Working with Community-Based Non-Physician Providers
The Role of the State Chronic Disease Prevention Programs

Introduction: Beginning in November 2010, a Community of Practice (CoP) consisting of NACDD members met monthly to learn more about the role of the states in improving health care quality, specifically exploring how non-physician community-based providers can play a role in these efforts. The following document summarizes their discussions, and provides links to resources and tools they found or created.

Members: The CoP members were mainly drawn from the CVH Council, representing each of its committees. Other members from different NACDD Councils also joined the group; the CDC Division for Heart Disease and Stroke Prevention was also represented.

Susan Allen	FL	Pat Jones	GA
Eric Cook-Wiens	KS	Kay Lowder	SC
Cathy Dillon	NE	Paj Nandi	WA
Linda Faulkner	AR	James Peacock	MN
Crystelle Fogle	MT	Holly Richards	ME
Deborah Glotzbach	FL	Teresa Robinson	SC
Robert Graff	ID	Nell Brownstein	CDC/HDSP
Michelle Hansen	CO	Cynthia Morrison	CDC/HDSP
Anita Holmes	NC	Chanel Recasner	CDC/HDSP
Tiana Howland	NY	Denyce Glover	CDC/DDT
Lucy Im	AR	Andrew Lanza	CDC/DDT
Sharon Jaycox	AZ		

State Chronic Disease Program Activity: Each participant shared information about work currently going on in his/her state:

Arkansas: In 2009, Dr. Thomas Bruce, a retired Cardiovascular Physician, chaired the startup of a Steering Group (for the *SE AR Health Improvement Initiative* which eventually became the *SE Targeted Area of Resources for Health-(STAR-Health)*. The purpose of the Group was to make a difference in health outcomes utilizing community health workers (CHWs) in three Delta counties chosen for this project. Lay persons from each county were recruited and trained as CHWs to expand the reach of the educational and service activities for STAR-Health. When compared to the state average, Chicot, Desha and Lincoln counties have a higher percentage of babies born prematurely; a higher percent of low birth weight babies; and have experienced a higher percent of people dying from heart disease. In addition, adults in Lincoln and Desha counties are more likely to have lost all of their permanent teeth. In order to accomplish their purpose, the Steering Group believed that working collaboratively with partners and pooling resources would assist in accelerating and sustaining the needed changes in these counties. Other state agencies such as the Department of Human Resources, the Department of Economic Development, The Department of Education and others were invited to help develop the intervention. Local media, schools, churches, and businesses, social and civic groups as well as professional individuals and organizations were invited to participate in ongoing community health campaigns around the health issues in these counties. The STAR-Health Initiative for 2011 moved to Phase II and 7 CHW's are now working in one of the three targeted counties and housed at the local health units (LHU). They work with the general public, LHU patients, Maternal and Child Health (MCH) patients with a focus on preventing 2nd pregnancies before 18-24 months. They share resources on RX Prescription programs, answer calls for assistance and also help people to navigate the Medicaid system. They provide

hypertension pamphlets and bookmarks as needed. The LHU administrators are doing more BP's in the units and are encouraging people to come to the unit for BP checks and referring them to physicians when appropriate. Other activities include Hypertension Out to Lunch Walks and Talks; 10 BP self check machines have been placed in grocery stores, restaurants and other public places where people can check their BP with "Know Your Blood Pressure" posters placed near machines; success stories have been documented on individuals who came to the LHU after taking their BP on one of the machines and then referred to a doctor and placed on BP medication.

Arizona: Has implemented the Hypertension Continuum of Care Project. The project, funded under the Heart Disease & Stroke Prevention Program (HDSP), goal is to develop and implement a system of care for hypertension patients that include the use of community health workers (CHWs) or promotoras/es as a key partner in the system of care. HDSP contracted with the Yuma County Department of Health (Yuma) and they recruited promotoras from the Regional Centers for Border Health (RCFBH) and the Sunset Clinics to implement workshops for patients who have been diagnosed with or are at risk of developing hypertension. The Promotoras have existing ties with the community they serve and live in the communities where they work. This creates an opportunity for the promotoras to serve as a liaison between the community and the health service providers at the health centers. Training of 12 promotoras representing 2 RCFBH and 6 Sunset Clinics was held at the RCFBH office in the Mexico border town of Somerton Arizona. The sessions conducted in Spanish were facilitated by the University of Arizona Mel & Enid Zuckerman College of Public Health utilizing the CDC's *Community Health Worker's Sourcebook: Training Manual for Preventing Heart Disease and Stroke (Spanish version).* The sessions focused on the chapters on; general signs and symptoms of heart attack and stroke, high blood pressure, high cholesterol, taking medicine, physical activity, and health eating. Subsequent promotora follow-up meetings, additional trainings, and fidelity checks will be held throughout the course of the contract.

