

Advancing Team-Based Care Through the Use of Collaborative Practice Agreements and Using the Pharmacists' Patient Care Process to Manage High Blood Pressure



Final Project Report

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This publication was supported by the 5NU38OT000225-05 funded by the Centers for Disease Control and Prevention (CDC). Its contents are solely the responsibility of the author and do not necessarily represent the official views of the CDC or the Department of Health and Human Services.

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Introduction

The National Association of Chronic Disease Directors (NACDD), in coordination with CDC's Division for Heart Disease and Stroke Prevention (DHDSPP), worked with state teams from **Arizona, Georgia, Iowa, Utah, Virginia, West Virginia and Wyoming** to participate in a learning program designed to accelerate team-based care to manage high blood pressure using the pharmacists' patient care process (PPCP) and collaborative practice agreements (CPA). To this end, state teams participated in an in-person workshop on May 24-25, 2017, in Atlanta, GA and subsequently worked in their home state toward the outcomes listed below.

Desired Outcomes

The desired outcomes of this workshop and follow-up activities included taking actions that lead to:

- Increased engagement between the state health department and state pharmacy and medical professional organizations.
- Increased use of the pharmacist patient care process for managing high blood pressure and other chronic conditions (e.g. smoking cessation, diabetes, dyslipidemia).
- Increased use of collaborative practice agreements between pharmacists and prescribers.
- Increased development of sustainable pharmacy practice models.
- Knowledge transfer from participating states and organizations to non-participating states and organizations.



Throughout the project, several key themes emerged:

- Public health is an important partner in helping pharmacists frame themselves as an integral part of supporting patient health and medication management to providers, patients, and families.
- Public health can increase awareness of the role of pharmacists through promotion of team-based care, the pharmacists' role in medication management, interprofessional training, and supporting models that broaden pharmacists' ability to be compensated for their time.
- Pharmacists can join forces with public health to institutionalize the PPCP in school of pharmacy curricula and establishing relationships with medical associations and health care practices.
- Pharmacy and public health can collaborate to address wider systems change and work with additional partners to develop sustainable models that go beyond a grant or project.

The following summarizes key learnings from the program, including state Successes and Systemic Changes Achieved; Opportunities for Innovation; Barriers/Challenges; and Facilitators/Lessons Learned. Each section depicts examples from the state teams, brief case studies, and links to additional information via success stories in the NACDD What's Working Database.

Successes/Systemic Changes Achieved

Building Partnerships: Cross-sector relationships were established and defined. State health departments and their pharmacy partners developed and/or solidified collaboration with schools of pharmacy, state pharmacy associations,

pharmacy boards, and other provider organizations. Several states also developed task forces and/or committees to support and formalize the pharmacy-public health collaboration within the state or within specific practices.

- Arizona: The Arizona Department of Health Services and the University of Arizona Medication Management Center established a state task force, including a Health Services Advisory Group representative and a Regional Vice President of AHA. They are also working to bring on board members from the Arizona Pharmacy Association (AzPA).
- Georgia: Pursuing CPAs within Georgia has strengthened relationships among the pEACHealth pharmacy sites, 10

pharmacies in rural areas with high burdens of hypertension and diabetes. The Georgia Department of Public Health has also increased collaboration with the South University School of Pharmacy (SUSOP), the Georgia Pharmacy Association (GPA), and the Georgia Clinical Transformation Team. Most recently, communication with the Georgia Board of Pharmacy has been successful and helpful in the pursuit of CPA template development.

- Utah: Utah established and continues to convene a Team-Based Care Committee to share information, prioritize, and give input on efforts to expand the role of pharmacists as part of the healthcare team throughout the University of Utah Health System. In addition to the University of Utah, there is also pharmacy representation from health systems, chain/grocery pharmacies, and independent pharmacies throughout the state. This workgroup identified metrics and methods of data collection to be used by pharmacists who are implementing the PPCP with the goal of following patients over time to track progress and demonstrate clinical value.
- Virginia: The Virginia Department of Health established a Thinkers in Residence Collaborative, to serve as a “think tank” and formalize relationships among the Virginia Pharmacists Association, The Center for Healthy Hearts, Medical Society of Virginia Foundation, American Heart Association, four schools of pharmacy, local health departments, Virginia

Community Pharmacist Enhanced Services Network (CPESN) and Walgreens. The unique partnership with Walgreens is determining how commercial pharmacy can enhance team-based care without CPAs in place.

