Managing a Clinical Practice

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Learning Objectives

1. List three critical clinic functions for your clinic to assess and review on an annual basis to sustain a top-level practice.
2. Develop a robust quality assessment program for your clinical service using the balanced scorecard.
3. Analyze sources of quality measures important to your organization, and select the measures important to your practice site or patient population.
4. Develop a credentialing and privileging process to ensure the competency of pharmacists providing direct patient care in your clinic setting.
5. Differentiate pharmacist billing opportunities between a hospital-based clinic, physician office, and community pharmacy.
6. Develop a proposal for pharmacists at your clinic site to participate in the range of current Medicare billing opportunities that will sustain the service for the next several years.
7. Describe how pharmacist services in your setting may be incorporated into the Merit-Based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs) outlined in the Medicare Access and CHIP Reauthorization Act (MACRA) legislation.

Self-Assessment Questions

Answers and explanations to these questions can be found at the end of the chapter.

1. Critical to a well-functioning clinic is for your work flow to be efficient and to seamlessly integrate with that of other team members. Evidence is building on how to develop optimal work flow in primary care practice. Which of the following is a strategy that improves clinic work flow?
   A. Strict adherence to policy and procedures.
   B. Develop a pre-visit planning program.
   C. Invest in technology and provider alerts.
   D. Set a consistent time frame for patient visits.

2. There are three dimensions of quality in health care: structure, process, and outcome. Optimal patient outcomes of your services are important to measure, in particular for those entities outside your team. Internally, however, it is difficult to produce the desired outcomes without paying attention to a term used in business management: *the balanced scorecard*. Which of the following group of organizational measures reflects a balanced scorecard?
   A. Percent of providers trained in correct blood pressure measurement, percent of patients with blood pressure values documented at each visit, percent of blood pressure values less than 140/90 mmHg, performance reimbursement for meeting blood pressure value goals.
   B. Errors made in computerized provider order entry (CPOE) system, patient satisfaction scores, hospital readmissions for heart failure, weight documentation in chart.
   C. Number of faxes versus electronic medical record (EMR) use for lab communication, HgA1c values less than 8, adherence rates to oral diabetic medications, number of diabetes visits per month per patient.
   D. "Incident to" evaluation and management code revenue, number of referrals for smoking cessation, documentation of smoking cessation education, maintenance of Board Certified Ambulatory Care Pharmacist (BCACP) credentials.

3. Your organization is moving toward value-based payment models. It recently has become a Medicare shared saving organization. To sustain your services within the organization you want to make sure you are contributing the quality measure set for this Medicare payment model. Which of the following measure sets should you review?
   A. Healthcare Effectiveness Data and Information Set (HEDIS) measures.
   B. Physician Quality Reporting System (PQRS) measures.
   C. Meaningful-use measures.
   D. Accountable care organization (ACO) measures.

4. Your practice is growing and in need of hiring another pharmacist practitioner. Your physician partners have clearly stated that they desire the same level of skills from the new hire that you have in order for them to be comfortable in extending the collaborative practice agreement to that person. Risk management is also concerned with consistency and a same standard of practice and skill. To mimic what

is used by the organization to higher physicians, nurse practitioners, and physician assistants, you develop a competency and privileging program for patient care pharmacists. Which of the following is the best tactic to use to provide assurance to your organization that the best hire has been made?

A. BCACP credentials.
B. Postgraduate year two (PGY-2) training.
C. Peer review of services at 90 days.
D. Medication therapy management (MTM) training certification.

5. You are a pharmacy director of a community hospital that lost 3% of its Medicare revenue this past year because of the readmission penalty. To rectify this problem, the hospital has a strategic plan to improve their ambulatory care presence. You have pharmacists currently in the ambulatory clinic attached to the hospital, but you have not pursued billing for their services. You believe the current pharmacists' services meet well the intent of the new strategic plan, but you also know revenue generation ability will be a key component in sustaining these services. Which of the following code sets will be most beneficial for you to pursue in sustaining and even growing these services?

A. 99605–99607 MTM service codes.
B. 99211–99215 "incident to" evaluation and management (E/M) codes
C. Ambulatory Payment Classification (APC) 5012, G0463 facility fee codes.
D. APC 5011, Current Procedural Terminology (CPT) 99490 Chronic Care Management codes.

6. Which of the following billing opportunities may a physician group use to generate revenue for patients services performed by pharmacists under general supervision?

A. MTM codes.
B. CCM codes.
C. "incident to" codes.
D. Wellness visits.

7. It is anticipated that the majority of Medicare Part B providers under MACRA will not qualify to participate in the Advanced Alternative Payment Model (APM) program and will be required to participate in the Merit-Based Incentive Payment System (MIPS). You currently run a heart failure pharmacist-based service for a large medical practice that is a recognized National Committee for Quality Assurance (NCQA) medical home. You want to make sure your services continue to be considered valuable as the practice prepares for adapting to MACRA rules for its Medicare patients. Which of the following is the best course of action for you to consider?

A. Recommend that when choosing from among the required six core measures, the practice include one that your service has contributed to above-average reporting in the PQRS for the medical group.
B. Development of patient decision aids for heart failure.
C. Integrating more pharmacists into the practice, because this is included in the proposed options for the practice improvement portion of the reimbursement.
D. Developing an information exchange with a community pharmacy for better patient coordination.

Summary of Case Examples

1. You have completed 1 year of services in the health-system outpatient clinic with primary care and medical specialty services. The initial purpose of your clinic was to assist in the management of patients with heart failure and chronic obstructive pulmonary disease (COPD) after hospital discharge with the goal of reducing 30-day readmissions. You currently are analyzing the results of the impact of your service on 30-day readmissions. Your services have been well received within your organization, and you currently enjoy a well-established practice. Your practice has grown significantly, including other patient referral types, particularly patients with diabetes in need of better disease control and education. Recently, however, it has become increasingly difficult to schedule patients with COPD and heart failure within the 72 hours post-discharge goal because of your patient volume.

2. The community pharmacy chain for which you manage clinical services is now 6 months into a contract with the local physician group. Stipulated in the contract is a formal review of services provided at 6 months. The 6-month review will primarily address processes. Another report focusing on quality measures and patient outcomes is due at 12 months. A lack of optimal communication processes has emerged as an important barrier to efficiency in services.

3. You are a co-funded ambulatory practice assistant professor with a practice site at a family practice office. The providers in the office have spent the past year retooling for the Merit-Based Incentive Payment System (MIPS). You have been providing clinical services to this office for 1 year. You have had students and residents at the site. The practice is pleased with the clinical pharmacy services and now wants to explore billing opportunities and explore your contribution to the MIPS quality measures. The practice is beginning to appreciate how best to use your services and would like to discuss expanding the scope of what you provide to the practice.

With an established practice, the focus will shift to maintaining and growing a successful clinical service. Similar to starting a service, there are key activities that you will need to pay attention to simultaneously.

I. GENERAL ONGOING MANAGEMENT *(Domain 4, Task 4)*

A. Maintaining Policy and Procedures. Despite careful planning and good intentions, some processes will not work as well as envisioned. Policies and procedures are guides that provide a level of standardization and quality for your program. If issues are identified in the early stages of implementation, address and revise them as they occur.
   1. Review policy and procedures yearly. Doing so will keep the review process manageable. Waiting too long will result in outdated policies that may require a major overhaul, often resulting in a large workload for you and your staff.
   2. Assign the reviewing responsibility to the staff members who perform the functions in the policies. Because they perform the process daily, they will be able to detect discrepancies or needed policy and procedure changes.

B. Maintain Your Practice to Meet the Minimum Current Standards of a Pharmacist Ambulatory Care Practice. Current minimum standards of patient care in ambulatory care are described in the following references: Am J Health Syst Pharm 2015;72:1221-36; Council on Credentialing in Pharmacy 2009; U.S. Public Health Service 2013; American Pharmacists Association and National Association of Chain Drug Stores Foundation 2008; Patient-Centered Primary Care Collaborative 2012; and Joint Commission of Pharmacy Practitioners Pharmacist Patient Care Process 2014.
   1. Collect: Gathering patient information from the medical record and interviewing patients or caregivers to obtain pertinent information needed for patient care
   2. Assess: Assessing the legal and clinical appropriateness of the medication regimen to identify, resolve, and prevent medication-related problems
   3. Plan: Participate with health care team members and the patient in medication and disease-state therapy decision-making and development of patient goals and plans of care.
   4. Implement: Initiate the plan, including educating patients and caregivers on disease, medication therapy, adherence, and preventive health
   5. Follow up, monitor, and evaluate: Monitoring the effect of medication therapy on patient health outcomes
   6. Documenting and communicating services provided, as well as creating and maintaining medication profiles, medication-related plans of care, and other needed patient care documentation

C. Stay Up to Date. Health care and practice is dynamic and constantly changing. Find effective processes for staying abreast of current practice. Pay particular attention to the following areas:
   1. Pharmacy practice and therapeutic literature
      a. Pharmacy and other appropriate practice organizations are valuable ways to stay abreast of practice changes and trends.
         i. Regularly review respective journals, reports, and web-based resources such as table of contents and e-mailed news briefings.
         ii. Become involved with at least one organization in some manner.
      b. Therapeutic literature
         i. Medical journals pertinent to your practice (e.g., primary care, general internal medicine, diabetes, cardiology)
         ii. Guidelines. These are often published in the respective specialty medical journals. You can also subscribe to the Agency for Healthcare Research and Quality's (AHRQ's) website (www.guideline.gov), which will send weekly e-mails of new guidelines available in the database.
   2. Laws and regulations: In today's environment, health care laws, rules, and regulations change often to adjust to the dramatic changes occurring in health care structure and payment.
      a. State board of pharmacy. Review state laws and the rules and regulations for pharmacy practice. With the potential for provider status and federal rules to dictate that the services provided must be within the state scope of practice, it is more important than ever that your state practice act completely cover the scope of services you are providing. Currently, there is wide variability in scope of practice amongst the state pharmacy practice acts.
      b. State government and state health care provider practice acts. Laws that may change, affecting practice and state-sponsored health insurance plans (e.g., Medicaid, third-party payers)
      c. Federal government
         i. U.S. Food and Drug Administration. Approves new medications and issues warnings or other recommendations for already-approved medications
         ii. U.S. Department of Health and Human Services and the Centers for Medicare & Medicaid Services (CMS). Determines the rules and regulations for federally sponsored health care or Medicare. Many of the rules and regulations for Medicare are updated yearly.
         iii. Centers for Disease Control and Prevention. Determines the rules and standard procedures for point-of-care testing, immunizations, and management of patients with transmittable diseases

iv. Protection of patient information (Health Insurance Portability and Accountability Act [HIPAA]). It is important to ensure that your processes in patient care and exchange of information comply with HIPAA.

d. Other organizations
   i. Occupational Safety and Health Administration (OSHA) guidelines. OSHA guidelines are particularly important if you are handling medications or other potentially hazardous materials.
   ii. Accreditation organizations. Establish standards for quality and safety. An accredited practice is often required by payers for contractual relationships and/or payment. What has been common in the institutional setting is becoming increasingly common in the ambulatory setting with the various types of standards supported by the organizations listed.
      (a) Joint Commission
      (b) National Committee for Quality Assurance (NCQA) PCMH recognition
      (c) Center for Pharmacy Practice Accreditation (CPPA)
      (d) URAC

D. Update and Review Your Collaborative Practice Agreement on a yearly basis or as dictated by state laws, rules, and regulations.

Practice Case 1

You are pleased to be receiving referrals for patients with diabetes in your clinic because this area of practice has always been a strong interest of yours. However, these referrals are slowing you down in the clinic because you do not have a collaborative practice agreement established for diabetes management. In addition, patients are calling your service instead of their medical providers for refills of medications, which was not included in your original collaborative practice. Moreover, you would like to discuss the current hypertension guidelines with your team so that you are clear on their interpretation and approach, particularly for patients with heart failure. For the yearly review of the program with the medical group physicians and administrators, you request that these issues be placed on the agenda. During the meeting, it was agreed to add authorization of refills to the collaborative practice agreement. An endocrinologist will be recruited to review your service, and you will work with that physician to develop a diabetes management collaborative agreement. You will provide an in-service on the recent hypertension guidelines to key physicians with the goal of developing an agreed-on standard patient approach for the clinic.

This case demonstrates a real situation in showing how much can change in 1 year. Therefore, it is good practice to set up a standard annual review of the documents that guide your daily practice.

II. MAINTAINING AN EFFECTIVE TEAM AND FUNTIONING AS AN EFFECTIVE HEALTH CARE TEAM MEMBER WITH A JOY IN YOUR PRACTICE

The triple aim of improving patients' experience of care (i.e., satisfaction and outcomes), reducing the cost of care and improving population health has been the driver of the dramatic change in health care we have witnessed in the past few years. The success of the triple aim is dependent on health care being delivered by teams of health care providers composed of many disciplines versus sole individual providers. The complexity of health care demands team-based care. However, systems of care, work flow, information technology and means of

communication have not kept pace with the needs and demands of team-based care. Your sustainability will rest on your ability to overcome these barriers by understanding features of effective teams and establishing standard reliable methods for work flow, communication, and documentation.