Florida: In 2011, the Florida Department of Health received a grant from the federal Centers for Disease Control and Prevention (CDC) which included an initiative to develop and promote the work of CHWs in the state. The Task Force met with Carl Rush who presented at the DHDSP Grantee Meeting in September 2010: http://www.orau.gov/hsc/hdspinstitute/2010/session-summaries/wk-22.htm They developed a survey to learn what projects who are working with CHW's are doing. Once they gathered this information, they developed a plan. This statewide task force — the Florida Community Health Worker Coalition — has four working groups devoted to policy, curriculum development, networking/ sustainability and research/grant writing. The Coalition has also developed a working definition for CHWs, modify the APHA definition to suit the coalition members. Members of the Policy group have scheduled meetings with legislators to raise awareness on the role CHWs play in health care and the need for recognition and reimbursement. The Curriculum group is working to define core competencies and training/certification requirements; and the networking/sustainability group is updating the website as a place for CHWs to communicate with each other and organizations in the market for CHWs to promote opportunities. The Research group is forming to determine data collection needs and research funding opportunities.

Georgia: working in three areas; working with CHW's in faith-based groups. They are planning a summit in January 2011 where they will be presenting a guide for this work. They target highest burden areas. First, they will work with EMS Directors and Morehouse University to train EMS providers on proper blood pressure measurement. Then, they will have these providers train CHW's in the faith-based projects. They plan to use video training guides which are being developed. Last area will be working with local pharmacists on medication adherence; they are exploring the key principles. **GA** has also done the SHAPP program, which has been evaluated with several articles published for those wanting more info.

Idaho: HDSP and DPCP are working together with community pharmacists on blood pressure; University nursing students developed a survey of pharmacists in Boise to gauge interest. One barrier they've encountered is payment for pharmacists.

Maine – In 2008, the Maine Cardiovascular Health Program along with their state-wide partners launched the Detection and Management of High Blood Pressure. This initiative takes a system's change approach and is being rolled out in various phases. Phase 1, has focused on training licensed health care professionals, such as registered nurses, as Blood Pressure Master Trainers. The course and curriculum are evidence-based using the AHA Recommendation for BP measurement and the JNC7 Prevention, Detection, Evaluation and Treatment of high blood pressure. Over 50 participants have completed the training and they are now embedded in health systems delivering BP trainings and implementing quality improvement system changes. In July 2011, Phase 2 was launched and the focus is improved management of hypertension through an integrated care team approach. The strategies go beyond the physician and include other members of the health care team with an emphasis on pharmacists as partners in a patient centered care process. Phase 2, seeks to develop a clinician-pharmacist integrated model that can be embedded in any health system for improved management of high BP. To evaluate potential impact, participating health care practices will track clinical measures including BP <140/90 mm Hg and BP <130/80 mm Hg for diabetics. An outcome of this work will be better management of patients' high blood pressure as tracked through national and state performance measurement programs such as Maine Health Management Coalition's *Pathways to Excellence* (PTE) and National Committee for Quality Assurance (NCQA). Phase 2, will also document and monitor progress of process measures including clinician participation, pharmacy team participation, patient satisfaction and use of the Plan Do Study Act (PDSA) cycle of improvement to track improvement strategies and implementation. A potential long range goal will be to explore the development and possible tracking of performance measures around BP medication guideline prescribing and fulfillment of prescription by patients.

