Public Health 2.0: Building the Next Generation of Community Pharmacy Programs

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Pharmacy Forward: Advancing Practice for a Healthier Tomorrow!

OPA Annual Conference & Trade Show April 9-11, 2026

OHIO PHARMACISTS ASSOCIATION

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- None of the planners for this activity have relevant financial relationships with ineligible companies to disclose.

- Jennifer Sabatino has no relevant financial relationship(s) with ineligible companies to disclose.
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Learning Objectives

At the completion of this activity, the participant will be able to:

1. Describe how upcoming legislative changes in Ohio will expand pharmacist authority through test-and-treat, nicotine cessation, and provider status updates;
2. Identify operational models that allow pharmacists to translate policy advancements into practical, reimbursable public health services; and Objective
3. Apply tools and templates to launch or expand public health programs in community and ambulatory settings.

Test and Treat – US Landscape

- Full authority: Multiple conditions under statewide protocols
- Condition specific
  - Influenza
  - COVID-19
  - Step throat
- Collaborative or Protocol based models

What is Ohio Senate Bill 230?

- Core Purpose: Expands pharmacist authority in Ohio to allow screening, testing, and treatment of respiratory conditions.

- What can pharmacists do?
  - Conduct screenings
  - Order and administer lab/diagnostic tests
  - Evaluate results
  - Initiate treatment (drug therapy)

What is Ohio Senate Bill 230?

- Conditions Included:
  - Influenza
  - Strep throat (Group A Streptococcus)
  - COVID-19
  - RSV
  - Additional respiratory conditions (via Board of Pharmacy rules)

- What can pharmacists do?
  - Conduct screenings
  - Order and administer lab/diagnostic tests
  - Evaluate results
  - Initiate treatment (drug therapy)

What is Ohio Senate Bill 230?

- How it works?
  - Must follow a statewide protocol developed by the Ohio Board of Pharmacy
  - Allows use of CLIA-waived tests
  - Permits delegation of technical tasks to technicians/interns under supervision

- Payment & Coverage
  - Requires insurers and Medicaid to reimburse pharmacists
  - Must be paid equivalently to other providers

Practice Implications

- Policy and Practice Alignment
  - Catching up
- Expanded clinical role
  - Frontline respiratory care
  - Convenience for patients

Practice Implications

- Access to care
  - Faster Treatment
  - Rural health deserts
- Reimbursement and Sustainability
  - Comparative to other testing sites
  - Building out a reimbursable clinical service
- Strategic Opportunities
  - Foot in the door approach

Audience Poll

What hurdles do you anticipate in starting a test and treat service?

Training	Workflow	Reimbursement	Time
“I don’t have the clinical confidence.”	“My team is not set up to do this.”	“There is no money in this service.”	“I do not have enough time.”

Nicotine Cessation

- What pharmacists can do now:
  - dispense nicotine replacement therapy (NRT) without a patient-specific prescription
  - to patients **18 years and older** who are seeking to quit tobacco-containing products
  - Documentation must be maintained for at least 3 years, and the pharmacist must notify the patient's primary care provider, if known, within 72 hours after screening.
  - The pharmacist may not delegate the authority to dispense NRT under protocol.

Upcoming Changes

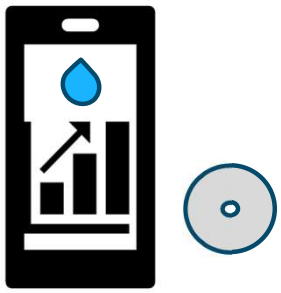
- Including prescription-only smoking cessation medications
- Potential changes to age
- Potential changes to protocol language

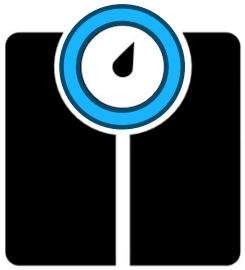
Practice Implications

- Access to Care
- Continuation of Care
- Foot in the door

Remote Physiologic Monitoring (RPM)

- A care delivery model involving the use of medical devices to electronically transmit patients' physiologic data to their healthcare team for monitoring and management outside of traditional healthcare settings