A. Features of effective teams. Weller, et al., reviewed extensive research in team performance from across a range of industries and adapted the identified best models and their respective features to health care team functioning. They are as follows:
   1. Team leadership. Team leaders not only should coordinate tasks of member and daily work planning but also are concerned with development of team members, motivation, and establishing a positive atmosphere. Team leaders are usually physicians.
   2. Mutual performance monitoring. Team members all require sufficient understanding of the environment within the workplace in order to monitor other team members such that any member is able to step in and assist when task overload or lapses are identified.
   3. Backup behavior. Team members have sufficient understanding of others' tasks to enable effective redistribution of workload or needed support with the variances in service demand.
   4. Adaptability. Adaptability enables the team to respond to changes in environment in order to change patient management and work flow as needed to maintain patient care and the desired outcomes.
   5. Team orientation. Willingness to take other's ideas and perspectives into account and a belief that team goals should be aligned with what is best for the patient, e.g., patient centeredness.

B. Characteristics of effective teams. Ambulatory pharmacists should strive to model these characteristics.
   1. Respect and trust in order to give and receive feedback on performance
   2. Good communication skills to accurately convey information
   3. Shared mental model defined as a common understanding of the situation, plan of care, roles, and tasks of individuals on the team. Weller describes this as being "on the same page."

C. Work flow. Your goal for success and sustainability is to be a high-performing clinic in a high-performing organization. The provision of health care and its subset of medication management and optimization are complex adaptive systems (CAS). A CAS is defined as a group of diverse individuals who learn together (e.g., learn about a patient) and is defined by interdependent connections that vary in intensity and may be inconsistent. For example, in your care of a patient, you may not need to contact another member of the health care team; or in another instance, you may need to contact them in a very short, simple way and another instance in a highly complex manner. Patient's conditions, evidence of treatment, and system complexity contribute to the intensity and inconsistency that is inherent in health care and optimizing medications.
   1. Recommendations for optimally working in a complex adaptive system. Ambulatory pharmacists should strive to model these recommendations.
      a. Mindfulness: Mindfulness is an awareness of the current system you work in and how your coworkers and team members think, work, and respond.
      b. Meaningful interactions and processes such that care providers can navigate efficiently and recover from inherent variability. Create standard work flow and communication processes that allow fluidity and a constant attention to trouble spots in order to set a culture for quick reworking and improvement. Learning and continuous problem-solving are vital to managing complexity. Three levers for managing complexity are proposed by Provost, et al.
         i. Conversation. Do not limit interactions to just information exchange; move to problem-solving and problem dissolving to remove the root cause of any issue if possible.
         ii. Relationships. Eliminate variation in training and status in the team because these differences limit conversations and the development of shared understanding and learning
         iii. Culture. Create an environment in which learning and action occur together and which does not need a hierarchy or excessive time to improve a problem.

2. Work flow as defined by Unertl, et al., is a dynamic construct that includes three pervasive elements:
   a. Temporality
   b. Aggregation of actors and actions
   c. Context that constrains and enables actions
3. Areas of variability in ambulatory clinic work flow to consider in your processes. Focus on building resiliency and efficiency and avoiding unnecessary stress points.
   a. Staffing
   b. Clinic pace
   c. Technology use during visits
   d. Computer access
   e. Access to clinical data
4. Evaluate the Pharmacist work flow in your clinic routinely. Allow for variation in work flow and sequence as individual patients' agendas, needs, and characteristics have a significant role in the process. When variability is not accounted for, the result is reduced productivity, increased chances of error, and other potentially negative outcomes.
   a. Use the Joint Commission of Pharmacy Practitioners (JCPP) standard patient care process as foundation for your work flow (presented in the Process of Care/Organizational Agreements/Special Issues in Practice Management chapter).
   b. Consider using the document "Workflow of Pharmacist Clinical Documentation Process in Pharmacy Practice Settings" as a resource, available from the Pharmacy Health Information Technology Collaborative. www.pharmacyhit.org/pdfs/workshop-documents/WG3-Post-2014-03.pdf
5. Evaluate patient flow through your system regularly.
   a. Collect required patient information once if possible.
   b. Minimize how often a patient is moved. Emerging evidence suggests that moving providers is more efficient.
   c. Use evidence-based practices in the treatment and monitoring of medical conditions as much as possible to reduce any disagreements in management within the team.
   d. Eliminate unneeded or excessive activities.
   e. Eliminate any duplicative communication whenever possible.
   f. Provided concise and clear information to the patient.
6. Data are emerging on ambulatory care pharmacist work flow. Two recent publications provide ambulatory pharmacists data on assessing and evaluating pharmacist patient care work flow in the clinic setting. Investigators evaluating workload data accumulated from the Collaboration Among Pharmacists & Physicians to Improve Outcomes Now (CAPTION) trial found that pharmacists in this trial spent around 33 minutes per patient in a face-to-face visit during initial encounters and 28 minutes, on average, for face-to-face follow-up visits. The average time spent on pre-visit work was 4.05 minutes and on post-visit activities, 8.85 minutes. At the Mayo Clinic, study investigators modified a nursing tool to track productivity and time management for pharmacists providing medication therapy management (MTM) services integrated into the health system's ambulatory setting. They found that pharmacists spent 41% of their time in non-visit patient care, 30% of their time in direct patient contact (70% face-to-face time), and 30% of their time in non-patient care activities such as meetings, educating health care providers, precepting, and research. Other investigators have developed a dashboard for benchmarking the productivity of an MTM program.
7. Joy in practice versus provider burnout. With the importance of primary care in current and future health care reform and in care of patients with chronic diseases, it is likely that primary care will be the principle location for pharmacist integration within team-based models. Primary care has a high prevalence of stress and burnout for physicians. There are no recent studies assessing pharmacists in this setting. Many of us have witnessed similar concerns for pharmacists practicing in primary care, requiring

consideration of workload in managing your clinic. Several recent studies (Linzer, et al.; Sinsky, et al.) have identified strategies to consider in clinic setup and work flow that may reduce provider burnout. The strategies include:

a. Work flow design
    i. Team and staff assignments and duties that have all members practicing at their highest skill level. Specific strategies that may reduce lower-level skill work include:
        (a) Pre-visit planning
        (b) Pre-visit laboratory testing
        (c) Sharing or splitting the documentation requirements
        (d) Specific patient care delegated to team members congruent with their scopes of practice
    ii. Flexible scheduling to meet ebbs and flows of patient demand (see Institute of Medicine Report "Transforming Health Care Scheduling and Access: Getting to Now" at www.nationalacademies.org/hmd/Reports/2015/Transforming-Health-Care-Scheduling-and-Access.aspx)
b. Improve communication:
    i. Between internal providers and staff. Evidence is building supporting the use of team huddles and meetings that are both spontaneous and planned.
    ii. Between patients and clinic providers and staff, through such technology as use of patient portals and texting
    iii. Between external provides and clinic providers and staff and through participation in local and state health information exchanges
c. Quality improvement projects that address concerns identified by patients and providers (see Measuring the Quality of Your Program section later in this chapter).

D. Health Care Communication. As previously stated, strong communication processes are one of the most vital aspects of ambulatory care. The success of the pharmacy service(s) will depend on how effectively you communicate with patients, with your immediate health care team, and with all the individuals involved in a patient's care. Setting up standard communications processes and structures that allow needed flexibility will help create efficiency in the program. Communication must occur bidirectionally between all members of the health care team and strive to be conversational versus solely information exchange.

1. Methods of communication that you may choose to consider. Note that *team huddles or meetings* has the highest number of benefits because it most embodies the team-based care concept. Team huddles are quick meetings (synonymous with a sports team huddle) in which the team discusses patient cases and clinic organization and develops a plan of care. This simple communication method is a cornerstone in the functioning of integrated models of care such as the medical home. Frequency of team huddles depends on the needs of the team.

Table 1. Methods of Communication

Type	Benefits	Barriers
Face-to-face	• Allows conversation and building of relationships • Allows body language interpretation • Immediate answer is usually provided • There exists an ability to elaborate and have in-depth discussions as needed	• May be inefficient and disrupt clinic or patient flow • Works only if you are physically located near other providers
Telephone or page	• May be able to receive immediate answer • There exists an ability to elaborate, although less so for conversation and in-depth discussions • May still be collegial because remains person-to-person contact	• Connecting with person may be difficult • May be intrusive • If unable to reach the person or need to use voicemail, this may negate the benefit of person-to-person contact
Fax and voicemail	• Record of communication • Nonintrusive	• Confidentiality issues; fax may go to wrong place • Loss of collegial aspect with personal interaction • No elaboration or discussion possible • Misinterpretation may occur because of the need for brevity • Requires additional effort to scan or document in the electronic medical record (EMR) • Delay in response
Electronic messaging	• Record of communication • May be nonintrusive • Easy and convenient • No intermediaries needed	• May not be secure or private • Loss of collegial aspect with personal interaction • No elaboration or discussion possible • Misinterpretation may occur. • Delay in response; however, may be less delayed than other methods because of convenience
EMR	• Accessible to all providers; aids efficiency • Written record of communication • No confidentiality issues	• Unable to discuss an issue • Communication is permanent and therefore not amenable to an off-the-record type of consultation • Without direct notification, others may not be read • Loss of collegial aspect with personal interaction
Team huddles or meetings	• Collegial and builds relationships • Allows body language interpretation • Immediate answer • Ability to elaborate and have in-depth discussion as needed • Efficient • No confidentiality issues • Allows interdisciplinary perspective when addressing patient needs (e.g., primary care physician, pharmacist, nutritionist, behaviorist)	• Optimal for team members to be in the same location • Balance between time needed for huddles and a busy workload; knowing how to perform a huddle is key so that the value is apparent

2. Tools for effective communication regarding patients
    a. Patient plan of care – One plan shared by all providers caring for patient
        i. Everyone is working toward the same goals (including the patient).
        ii. Responsibilities for action within the plan of care are clear.
    b. Medication list – Should contain information other providers need and in an easy-to-use format
        i. Basic patient demographics (e.g., name, date of birth, height, weight)
        ii. Date prepared, preparer name, and contact information
        iii. Allergies and intolerances with symptoms the patient experienced
        iv. Medications listed under the conditions for which they are used
        v. Medication generic name with trade name in parentheses, total dose taken, and direction for taking it, together with how supplied, if needed, in parentheses
        vi. Start dates, if known
        vii. Include herbals, over-the-counter medications, and vaccinations.
        viii. Prescribing providers, their specialty, and contact information
        ix. A list of medications that were discontinued and reason for discontinuance
3. Continuity of care. After a patient visit, it is your responsibility to communicate the important aspects of that visit to other providers or caregivers who need the patient information related to your visit. This communication should include the following:
    a. Updates or changes to the plan of care with the subsequent expectations and follow-up
    b. Any new, pertinent patient information discovered
    c. Adherence/persistence with medications
    d. Drug-related problems and plans to resolve them
    e. Education or advice provided

E. Internal Communication. Determine how to interact with team members caring for a mutual patient. Your physical proximity to the other team members is critical in setting up the communication process. There is no standard method for directly communicating within a patient's health care team. Each situation may dictate a preferred method, as may each provider.
1. Notify other providers of how you plan to communicate with them for routine and acute medical situations.
2. Determine a standard method for obtaining needed information from others.
    a. AHRQ. Improving Medication Safety in High-Risk Medicare Beneficiaries Toolkit (http://effectivehealthcare.ahrq.gov/index.cfm/search-for-guides-reviews-and-reports/?productid=1186&pageaction=displayproduct). Provides an easy-to-complete one-page form that can be sent to other providers to gather key patient information you may need to provide your services.
    b. As a standard function during their rotations, pharmacy rotation students could pull data from an EMR or other sources.
    c. EMR pharmacist documentation. Your EMR vendor can design a template in which key information you may need will auto-populate the template from data already in the EMR.
    d. Use a pharmacist-specific technology tool that fits your workload process and integrates with the EMR.
3. Determine which team members may deviate from the standard method and prefer a different means of communication (e.g., a fax vs. a page). Keep a record of the communication process for your primary team members or other key providers.

F. External Communication. All external communications are considered transitions of care. Establish standard methods to communicate patient information between providers, organizations, and settings outside your service and organization.
1. Information that should be communicated to the next setting should be the same as noted under continuity of care.
    a. Updates or changes to the plan of care with the subsequent expectations and follow-up

b. Any new, pertinent patient information discovered
c. Adherence to/persistence with medications
d. Drug-related problems
e. Education or advice provided

2. Hospital discharges. Quality standards have been established for transition from a hospital stay. Discharge from a hospital is a transition that is known to have risks for significant medication-related problems. You may wish to use this quality measure as a tool in your clinic or the guidance document by Kirwin, et al.
   a. Standards for discharge documentation based on National Quality Forum measure
      i. Transition record: Patient's diagnosis, treatment, and care plan provided to patient in printed or electronic format and transmitted to the facility/physician/other health care professional providing follow-up care
      ii. Current medication list: All medications to be taken by patient after discharge, including all continued and new medications
      iii. Clear instructions on which medications the patient should no longer take or use and instructions for disposal
      iv. Advanced directives for medical care at end of life or when they may be unable to do so. The transition should contain a statement of what the wishes are for the patient (e.g., do not resuscitate).
      v. Documented reason for not providing advanced care plan
      vi. Contact information/plan for follow-up care
      vii. Plan for follow-up care: Includes post-discharge therapy needed, any durable medical equipment needed, and family/psychosocial resources available for patient support
      viii. Primary physician or other health care professional designated for follow-up care
   b. Standard 24-hour/7-day contact
   c. In efforts to ensure coordination of care, you may find several individuals representing various health care groups or providers calling a patient post-hospitalization. To avoid overburdening the patient, be aware of others who plan to contact the patient and coordinate these efforts because too many organizations calling a patient can be as negative as no coordination.
   d. Medical office transition-of-care visit is a billable visit (addressed later in this chapter).
3. Long-term care
   a. Although there has been significant work to improve transitions from hospital to long-term care, there has been much less attention to the transition from long-term care to home. Currently this transition is very difficult because no standards exist.
   b. Often difficult to obtain information because there is no point person who can provide the information, or that person is not readily available
   c. Patients discharged with their medications in the blister packets used in the long-term care setting, may result in duplications of some of the patient's medications at home and is often confusing to patients
4. Specialists and other providers: Home nursing. Home-visiting nurses may be a very useful resource because they can assess how patients are functioning in their homes. These providers are required to perform an extensive home assessment, which includes a list of medications found in the home.
5. Others. In integrated models of care, such as ACOs and medical homes, community-based workers, such as listed in the following, are part of the health care team and may be very helpful in assisting the transitions process.
   a. Case workers
   b. Community health workers
   c. Rehabilitation centers

III. ESTABLISH A STANDARD PROCESS FOR DOCUMENTATION *(Domain 4, Task 1, Item 2)*

A. Goals of Documentation. Medical care documentation must meet many goals, as listed in the following. It is important to keep these in mind when developing your documentation templates and processes.
   1. Meet professional standards and legal requirements.
   2. Communicate effectively and efficiently with other health professionals.
   3. Establish accountability for medication-related aspects of direct patient care.
   4. Facilitate transitions and continuity of care.
   5. Create a record of critical thinking and judgment.
   6. Provide evidence of provider value and workload.
   7. Justify reimbursement for cognitive services.
   8. Provide data for tracking patient health outcomes.