Maryland: Dr. Prince provided some background on the project called P3 – Patient-Pharmacist Partnership. This grew out of the 10-Cities Challenge in 2006; one of the cities was in western MD. The project was built on the Asheville Project, which has shown effectiveness. Maryland received $50,000 in state funds to support the project. The project currently covers diabetes; trained pharmacists receive $50 to spend 30 minutes with diabetic patients and discuss self management, medication management, etc. Pharmacists go directly to the worksite, so workers do not need to leave work to receive counseling; pharmacists communicate all interactions to the primary care physician. The employer waives the co-pays on medicine and provides time off for counseling sessions. Maryland has a collaborative practice law that allows pharmacists to change medication under a physician protocol. The law is underused; it is used more in clinics that have onsite pharmacy services. Including hypertension in the project has been difficult; the large employers have sites in other states and don't like providing benefits that are not available to all workers in the company. Maryland partners with the University of MD School of Pharmacy; they provide training and data analysis. Dr. Prince stated that this project fulfills the public health role of assurance. The program provides the funds for training the pharmacists through a contract with the University. One policy implication is support of the use of the collaborative practice law. Marketing the program is also challenging; only self-insured employers can do this. The program works through the Healthy Business coalition, with CEO's in the program talking to others about its benefits. There has been some opposition by physicians but working with the state Medical Society really helped. The state program will pay for evaluation.

Massachusetts: Because of the state's health reform restrictions, pharmaceutical companies are greatly limited in their interactions with providers and MA has begun an academic detailing program to educate providers. MA also has a collaborative drug therapy law which is covered in the detailing sessions. There is a shortage of primary care providers. The HDSP and Diabetes Prevention and Control Program (DPCP)

partnered with University of Massachusetts to pilot a link between private doctors and local pharmacists, identified by the Pharmacists Association. The University trains the pharmacists on hypertension, cholesterol and diabetes management. The program is starting in areas underserved by primary care. They want to learn if it will improve control and increase access to care, as well as its cost effectiveness. They will include a link to community resources such as visiting nurses. If effective, they will push for health insurers to adopt and pay for this type of program.

Minnesota: In 2006, they got involved in Community Health Workers (CHWs) for two reasons:

- They understood from CDC that implementation of the chronic care model with the FQHCs was a strategic priority, specifically, helping the FQHCs to implement and spread the HRSA quality improvement CVD modules. MN had recently added a nurse consultant, part-time, to the team so had the capacity to explore some new partnerships with FQHCs.
- CHWs were also listed as an intervention strategy in the state 2004-2010 plan based on input feedback from the Latino community.

They conducted a very brief on-line survey with the FQHCs in MN re: their technical assistance needs; they didn't need technical help with guidelines/protocol, etc. However, a few mentioned utilization of CHWs as strategy of interest. MN worked with:

- At FQHCs: Clinic managers, Medical directors, quality improvement specialists and/or Executive Directors.
- MN Association of community health center—quality improvement nurse, with buy-in from executive director at Association.
- Foundation: Researched directory of possible funders and found one that was interested in health disparities and building social capital. The approach was that people would be more engaged in their communities and more active citizens if they were healthier. Healthier people lead to improved social capital.
- Various staff within MDH: Center for health statistics and Office of Minority and Multicultural Health

They hoped to accomplish:

- Test the model: what could a CHW do with, for patients with heart disease risk factors?
- Partner with a few FQHCs on a demonstration project, share the results with all FQHCs and see if replication was feasible/possible.
- Add to the "body of knowledge" about what CHWs can do in FQHCs, that the policy council/alliance/institute could use
- Help FQHCs look at their internal policies about care management teams and who they are and who they include.

They actually accomplished:

- Tested the model in two clinics.
- Had an opportunity to contribute on a broader level to the Community Health Worker Institute which promotes the industry/certification; advocates for policy changes such as curriculum certification and reimbursement.
- Strengthened our relationship with the FQHCs.

A final report of the data collected is being prepared but the data were tough to collect because of the small patient numbers and their fluidity in and out of the clinics. Elizabeth recommended that the staff/CHWs be better trained in behavior change; the certification process may not be enough training. We need to think through the expectations of CHWs ahead of time and make sure they have the training and skills to do what's expected. HRSA now has a Registered Apprenticeship program which may help.