Alignment with Pharmacy Practice

- 50% of US adults have 2 or more chronic conditions
- Pharmacists manage chronic disease states as accessible care providers
- RPM can be implemented or added to existing pharmacy services to
  - improve the quality of care provided
  - expand access to care by addressing barriers to traditional models
  - and provide additional reimbursement opportunities

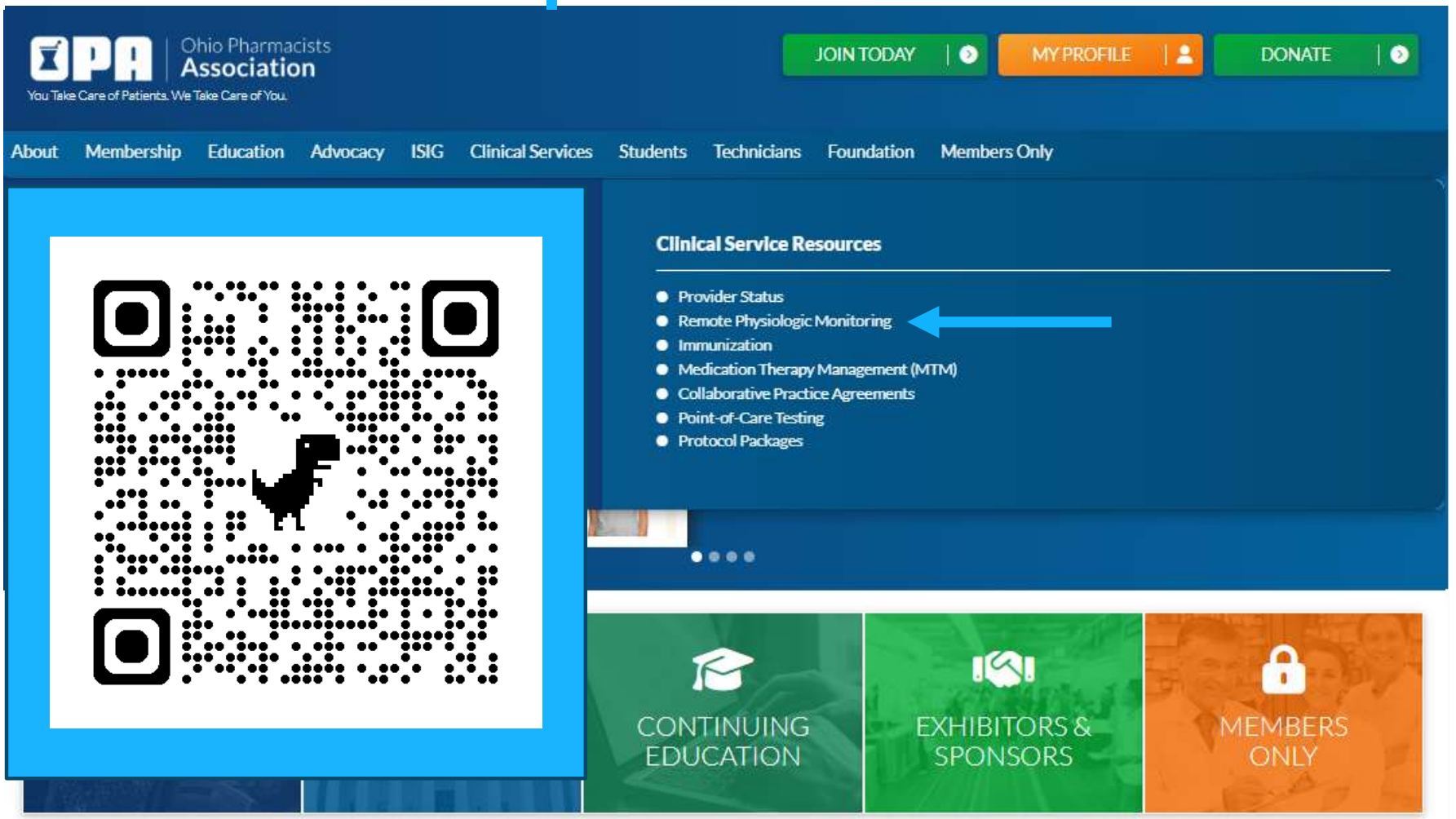
Audience Poll

How would you rate your current level of knowledge of and experience with RPM?