B. Electronic Portals for Documentation
   1. American Recovery and Reinvestment Act of 2009, or the Health Information Technology Act, has changed the landscape for documentation, creating the meaningful-use initiatives. The act incentivized health care organizations to use electronic portals for documentation. With the passage of the Medicare Access and CHIP Reauthorization Act (MACRA) in 2015, the meaningful use initiatives are now part of MIPS in the Advancing Care Information category (discussed under the Quality section of this chapter).
      a. Health information exchanges – Congress allocated funding for each state to develop a process for electronic health information exchange. For more information, visit the government website www.healthit.gov/providers-professionals/health-information-exchange/getting-started-hie.
      b. Systematized Nomenclature of Medicine—Clinical Terms (SNOMED CT) codes will be the standard for health information exchange. MTM codes and other codes useful for pharmacists in ambulatory patient care are currently being identified or under development for SNOMED by the Pharmacy e-Health Information Technology Collaborative.
   2. Terminology for electronic portals for documentation
      a. Electronic health record (EHR): Individual patient medical record digitalized from many locations or sources, including patient access
      b. EMR: Portal that shares relevant patient information among health professionals
      c. Personal or patient medical record (PMR): A record of health information created for or by an individual patient
   3. Feasibility of using the EMR for pharmacists in the ambulatory setting
      a. Often structured primarily for the physician and may not meet the documentation needs of a pharmacist. For example, ability to pull the data from various fields in the EMR into a note template may not exist for the particular needs of a pharmacist (e.g., data from vendor prescription refill hubs).
      b. Potential access issues if working virtually or offsite
      c. The EMR (often built for physician work flow) may not accommodate the pharmacist work process and may affect the efficiency of pharmacy work flow. For example, medication lists located at the beginning of a template may not be updated when changes are made because they are not visible to trigger the need to update the medication list or they require an action to return to a different screen, causing a disruption in work flow.
      d. Pharmacist documentation often too long and cumbersome
   4. Solutions for documentation difficulties
      a. Collaborate with information technology (IT) department to determine the flexibility of the EMR to meet pharmacists' needs.
      b. Create a work flow process and templates for IT to incorporate into the EMR.

c. Interface pharmacist documentation software into the EMR.
   i. Expensive or not met with support from the organization because of integration and other IT concerns.
   ii. Pharmacist documentation software is early in development.

d. CMS Medicare evaluation and management (E/M) documentation requirements for billing Medicare Part B (addressed later in this chapter) when using E/M codes. Documentation must state that the service is medically reasonable and necessary and describe the work the provider performed. You will note that the requirements are physician focused; however, when pharmacists, as auxiliary personnel, are providing services that are billed "incident to" physicians, they must follow the E/M requirements. The elements listed in the following must be in your documentation if you are using E/M CPT codes (explained later in the chapter). CMS has provided an excellent resource for E/M documentation in the Medical Learning Network: www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/eval-mgmt-serv-guide-ICN006764.pdf.

Table 2. E/M Determinants of Complexity of Decision-Making

Type of Decision-Making	No. of Diagnoses or Management Options	Amount and/or Complexity of Data to Be Reviewed	Risk of Significant Complications, Morbidity, and/or Mortality
Straightforward	Minimal	Minimal or none	Minimal
Low complexity	Limited	Limited	Low
Moderate complexity	Multiple	Moderate	Moderate
High complexity	Extensive	Extensive	High

   i. Four levels of service are used in E/M rules that denote increasing complexity (and therefore reimbursement) should be evident in the documentation.
      (a) Medical problem focused
      (b) Expanded medical problem focused
      (c) Detailed
      (d) Comprehensive
   ii. History component – Information provided should substantiate medical decision-making.
      (a) Chief complaint (CC)
      (b) History of present illness (HPI)
      (c) Past, family, and social history (PFSH)
      (d) Review of systems (ROS)
   iii. Examination: Physical examination according to body area or organ system
   iv. Medical decision-making is evident by the assessment and plan of the documentation.
      (a) Assessment – Includes list of diagnoses or potential diagnosis
      (b) Must address the chief complaint
      (c) Plan – Must list orders
   v. Four levels of complexity or risk with medical decision-making. This factors into payment for the service.
      (a) Minimal
      (b) Low
      (c) Moderate
      (d) High

5. Documentation recommendations: The Patient-Centered Primary Care Collaborative (PCPCC) Guidelines for the Practice and Documentation of Comprehensive Medication Management in the Patient-Centered Medical Home. These recommendations have the input of experts from several disciplines, including physicians, regarding the desired content of a pharmacist's note.
    a. Assessment of the patient's medication-related needs
        i. All medications reviewed and documented
        ii. Patient medication experience is discussed and recorded.
        iii. Medication history, including allergies/reactions
        iv. Review and document current medications and doses; how they are actually being taken
        v. Each medication assessed for indication or condition.
        vi. Patient clinical status is assessed for each medication and condition for indication, appropriateness, and effectiveness.
        vii. Clinical goals of therapy for each medication
    b. Identifying the patient's medication-related problems by asking the following questions:
        i. Appropriateness of the medications
        ii. Appropriate for indication
        iii. Is there an indication not being treated or prevented?
        iv. Effectiveness of the medication
        v. Is it the most effective product?
        vi. Is the dose appropriate, and are the goals of therapy achievable?
        vii. Safety of the medication
        viii. Patient experiencing any adverse events?
        ix. Is the dose too high?
        x. Adherence: Is the patient able and willing to take medication?
    c. Recommended documentation framework for drug problems
        i. Indication
        ii. Effectiveness
        iii. Safety
        iv. Adherence
    d. Plan of care
        i. Intervention to solve problems
        ii. Goals of therapy
        iii. Education for self-management
        iv. Outcome variables to be monitored
        v. Follow-up time interval
6. Center for Pharmacy Practice Accreditation (CPPA) Community Pharmacy Practice Standards
    a. Standard 1.4.1: "Systems that allow documentation into a patient record of appropriate medical/health information: Medication list, immunizations, allergies, laboratory values, diagnoses, and other information required to deliver patient care services"
    b. Standard 2.1.1.5: "Appropriate documentation and communication of patient care to physicians and other health care providers"
    c. Standard 2.1.2: "Pharmacists deliver MTM services. … Whereby pharmacist documents the MTM visit in the patient's chart, including goals of therapy, care plan, interventions and referrals, communication with other providers, in a retrievable format that is accessible to all pharmacy staff."

7. American College of Clinical Pharmacy documentation standards of practice: "Clinical pharmacists document directly in the patient's medical record the medication-related assessment and plan of care to optimize patient outcomes. This documentation should be compliant with the accepted standards for documentation (and billing, where applicable) with the health system, health care facility, outpatient practice, or pharmacy in which one works."
    a. Use the format of a traditional SOAP (subjective, objective, assessment, plan) note or other standard framework.
        i. Medication history
            (a) Summary of medication-related health problems (i.e., symptoms, achieving goals of therapy)
            (b) Patients' current and past medication use
        ii. List of all current medications
            (a) Attitudes
            (b) Adherence
    b. Allergies and adverse drug event history
    c. Active problem list
        i. Current health conditions and status of each condition, emphasizing medications and medication-related problems
        ii. Any additional medication-related problems or other medication issues unrelated to current health conditions
    d. Plan of care
        i. Medication therapy plan (drug, dose, route, frequency, and relevant monitoring parameters)
        ii. Plans for implementation
    e. Plan for follow-up, evaluation, and future visits

Practice Case 2

In establishing your relationship with the physician group, you decide to use current pharmacy medical office communication processes because that was determined to be least disruptive to pharmacy operations. The MTM referrals were sent through a computerized physician order entry process to the pharmacies for the MTM services. The pharmacist completing the MTM services would then send a fax back to the physician office with recommendations. Access to the physician group's EMR was not provided in the original agreement because of HIPAA (Health Insurance Portability and Accountability Act) and security concerns expressed by the manager of the physician group's IT department. The agreed-on decision was to use the patient information tool from the AHRQ MTM toolbox. The MTM pharmacist would contact the office and ask the medical assistant to fill out that tool and submit it to the pharmacy after a referral had been established. Process analysis identified the following concerns. The AHRQ patient information tool was not being completed in a timely manner for the visit because of medical assistant workload. The pharmacists providing MTM noted that it was difficult to contact physicians because each preferred his or her own method of communication (e.g., page, faxed note, telephone call). In addition, it was difficult to keep track of the desired communication strategy because of the many providers. The physicians stated that the SOAP notes from the pharmacists were too long and that it was difficult to quickly identify the pharmacists' recommendations. Moreover, different pharmacists used different note styles. You meet with the medical director to discuss the communication barriers. Together, you develop a proposal to administration that discusses the pros and cons of EMR access by pharmacy. Using the *plan, do, study, act* [cycle] (PDSA) quality improvement process, members of the pharmacy team develop a standard template for MTM using the PCPCC documentation recommendations. A 6-month review will be conducted to look at the timeliness of reacting to recommendations to determine the effectiveness of this process.

Documentation and communication remain real challenges in patient care practice for pharmacists and other providers. Since the passage of the American Recovery and Reinvestment Act in 2009, which contained the Title XIII Health Information Technology for Economic and Clinical Health Act, much work has occurred to use technology to improve documentation and communication at the federal and state levels. The Pharmacy Health Information Technology Collaborative is actively involved in pharmacy's participation in this work, and it is important for pharmacy practitioners to stay up to date with the work and documents created from this collaborative as well as the health information exchange processes that are federally supported and occurring in each state.

IV. MEASURING THE QUALITY OF YOUR PROGRAM *(Domain 4, Task 5; Domain 5, Task 1)*

A. Importance of Measuring the Quality of Your Services, Your Organization, and Health Care in the United States. The movement in health care to focus on quality of care through organizational systems and payment began with disturbing data regarding the U.S. health system's lack of safety.
   1. The Institute of Medicine (IOM) 1999 report "To Err Is Human" brought attention to the harm being done to patients in the health system.
      a. 100,000 patients die each year because of error.
      b. Medications are a major source of error.
   2. Quality gap in health care
      a. Quality gap is the difference between top-performing organizations and average-performing organizations.
      b. In health care, the quality gap is around 20% (NCQA 2004).
      c. For other "potentially dangerous" industries, such as airline travel, the quality gap is 1%.

3. The quality ranking of the United States is around 30th in industrialized countries, yet the United States spends the most on health care (World Health Organization 2000; Woolf 2013; JAMA 2013;310:591-608).
4. In particular, a recent large study that evaluated quality of care delivered to adults in 2002-2013 evaluated data from the Medical Expenditure Panel Survey and found that, in the outpatient setting, improvement in quality was mixed with some measures of quality improving, some staying the same, and some worsening (JAMA Intern Med 2016;176:1778-90).
5. Slight improvement to no improvement, despite 16 years of focus on quality in the United States. U.S. quality rankings have remained the same.
6. High cost of health care is driving demand for the best value/cost ratio, placing emphasis on quality measures, including the value component of the ratio.

B. Response by Payers in the Health Care System
   1. U.S. government and initiation of the Triple Aim – A framework for health care improvement. The components are as follows:
      a. Better care for individuals
      b. Better health for populations
      c. Reducing per capita costs
   2. Models of care that emphasize quality versus volume as drivers of payment
      a. ACOs
         i. Voluntary groups of physicians, hospitals, long-term care providers, and other health care providers
         ii. Assume responsibility for the care of a clearly defined population of beneficiaries assigned to them by a payer(s) (e.g., Medicare), based on patients' use of primary care services
         iii. Shared savings. If the triple aim is met at better care and health with reduced costs, the savings are shared between the ACO and the payer.
         iv. Quality and quality measure reports on populations are a major part of the ACO goals.
      b. PCMH – A model of primary care with the following principles:
         i. Comprehensive team-based care. Team members vary; however, they include a physician, a nurse or nurse practitioner, and a patient coach as core members. Others include pharmacists, dietitians, social workers, and physical and occupational therapists. Members have varied widely and have included almost any health provider.
         ii. Patient-centered or whole-person orientation
         iii. Care that is coordinated
         iv. Superb access to care. Ensuring that patients receive their desired care whenever they need it
         v. Systems-based approach to quality and safety
         vi. Payment reflective of care given

C. Alternative Payment Models. Several emerging models and terms are being used to describe the payment models that are associated with reimbursement based on the quality of services provided and the resultant patient outcomes.
   1. Value-Based Purchasing Payment Models: Payment models and contracts for services that reward quality of the services provided as opposed to the number of patients served (fee-for-service model)
      a. Pay for performance is payment for health care services aligned with quality measures and performance of the providers, usually through incentives or disincentives.
      b. Global or capitation payment with quality benchmarks: A set per-patient fee paid to the provider that encompasses the total cost of care for patients' services during a set time interval. May be payment per patient per month or per year.

c. Episodes of care or bundled payment: Payment arrangements that include financial and performance accountability for episodes of care (e.g., a set fee for a hip replacement)
d. Risk sharing
    i. Full risk is when the organization and providers are at full financial risk for negative events that increase costs, such as hospitalizations.
    ii. Partial risk or risk sharing is when the organization and the payer share the financial risk for negative events that increase cost. The shared percentage is usually pre-negotiated.
    iii. Prometheus payment is usually a capitated payment model that is continuously restructured during a set period and is based on how the organization compares with the average quality measure in its community or region.