- West Virginia: West Virginia Department of Health and Human Resources’ WISEWOMAN program identified 10 counties in need of hypertension providers and will be partnering with the University of West Virginia School of Pharmacy to provide high blood pressure education in those communities and webinar-based trainings for pharmacists.
- Wyoming: The Wyoming Department of Health developed a relationship with the Wyoming Board of Pharmacy and the Wyoming Pharmacy Association, and there is interest from both groups in collaborating to advance use of the PPCP and CPAs across the state.

“A big success has been using this Advancing Team-Based Care Project as momentum to begin including Pharmacists in our annual Quality Improvement Symposium we do every year. We plan to continue keeping the state health department involved in the promulgation of nationally recognized pharmacy service-delivery practices.”

Dave Health, Arizona Department of Health Services

Spotlight on Iowa:

The Iowa Department of Public Health (IDPH) has sustained or developed partnerships with many pharmacy partners, and IDPH and the Iowa Pharmacy Association (IPA) continued their strong collaboration through this effort. IPA has assisted IDPH to obtain Medicaid and Wellmark BCBS medication adherence data for performance measures and is also helping to obtain Medicare data. IPA sits on several committees / task forces that support mutual activities, such as the Telligen (QIO/QIN) Advisory Committees, Iowa SIM Advisory committees, and follow-up to the Iowa's Million Hearts State Action Plan. IDPH provides resource materials at annual IPA conferences. They have also collaborated to provide two mini-grants to self-insured employers to support the utilization of medication therapy management (MTM) services.

IDPH further solidified their relationship with the Iowa Healthcare Collaborative and the two schools of pharmacy in the state, Drake University and the University of Iowa. They also began working with the Iowa Medical Society and the Iowa Board of Nursing to recommend updates to their statewide protocols for pharmacy collaboration.

Needs Assessment: Public health and pharmacy surveys were developed or adjusted to capture use of the PPCP and its elements, as well as the establishment and intended implementation of CPAs.

To gain more insight into this work, the state teams collaborated with pharmacy associations and schools of pharmacy to survey pharmacists about their capacity to provide comprehensive patient services utilizing the PPCP and CPAs.

New surveys developed include:

- Virginia: Virginia surveyed the 61 physicians who attended the Virginia Academy of Family Physicians Annual Meeting on CPA interest and resource needs. More than half requested additional information on CPAs, though their current use is low (8% have a CPA with an outside pharmacist, 16% with a community pharmacy). The state also conducted a survey of 53 pharmacists during the Virginia Pharmacist Association Annual Convention regarding CPA use and interest, where 60% of attendees said they do not have a CPA in place but would like to pursue one.
- West Virginia: West Virginia administered a survey to the 81 pharmacists who attended the August 2017 training. The survey covered current use of PPCP and CPAs, current workflow processes, practice site (community, hospital, etc.) interest in learning more about PPCP/CPA, and benefits & challenges to date. They are also developing a survey for distribution to these same attendees in spring 2018 to capture progress on PPCP and CPA implementation. Lastly, the Wigner Institute from the WV School of Pharmacy plans a survey of all pharmacies in the state for 2018 on the

clinical services they offer, including high blood pressure and diabetes management, in which they will also assess use of and interest in PPCP.

- Wyoming: Wyoming is planning for a March 2018 survey to collect data on knowledge and use of PPCP and CPAs across all pharmacies in the state.

Spotlight on Georgia:

GA distributed two surveys in mid-September. The first, Georgia Implementation Assessment of PPCP, CPAs, and Collaborative Healthcare Relationships, was sent to pharmacists, pharmacies, and chronic disease staff who received support material, the CPA template, and information on who to contact to establish collaboration to get a better sense of whether they are interested in getting more info about PPCP. The second, Georgia Medical Provider Implementation of CPAs and Collaborative Healthcare Relationship, was sent to medical providers who received the CPA template and information on who to contact for collaboration. Based on the data received from the surveys, GDPH will connect pharmacists with providers and chronic disease staff to meet regionally.

Existing surveys augmented:

- Arizona: Arizona developed a CPA expanded survey in collaboration with the Arizona Pharmacy Association and the Colleges of Pharmacy Preceptor group (both Midwestern University and the University of Arizona). The survey,

designed to assess use of the PPCP, also asked several questions regarding whether CPAs were in place and what type of drug therapy it allows, which diseases are included and what type of institutions are partners. This survey was sent via email to all ~600 preceptors and ~1200 pharmacy association members.