Unfamiliar	Beginner	Intermediate	Expert
“I have little to no knowledge of this care model.”	“I know the basics but have not yet implemented.”	“I have some experience in my practice.”	“I regularly utilize RPM in my practice.”

OPA's RPM Toolkit

- Practice implementation resource created by the Practice Advancement and Innovation Committee
- Designed to be a reference for Ohio pharmacists in a variety of practice environments
- Details the "Who, What, When, Where, and Why" of implementing billable RPM services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Provider Status
Remote Physiologic Monitoring
Immunization
Medication Therapy Management (MTM)
Collaborative Practice Agreements
Point-of-Care Testing
Protocol Packages
CONTINUING EDUCATION
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Table 1: RPM CPT code details as outlined in Medicare Physician Fee Schedule (MPFS)

CPT Code	Description from MPFS	Additional Notes and References	CY2025 payment rate*	wRVUs
99453	*Remote monitoring of physiologic parameter(s) (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate), initial; SET UP and PATIENT EDUCATION on use of equipment*	• Initial set-up and patient training on use of equipment • Billed once per episode of care after cumulative monitoring of at least 2 days in a 30-day period • Practice expense-only code valued to reflect clinical staff time that includes instructing a patient and/or caregiver about using one or more medical devices[A]	MPFS non-facility: $18.04 MPFS facility: $0 (OPPS)	-
99445	*Remote monitoring of physiologic parameter(s) (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate), initial; device(s) SUPPLY with daily recordings or programmed alert(s) TRANSMISSION, 2-15 days in a 30-day period*	• Practice expense-only; valued to include the clinic-owned medical device(s) supplied to the patient and programming of the medical device for repeated monitoring (so should not be reported if device is patient-owned) • Data cannot be self-recorded and/or self-reported[C] • 99445 and 99454 are not additive. Only one should be selected per 30 days based on the appropriate number of days transmitted.[B] • Valued the same as 99454 because the device is supplied for 30 days regardless of days of data transmission[B]	N/A; anticipated to match 99454	-
99454	*Remote monitoring of physiologic parameters(s) (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate), initial; device(s) SUPPLY with daily recording(s) or programmed alert(s) TRANSMISSION, 16-30 days in a 30-day period*	• Practice expense-only; valued to include the clinic-owned medical device(s) supplied to the patient and programming of the medical device for repeated monitoring (so should not be reported if device is patient-owned)[A] • Data cannot be self-recorded and/or self-reported[C] • 99445 and 99454 are not additive. Only one should be selected per 30 days based on the appropriate number of days transmitted.[B]	MPFS non-facility: $39.23 MPFS facility: $0 (OPPS)	-

References

A. MPFS CY 2019 Final Rule
B. MPFS CY 2026 Final Rule
C. MPFS CY 2021 Final Rule
D. MPFS CY 2024 Final Rule

*Calendar Year 2025 payment rate specific to 15202 Ohio MAC

Implementing RPM

The Who | The What | The When | The Where | The Why | References

The Who

When establishing RPM within an organization, it is important to first identify the need, ensuring that the efforts to establish the program align with the organization's priorities. This can be difficult in a large organization. While there are many different opportunities for RPM, beginning with implementation of one RPM service may lend itself more successful to ensure sustainability. Once the initial service is established, then the program can be expanded to other RPM services and/or other locations. To ensure program success, key stakeholders need to be included as part of the implementation team. Team composition for a large-scale RPM implementation project can be categorized into clinical and operational stakeholders. Many of these team members are brought into the work after the initial business request (or case for change) has been submitted by a clinical lead and approved by the business/technology expansion committee. The following list describes roles that are often included, though may not be essential, in an institution's RPM implementation project.