2. Health Care Payment Learning & Action Network (HCPLAN). In January 2015, CMS announced plans for 90% of Medicare payment to be tied to quality or value through alternative payment models by 2018. This was followed by a similar announcement from the commercial sector. In March of 2016, MACRA was passed with dramatic changes in payment for strategy discussed under the reimbursement section later in this chapter. As part of the act, the HCPLAN was established. It is a collaborative network of public and private stakeholders, including health plans, providers, patients, employers, consumers, states, and federal agencies within the health care community. These stakeholders will accelerate the adoption of value-based payment by working together through the Learning & Action Network (LAN) to align efforts, capture best practices, disseminate information, and apply lessons learned. A Guiding Committee, multi-stakeholder work groups, and single-sector affinity groups will play critical roles in this work. The LAN, through its work groups, has produced several guidance documents. In the Alternative Payment Model Framework white paper, it presents the following payment model framework: (https://hcp-lan.org/groups/apm-refresh-white-paper/) (See Figure 1).

D. Defining Quality
1. There is no universally accepted definition for what defines health care quality. Differences in perspective can drive what any one individual or entity may consider as quality, resulting in layers of complexity in attempts to define the term. The various perspectives may not be well aligned, further contributing to the problem.
    a. Patients – May primarily care how they are treated or if they feel better
    b. Provider – May care about surrogate measures such as blood pressure or improvement in disease
    c. Administrator – May care that services are efficient and not costly
    d. Payer – May care that hospitalizations are reduced as well as other overall health care costs
2. The IOM defines *quality* as the degree to which health services for individuals or populations increase the likelihood of desired health outcomes that are consistent with current professional knowledge (IOM 1990). Although not considered a universal definition, it encompasses what many would consider as quality.
3. World Health Organization definition of quality
    a. Safe: Delivering health care that minimizes risks and harm to service users, including avoiding preventable injuries and reducing medical errors
    b. Effective: Providing services based on scientific knowledge and evidence-based guidelines
    c. Timely: Reducing delays in providing and receiving health care
    d. Efficient: Delivering health care in a manner that maximizes resource use and avoids waste
    e. Equitable: Delivering health care that does not differ in quality on the basis of personal characteristics (e.g., sex, race, ethnicity, socioeconomic status)
    f. People-centered: Providing care that considers the preferences, aspirations, and culture of individuals and their community

Figure 1. Alternative Payment Model Framework.

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E. Donabedian Domains to Determine and Measure Quality in Health Care. Dr. Avedis Donabedian proposed these domains for health care quality measurement more than 25 years ago, and they still are the foundation of quality improvement today.
   1. Structure – How resources and systems affect patient care
   2. Process – How provider-patient interactions and the care and services provided affect the patient
   3. Outcome – What happens to patients: Further categorized by the (ECHO) model
      a. Economic outcomes
      b. Clinical outcomes
      c. Humanistic outcomes

F. Methods Used by Organizations to Evaluate Quality
   1. Lean process:
      a. Developed within the Japan auto industry and subsequently popularized by a Massachusetts Institute of Technology study. Often called the Toyota method
      b. Has five key principles
         i. Achieving value outcomes with the least amount of work possible
            (a) Define value.
            (b) Evaluate work flow for inefficiencies.
         ii. Eliminate waste or remove any activity that does not add value, such as:
            (a) Overproduction or duplication of action
            (b) Waiting for information or other needs
            (c) Poor material movement or not having items when and where needed
            (d) Excessive motion or time wasted in inefficient movement
            (e) Inappropriate processing
            (f) Inventory or not having the items needed to provide services
            (g) Correction or having to fix errors
            (h) Underuse or when something should have occurred but did not
         iii. Jidoka or ”just in time”
            (a) Automatically detect and stop the process when a problem occurs
            (b) Identify defects as close to the source of the problem as possible, and halt the process until fixed
            (c) Ability to respond to day-to-day shifts in demand
         iv. Identify value streams
            (a) Identify the steps most critical and valuable to the service
            (b) Understanding the complex adaptive system (many interacting points that vary with circumstances)
         v. The Lean approach or every worker needs to be a problem solver
   2. Six Sigma – By focusing on variations in process, error may be reduced..
      a. A method focused on reducing variation and defects within processes to consistently create a desired outcome
      b. Six Sigma is a statistical term of measurement that denotes 0.6 deviations from the mean or 3.4 defects per 1 million opportunities. Six Sigma represents an almost error-free process.
      c. The steps in the Six Sigma process are as follows:
         i. Identify and define what has to be improved.
         ii. Measure what is currently occurring by collecting data; analyze the results.
         iii. Use creative solutions to improve, and then control, the process with policies, guidelines, and strategies.

3. Plan, do, study, act (PDSA) cycle – Quick and manageable process for small groups
    a. This method uses three key questions:
        i. What are we trying to accomplish?
        ii. What change can we make that will result in improvement?
        iii. How will we know that a change is an improvement?
    b. Planning stage
        i. Aims are established according to the outcome desired.
        ii. Strategies for change are developed.
        iii. Measures are chosen that will determine whether you achieved your aim.
    c. Do phase: Implement the change.
    d. Study phase: The change is tested using the defined measures.
    e. Act phase: Results are used from the study phase to reenter the cycle for further improvement.

G. Creating Your Program. Consider using a business concept called *balanced scorecard* that states you should not focus on only one area of your service (e.g., just patient outcomes). Doing so may result in gains in one area but failures in the other areas; this in turn may sabotage the overall quality of your program. For example, if you just focus on blood pressure as an outcome but do not make sure that the staff performing blood pressure measurements are doing so correctly or that blood pressure measurement is easily captured in your process, you may not achieve the outcome goal you desire. There are four areas you need to measure to ensure quality.
    1. Structure examples include the following:
        a. Staff is adequately trained.
        b. Communication systems work and are efficient.
        c. Workload is manageable.
        d. Employee satisfaction and retention
    2. Process examples include the following:
        a. Error rates
        b. Timeliness of services
        c. Documentation meeting standards
        d. Task performance quality measures
    3. Patient outcomes. Examples include the following:
        a. Clinical markers
        b. Patient satisfaction (as well as other customers)
        c. Care experiences
    4. Financial outcomes. Examples include the following:
        a. Clinic growth and referrals
        b. Cost avoidance
        c. Reimbursement and revenue capture
        d. Cost/value ratio

H. Although in today's environment quality measures are often dictated by payers, try to influence measure choices whenever possible by considering the following characteristics:
    1. Meaningfulness
        a. The measure must be meaningful to you and your patients.
        b. Measure an area known to need improvement.
    2. Feasibility
        a. Can you collect the data needed?
        b. How disruptive will collecting data be to your work flow?

c. Do you have the resources to collect the data?
d. Will the collection and analysis be timely for action?

3. Actionable
   a. You must be able to use the results you obtain.
   b. Can you make the necessary changes on the basis of results?

I. Sources for Measures. More than 8000 health care quality measures are currently available, and health care organizations in the business of measure development continue to create more measures to fill gaps where quality measurement is needed. Many of these measures have been tested and evaluated with some rigor to ensure a level of validity and quality. Your service may be affected by many of the measures adopted by payers and accreditation organizations. It is important to understand measure developers, validators, promoters, and users so that you can understand the measures you and your organization are asked to report on, or the measures you are able to choose that are most meaningful for your practice and organization. The following are a list of the main organizations working on the national stage. Additional organizations not listed may be important to your particular organization, and you may need to be aware of that work in the private, state, or local level for your community.

1. Government-related organizations
   a. AHRQ
      i. Sets national strategy for quality improvement in health care. See Table 3 for current national quality priority measures important for ambulatory care pharmacists.
      ii. Developed a collection of evidence reports since 2002 titled "Closing the Quality Gap Series"
   b. National Quality Measures Clearinghouse (NQMC)
      i. A public resource for evidence-based quality measures housed by AHRQ
      ii. Eight thousand measures currently reside in the database.
      iii. Measures are categorized, providing information for the user necessary to evaluate measures for validity, importance, scientific soundness, and feasibility.
      iv. Search functions are user friendly.
   c. Centers for Disease Control and Prevention
      i. Healthy People 2020
      ii. National Health Interview survey
   d. Universal Data Set (UDS)
      i. Established by Health Resources and Services Administration (HRSA) program for Health Center Program grantees
         (a) Federally Qualified Health Centers (FQHCs)
         (b) Migrant Health Centers
         (c) Health Care for the Homeless
         (d) Public Housing Primary Care Program
      ii. Twelve tables to report clinical, operational, and financial data including quality of care and health outcome measures
   e. Institute of Medicine (IOM)
      i. An independent, nonprofit organization established under the National Academy of Sciences
      ii. Role is to work outside government to provide unbiased and authoritative advice to decision-makers and the public.
      iii. Almost 200 reports on health care quality and patient safety are available.
   f. Pharmacy Quality Alliance (PQA)
      i. One of four quality alliances (i.e., Hospital Quality Alliance [which is responsible for the Hospital Compare System], Ambulatory Quality Alliance, and Long-Term Care Quality Alliance)

ii. Established as public-private partnerships to assist CMS and health care in general in ensuring the provision of quality services to Medicare beneficiaries and all patients
iii. Work groups consisting of multidisciplinary representatives from member organizations develop measure concepts that are then tested, voted on, and moved forward for public use.

Table 3. 2013 National Strategy Priority Measures Important to Ambulatory Care Pharmacists

Measure Focus	Measure Name/Description	Baseline Rate	Most Recent Rate	Aspirational Target
Hospital readmissions	All-payer 30-day readmission rate	14.4%, based on 32.9 million admissions	14.4%, based on 32.7 million admissions in 2011	Reduce all readmissions by 20% by the end of 2014
Decision-making	People with a usual source of care whose health care providers sometimes or never discuss decisions with them	15.9%	Update available in fall 2013	Reduce to < 10% by 2017
Aspirin use	Outpatient visits in which adults with cardiovascular disease are prescribed/ maintained on aspirin	47%	53%	Increase to 65% by 2017
BP control	Adults with hypertension who have adequately controlled BP	46%	53%	Increase to 65% by 2017
Cholesterol management	Adults with high cholesterol under adequate control	33%	32%	Increase to 65% by 2017
Smoking cessation	Outpatient visits in which current tobacco users receive tobacco cessation counseling or cessation medications	23%	22%	Increase to 65% by 2017
Depression	Percentage of adults reporting symptoms of a major depressive episode in the past 12 mo who receive treatment for depression in the past 12 mo	68.2%	68.1% for 2011	Increase to 78.2% by 2020
Obesity	Proportion of adults with obesity	35.7%	Update available in 2014	Reduce to 30.5% by 2020

BP = blood pressure.

Adapted from: Agency for Healthcare Research and Quality (AHRQ). 2012 National Healthcare Quality Report. AHRQ Publication No. 13-0002. Rockville, MD: U.S. Department of Health and Human Services, May 2013. Available at www.ahrq.gov/workingforquality/nqs/nqs2012annlrptapa.htm. Accessed February 14, 2014.

g. Quality improvement organizations
   i. Independent organizations contracted with CMS to improve the effectiveness, efficiency, economy, and quality of services delivered to Medicare beneficiaries
   ii. Located in every state
   iii. Work to monitor, educate, and assist providers and patients in the delivery and receipt of quality services
   iv. Have scope-of-work contracts with CMS to focus on certain outcomes. Current 11th scope of work has the following focus:
      (a) Improving cardiac health and reducing cardiac disparities
      (b) Reducing disparities in diabetes care

(c) Coordinating care through immunization information systems
(d) Coordinating prevention through health information technology meaningful use
(e) Reducing care-associated infections
(f) Reducing care-acquired conditions
(g) Coordinating care to reduce readmits and adverse drug events

h. Alliance for Integrated Medication Management Collaborative (formerly Patient Safety and Clinical Pharmacy Services Collaborative [PSPC])
   i. Initiated by the Health Resources and Services Administration (HRSA) in 2007 to address adverse medication events for uninsured, isolated, or medically vulnerable patients serviced by "safety net" providers such as FQHCs
   ii. Uses the PDSA process to integrate clinical pharmacy services in patient care settings to improve patient safety and health outcomes
   iii. Membership has expanded to include any multidisciplinary, community-based group with high-risk patients that has integrated or that can integrate clinical pharmacist services.
   iv. In 2014, became an independent nonprofit organization
   v. Focus of quality measurement has been on diabetes, hypertension, hyperlipidemia, and adverse drug events.

i. National Quality Forum (NQF) created in in 1999 by a Presidential Commission to review health care quality and consumer protection
   i. Measure endorsement is primary role. Criteria for approval are as follows:
      (a) Be in the public domain.
      (b) Be fully tested for reliability and validity.
      (c) Have importance, scientific merit, feasibility, and usability compared with competing similar measures.
   ii. Endorsed measures are easily found within the NQMC database.