- Iowa: The Iowa Pharmacy Association, in partnership with the American Society of Health-System Pharmacists, regularly educated and conducted outreach to pharmacies to complete the Practice Advancement Initiative Ambulatory Care Survey throughout 2017. By June 2017, there were 14 practitioner surveys and 14 system surveys completed.



Spotlight on Virginia:

The Virginia Department of Health successfully added a question regarding PPCP implementation and another regarding CPA use to the Pharmacist Healthcare Workforce Survey, administered by the Virginia Department of Health Professions. The survey is administered to pharmacists during their license renewal and achieves over 90% participation (n=12,840). The process for adding questions usually takes two years, but was expedited given collaboration with Board of Pharmacy members, and research into the protocol. It was not previously known that requesting changes during a meeting's public comment period was an avenue to adjust survey content, which was the novel path pursued in this case. The new questions added ask about the type of services that a pharmacist provides and if they participate in a collaborative practice agreement for disease state management, which ones are being managed. The 2017 Pharmacist Workforce report will be presented at the Board of Pharmacy in March 2018.

Education and Training: Trainings and dissemination meetings were held with a focus on use of the PPCP and CPAs within all participating states. State teams held both virtual and in-person trainings and seminars by adding pharmacy-specific tracks to existing meetings, by presenting at annual conferences of pharmacy associations and partners, and by holding state-wide webinars/teleconferences.

- **Arizona:** Arizona presented on the PPCP to 30 physicians from the Abacus ACO during their November 2017 quarterly meeting. In addition, this was the first year that a joint pharmacy and healthcare track was included during the ADHS CQI Symposium to 90 attendees in December 2017. The session, entitled "Optimizing the Medical Neighborhood: Transforming Care Coordination through Collaborative Practice Agreement," was presented by the Director of Network Development at CPESN USA. Arizona also presented to their DM Leadership Council on the PPCP in January and February 2018. The pharmacy lead led an internal project and training for staff at their primary practice site on the PPCP and its role in that organization in May 2018.
- **Georgia:** GDPH and SUSOP held an APCE-approved webinar titled, "Using the Pharmacists' Patient Care Process, Collaborative Practice Agreements and Collaborative Relationships in Providing Patient Care." Ten pharmacy sites attended this webinar, and it was recorded and distributed through SUSOP and GDPH networks. Results from the evaluation showed a strong will to change and incorporate PPCP into pharmacy practice, and GDPH will administer a follow up survey 6 months post-webinar to assess changes regarding PPCP and CPA implementation. Georgia also conducted teleconferences throughout December 2017 and January 2018 with two pharmacies, one identified through the webinar training and the other due to

the high degree of patient care they provide, who are interested in developing and piloting CPAs. Georgia is planning two additional APCE-approved webinars: one on PPCP and one on CPAs (which are called Drug Therapy Modification Protocols in GA); and held a preceptor conference with PPCP as a topic for 97 attendees.

- Iowa: The Iowa Pharmacy Association provided educational resources on PPCP via webinars and/or conference calls with its membership on August 8, 2017, and September 8, 2017. IPA also presented at the Iowa Healthcare Collaborative Care Coordination Conference in June 2017 through a panel of pharmacists titled "Community Pharmacy Enhanced Services Networks: A Leading Edge in Medication Management," as well as in November 2017 at the Iowa Healthcare Collaborative Annual Conference. In collaboration with the IDPH, IPA also hosted the Practice Advancement Forum in June 2017, a program that explores implementing innovation across various practice settings while addressing improving patient outcomes and care delivery. In addition, IPA conducts monthly ChargeUP calls for pharmacies engaged in enhancing their service offering and recently focused on CPAs and the pharmacist role in broader patient management. Furthermore, IPA Goes Local meetings discuss how pharmacists could provide care management assistance to providers and their patients.
- West Virginia: WV held an all-day training with 6 hours of CE credits in August 2017, focusing on promoting the PPCP, the 2017 Hypertension Clinical Practice Guidelines, and developing CPAs in the state. Eighty-one pharmacists attended. In addition, in September 2017, the WV Pharmacist Association CE program held a training on PPCP and CPAs for 99 pharmacists. The training included a review of hypertension and lipid guidelines, introduction and review of pharmacist patient care process, and an overview of how to develop and build a collaborative practice agreement in the state, including how to get the CPA approved through the appropriate channels. The training finished with panel discussion among two providers with specialty CPAs. Evaluation results from the August training concluded that 68% of those who completed the evaluation are considering establishing collaborative practice agreements; 31% use multi-professional team-based care, and 31% are currently utilizing the PPCP. Looking forward, three webinar-based trainings will be held for the ~20 pharmacists who will be trained as WISEWOMAN hypertension providers.
- Wyoming: WDOH presented at the 100th annual Wyoming Pharmacy Association Convention in a session titled "Chronic Disease Management and the Role of Pharmacists." The roughly 50 pharmacists in attendance included representatives from the WY Pharmacy Association Board, as well as representatives from the regulatory side