Clinical Stakeholders

- Executive Leadership: Director of Pharmacy, VP of Ambulatory Care, VP of Enterprise Clinical Services, etc.
  - Ensure alignment with institution's over-arching vision, mission, and budget parameters.
  - Serve as Executive Sponsor for the formal project – provide final sign-off on the project charter and intended scope from the clinical leadership perspective.
- Pharmacy Lead
  - Write up and submit formal business request – pharmacist may be responsible (in whole or with physician) for this initial step, as many institutions value pharmacists as integral to innovative health monitoring programs.
  - Work closely with physician champion to establish qualifying criteria for patient enrollment, standard patient care process, and technical workflow.
  - Attend all project meetings and work groups to serve as liaison between clinical stakeholders and operational stakeholders.
    - Pharmacist is ideal patient-facing, "front-line" team member for this role.
  - Physician/Advanced Practice Provider (APP) Champion
    - Represent physician/APP team's preferences regarding both patient-centered and practical aspects of workflow, including documentation and billing.
  - Physician/APPs serve as "billing provider" when utilizing formal RPM billing.
- Provide, along with pharmacist, insight on scalability to other practice sites with differing staff make-up and patient populations.

Operational Stakeholders

- Project Manager
  - Host focus groups with clinicians to solidify scope of project and outline of goals based upon initial business request and IT department capacity.
    - Review and obtain approval from Executive Sponsor.
  - Hold consistent (often weekly - biweekly) "discovery calls" to allow a forum for essential information flow between operational and clinical stakeholders.
  - Set timelines, track progress and communicate consistently to entire team regarding successes, barriers, and recommended shifts in project focus.

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The What

Devices

Must meet the FDA definition of medical device per Section 201(h)(1) of the Food, Drug, and Cosmetic Act[1]: *An instrument, apparatus, implement, machine, contrivance, implant, in vitro reagent, or other similar or related article, including a component part, or accessory which is:*

(A) recognized in the official National Formulary, or the United States

Pharmacopoeia, or any supplement to them,
(B) intended for use in the diagnosis of disease or other conditions, or in the cure,

...

Disease states

RPM can be used to manage acute or chronic conditions including but not limited to:

- Diabetes
- Hypertension
- Heart disease/Heart Failure
- COPD/Asthma
- Weight management
- Cellulitis
- UTI
- COVID-19
- Pneumonia

Consent process

Verbal or written consent must be documented before or at the point of engagement in an RPM service. While CMS does not dictate the specific components of RPM consent beyond billing and the treatment plan, the following may be considered for inclusion in consultation with organization legal and compliance representatives:

- An explanation that only one provider can bill for the service in a 30-day period, so that the patient is an informed participant in preventing duplicative billing
- What data will be transmitted and how that data will be used to inform the care plan
- The expectation for frequency of monitoring to encourage engagement
- When to seek urgent medical evaluation based on readings taken on RPM device
- That the RPM enrollment can be terminated and how to do so

Data and billing management

- Continuous data allows for proactive care but can be a challenge for integration into standard workflows. Options exist within some EHR platforms to set alert parameters so that the care team is notified of alert values in real time, but not of every value taken and can review

Implementing RPM

Table 3: Timeline of strategies for implementation[3]

Implementation Process	Strategies and associated characteristics	Example duration
Planning	Gather information • Learn about RPM: reference primary resources on RPM billing considerations and best practices for implementation • Complete a Strengths, Weaknesses, Opportunities, Threats (SWOT) analysis • Talk with others who have implemented RPM services • Talk with potential stakeholders about qualities of a desirable service	3 months
	Select strategy • Develop business plan or project proposal that outlines steps for implementation and measures of success • Identify the disease state(s) to be targeted with the RPM intervention • Identify RPM-compatible devices to be used • Complete usability testing - test the education and use of the device with an individual who can represent a real patient • Design a pilot as proof of concept and a plan for gradually rolling out to additional patients/care teams • Establish a consent process • Establish enrollment and un-enrollment processes	3 months
	Establish leadership, buy in, and relationships • Form implementation team to include physician/APP champion(s), key clinical staff, administrative personnel, stakeholders, and specialists from information technology, legal/compliance, and billing • Highlight the need that is being met by the service with potential partners and consider engaging champions of the service to market to others • Designate project leaders to be responsible for management of the service • Establish contracts with partners such as provider practices or RPM vendors • Identify a pilot care team • Consider direct-to-patient marketing of the service	6 months
Financing	Facilitate financial support • Secure funding for the new service • Establish billing/reimbursement structure • If using RPM billing codes, develop a process to tabulate days of readings transmitted and time spent and work with IT support to automate this process if possible • Identify and highlight cost-savings benefits for patients and stakeholders	6 months