2. Accreditation organizations
   a. NCQA
      i. Founded in 1979 by the managed care industry to review preferred provider organization (PPO) plans and health maintenance organizations (HMOs)
      ii. "Reestablished" itself in 1990 as a private, independent, nonprofit health care quality oversight organization
      iii. Developed the Healthcare Effectiveness Data and Information Set (HEDIS) measures for employers to evaluate the health plans they use for employee benefits
         (a) Providers who contract with these health plans are responsible for meeting the applicable measures.
         (b) Each year, a significant portion of the HEDIS measures revolve around medication use and the patient care work of pharmacists in the ambulatory care setting. The 2016 HEDIS measures are available at www.ncqa.org/Portals/0/HEDISQM/HEDIS2016/HEDIS%202016%20List%20of%20Measures.pdf.
      iv. Provides accreditation, certification, and recognition programs
         (a) ACO accreditation
         (b) PCMH recognition
         (c) Diabetes management recognition program
   b. CPPA
      i. Established in 2012 through the efforts of the American Pharmacists Association, the National Association of Boards of Pharmacy, and the American Society of Health-System Pharmacists
      ii. Initial accreditation program offered by CPPA is for community pharmacy practice.
      iii. Plans to cover the complete ambulatory practice arena

c. Utilization Review Accreditation Commission (URAC)
    i. Grew out of the utilization review industry
    ii. Provides a wide variety of accreditation programs
        (a) ACO accreditation
        (b) PCMH achievement
        (c) Drug therapy management accreditation
        (d) Mail service pharmacy accreditation
        (e) Pharmacy benefit management accreditation
        (f) Specialty pharmacy accreditation
        (g) Community pharmacy accreditation
d. Joint Commission: Offers accreditation for medical practices and a certification for primary care medical homes

3. Professional organizations and collaboratives
    a. Institute for Healthcare Improvement (IHI)
    b. Patient-Centered Primary Care Collaborative (PCPCC)
    c. Physician Consortium for Performance Improvement (PCPI)
4. Payers: Payers currently are the main drivers of determining quality measurement for most organizations. Payers are either within a government or commercial sector. The commercial sector commonly use NCQA HEDIS measures because they directly relate to the payers accreditation. They, however, may also use measures from other sources and select specific set of measures in contractual agreements with your organization. Government payers may include state, federal, or the health care exchanges. State provider payment program requirements for quality measures vary for each state, and if you are providing services to patients insured under state programs you will need to investigate the quality measure within the particular state insurance programs. Center for Medicare and Medicaid Services quality programs are used by the Medicare system. In 2016, CMS reported on their Quality Strategy, setting goals, objectives, and expected outcomes based on the national strategy for quality improvement in health care (Table 4). The current CMS quality programs are listed later in this chapter.

Table 4. CMS Quality Strategy Goals

• Make care safer by reducing harm caused in the delivery of care
• Strengthen person and family engagement as partners in their care
• Promote effective communication and coordination of care
• Promote effective prevention and treatment of chronic disease
• Work with communities to promote best practices of healthy living
• Make care affordable

www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/qualityinitiativesgeninfo/downloads/cms-quality-strategy.pdf

5. Federal government:
    a. Physician Quality Reporting System (PQRS) and Meaningful Use measures from the Medicare system are no longer in use as of 2017. They are still mentioned as the reporting of measures in both of these programs from 2016 and will influence the Medicare payment rate to providers in 2018. Both programs were merged into the MACRA Quality Payment Program (QPP).

b. Quality measurement and MACRA. Quality measurement and payment based on reported quality measures is the cornerstone of the MACRA law and the changes in reimbursement for Medicare Part B. The law went into effect January 2017. Eligible clinicians or groups have two avenues of participation: the Advanced Alternative Payment Models (Advanced APMs) and the Merit-Based Incentive Payment System (MIPS). Medicare Part B providers required to participate in 2017 are physicians, physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists. Guidance for the two tracks included in the program, the MIPS and the Advanced Alternative Payment Models (APMS), may be found at the QPP website (https://qpp.cms.gov/).
   i. QPP aims
      (a) Support care improvement by focusing on patient outcomes, reducing provider burden, and preserving the independent clinical practice
      (b) Promote adoption of APMs that align incentives across health care stakeholders
      (c) Advance existing efforts of delivery system reform, including ensuring a smooth transition to a new system that promotes high-quality and efficient care
   ii. MIPS is a payment adjustment to all Medicare claims based on the performance data and performance information submitted by eligible providers.
      (a) Providers will be evaluated and scored on four measurement categories, three of which will be scored for 2017. Requirements for each category are listed in Table 5.
         (1) Quality comprises 60% of the score.
         (2) Improvement activities comprise 15% of the score.
         (3) Cost has no requirement for 2017 but will begin in 2018.
         (4) Advancing Care Information comprises 25% of the score.
      (b) Measurements that eligible providers submit in 2017 will affect the payments they receive from Medicare in 2019. Providers' overall Medicare reimbursement will be adjusted on the basis of what is reported from 2017 within a range of negative 4% to positive 4%.
         (1) No participation results in the negative 4% adjustment.
         (2) Submitting a minimum amount of data such as one quality measure will result no positive or negative adjustment.
         (3) Submitting 90 days of data may earn a neutral or small positive payment adjustment.
         (4) Submitting a full year of data may earn a positive payment adjustment.
      (c) The payment adjustment will widen each year from ±4% in 2019 to ±5% in 2020, to ±7% in 2021 to ±9% in 2022.
      (d) For 2018 and 2019, cost will be calculated at 10% and 30%, respectively, and the Quality portion of the score will decrease to 50% and 30% the respective years.
      (e) Providers may review and select the quality measures that fit their practice. The goal of QMP is for practices to choose quality measures that are meaningful to them and the patients they serve.
         (1) Providers have 271 measures to choose from, which may be found at https://qpp.cms.gov/measures/quality.
         (2) Pharmacist services may affect 25%–30% of the measures that are available to providers
      (f) To meet the practice improvement measures, there are 92 options. One option of the 92 is implementing a medication management practice improvement program defined as "medication management to maximize efficiency, effectiveness and safety that could include one or more of the following: Reconcile and coordinate medications and provide medication management across transitions of care settings and eligible clinicians or groups; Integrate a pharmacist into the care team; and/or conduct periodic, structured medication reviews."

(g) Certain groups are not subject to MIPS: providers in their first year of Medicare Part B participation and providers who bill $30,000 or less and provide care to 100 or fewer Medicare patients in 1 year.

Table 5. Requirements for MIPS Measurement Categories

Category	Requirements
Quality	**Most participants:** Report up to six quality measures, including an outcome measure, for at least 90 days **Groups using the web interface:** Report 15 quality measures for a full year **Groups in APMs qualifying for special scoring under MIPS (Shared Savings Program Track 1 or the Oncology Care Model):** Report quality measures through your APM. You do not need to do anything additional for MIPS quality
Improvement activities	**Most participants:** Attest that you completed up to four improvement activities for at least 90 days **Groups with £ 15 participants or in a rural or health professional shortage area:** Attest that you completed up to two activities for at least 90 days **Participants in certified patient-centered medical homes, comparable specialty practices, or an APM designated as a Medical Home Model:** You will automatically earn full credit **Participants in certain APMs under the APM scoring standard, such as Shared Savings Program Track 1 or the Oncology Care Model:** You will automatically receive points according to the requirements of participating in the APM. For all current APMs under the APM scoring standard, this assigned score will be full credit. For all future APMs under the APM scoring standard, the assigned score will be at least half credit
Advancing care information	Fulfill the required measures for at least 90 days: Security Risk Analysis e-Prescribing Provide Patient Access Send Summary of Care Request/Accept Summary of Care Choose to submit up to nine measures for at least 90 days for additional credit. For bonus credit, you can: Report Public Health and Clinical Data Registry Reporting measures Use certified EHR technology to complete certain improvement activities in the improvement activities performance category
Cost	No data submission required. Calculated from claims

EHR = electronic health record.

iii. APMs are an incentive payment for eligible clinicians who are currently in an approved CMS APM.
   (a) Advanced AMPs for 2017
      (1) Comprehensive End-Stage Renal Disease Care – Two-sided risk
      (2) Comprehensive Primary Care Plus (CPC+)
      (3) Next Generation ACO Model
      (4) Shared Savings Program Track 2
      (5) Shared Savings Program Track 3

(6) Oncology Care Model (OCM) – Two-sided risk
(7) Comprehensive Care for Joint Replacement (CJR) Payment Model (Track 1-CEHRT)

(b) Eligible clinicians for this track must receive 25% of their Medicare Part B payments through an advanced APM, and 20% of the Medicare patients seen must be part of an APM.
(c) This group of eligible clinicians will automatically receive a 5% lump sum bonus over Medicare fee-for-service billing starting in 2019.
(d) Other requirements for this group include: use of a certified EHR, have existing base payments on quality measures similar to those in MIPS, and bear a certain amount of financial risk in existing payment models.
(e) CMS has stated a goal of moving eligible providers over time from MIPS into APMs.

c. Five-star quality rating programs. The CMS 2018 star measures are available at https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/Downloads/2018MeasureList.pdf.
   i. A mandatory program for Medicare Part C and Part D plans
   ii. In 2018, there will be 46 measures to evaluate the performance and quality of services of the participating plans. The purpose of star ratings is to assist beneficiaries in choosing the best plans and to determine payment and participation in Medicare by plans.
   iii. Three medication measures developed by PQA on medication adherence continue in 2018 star measures weighted as a 3, or the highest level for scoring.
   iv. One process measure, Medication Therapy Management Program Completion Rate for Comprehensive Medication Reviews for Medicare Part D plans, is continued in 2018 with a weight of 1 (not an elevated weight because it is a process measure, not an outcome measure).

d. CMS Hospital Readmissions Reduction Program: An important hospital-based quality program for ambulatory pharmacists to be aware of is the Hospital readmissions Reduction Program, which is part of the Hospital Value-Based Purchasing Program started in 2012. The Hospital Readmissions Reduction Program provides an opportunity for ambulatory pharmacists' patients care services to help hospitals realize financial gains and avoid the financial penalty.
   i. The program provides financial incentives to reduce costly and unnecessary hospital readmissions.
   ii. A hospital readmission is when a patient has an unplanned admission to any hospital within 30 days for the same specified diagnosis.
   iii. Hospital payment for the diagnosis-related group is adjusted according to a calculated risk adjustment excess readmission ratio for each applicable condition.
   iv. Current diagnosis-related groups affected by this quality program are:
      (a) Acute myocardial infarction
      (b) Heart failure
      (c) Pneumonia
      (d) Hip and knee surgery
      (e) Chronic obstructive pulmonary disease
      (f) Coronary artery bypass grafting surgery

e. The CMS APMs all use a set of quality measures within their programs. Although these measures cross over, it is best to review each program-designated set of measures. Following is an example outline of one of the largest CMS APM programs, the Medicare Shared Savings ACO.
   i. Report on 31 performance measures.
      (a) Four domains (Table 6)
      (b) Sixteen of the 31 measures may be positively impacted by pharmacists' patient care services.
   ii. Measures may be changed and updated yearly.

Table 6. Domains for ACO Measures with Measures Pharmacists May Affect

Domain	No. of Individual Measures	Measures Pharmacist Patient Care Services May Affect
Patient/caregiver experience	8	Health promotion and education
Care coordination/ patient safety	10	All-cause unplanned admissions for patients with diabetes All-cause unplanned admissions for patients with heart failure All-cause unplanned admissions for patients with several chronic conditions Medication reconciliation post-discharge Falls: Screening for future fall risk
Preventive health	8	Preventive care and screening: Influenza immunization Pneumonia vaccination status for older adults Preventive care and screening: Body mass index screening and follow-up Preventive care and screening: Tobacco use: screening and cessation intervention Preventive care and screening: Screening for clinical depression and follow-up plan Statin therapy for preventing and treating cardiovascular disease
At-risk population	5	Depression remission at 12 months Diabetes: Hemoglobin A1C poor control Controlling high blood pressure Ischemic vascular disease: Use of aspirin or another antithrombotic
Total in all domains	31	16 measures

Information from: Centers for Medicare & Medicaid Services (CMS). Accountable Care Organization 2017 Quality Measure Narrative Specifications. Available at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/2017-reporting-year-narrative-specifications.pdf. Accessed June 12, 2017.

J. Challenges to Using Quality Measures
   1. Attribution. The ability of the quality measure to describe the quality of a particular provider, team, organization, etc.
   2. Statistical accuracy and sampling. Most measures have not gone through the scientific rigors of research-based evaluations to ensure the results are statistically accurate or what minimal sample is needed for accuracy.
   3. Accounting for exceptions. Because not all patients are alike, there will be situations where the most appropriate care is contrary to the measure. A determination has to be made of what percentage is considered an acceptable exception rate and how providers and organizations are protected when they deviate from a selected measure when it is the correct patient decision.
   4. Risk adjustment. It is well known that for certain populations, the goals of any particular measure may be more difficult to achieve. Many items may be used to determine risk adjustment such as poverty level, number and type of diagnoses, age, and social-related risks. How is that accounted for in the measures chosen for your organization? Many measures do not have risk adjustment specifications, creating a situation where organizations may refuse to accept those patients who may place them at financial risk
   5. Appropriate benchmarks. Current measures are often targeted to one topic that may not reflect the health of the patient. Are we measuring what matters to patients? Is that what we should be measuring?

