent. When you are trying to implement new services, expect resistance, but if you are passionate and motivated to improve patient care and our pharmacy profession, you will overcome it.

ASHP offers plenty of continuing education for professional development, and multiple opportunities to network with colleagues. There are mentors to guide you through the various stages of your career, and there are also many resources available for the different pharmacy specialties. ASHP serves as an advocate for national policies that promote improved patient care and the advancement of our pharmacy profession, including provider-status recognition. One way to obtain a possible mentor is the Mentor Match Program provided by ASHP[1]. The purpose of the program is to "provide an opportunity for members to establish a mentorship relationship and engage in opportunities that serve to further their professional and personal growth"[1].

Reference
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VIII. Contributors and Acknowledgements

CONTRIBUTORS

Adrian Sandoval, PharmD, BCPS, BCACP
Assistant Professor
UTRGV School of Medicine
Division Chief of Research & Clinical Pharmacology Director
Department of Family Medicine
Edinburg, TX

Amanda Martinez, PharmD, BCACP, CPh
Pharmacotherapy Specialist – Ambulatory Care
Co-Director – PGY2 Ambulatory Care Residency Program
Tampa General Hospital

Heba Bakhach, RPh, BCACP
Pharmacist, Pharmaceutical Resource Clinic
Multicare Health Systems
Tacoma, WA

Kate Jeffers, PharmD, MHA, BCOP
Ambulatory Oncology Clinical Pharmacy Specialist
PGY1 Pharmacy Residency Program Director
PGY2 Oncology Residency Program Director
UCHealth Memorial Hospital
Colorado Springs, CO

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Ashley N Sandoval, PharmD
Staff Pharmacist
Women's Health Center
Nuestra Clinica del Valle (FQHC)
San Juan, TX