Implementing RPM

The Who | The What | The When | The Where | The Why | References

The Where

RPM represents a versatile care model for pharmacists working in a variety of practice settings and can be utilized either to support a new service or to enhance an existing service. The following summaries of setting-specific considerations were prepared following one-on-one interviews and small group discussions among OPA Practice Advancement and Innovation Committee members and other Ohio pharmacists.

Hospital Outpatient Department (HOD)

Practice site specific considerations:

- Pharmacist contracting practices in hospital-based clinics can interfere with provider reporting of care management billing codes based on pharmacist time, as the pharmacists may not be credentialed within the same department as the physician or qualified healthcare professional. Facility billing and pharmacist contracting practices can impact reimbursement and the model under which pharmacy services are financially supported.
- When traditional RPM billing is not supported, HOD pharmacists may propose RPM care models for services that align with cost-avoidance and quality improvement priorities for the organization. Many health systems participate in risk-based or value-based payment contracts. As such, a health system may support, for example, a pharmacist-led heart failure service aimed at reducing readmissions and ED utilization by utilizing clinic-provided weight scales that transmit to the EHR, allowing for earlier detection of clinical deterioration.

Example program:

- Multiple, in various stages of implementation

partnership directly with the payer. This model often retains all of the logistical elements of a traditional RPM service but eliminates the need for a physician or qualified healthcare professional to submit charges, as reimbursement to the pharmacy occurs not through payment of CPT code-based billing, but through contracts with per-member-per-month or value-based terms.

Example program:

- Shrivers Pharmacy, Multiple locations, Southeast Ohio

Contact:

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  Shrivers Pharmacy
  Andrea.Kowalski@shriverspharmacy.com

Implementing RPM

The Why

Evidence suggests that remote physiologic monitoring (RPM) can improve clinical outcomes for a variety of chronic conditions, including hypertension, heart failure, and diabetes. For example, a 2025 study of 5057 patients engaged in hypertension management by a pharmacist utilizing RPM demonstrated higher rates of BP control across racial subgroups when compared to usual care.[9] Hassan et al. reported that 90% of participants in a remote hypertension management program maintained their target systolic blood pressure 42 months after enrollment, demonstrating long-term benefits of RPM for hypertension management.[10] Similarly, systematic reviews demonstrate that telemonitoring and telehealth reduce heart failure rehospitalization and mortality.[11] For diabetes, Aggarwal et al. found that continuous glucose monitoring (CGM) improved HbA1c levels, reduced hospitalizations, and reduced instances of diabetic ketoacidosis.[12] These findings highlight the wide-ranging benefits of RPM in chronic disease management.

In addition to improving clinical outcomes, RPM has demonstrated the ability to lower healthcare costs. Tan et al. conducted a systematic review that found RPM interventions demonstrated a downward trend in the risks of hospital admission/readmission, length of stay, number of outpatient visits and non-hospitalization costs.[13] Similarly, Lynch et al. found that telehealth can lead to cost savings through in-home monitoring for heart failure patients.[14] In their study, nurse and pharmacist interventions utilizing home monitoring prevented 26 emergency room visits over five months.

Pharmacists are well-positioned to support RPM services due to their accessibility and expertise in management of chronic disease. Pharmacists have demonstrated the ability to provide effective clinical interventions in patients with chronic conditions such as hypertension, diabetes, and heart failure when utilizing RPM.[14-16] Notably, in a meta-analysis of randomized controlled trials of interventions targeting barriers to hypertension control, Mills et al. found that pharmacist led-interventions resulted in the greatest blood pressure reductions, making them significantly more effective than multiple health care professionals, nurses, and physicians at delivering interventions.[17]

Pharmacists can leverage the RPM model of care to provide accessible, efficient, and effective chronic disease state management and lower healthcare costs.