Montana: replicating a mini-Asheville Project with the University Of Montana School Of Pharmacy. They plan to work with hypertensive employees of self-insured University. Individuals will meet with a

specially trained pharmacist monthly until blood pressure is controlled, then every 3 months; beginning a 6-month planning phase in 2011 and will develop the training curriculum and the database.
New York: providing funds via a contract with the NY City Health Dept for them to do "public health detailing" with pharmacists in high need areas, for hypertension and cholesterol medication adherence. PH detailing is similar to academic detailing as described by Michael Fischer at the Sept. grantee meeting. Once trained, the pharmacists talk to consumers about their medication and sticking to the regimen prescribed. They will evaluate the project with a pre- and post-test looking at its spread and reach.
http://www.nyc.gov/html/doh/html/csi/csi-medication-adherence.shtml
North Carolina - working with NC Academy of Family Physicians – over 2700 doctors– sharing policy priorities and the ABC'S guidelines. Planned efforts include hypertension protocols, including accurate measurements. Work with other provider groups as part of a NC Tri-State Stroke Network initiative with two NC cities in the Stroke Buckle was carried out in partnership with the American Pharmacists Association and community pharmacists. Pharmacists provided counseling sessions addressing self-management. Another key focus was the establishment of supportive worksite policies. NC is also working to expand partnership opportunities with other organizations and programs in implementing initiatives that address the hypertension indicators (e.g., NC Community Health Center Association and local health departments providing primary care services). NC is partnering with the NC Office of Minority Health and Health Disparities on a project with community health workers called Community Health Ambassadors (CHA). NC partnered with the NC Diabetes Prevention and Control Program on a Chronic Disease Self Management Program utilizing the Stanford University model. The training engaged a broad cross-section of the community with participants committing to provide education sessions to members of various community networks. The program was in a very rural county with one of the highest diabetes and heart disease rates and without a physician or hospital. The county health department was a partner and active participant in the training. The HDSP Program provided technical support and training assistance.
South Carolina: working on a new Asheville Project since April 2010; will have baseline data by the end of January 2011. They are working with a municipality; HDSP program is paying costs upfront, then the employer (City of Akin) will pay for the pharmacist recruitment, training and education. They are working with American Health Care, who does the work; they are founding members of the original Asheville Project. They provide a data system that is very thorough – DOCS. Employees receive incentives in the form of no or low co-pays for their medications and diabetes test strips. **SC** is also working with Palmetto Health System Geriatric Center on Lifestyle University. Patients with hypertension are recruited for a 6-week course on lifestyle changes and medication management. From the graduates of the program, they recruit people for the Community Health Advisor program. This program showed success and had spread to other counties until funding was reduced. It continues, funded by Palmetto Health System, partnering with faith-based communities, doing Search Your Heart program. The manual used to train Community Health Advisors is based on the Community Health Worker Source Book.
Washington: working with EMS providers in fire stations on accurate blood pressure measurement, working in a large, diverse county. They've had a successful pilot in which providers were trained and demonstrated their accuracy and confidence. Sustainability of the project is a concern due to lack of funding. They have developed videos and CD's and partners will use these to do train-the-trainer programs. WA is also implementing a patient-centered medical home collaborative as part of a primary care redesign, using the Chronic Care Model to improve the quality of care and health outcomes for patients with chronic disease. There is a place for CHW's in this effort although they have not been the focus thus far. The WA Tobacco Prevention program is using academic detailing in clinics in 17 counties, reaching 3600 unique providers that refer patients to the Quitline. Because this is a good linkage to the

ABC'S, the HDSP program is exploring where they fit in; they may provide financial support when the state money being used goes away. HDSP supported lay educators as part of the state's Chronic Disease Self Management Program (CDSMP) using ARRA funding and by partnering with the Diabetes Control and Prevention program and Area Agencies on Aging. HDSP has also specifically worked with faith-based organizations to train lay educators on CDSMP. WA Cancer program is supporting a Patient Navigation project with their prime contractors. Navigators ensure that screening happens as it should and that follow up occurs as needed.

Centers for Disease Control Activity - There has been much activity on this issue at CDC:

- The CHW Brief: "Addressing Chronic Disease through Community Health Workers: A Policy and Systems Level Approach" (a collaboration between DHDSP, DDT, DACH (REACH), DCPC) is posted to the opening page of the DHDSP website. http://www.cdc.gov/dhdsp/docs/chw_brief.pdf; http://www.cdc.gov/dhdsp/pubs/science_in_briefs.htm
- On the Science-in-Brief section: Addressing Chronic Disease Through Community Health Workers: A Policy and Systems-Level Approach. http://www.cdc.gov/DHDSP/pubs/docs/Science_in_Brief_CHW_Chronic.pdf
- DHDSP has developed a e-learning training series on CHW's and on CHW policy and systems changes; it will be available in September 2011. The generic nature of the e-learning training will make it useful to all chronic disease state programs and any others who are broadly interested. It will be placed on the DHDSP website.
- Manuscripts submitted for publication:
    - Balcazar, H., Rosenthal, E L., Brownstein, J. N. Rush, C.H., Matos, S. and Hernandez, L Emerging Public Health Force For Change: A community health worker's paradigm shift for reforming health and wellness opportunities in the U.S. American Journal of Public Health In press
    - Brownstein JN, Hirsch GR, Rosenthal EL, Rush CH. Community Health Workers 101 for Providers and Other Stakeholders. J. Ambul Care Management. 2011, 34(5):2010-2020. http://www.chronicdisease.org/nacdd-initiatives/cardiovascular-health/about-the-council/practice-groups/community-health-worker-pharmacist-practice-group/community-health-workers-101
    - Brownstein JN. Science-in-Brief. Community Health Workers 101 for Providers and other stakeholders. http://www.cdc.gov/DHDSP/pubs/docs/Science_in_Brief_CHW_101.pdf
- Update and increase efforts to disseminate the English and Spanish versions of: The Community Health Worker's Sourcebook: A Training Manual for the Prevention of Heart Disease and Stroke. The English version will be updated in the Fall. The Spanish Sourcebook as been updated and is on the CVH Council website. There will be a link from the DHDSP website to the CVH council website page. Here is the link to the actual document: http://www.chronicdisease.org/nacdd-initiatives/cardiovascular-health/about-the-council/practice-groups/community-health-worker-pharmacist-practice-group/community-health-worker-brief-spanish-version
  Here is the link to the page that it's posted on: http://www.chronicdisease.org/nacdd-initiatives/cardiovascular-health/about-the-council/practice-groups/community-health-worker-pharmacist-practice-group

Practice Group Discussions

The Practice Group discussed what issues or topics they need to know more about before beginning an intervention:

- The Washington Chronic Disease unit had a learning session in which Massachusetts presented on their pharmacists project. From that, they determined that they needed to do an **environmental scan** to learn what providers are in the state, where they are located, who they work for, etc. Nell stated that the CHW Brief addresses this need and might be a good starting point.
- **Reimbursement** for these non-physician services is an issue; if we are moving away from a fee-for-service model, we need to figure out how to pay for these benefits. CDC Division of Diabetes Translation is exploring this issue.
- Knowing where to find what the **legal scope of work** for non-physicians in a state will help states. Siobhan Gilchrist at CDC is working on a summary for CHW's; we will also need info for pharmacists and perhaps nurses.
- States need to know in **what capacity CHW's are used and by whom**, and where to find this information in their state. They also need to learn how to cultivate partners and champions for these efforts.
- One major discussion we need to have is what **the state's role is in these efforts**, especially regarding **funding**. How do states encourage/assure that others provide appropriate training.
- **Training** is an issue that states need information on – how to find out who in their state is providing it, whether they are certified or need to be, how they recruit people to be trained, what scholarship opportunities exist. Nell pointed out that HRSA is beginning a registered apprenticeship program, being piloted in NE and TX.
- States could use **templates for MOU's** since most of their efforts will be in partnership with other organizations.

Members heard a report on the Maryland School of Pharmacy June 9 meeting: *National Leadership Roundtable, "The Prescription for Health Care Reform: Where are the Pharmacists?"*

- National Leadership Roundtable meeting with audience of physicians, pharmacists, other providers and non-providers; there was clear interest in involving pharmacists in a more meaningful way with patient care.
- Dr. Terry McInnes was the keynote speaker and spoke with a panel later in the day. She challenged the pharmacists to do more than dispense medication, to expand their role. She described the Pharmaceutical Care Model and the Patient-Centered Primary Care Collaborative, detailed in *PCPCC Resource Guide- Integrating Comprehensive Medication Management to Optimize Patient Outcomes*: http://www.pcpcc.net/files/medmanagement.pdf
- One of Dr. McInnes' main points was that patient adherence to the treatment regimen is not as much a factor as most think. More often, it is the need for either a higher dose of the current medication, or an additional drug added to the regimen. Some have described this as "physician inertia" and pharmacists can play a key role in moving the physician from the original treatment plan if it's not effective.
- Another presentation was given by Dr. Anthony Rodgers, Deputy Administrator and Director, Center for Strategic Planning, Centers for Medicare and Medicaid Service. He spoke about issues in e-prescribing and getting that system up and running, as described in the Affordable Care Act.
- Great support for pharmacists was demonstrated by the talks by the Maryland Lt. Governor and Health Department Secretary.
- We need to be aware of and better define the difference between "clinical" and "community" pharmacists. Is it just a matter of practice setting? Or is it because of a difference in educational level? In GA, all pharmacists are now required to have a PharmD; this isn't true for SC. This is decided state by state by the Board of Pharmacy or the state's regulating body.