6. Potential for gaming. *Gaming* refers to documentation that an outcome is achieved, but in reality, the intent of the outcome did not occur at the patient level. This potential should be a consideration when choosing measures, and it is more problematic with process measures. For example, a check box can indicate that counseling was provided to exercise 30 minutes 5 days a week and lead to a value-based payment. If the patient did not or could not act on the counseling, should that provider be rewarded with payment?
7. Gaps in measures. Despite the many measures in the marketplace, significant gaps remain in needed measures. Examples of gaps are measures that assess cost, affordability, and patient engagement.
8. Measurement burden. Because the focus of quality has become a priority for many payers and organizations, providers and organizations alike are feeling the burden of the measurement requirements. It is not uncommon for organizations or providers to collect data and report on well over 100 measures. Many times, the measures are overlapping and redundant yet not similar enough to merge, or they are narrow in focus. This results in both time and financial burdens and potentially little quality improvement.

K. The Call to Measure What Matters to Patients. IOM Vital Signs: Core Metrics for Health and Health Care Progress (http://iom.nationalacademies.org/Reports/2015/Vital-Signs-Core-Metrics.aspx). The IOM in this recent report recommends the development of core measures. For health care in the United States to improve, there has to be a set of measures that the entire enterprise can use, that are meaningful to all patients, and that can be affected by health care providers. The IOM has challenged each stakeholder in health care, from the Department of Health and Human Services to each individual practitioner, to determine which of the following core measures and priorities they can affect. The IOM has also recommended that leaders in health care adopt these measures.
   1. Keys to development of core measures
      a. Are your patients getting better?
      b. Are your patients' opinions, concerns, health care desires respected?
      c. Are you causing harm to your patients?
      d. Do your patients consider the care you provide accessible, available, and affordable?
   2. Proposed core measures and priorities. Although the priority measures listed may not be optimal, they were determined to be the best available at this time.
      a. Healthy people
         i. Life expectancy
         ii. Well-being
         iii. Overweight and obesity
         iv. Addictive behavior
         v. Unintended pregnancy
         vi. Healthy communities
      b. Care quality
         i. Prevention: Immunizations and disease screening
         ii. Access to care
         iii. Safe care: Includes medication reconciliation
         iv. Appropriate treatment: Reduction in chronic disease, improved control of chronic disease, and preventable hospitalizations
         v. Person-centered care
      c. Care
         i. Affordability
         ii. Sustainability
      d. Engaged people
         i. Individual engagement
         ii. Community engagement

L. CMS Quality Strategy 2016. The CMS quality strategy report released in 2016 guides the quality strategy that will be used in quality measurement rules and regulations for Medicare benefits. The strategy will be guided by the following goals and objectives.
   1. Make care safer by reducing harm caused in the delivery of care
      a. Improve support for a culture of safety
      b. Reduce inappropriate and unnecessary care
      c. Prevent or minimize harm in all settings (includes medication errors)
   2. Strengthen individuals and their families as partners in their care
      a. Ensure all care delivery incorporates person and family preferences
      b. Improve experience of care for individuals and families
      c. Promote self-management
   3. Promote effective communication and coordination of care
      a. Reduce admissions and readmissions
      b. Embed best practices to enable successful transitions between all settings of care
      c. Enable effective health care system navigation
   4. Promote effective prevention and treatment of chronic disease
      a. Increase appropriate use of screening and prevention services
      b. Strengthen interventions to prevent heart attacks and strokes
      c. Improve quality of care for people with several chronic conditions
      d. Improve behavioral health access and quality care
      e. Improve perinatal outcomes
   5. Work with communities to promote best practices of healthy living
      a. Partner with and support federal, state, and local public health improvement efforts
      b. Improve access within communities to best practices of healthy living
      c. Promote evidence-based community interventions to prevent and treat chronic disease
      d. Increase use of home and community-based services
   6. Make care affordable
      a. Develop and implement payment systems that reward value over volume
      b. Use cost-analysis data to inform payment policies

M. Core Measure Set. There has been great interest in developing a core measure set that would transcend all health care practice sites. This was the initial plan by CMS for MACRA. However, because of feedback from providers, the MIPS program altered the core measure set plan to allow providers to select quality measures that best fit their particular practice from the approved measure list. This allows specialties such ophthalmology or rheumatology to select more appropriate measures for their populations. CMS did identify 168 measures in the QPP that are considered high priority. Included as high priority are measures such as controlling blood pressure and five measures around medication use. However, CMS was required by the Patient Protection and Affordable Care Act (PPACA or ACA) of 2010, known as Obamacare, to establish a core measure set for Medicaid. The 2017 set may be found at www.medicaid.gov/medicaid/quality-of-care/downloads/2017-adult-core-set.pdf. The Medicaid set has 20 measures out of the core set that may be affected by ambulatory pharmacist patient care services. How best to use a high priority or Core Measure Set is to understand how specific measures may be applicable to your particular group of patients or service may roll up into larger, more global measures. In Figure 2, this has been graphically depicted by work from the HCPLAN.

N. Choosing Measures for your practice. Currently, in the majority of ambulatory pharmacist practices, measures for your organization are primarily predetermined by the payer. It is important for you to understand what measures your organization are required to report, which of that measure set your service may have a positive impact on, and subsequent benefit to the organization and your patients. The most appropriate starting points are HEDIS for your commercial payers and CMS programs for Medicare. That information coupled with knowledge of your patient population, payer mix, and organizational contracts will help direct you to the appropriate measures for your service. Looking to the future, CMS rules for MACRA and its implementation in the next few years will be key in how organizations incorporate quality measurement into their work flow and payment methods. It is important to account for the direction of Medicare quality measurement and address how your services fit into the Medicare quality strategy because it will ultimately determine the sustainability of your services.

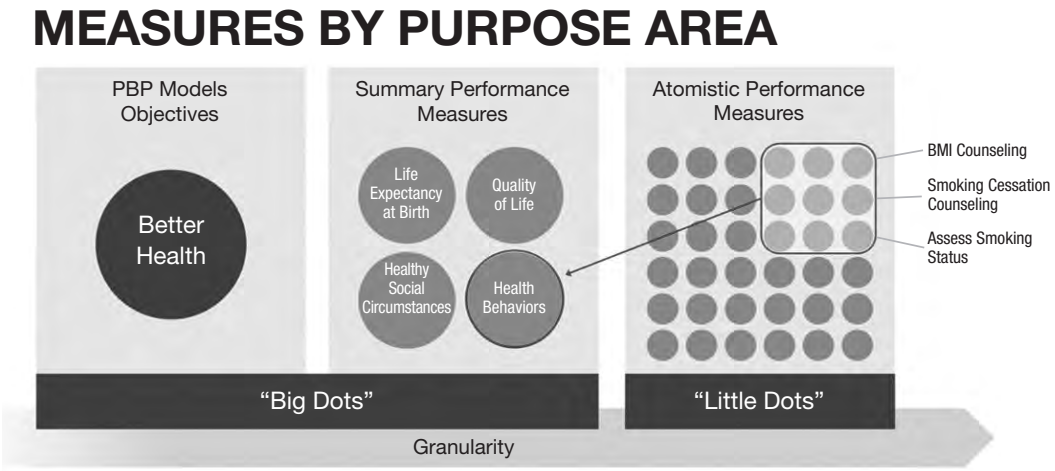

Figure 2. Flow of granular measure to core measures.

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V. ENSURING THE CONTINUED COMPETENCY OF YOUR STAFF

A. Domains of Competency: It is important to ensure that pharmacists in your practice have the knowledge, skills, attitudes, and behaviors to successfully provide the ambulatory services in your program. Brown and Ferrill in 2009 introduced a taxonomy of professionalism that outlines domains of competency.
   1. Information competency
      a. Base knowledge needed for your practice
      b. Self-directed learning; ability and drive to keep up with literature and new knowledge
      c. Ability to apply your knowledge to patient care
      d. Willing to seek out information when it is not known
      e. Wisdom in decisions in unclear or challenging situations
   2. Communication competency
      a. Compassion as a driver of patient care
      b. Empathy as a driver in patient care
      c. Self-control in challenging situations

d. Kindness to patients, caregivers, and coworkers
e. Influence on patients, other providers, and coworkers so that patients receive optimal care to produce optimal outcomes

3. Character competency
   a. Honesty and integrity
   b. Humility
   c. Takes responsibility
   d. Motivated to provide best service possible
   e. Moral courage to do what is right, even if it is difficult

B. In 2016, ACCP charged the Certification Affairs Committee to update the ACCP Guideline on Clinical Pharmacist Competencies that was published in May 2017. The competencies mirror and expand those that listed earlier and are summarized in Table 7.

Table 7. ACCP Description of Clinical Pharmacist Competencies[a]

Competency Domain	Elements of the Competency[b]
Direct patient care	Assess patients, including identifying and prioritizing patient problems and medication-related needs. Evaluate drug therapy for appropriateness, effectiveness, safety, adherence, and affordability. Develop/initiate therapeutic plans and address medication-related problems. Follow up on and monitor the outcomes of therapeutic plans. Collaborate with other members of the health care team to achieve optimal patient outcomes across the continuum of care. Apply knowledge of the roles and responsibilities of other health care team members to patient care.
Pharmacotherapy knowledge	Demonstrate and apply in-depth knowledge of pharmacology, pharmacotherapy, pathophysiology, and the clinical signs, symptoms, and natural history of diseases and/or disorders. Locate, evaluate, interpret, and assimilate scientific/clinical evidence and other relevant information from the biomedical, clinical, epidemiological, and social-behavioral literature. Use scientific/clinical evidence as the basis for therapeutic decision-making. Possess the knowledge and experience commensurate with certification in one or more BPS specialties. Maintain and enhance pharmacotherapy knowledge, including recertification or other appropriate methods of self-assessment and learning.
Systems-based care and population health	Use health care delivery systems and health informatics to optimize the care of individual patients and patient populations. Participate in identifying systems-based errors and implementing solutions. Resolve medication-related problems to improve patient/population health and quality metrics. Apply knowledge of pharmacoeconomics and risk-benefit analysis to patient-specific and/or population-based care. Participate in developing processes to improve transitions of care. Design quality improvement processes to improve medication use.

Table 7. ACCP Description of Clinical Pharmacist Competencies[a] *(continued)*

Competency Domain	Elements of the Competency[b]
Communication	Communicate effectively with: Patients, caregivers, families, and laypersons of diverse backgrounds. Other health professionals and stakeholders. Provide clear and concise consultations to other health professionals. Develop professional written communications that are appropriate to the audience. Use verbal communications tailored to varied clinical and patient-specific environments. Communicate with appropriate levels of assertiveness, confidence, empathy, and respect.
Professionalism	Uphold the highest standards of integrity and honesty. Commit to a fiducial relationship with patients, always working in their best interests. Serve as a credible role model/leader for students, trainees, and colleagues by exhibiting the values and behaviors of a professional. Advance clinical pharmacy through professional stewardship, training of future clinical pharmacists, and active engagement in professional societies.
Continuing professional development	Commit to excellence and lifelong learning. Demonstrate skills of self-awareness, self-assessment, and self-development. Identify and implement strategies for personal improvement through continuing professional development. Provide professional education to students, trainees, or other health professionals. Maintain BPS certification to ensure that therapeutic knowledge is up-to-date.

[a]These competencies are necessary to provide CMM in team-based, direct patient care environments. Other competencies should be acquired as the clinical pharmacist progresses through his/her career and engages in additional professional activities.

[b]These elements of competency help describe each competency but are not intended to be all-inclusive. Other, related elements may apply, depending on the clinical pharmacist's practice setting and activities.

C. Processes to Ensure Competency
   1. Determine the minimum or desired training needed to perform the job at hand.
      a. Level of base degree or licensure
      b. Level of postgraduate training, if desired
      c. Level of experience that may offset other requirements
      d. Certification required or desired – There are many certifications; some have greater recognition than do others in practice. Listed are the certifications most commonly recognized.
         i. Board Certified Pharmacotherapy Specialist (BCPS)
         ii. Board Certified Ambulatory Care Pharmacist (BCACP)
         iii. Other
            (a) Pediatric
            (b) Psychiatric
            (c) Oncology
            (d) Geriatric
            (e) Cardiology
            (f) Infectious Diseases
         iv. Certified Diabetes Educator (CDE)
         v. Board Certified Advanced Diabetes Management (BC-ADM)
         vi. Immunization certification
         vii. Other (i.e., anticoagulation, asthma, pain, smoking cessation). Before deciding to obtain a particular certification, due diligence in ascertaining the quality and recognition of the certification should be performed.