Implementing RPM

The Who | The What | The When | The Where | The Why | References

References

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Additional Resources:

- American Medical Association - Remote Patient Monitoring Playbook
- Bipartisan Policy Center - The Future of Remote Patient Monitoring
- National Association of Community Health Centers - Self-measured Blood Pressure Monitoring (SMBP) Implementation Toolkit
- National Association of Community Health Centers - Reimbursement Tips: Remote Physiologic Monitoring (RPM) & Remote Therapeutic Monitoring (RTM)
- US Department of Health and Human Services - Billing for remote patient monitoring
- Independent Pharmacy Cooperative - Digital Health for Independent Pharmacies

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- **Ariel Williams, PharmD, BCACP**
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Rural Health Transformation Program

What is the Rural Health Transformation (RHT) Program?

- State-led initiative through the Ohio Department of Health (ODH)
- Focused on improving healthcare access across 73 rural counties in Ohio
- Addresses:
  - Workforce shortages
  - Limited infrastructure
  - Poor care coordination

Why Pharmacy is Central to RHT

- CMS requested pharmacy call out in each state's plan for RHT
- Cicero Institute Report*
- Ohio's proposal included pharmacy

*In the Cicero Institute's 2025 pharmacist full practice authority scoring, **Ohio scored 1 out of 10**, placing it near the bottom nationally.