of pharmacy, and community and independent pharmacies. The presentation focused on an overview of why pharmacists have a significant role in chronic disease prevention and care and highlighted the regulations for CPAs in WY. This was the beginning of building a trusting relationship between the state and pharmacies, highlighting the potential for this new collaboration. In addition, 15 pharmacies working under the Wyoming Integrated Pharmacy Project have received education on PPCP and are in the process of incorporating the process into their pharmacies.

The conference went AMAZING. There was a lot of focus on expanded services provided by pharmacists, collaboration with health care teams, and everything else that we're pushing with the PPCP and CPAs. Many of the participants seemed extremely interested in what I had to say, and were happy to hear that the state is on their side as a champion for involving pharmacists in the care team.

Hannah Herold, Wyoming Department of Health

Spotlight on Utah:

The Utah Health Department and the University of Utah Health System gave a joint presentation to local health departments working with pharmacists through DP14-1422 to review available resources from CDC and APhA, as well as provide the pharmacy perspective on collaboration with public health. Approximately 40 local health departments were in attendance. In addition, the Utah pharmacy lead for this effort gave presentations to University of Utah Health System Medical Directors and department chairs in the school of pharmacy to explain background, goals, and vision behind PPCP use with the objective of gaining buy-in from these leaders. Furthermore, 31 individual pharmacy staff (including pharmacists, residents, technicians) have been receiving ongoing training on the PPCP. It was first formally introduced, discussed, and role played in July 2017. Since then, it has been and will continue to be part of team discussions during monthly staff meetings, including working through challenges and solutions.

Agenda and curricula changes were made by schools of pharmacy. State teams worked with academic partners and schools of pharmacy to incorporate the PPCP into curriculum requirements and several presented to students about the use of PPCP and CPAs.

- Arizona: In March 2018, the pharmacy lead presented to 30 Midwestern University-Phoenix faculty members and preceptors presentation on the PPCP.

Arizona will continue to work with Midwestern and the University of Arizona to incorporate the PPCP in all Introductory Pharmacy Practice Experience/Advanced Pharmacy Practice Experience rotation sites.

- Virginia: Four schools of pharmacy in VA adjusted their curricula to incorporate PPCP- Appalachian College of Pharmacy, Hampton School of Pharmacy, Shenandoah University Bernard J. Dunn School of Pharmacy, and the Virginia Commonwealth University School of Pharmacy. The VDH will be following up with the schools for additional information and to track the implementation/incorporation of PPCP for each school and residency programs that facilitate learning and implementation of PPCP in community settings.
- West Virginia: The PPCP is now a component of all three WV School of Pharmacies' curriculum. In addition, pharmacists from two stores who indicated they were already incorporating PPCP now ensure that the students with whom they work are trained and patients are introduced to



the process when they come in for an appointment.

Spotlight on Wyoming:

The Wyoming Department of Health successfully presented to the University of Wyoming School of Pharmacy 3rd and 4th year students on the PPCP, and the school will integrate the lecture into their annual curriculum moving forward. In addition, UW School of Pharmacy is evaluating the 4th year rotation curriculum to assess the potential for writing PPCP into requirements for students in pharmacy practice sites, working toward embedding PPCP in 4th year pharmacy student requirements. These efforts were written into UW School of Pharmacy's accreditation plan, and the state will be providing continuing education and information on PPCP.

Sustainability: Sustainability was sought through regulatory changes (including adjustment to CPA protocols), as well as through payer engagement. State teams are also working to engage payers to expand the role of pharmacists and seek compensation for comprehensive care coordination.

- Iowa: IPA worked to build its relationship further with the three Medicaid MCOs to showcase the value of pharmacy delivered care.
- West Virginia: WV researched coverage by Medicaid and PEIA and is looking into other reimbursement resources.
- Wyoming: WDOH held meetings with Wyoming Medicaid to discuss the value of pharmacists in case management and plan to work with them to expand

payment for services provided by pharmacists.