All speaker slides and other meeting materials are available:
http://www.pharmacists4knowledge.org/cips/articles

The Practice Group also discussed a policy brief on community-based pharmacists being prepared by staff at CDC. Members were asked to contribute to the "how-to" section of the document.

CVH Council Portion of Pharmacist Policy Brief
Draft – August 2011

Working with community-based pharmacists can help states achieve positive health outcomes in hypertension and high cholesterol control. Pharmacists who are engaged in medication therapy management can reduce health care costs and improve patients' health at the same time. There are many ways that state chronic disease prevention and control programs can encourage and support pharmacists. It is helpful to think of these as steps in a continuum.

1. **Learn** what pharmacists can and can't do in your state – what is their scope of practice? You can get an overview of the topic from a document on the NACDD website: Contemporary Pharmacy Practice. This document details the types of practices open to pharmacists and pharmacy technicians, and describes the scope of each. However, before you begin a pharmacy-related intervention, you will need to know the regulations for the pharmacy scope of practice within your state. This is usually available from your state Board of Pharmacy. You should be able to find a link to your state Board here: http://www.nabp.net/boards-of-pharmacy/. The regulations you find will be lengthy, and it may be difficult to determine the answers to these questions:
    a. Do the regulations prohibit pharmacists from engaging in Medication Therapy Management (MTM) in partnership with the patient and his/her physician?
    b. Can pharmacists adjust the dose of a medication without having the patient return to the physician?
    c. What are the reporting requirements for a pharmacist engaged in MTM?

You may need help to learn all you can, so after doing your initial research, it's time to move on to Step Two.

2. **Partner** with an organization or group that understands this area well. First, look within your state health department to make sure no other program is conducting a similar project. It will be easier to add your area of focus to an existing project than to continue to develop your own. Look throughout your state health department, if possible. Some of the communicable disease or maternal-child health programs may be engaged with pharmacists. An ideal partner in any pharmacist-based intervention is your state Medicaid program. This program struggles to reduce costs, and pharmacist-based programs have been shown to do that. When you are ready to look externally for partners, consider a College or School of Pharmacy. Management of chronic disease is an area of interest for many schools so you may be able to find a willing partner with much to offer. Find a list of the schools in your state at the website for the American Academy of Colleges of Pharmacy. Another potential partner is your state Pharmacy Association. These groups work to improve quality of care, promote medication adherence and patient safety. Also consider your state or regional business group on health as a potential partner.
3. **Explore** model programs listed above and, together with your partners, decide which will work best for you. You may decide to do a pilot project in a specific region or with a specific large employer. As you begin planning, be sure to build in a rigorous evaluation for the project. This will help you scale up and add regions or employers over time, if you can demonstrate effectiveness. Collecting health outcomes from participants would be ideal, and you will want to include costs and return on

investment as a major piece of the evaluation. Issues you and your partners will want to explore as you decide on your intervention include:

   a. **Recruiting participants** – you will need to determine how to select pharmacists for the project, and how to recruit employers (if you select an employer model such as the Asheville Project.)
   b. **Training for pharmacists –** decisions will need to be made about curriculum, who will provide the training, where and how will training be conducted, and who will pay for the training.
   c. **Reimbursement** – How will pharmacists get paid for their services during the program? Will a session with the pharmacist be a covered benefit? Or perhaps you will work with community health centers where the pharmacist is a salaried employee with new duties. Is there a role for health plans or other payers in the project?

4. **Policy and/or systems changes** will be one way to spread your program and support its sustainability. Be looking for opportunities to change systems or support policies as you move ahead with program development:
   a. Does the pharmacist scope of practice need to be extended to include the ability to practice Medication Therapy Management or work as part of the health care team?
   b. Can the pharmacists' training be added to the School(s) of Pharmacy curriculum?
   c. Can the community health centers require that the employed pharmacists provide MTM services for patients?
   d. Can these services become a routine part of the health benefits provided by health plans or large self-insured employers in the state?