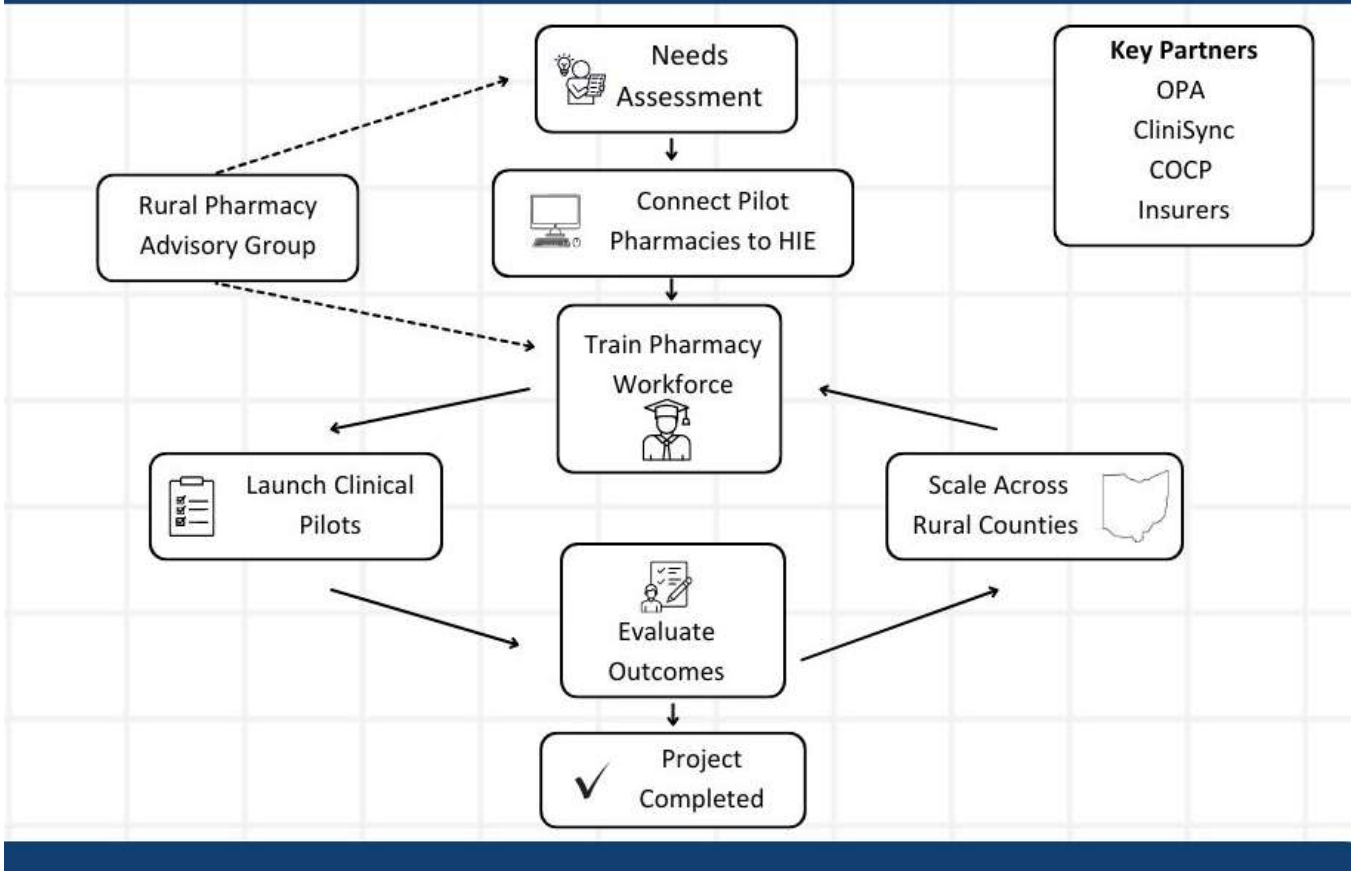
Ohio's Rural Pharmacy Transformation

- Core Vision, build a statewide rural pharmacy network that:
  - Connects pharmacies to CliniSync (HIE)
  - Expands pharmacist-led clinical services
  - Integrates pharmacies into the broader healthcare system
- End Goal to improve:
  - Patient outcomes
  - Medication safety
  - Access to care
  - System efficiency

OPA Program Model

1. Needs Assessment
2. Connect pharmacies to HIE
3. Train pharmacy workforce
4. Launch clinical services
5. Evaluate outcomes
6. Scale statewide

OPA RURAL PHARMACY TRANSFORMATION MODEL



Phase 1: Needs Assessment + Advisory Group

What happens first

- Statewide survey of pharmacies in 73 counties
- Identify:
  - Connectivity gaps
  - Workforce readiness
  - Clinical service opportunities

- Rural Pharmacy Advisory Group

Rural Pharmacy Advisory Group

- Pharmacists
- Health system leadership
- FQHCs
- Payors
- Patients
- And more….

- Goal: Advise OPA on needs assessment and pilot sites

Phase 2: Pilot Pharmacies

- Pharmacy group including:
  - Independent
  - Small chain retail
  - Large chain retail
  - FQHC
  - Hospital outpatient

- Goal: Test HIE integration, workflow, service implementation

Phase 3: HIE Integration + Training

- Connection to CliniSync (statewide HIE)
- Technical onboarding
- Workflow integration support
- Workforce training:
  - Clinical decision-making
  - Test and treat
  - Remote patient monitoring
  - Chronic disease care

Phase 4: Clinical Service Implementation

- Pharmacist-led services include
  - Chronic disease management
  - Remote patient monitoring
  - Point-of-care test and treat
  - Medication safety interventions

Sustainability?

- Pilot programs
- Legislation following clinical needs
- Lobbying for practice change

Phase 6: Scale Across Ohio

- Expansion strategy
- Use RE-AIM framework:
  - Reach
  - Effectiveness
  - Adoption
  - Implementation
  - Maintenance

Phase 6: Scale Across Ohio

- Long-term vision
- Expand to all 73 counties
- Build a sustainable rural pharmacy network
- Integrate pharmacies into:
  - Referral pathways
  - Health systems
  - Payer models

Why This Matters for Public Health

- Rural populations have:
  - Higher mortality rates
  - More chronic disease burden
  - Less access to care

- This program addresses:
  - Access gaps
  - Care fragmentation
  - Medication safety risks
  - Delays in treatment

Why This Matters for Pharmacy

Practice transformation

- Moves pharmacists into:
  - Clinical roles
  - Care team integration
  - Population health

Sustainability

- Supports:
  - Reimbursement models
  - Workforce development
  - Technology integration

What is Next?

- News from ODH, coming soon!

- In the meantime:
  - Consider participating if you are in the 73 counties
  - Fill the needs assessment
  - Leadership role?
  - Clinical expertise?

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Need More Information?

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