State health departments worked with pharmacy associations and boards of pharmacy to incorporate CE opportunities, develop CPA templates, and change board of pharmacy regulations to ease CPA establishment.

- Georgia: GDPH and SUSOP constructed CPA agreements and disease-state management protocols in collaboration with some of the pEACHHealth pharmacies for submission to the Georgia Board of Pharmacy. The Board encouraged the current collaborating team to develop the programming to educate pharmacists on Drug Therapy Modification Protocols in addition to PPCP and how to use them. The program also discussed opportunities for pharmacies to partner with self-insured employers to establish financial agreements, which has been successful for some of the pEACHHealth pharmacy sites in Georgia. Discussion regarding these billing options will be included in upcoming CE opportunities.
- Iowa: IPA presented at the Iowa Board of Nursing meeting in June 2017 regarding this project and the expanded CPA regulations between advanced practice registered nurse and pharmacists. Currently, IPA is awaiting the final proposed regulations from the Iowa Board of Nursing. At that point, they plan to submit supportive comments to the rule-making progress. Barring no unforeseen delays, the Iowa Board of Nursing should adopt final regulations to permit ARNPs and

pharmacists to enter into collaborative practice agreements during the summer of 2018. IPA also submitted a letter of request to the Iowa Board of Medicine to modernize their CPA regulations and was invited to present on CPAs to the Board in February 2018. IPA presented and requested to the Board of Medicine to create a work group to collaborate with IPA and the Board of Pharmacy to modernize their CPA rules. They are currently working with the Board of Medicine staff to follow-up on their request and address next steps.

- Utah: The Utah Pharmacy Association board voted to require all continuing education (CE) opportunities to include PPCP if they have a therapeutics component. They also developed a Community Pharmacy Enhanced Services Network to support the role of pharmacists as part of the healthcare team. Through a subsequent project, their work with CPESN is progressing and deepening. They currently have 8 pharmacies who have signed national agreements (with several more who are in the process of signing), and 92 signed local agreements.



Spotlight on West Virginia:

The West Virginia team facilitated the doubling of CPAs on file (from 9 to 18) with the Board of Pharmacy by working on this project and collaborating with the National Alliance of State Pharmacy Associations. Twelve more pharmacies are working on their applications or have already submitted to Board of Pharmacy, and two hospital facilities have contacted the Wigner Institute to complete their protocols and CPAs. In addition, the WV team has been working with the Board of Pharmacy to facilitate a more fluid CPA approval process, attempting to shorten the 3-month process, as well as examine other types of CPA protocol templates to improve access to care and health outcomes.

many medication therapy problems (MTPs) were identified and resolved because of using the PPCP. Uptake and use of these measures has been strong, with 1660 MTPs reported in February 2018 alone.

Virginia Department of Health is also working on a partnership with Walgreens, determining how the commercial pharmacy can enhance team-based care without CPAs in place. At six pilot sites, Walgreens will offer a coupon for \$10 in Walgreens rewards if a patient buys a blood pressure monitor. Community Health Workers working in the local health department will then meet with patients at Walgreens, provide the coupon, introduce the patient to the pharmacist, and help with healthy purchasing.

Opportunities for Innovation

This learning program also shed light on innovative efforts being pursued by participating states, including:

Iowa is working with a new health information exchange (HIE) vendor. IPA has held several meetings with the vendor that manages the HIE to evaluate mechanisms to track and showcase the services pharmacists provide. IPA also continues to collaborate with Telligen, Iowa's QIO-QIN, to demonstrate the value of pharmacist-delivered care throughout their current scope of work.

University of Utah Health System's EMR, EPIC, was updated in September 2017 to include options in EPIC I-vents on how

Spotlight on Arizona:

Arizona's Department of Health Services has an Intergovernmental Agreement with the University of Arizona's College of Pharmacy Medication Management Center (MMC) to provide telephonic MTM services with pharmacists in rural underserved areas. The MMC established CPAs with two rural AZ Community Health Centers. Community Health Workers are included in the client phone appointments. Additionally, the MMC has an EHR read-sharing agreement with both clinics, enabling the data "collect" process to be as thorough telephonically as it would be in person. The program has provided MTM services to over 600 clients and is currently carrying a load of "high-risk" patients.

Barriers/Challenges

Participating state teams noted multiple barriers to PPCP implementation and CPA development, despite their many successes.