2. State laws or payer stipulations on credentials and training
    a. Immunization certification
    b. New Mexico – Pharmacist-clinician: Requires that additional physical assessment training and 150 hours/300 patient contact preceptorship be supervised by a physician or other practitioner with prescriptive authority
    c. North Carolina – Clinical pharmacist practitioners: Must complete an application with credentials and all the physicians' signatures with whom they will be collaborating. Must be approved by the Board of Medicine and the Board of Pharmacy.
    d. California – Advanced practice pharmacists (APPs): Requires the attainment of certification in a relevant practice area, a postgraduate residency, and 1 year of service under a collaborative practice agreement or protocol
    e. Iowa, Florida, Minnesota, Montana, and Ohio require completion of training requirements to participate in state programs for the provision of services.
3. Ensuring maintenance of competency
    a. Credentialing is a process to ensure or validate that the pharmacist (or health professional) has the credentials, experience, or demonstrated ability and the license to be granted practice rights and responsibilities in an organization.
    b. Privileging is the granting of approval to perform a set of services within the providers' scope of practice in the organization.
    c. May be required by a payer or an organization
    d. Methods for credentialing and privileging that may occur at time intervals such as 90 days for newly credentialed and privileged providers to every 24 months for maintenance of privileges.
        i. Required to perform a certain number of services during a certain period for which they are credentialed and/or privileged in providing
        ii. Quality evaluation of the services provided by a provider at some period determined by the organization.
        iii. Peer review of a subset of the services provided at regular intervals
        iv. Continued education in areas that are credentialed and privileged during a time interval

Practice Case 3

The practice is beginning to appreciate the skill set and level of services provided by the pharmacy practice faculty, students, and residents. The medical director approaches you about expanding your services to assist in improving the performance-related quality measures the practice must report to payers. Because the population of the practice is primarily fee for service, the practice will participate in the MIPS program; it is also seeking NCQA PCMH status. The director, who noted the student resources at the clinic, would like to explore using students to help identify patients not meeting the medication-related measure goals and establish standard pharmacy interventions to improve the measures. You recognize this as a good opportunity for students to learn and participate in a pharmacist-based role as well as an opportunity for scholarship. You engage one of the tenure-track faculty members to assist you in developing the project as well as a research protocol to study the outcomes of pharmacy students and pharmacists assisting in measure and pay-for-performance attainment in a primary care office. Your college is struggling to identify suitable ambulatory experience sites for students, and this opportunity may enable you to take an additional student for each rotation.

The training of future pharmacists is important for all practitioners to consider as part of their professional responsibilities. This case is an example of a win-win situation, where students can learn about ambulatory practice and also provide needed services to the organization at minimal expense.

VI. REIMBURSEMENT FOR PHARMACIST SERVICES IN THE AMBULATORY SETTING *(Domain 4, Task 2)*

A. Potential Revenue Sources for Pharmacist Services. As pharmacists are not federally recognized providers (there are exceptions with recent advances at the state level in several states), pharmacist services cannot be directly billed for most patient care services through federal and most state government entities. (Exceptions are immunizations, diabetes education, and MTM in Medicare Part D through those Prescription Drug Plans that have that mechanism.) However, revenue for pharmacist patient care services may be captured through programs that currently exist at the federal level. This section will review the structure and language of billing based on CMS, critical to understanding how Medicare works and the rationale for the rules that are established. The opportunities for current and future opportunities for revenue generation for pharmacist services will follow.

1. Federal government and Medicare services. Medicare is a federal program that provides health coverage for people 65 or older or who have a severe disability, no matter the income. Government payers are not for profit and must focus on management of risk because generally they are supporting high-risk patients.
    a. Medicare Part A
        i. Administers rules and payment for services from hospitals, health systems, long-term care facilities, and hospice and home health services
        ii. Benefit available for all eligible beneficiaries (must have contributed to social security during one's life)
    b. Medicare Part B
        i. Administers rules and payments for medically necessary outpatient services
        ii. Regulated by rules set forth in the Physician Fee Schedule (PFS)
        iii. Covers services provided by those with Medicare Part B provider status. Those with Medicare Part B provider status are physicians and other nonphysician providers. CMS uses the terminology *qualified health-care providers* when referring to providers approved under Medicare Part B that are nonphysicians and groups from the approved list that may be identified as eligible to participate in the various programs. The complete list can be found at www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedEnroll_PhysOther_FactSheet_ICN903768.pdf.
            (a) Anesthesiology assistants and certified registered nurse anesthetists
            (b) Audiologists
            (c) Certified nurse midwives
            (d) Clinical nurse specialists and nurse practitioners
            (e) Clinical psychologists
            (f) Clinical social workers
            (g) Individuals who provide mass immunization
            (h) Physical and occupational therapists in private practice
            (i) Physician assistants
            (j) Registered dietitians or nutrition professionals
            (k) Speech-language pathologists
        iv. Covers some preventive services (immunizations) and some home care services
        v. Not available to those without Social Security benefits
        vi. Eligible beneficiaries may opt out of having this benefit; therefore, not every Medicare patient has this coverage.

c. Medicare Part C or Medicare Advantage
    i. A Medicare health plan offered by a private company that contracts with Medicare to provide Part A and Part B benefits. Many plans also provide Part D benefits. Medicare pays a fixed amount for each beneficiary each month to the contracted companies. Part C must provide benefits that are at least equivalent to those of traditional Part A and Part B; however, more benefits may be offered as well.
    ii. Beneficiary choice of this model may grow with the implementation of the new models of care. Medicare Part C has almost doubled over the past 10 years and now enrolls 31% of Medicare beneficiaries.
    iii. Beneficiaries opt to join.
d. Medicare Part D – Prescription benefits
    i. Administered by commercial payers or prescription drug plans (PDPs)
    ii. Houses MTM services
    iii. Beneficiaries opt to join.

2. Private organizations. These organizations tend to be for profit and are more focused on managing costs as they, unlike government entities, do not need to cover the higher-risk patients that the government payers have as beneficiaries (low income, disability, etc.).
    a. Commercial insurers
    b. Self-insured employers or employer groups
    c. Types of commercial plans
        i. Conventional indemnity plan; Allows the participant the choice of any provider without effect on reimbursement. Reimburse as expenses are incurred.
        ii. Preferred provider organization (PPO). Coverage is provided through a network of selected health care providers. Enrollees may go outside network but incur larger costs.
        iii. Exclusive provider organization (EPO). A more restrictive type of preferred provider organization plan. Employees must use providers from the specified network. There is no coverage for care received from a non-network provider except in an emergency situation.
        iv. Group Model HMO. Contracts with a single multispecialty medical group. The group may only see HMO patients, or it may also provide services to non-HMO patients.
        v. Staff Model HMO. Closed-panel; members receive services only from providers who are HMO employees.
        vi. Network Model HMO. Contracts with many physician groups to provide services to members.
        vii. Individual Practice Association (IPA) HMO. A group of independent providers who maintain their own offices and band together to contract their services.
        viii. Point of service (POS). A POS plan is an HMO/PPO hybrid. They resemble HMOs for in-network services. Outside of the network are reimbursed like an indemnity plan (reimbursement based on a fee schedule or usual, customary, and reasonable charges).
        ix. Physician-hospital organization (PHO). Alliances between providers and hospitals to help providers attain market share, improve bargaining power, and reduce administrative costs. They sell their services to managed care organizations or directly to employers.
        x. Medigap Supplemental Plans. Pays the Medicare deductibles, copayments, and other expenses.

3. State-run programs
    a. Medicaid is a state and federal program that provides health coverage for very low income. The federal government pays a specified percentage of their program costs, which averages 57% of costs per state.
    b. Patients who are eligible for both Medicare and Medicaid coverage are termed *dual eligible.*
    c. Insurance exchanges: The ACA established the Health Care Exchange program in each state. The purpose of the legislation was to address the many individuals in the United States without health care insurance. The exchanges provide individuals, families, and small businesses with the means

and option to purchase health care coverage that meets the rules dictated in the act regarding affordability, benefits, and market standards. Those with low or modest income have the opportunity to receive premium and cost-sharing subsidies. States may create their own exchanges, collaborate with other states, or participate in a federal nationwide exchange.

4. Self-pay, although possible, is not common and is difficult to sustain.

B. Generating Revenue for Pharmacist Patient Care Services
   1. Understanding reimbursement terminology and language
      a. Healthcare Common Procedure Coding System (HCPCS) codes, often called "Hic-Pic" codes, describe which service, product, or procedure the patient received from the billing heath care provider. HCPCS has two levels.
         i. Level 1 – Current Procedural Terminology (CPT) codes
         ii. Level II – Codes for product supplies and services not covered under CPT (e.g., ambulance, durable medical equipment). Codes range from A to V alphanumeric codes. Examples include G codes, which are classified as temporary procedures and professional services and include diabetic education codes; and J codes, which are codes for drugs administered other than oral method and are often used in outpatient infusion clinics.
      b. CPT codes or level 1 HCPC codes
         i. Set of medical nomenclature used to report medical procedures and services to public and private health insurance programs
         ii. These codes were developed and are currently maintained and owned by the American Medical Association (AMA).
         iii. There are three categories of codes. For pharmacist services, only the first category E/M codes and the last category where MTM codes reside are used to describe pharmacist patient care services. (Table 8)

Table 8. CPT Code Categories

Category 1 Evaluation and management (E/M): 99201–99499 Example 99211 "incident to" code Anesthesia: 00100–01999; 99100–99150 Surgery: 10000–69990 Radiology: 70000-79999 Pathology and laboratory: 80000–89398 Medicine: 90281–99099; 99151–99199; 99500–99607 Example 99605–99607 medication therapy management services
Category 2 Supplementary tracking codes that can be used for performance measurement
Category 3 Emerging technology codes

      c. E/M codes
         i. Five-digit CPT codes that start with 99; describe services related to physician visits in the ambulatory setting
         ii. Documentation requirements for these codes are discussed in the Documentation section.
         iii. Requires that evaluation and management services are conducted as defined by the E/M regulations

d. Resource-based relative value scale (RBRVS)
   i. Standardized reimbursement model created as a method of analyzing resources involved in the provision of health care services or procedures. Allows for discrimination between the varied work of physicians.
   ii. The RBRVS considers the following factors:
      (a) Physician work or the complexity and difficulty of the procedure or visit utilizing time, technical skill, effort expended, judgment, and stress level
      (b) Practice expense, such as rent and wages of staff
      (c) Professional liability insurance
   iii. A relative value unit (RVU) is assigned to each CPT code; this determines the final payment a provider will receive for that code.
   iv. RVUs are determined yearly by an AMA committee
   v. RVUs are adjusted according to geographic practice cost indexes (GPCIs), which are then multiplied by a conversion factor to determine the payment adjustment for the CPT code. The conversion factor formula is determined by statute and updated annually.
   vi. MTM codes do not have RVUs.

e. ICD-codes: Stands for International Statistical Classification of Diseases and Related Health Problems (i.e., disease and condition codes), which is a medical classification system maintained by the World Health Organization under the direction and authority of the United Nations.
   i. Describes why the service being billed was provided
   ii. The next version ICD-11 is expected to be released in 2018
   iii. ICD-10 code structure
      (a) 69,000 code numbers are available in ICD-10.
      (b) All codes are alphanumeric; they begin with a letter followed by a number and then a mix of letters and numbers thereafter.
      (c) ICD-10 code lengths vary from four to seven digits.

f. Medicare Administrative Contractors (MACs) – In the past, also called *fiscal intermediaries* or *Part B carriers.* MACs are private companies contracted with Medicare to administer Medicare funds to providers. Moreover, MACs provide reimbursement services, medical coverage review, and audits; respond to provider inquiries; educate providers; establish local coverage determinations; and process claims. Currently, there are 12 Medicare Part A/B MACs and four durable medical equipment (DME) MACs. Because MACs may add additional interpretation to CMS billing rules, it is important to regularly review your region's MAC website for any additional rules and regulations pertaining to any billing codes that are being used for your service. You may find more information regarding the role of MACs and determine whom your MAC may be at the following links: https://www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/What-is-a-MAC.html www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/#zpic

g. Health Care Financing Administration 1500 form (HCFA-1500) and the Electronic Format Called the 837P
   i. The official standard form and electronic format used by individual health care providers (e.g., physicians, nurse practitioners) when submitting bills or claims for reimbursement to payers
   ii. Primarily a federal government form, but used universally

h. The CMS-1450 (previously called UB-04 or UB-92) and its electronic format called the 837I
   i. Form or electronic format used by facilities or institutions (e.g., hospitals, long-term care facilities) when submitting bills
   ii. Some private payers may still use UB-04.

i. National Provider Identifier (NPI) is a a 10-digit identification number available for issue to all health care providers, including pharmacists, and to all health care organizations in the United States. Must have NPI for electronic billing and for those who use electronic transaction of protected personal health information

j. Medical necessity. The services you provide must be deemed medically necessary. CMS defines *medically necessary* as "services or supplies that are proper and needed for the diagnosis or treatment of a medical condition and are provided for the diagnosis, direct care, and treatment of the medical condition, meet the standards of good medical practice in the local area, and are not mainly for the convenience of the patient or the provider" (www.medicare.gov/glossary/m.html).

2. Rules and regulations are constantly changing with frequent updates. Staying abreast of these changes are generally the responsibility of the compliance officer and billing and coding personnel. It may be difficult to try to keep up with them yourself. Instead, develop relationships with those responsible for billing in the organization so that you stay informed.
   a. Medical billing companies or organizations
   b. Compliance officer – Person within an organization responsible for ensuring compliance with payers, regulators, contractors, and accreditors
   c. Office manager
   d. You can connect with the Medicare Learning Network and sign up for their e-newsletter and other resources (www.cms.gov/Outreach-and-Education/Outreach-and-Education.html). This is highly recommended because CMS has made significant effort through this forum to assist providers in understandable terms the rules and regulations of their programs.

C. Medicare Rules for Billing – By law, Medicare beneficiaries must be billed usual and customary prices. This means that a provider cannot discriminate against Medicare patients in billing or give another group of patients a substantially cheaper rate for the same service. Consequently, most organizations will follow Medicare rules for all patients (non-Medicare patients) unless there are specific state rules for state-run programs or unless there is an existing contractual relationship that dictates a different process with commercial payers.

