

Immunizations, diabetes management, and diabetes and dyslipidemia screenings were the most common services provided in community settings. A total of 190 (54.5%) pharmacists stated they were billing for pharmacy services. Only 49.6% of pharmacists practicing in a physician office were billing for services, with 71.0% using the incident-to-billing technique. A statistically higher number of community pharmacists were billing for services, compared with other combined practice settings (69.2% versus 46.7%, $P < .001$). The most common billing technique in community settings was fee-for-service (94.0%).

Conclusion: A baseline summary of outpatient pharmacy practice before the initiation of the MMA and medication therapy management (MTM) is essential. This study provides baseline data regarding services that have been successfully implemented into specific practice settings and which billing techniques were used to receive reimbursement. This information will be extremely valuable for pharmacists wanting to implement pharmacy services, including MTM, in the future.

63—GETTING PAID FOR MEDICATION THERAPY MANAGEMENT SERVICES: RESULTS FROM THE CCRX COMMUNITY PHARMACY MTMS PROGRAM. Brown L, James C, University of Tennessee College of Pharmacy, E-mail: LB@utm.edu

Objective: To describe the use and economic trends during the first 9 months of a Medicare-sponsored drug discount card program that reimbursed pharmacists for providing medication therapy management (MTM) services in the community setting.

Methods: MTM services were provided by qualified community pharmacists to patients using the Community Care Rx Prescription (CCRx) Drug Discount Card. A retrospective descriptive analysis was performed on all prescription and MTM services claims. Data were provided by Outcomes Pharmaceutical Health Care.

Results: Dates of services ranged from October, 14, 2004, to June 30, 2005, and services were provided by 184 pharmacies in 38 states. Over this time period approximately 2,619 patient encounters were documented, resulting in 6,766 reimbursable encounter claims, for a total of \$87,846 reimbursed to pharmacies. The overall mean revenue per patient was \$33.54. The number of patient encounters per quarter increased from 167 in Quarter 4 of 2004 (Q4-04) to 1,131 in Q1-05 and then to 1,876 in Q2-05. Claims increased from 363 (Q4-04) to 2,374 (Q1-05) and then to 4,029 (Q2-05). Mean revenue per CCRx prescription dispensed at each pharmacy also increased each quarter, from \$0.06 (Q4-04), to \$0.29 (Q1-05), and \$0.46 (Q2-05).

Conclusion: The results from this study show the economic benefit of pharmacist-provided MTM services from a pharmacy perspective. A pharmacy that provided MTM services under this drug discount card could expect an average additional monthly income of \$3,354 per 100 patients who received MTM services.

64—HYPERTENSION MEDICATION THERAPY MANAGEMENT: OVERCOMING OBSTACLES AND ASSESSING OUTCOMES.

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Objective: To create and gather the resources and tools needed to implement medication therapy management (MTM) services to seniors with hypertension (HTN) including a pharmacist educational program, documentation tools and a Microsoft Access database; pilot the use of these resources and tools in a MTM program in six community pharmacies using a randomized controlled design; and assess the economic, clinical, and humanistic outcomes of the MTM services program.

Methods: Following development of program resources and tools, 150 ambulatory senior adults (> 65 years) diagnosed with HTN will be randomized to either the MTM group or the control group at six community pharmacies. Blood pressure (BP), pulse rate, and health-related quality of life (HRQOL) using the 12-item Short Form version 2 (SF12v2) will be assessed at baseline, 3 months, and 6 months in each group. All patients will receive printed prescription refill records from their pharmacies. Patients in the MTM group will receive additional care including a personal medication record, assessment for medication-related problems (MRP), a Medication Action Plan, and education regarding HTN, risk reduction, and medication adherence. Upon completion of the 6-month program, patients in both groups will anonymously complete a previously validated patient satisfaction survey. The primary clinical outcome marker, a between-group comparison of mean BP changes over the 6-month period, will be analyzed with the Student t test. A within-group analysis for change in BP over 6 months will be made using a paired t test. Additional clinical outcomes reported will include medication adherence, the number and types of MRPs identified, and the percentage of recommendations accepted by physicians. Reported economic outcomes will include the length and number of pharmacy visits. Humanistic outcomes documented will include HRQOL and patient satisfaction with the program.

Results: NA (research in progress).

Conclusion: NA (research in progress).

65—IDENTIFYING THE PRESENCE OF PERIPHERAL ARTERY DISEASE IN PATIENTS WITH AND WITHOUT DIABETES. Brown L, Kerr Drug, Inc., Herring C,

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Objective: To quantify Primary Assessment by clinical pharmacists in the community pharmacy and/or health fair settings throughout North Carolina, of the prevalence of previously unidentified peripheral artery disease (PAD) in patients with versus without diabetes using ankle-brachial index (ABI) measurements and secondarily to demonstrate com-

munity pharmacy PAD testing model such that other community pharmacists will be able to easily replicate this model in their practices.

Methods: Approval for this demonstration project was obtained from the Campbell University Institutional Review Board. Patients were recruited from January through September 2005 via in-store marketing. Patients were excluded from the study if they had a previous diagnosis of PAD or history of limb amputation. Inclusion criteria were based on risk factors for PAD (including age 50 years or older, or any age with one or more of the following risk factors: smoking, heart disease, hypertension, and/or diabetes). ABI tests were performed in various community locations, including health care centers located in the community pharmacy and health fairs. Informed consent was obtained from each patient and risk factor information gathered using standardized intake questionnaire. ABI was measured using Doppler ultrasound device and a blood pressure cuff. Patients educated by pharmacist about the ABI value and appropriate follow-up. Patients were educated regarding their ABI value and appropriate follow-up. Patients were referred to their physician if their ABI value was less than 0.90, and patients were asked to complete the brief survey regarding value of test and opinion of test provider (pharmacist) and testing location (pharmacy, health care centers, physician offices).

Results: To date, 250 ABI measurements have been performed and 230 surveys completed. Preliminary findings indicated that patients are satisfied with pharmacists being the health care providers to offer PAD testing and educate them about their results.

Conclusion: NA (research in progress).

66—IMPLEMENTATION OF A CONTINUING PROFESSIONAL DEVELOPMENT (CPD) PLAN. Carruthers K, Main at Locust Pharmacy Clinic and Medical Supply, McDonough R, University of Iowa, Ploehn L, Main at Locust Pharmacy Clinic and Medical Supply, Moulton J, Iowa Pharmacy Association, E-mail: karac@mainatlocust.com

Objective: To describe the implementation of a Continuing Professional Development (CPD) plan for pharmacists as an alternative to continuing credits (to meet licensure requirements) and provide a model for pharmacists who wish to develop their own plan. Continuing Professional Development is an important topic in pharmacy.

Methods: A comprehensive literature search with the search terms CPD, pharmacy, and health care, was used to identify background on CPD. Development of a CPD guide occurred from August 2004 through October 2005. The effort was undertaken by the owner of an independent pharmacy, a clinical and staff pharmacist, staff from the state pharmacy association with a goal of helping pharmacists to direct their own lifetime education and thereby benefit patient care practices. The guide posed these questions: What is CPD? Why do we need CPD? How do we implement CPD?