Monitoring and tracking use of PPCP

- Some pharmacists roll out the PPCP too quickly, therefore inadequately / improperly implementing and tracking their efforts.
- The absence of structured data and standard performance measures to track implementation and progress on PPCP use negatively affects data collection and value proposition definition; would like to see PPCP measures built into EMRs.
- The lack of EMR/HIE infrastructure between pharmacies and clinics / practices hinders information sharing.

Lack of awareness

- Low patient awareness of PPCP services creates little demand.
- Little awareness among pharmacy of the role public health can play, and vice versa, hampers collaboration.
- PPCP elements are widespread practice, but the nomenclature is new to many – need ‘branding’ of the consistent process for those outside pharmacy and need to educate pharmacists that this is largely what they already do and not something new.

Relationship between Physicians and Pharmacists

- There can be a level of mistrust between physicians and pharmacists, as they tend to be very siloed, and consequently, getting physicians to the table to discuss CPAs can take time. Physician interest in and willingness to share patient management with pharmacists is variable; conversely, pharmacists’ need to be comfortable with the providers in their area to effectively establish CPAs.
- Pharmacists need to work with people at every level of a practice / health system / organization to create awareness of CPAs and the potential pharmacist role, as well as to secure lasting systematic change.

Regulatory Concerns

- Lack of reimbursement for PPCP services, especially given the time it can take to implement, creates a hesitancy among pharmacists to take on more work.
- Corporate regulations and policy often prevent engagement with chain pharmacies.
- The duration of and process for pharmacists to receive CPA approval can be lengthy and difficult to navigate.
- Cost saving data on the PPCP to convince payors to reimburse for services is sparse.
- The advent and expansion of mail delivery prescriptions makes patient interaction less common / frequent.
- States with more independent leanings may be hesitant to listen to the state health department, lest it seem they are being told what to do.

Facilitators and Lessons Learned

Looking toward future work in this area, participants in this project report multiple catalysts to success:

- Obtain buy in from leadership within a health system.
- Capitalize on strong enthusiasm among many front-line pharmacists.
- Leverage prior existing collaborations (1305, 1422).
- Frame the PPCP and CPA benefits to fit the mindset of the audience; speaking to both pharmacy and prescriber is critical.
- Prepare tools to help pharmacists measure their progress on PPCP implementation and track patients.
- Lay the groundwork for CPAs by developing templates and sharing experiences.
- Work with state pharmacy associations to remove regulatory barriers which prevent pharmacist participation on care teams.
- Assess pharmacy and practice capacity to implement PPCP before pursuing it.
- Continue / pursue national level organization collaboration and promote PPCP implementation through a variety of communication channels.

Acknowledgement of CDC and Faculty:

NACDD is grateful for the guidance and support of our CDC colleagues, including:

- Paris Brookins, MPH, Public Health Advisor, Program Development and Services Branch (PDSB), Division for Heart Disease and Stroke Prevention (DHDSP), CDC
- Jeff Durthaler, MS, RPh, Population Health Consultant Pharmacist, Applied Research and Evaluation Branch, DHDSP, CDC
- Lazette Lawton, MS, Team Lead, Advancing Population Health Team, PDSB, DHDSP, CDC

In addition, expert faculty contributed invaluable assistance to NACDD and participating state teams in the development of this learning program and its resources. These faculty include:

- Marialice S. Bennett, RPh, FAPhA, Professor Emeritus, The Ohio State University College of Pharmacy
- Lindsay Kunkle, PharmD, Director, Practice & Science Affairs, American Pharmacists Association
- Troy Trygstad, PharmD, MBA, PhD, Consultant
- Krystalyn K. Weaver, PharmD, Vice President, Policy and Operations, National Alliance of State Pharmacy Associations

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Arizona	David Heath, Program Manager, Heart Disease and Stroke Program, ADHS	Stephanie Forbes, University of Arizona, Medication Management Center
Georgia	Shana Scott, Health Systems Lead, GDPH	Andrea McKeever, South University School of Pharmacy
Iowa	Terry Meek, Health Systems Coordinator, IDPH	Anthony Pudlo, Iowa Pharmacy Association
Utah	Teresa Roark, Health Program Coordinator, UDOH	G. Benjamin Berrett, Manager, Pharmacy Primary Care Services at University of Utah Health
Virginia	Kayla Craddock, VDH	Cynthia Warriner, VA Pharmacists Association
West Virginia	Jessica Wright, WVBPH	Krista Capehart, WV School of Pharmacy
Wyoming	Hannah Herold, Chronic Disease Prevention Program Manager, WDH-PHD	Thanh-Nga Thi Nguyen, UW School of Pharmacy

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