D. Institutional Revenue Generation Options for Pharmacists – Medicare Governed by the Hospital Outpatient Prospective Payment System (HOPPS or OPPS)
   1. "Facility fee" billing
      a. Typically used for non–Medicare B-recognized providers who are employed, contracted, or leased by a hospital or health system
      b. Essentially pays the hospital the costs of using the facility to provide services to the beneficiary
      c. Use Ambulatory Payment Classification (APC) system codes – a coding system housed under HCPCS II).
      d. APC was established as a method of paying for facility outpatient services; it is analogous to the way in which inpatient services or diagnosis-related groups are paid.
      e. When billing the facility fee as of 2015, APC code 5012 is used together with the HCPCS II G0463 code.
   2. Requirements for facility fee billing
      a. Medically necessary
      b. Sufficiently documented
      c. Established patient (seen within the past 3 years)
      d. Meet "incident to" rule requirements – See Table 9. Changes in requirements specific for HOPPS are:
         i. The supervising provider must be in the building where the "incident to" services are being performed.
         ii. Must have an employee relationship with the hospital as an employee, leased employee or independent contractor.

3. Barriers for facility fee billing
    a. Copayment for the patient for Medicare
    b. May be lumped into deductibles for commercial payers

E. Clinic or Physician Office Revenue Options for Pharmacists – Medicare
1. "Incident to" billing is an indirect billing mechanism whereby auxiliary personnel under their state scope of practice may provide patient care services under the direct supervision of a physician or other approved Medicare Part B provider (physician, physician assistant, nurse practitioner, clinical nurse specialist, nurse midwife, or clinical psychologist). The service must be a necessary service that is under, and integral to, the service provided by the approved Medicare Part B provider. Medicare Part B pays for management for medical conditions or problems; it does not pay for medication management, which CMS considers a Part D benefit.
2. Requirements for "incident to" billing. Patient must be established with the practice (seen in the practice within the past 3 years).
    a. Must have a face-to-face visit with the physician before the "incident to" visit
    b. Service must be medically necessary.
    c. Service is an integral, although incidental, part of the physician's service.
    d. Service is commonly provided in the physician's office.
    e. Service is part of the physician's bill.
    f. Must be provided under direct supervision by the physician (physician must be present in the office space)
    g. The physician must be actively involved by continuing to have face-to-face visits and E/M of the problem associated with the "incident to" billing. There are no hard and fast rules on frequency, but the industry often suggests the one-in-three rule, or physician sees patient every third visit.
    h. The service provided must be within the state scope of practice of the auxiliary personnel.
    i. Meet all the requirements listed in Table 9
3. Levels of billing
    a. Five levels (Table 10)
    b. Specifics of the required elements outlined in Medicare E/M 1997 regulations

Table 9. Medicare Requirements for Incident-to Services and Billing

Criteria for Billing Incident-to Services	
Physician Office Services	**Hospital Outpatient Services**
Service is provided under the direct supervision of an eligible physician or non-physician practitioner. Defined as within the suite or office space where the service is performed and immediately available to furnish assistance	Service is provided under the direct supervision of an eligible physician or non-physician practitioner. Defined as present on the same campus where the services are being furnished or present within the off-campus provider-based department if the setting is off-campus, and immediately available to furnish assistance
Established patient: Patient must be an established patient with the eligible provider. Must have an initial face-to-face visit with the provider where the plan of care is established	Same
Service is an integral, though incidental part of the eligible provider's services	Same
Services are commonly rendered without charge or included as part of the eligible provider's bill	Same

Table 9. Medicare Requirements for Incident-to Services and Billing *(continued)*

Criteria for Billing Incident-to Services	
Physician Office Services	**Hospital Outpatient Services**
Services are of a type that is commonly furnished and appropriate to be provided in a physician's offices or clinic	Same
Service must be medically necessary, authorized (authorized practitioner's order), and documented	Same
Authorized provider must provide subsequent services at a frequency that reflects active participation in treating the patient and plan of care	Same
A financial relationship must exist between the auxiliary personnel and the eligible provider	An employee relationship must exist with the hospital as an employee, leased employee, or independent contractor
Services provided are within the scope of practice for the auxiliary personnel as dictated by the state practice act	Same

4. "Incident to" billing and pharmacist-specific rules and interpretations
    a. Pharmacists are considered auxiliary personnel; therefore, supervising eligible Medicare Part B providers may bill for pharmacists' services under incident-to rules.
    b. Billing at levels higher than 99211 is determined by state scope of practice. MACs have historically used their ability to establish local coverage determinations to weigh in on what level pharmacists can bill. However, the 2016 Physician Fee Services rules from CMS provide clarification in the background section regarding this issue: "the supervising provider should bill and get paid for 'incident to' services provided by auxiliary personnel just as if the supervising provider were personally providing the service." This would suggest that as long as "incident to" rules are met and the service is within the pharmacist's state scope of practice for pharmacy, pharmacists should be able to bill the range of "incident to" codes that describe their services and that have documentation supporting the code chosen to be billed.
    c. MTM cannot be billed under "incident to" codes because MTM is a Part D benefit, not a Part B benefit.

F. Special Billing Situations Available for Pharmacists – Medicare
1. Diabetes education G codes
    a. G0108 – Individual visits
    b. G0109 – Group visits (two patients or more)
    c. Billed and paid in 30-minute increments
    d. Requires a physician order that states the following:
        i. Initial and follow-up hours needed (maximum of 10 hours/first year, followed by a maximum of 2 hours each year thereafter)
        ii. Topics to be covered
        iii. Whether patient should receive individual or group training
    e. To bill Medicare, must be accredited from the American Association of Diabetic Educators, American Diabetes Association, or Indian Health Service program (other payers may not require certification)

Table 10. Incident-to E/M Code for Billing According to Levels of Service and Required Supporting Elements

Assessments of care	N/A	Problem focused	Expanded problem focused	Detailed	Comprehensive
Level of decision-making	N/A	Straightforward	Low	Moderate	High
Established patient E/M codes	99211	99212	99213	99214	99215
CC	N/A	Required	Required	Required	Required
HPI elements	N/A	Brief or 1–3 elements	Brief or 1–3 elements	Extended ≥ 4 elements(1995) > 4 elements or 3 from chronic conditions (1997)	Extended ≥ 4 elements (1995) > 4 elements or 3 from chronic conditions (1997)
ROS elements	N/A	N/A	Problem pertinent	Extended 2–9 elements	Complete Minimum of 10 elements
PFSH elements	N/A	N/A	N/A	Pertinent or 1 item from any of the areas	Complete 1 element from 2 or 3 of the 3 categories
PE elements	N/A	1–5 elements in ≥ 1 organ system	≥ 6 elements in 1 or more organ system	2 elements in at least 6 organ systems or 12 elements in ≥ 2 organ systems	Elements from 8 organs systems (1995) Two elements from 9 organ systems (1997)
Usual length of visit (minutes)	5	10	15	25	40

CC = chief concern; HPI = history of present illness; PE = physical examination; PFSH = past family and social history; ROS = review of systems.

Information from: Centers for Medicare & Medicaid Services Medicare Learning Network. Evaluation and Management Services. Available at www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/eval-mgmt-serv-guide-ICN006764.pdf. Accessed November 2, 2016.

2. CMS annual wellness visits (AWVs)
    a. HCPC II codes
        i. G0402 (initial preventive physical examination)
        ii. G0438 (initial AWV, once in lifetime)
        iii. G0439 (subsequent visits, AWV)
    b. Initial preventive physical examination (welcome to Medicare physical examination) may only be done by a physician or nonphysician practitioner (not a pharmacist).
    c. This service is only available under Medicare Part B.
    d. Will pay either the practitioner or the facility for furnishing the visit
    e. Who is eligible to provide AWVs?
        i. A physician
        ii. Nonphysician practitioners: Physician assistant, nurse practitioner, clinical nurse specialist
        iii. Medical professional—defined as a health educator, registered dietitian, nutrition professional, other licensed practitioner, including pharmacists or a team of such medical professionals—working under the direct supervision of a physician

f. Initial AWV includes 10 to-dos:
   i. Establishment of an individual's medical/family history
   ii. Establishment of a list of current providers and suppliers that are regularly involved in providing medical care to the individual
   iii. Measurement of an individual's height, weight, body mass index (or waist circumference, if appropriate), blood pressure, and other routine measurements, as deemed appropriate, based on the beneficiary's medical/family history
   iv. Detection of any cognitive impairment the individual may have, as defined in this section
   v. Review of the individual's potential (risk factors) for depression, including current or past experiences with depression or other mood disorders, based on the use of an appropriate screening instrument for individuals without a current diagnosis of depression, which the health professional may select from various available standardized screening tests designed for this purpose and recognized by national medical professional organizations
   vi. Review of the individual's functional ability and level of safety. This may be based on direct observation, use of appropriate screening questions, or a screening questionnaire selected by the health professional, who may select from various available screening questions or standardized questionnaires designed for this purpose and recognized by national professional medical organizations.
   vii. Establishment of a written screening schedule for the individual, such as a checklist for the next 5–10 years, as appropriate, based on recommendations of the U.S. Preventive Services Task Force (USPSTF) and the Advisory Committee on Immunization Practices (ACIP), as well as the individual's health status, screening history, and age-appropriate preventive services covered by Medicare
   viii. Establishment of a list of risk factors and conditions for which primary, secondary, or tertiary interventions are recommended or are under way for the individual, including any mental health conditions or any such risk factors or conditions that have been identified through an initial preventive physical examination, and a list of treatment options and their associated risks and benefits
   ix. Furnishing of personalized health advice to the individual and a referral, as appropriate, to health education or preventive counseling services or programs aimed at reducing identified risk factors and improving self-management, or community-based lifestyle interventions to reduce health risks and promote self-management and wellness, including weight loss, physical activity, smoking cessation, fall prevention, and nutrition
   x. Any other element(s) determined appropriate by the Secretary of Health and Human Services through the National Coverage Determination

g. Subsequent wellness visits: Depression and functional status screening are no longer required for the visit.

h. As of 2016, CMS will pay a Part B practitioner or a facility for AWV, thus allowing hospitals to provide this service under HOPPS.

3. Transitional care management (TCM)
   a. CPT E/M codes
      i. 99496 (seen within 7 days of discharge) Medical decision-making of high complexity during the service period
      ii. 99495 (seen within 14 days of discharge) Medical decision-making of at least moderate complexity during the service period

b. May be billed by physicians or qualified nonphysician providers of care management for discharges from the following:
    i. Inpatient hospital setting (including rehabilitation and psychiatric institutions)
    ii. Observational setting (less than 48-hour inpatient stay)
    iii. Skilled nursing facility
c. Must be discharged to a community setting (home or assisted living)
d. Bundle face-to-face and non–face-to-face coordinated activities into one payment.
e. Face-to-face interview must be done by a Medicare-recognized qualified provider; the non–face-to-face interview can be done by a provider working within the scope of his or her practice.
f. Pharmacists may do non–face-to-face interviews and coordination of activities and may assist the physician or other Medicare-recognized provider during the face-to-face visit.
g. Must follow "incident to" rules; however, in 2015, CMS relaxed the rule of direct supervision to general supervision by the Medicare Part B provider for auxiliary services (includes pharmacists) for the non–face-to-face coordinated activities with transitions of care. The face-to-face services remain under direct supervision. General supervision is defined as a direct oversight relationship between the supervising practitioner and the clinical staff who provide after-hours services.
h. Before 2016, had to bill at 30 days post-discharge, not on date of visit(s). In 2016, able to bill on date of service. However, if the patient is readmitted within 30 days, and the practice has already billed TCM for that patient, they cannot bill for TCM when the patient is discharged the second time. If the patient is readmitted and the practice has not yet billed, they can wait until the patient is discharged the second time, track the patient for TCM, and bill after the second face-to-face visit.
i. Required components for billing
    i. Communication with patient or caregiver within 2 days of discharge
    ii. Face-to-face visit within either 7 or 14 days
    iii. Required documentation
        (a) Complexity of medical decision-making (moderate or high)
        (b) Date of discharge
        (c) Date of interactive contact with patient or caregiver
        (d) Date of face-to-face visit
    iv. Only one health care professional may report TCM services.
j. Components of service that may be furnished by physicians or other Medicare-recognized providers
    i. Obtaining and reviewing discharge information
    ii. Reviewing the need for follow-up on pending diagnostic tests and treatment
    iii. Interacting with other health care providers (specialists) who will assume or reassume care of the beneficiary
    iv. Providing education
    v. Establishing or reestablishing referrals and arranging needed community resources
    vi. Assisting in scheduling any required follow-ups with community providers and services
k. Components of service that may be furnished by non–Medicare-recognized health care providers
    i. Communicating with agencies and community services used by the beneficiary
    ii. Providing education to support self-management, independent living, and activities of daily living
    iii. Assessing and supporting treatment regimen adherence and medication management
    iv. Identifying available community and health resources
    v. Assisting the beneficiary and/or family in accessing needed care and services
l. Cannot be billed under Part A
m. Cannot be billed simultaneously with a global period procedure code (see regulations for list of codes). These include home health care services, care plan oversight, chronic care management (CCM), and end-stage renal services.

4. "Incident to" visits for CCM – CMS, in efforts to support primary care and recognize CCM as a critical component of primary care, has created initiatives to improve payment for, and encourage long-term investment in, CCM. In 2017 CMS added additional codes with increased payment for more complex patients.
    a. Requirements for billing all available CCM codes
        i. An initiating visit must be done by a Medicare Part B–eligible provider for any new patient or patients not seen within 1 year before the provider billing for CCM services.
            (a) The eligible provider may use any of the following visit types: an AWV, IPPE, or face-to-face E/M visit (level 4 or 5 visit not required).
            (b) CMS provided an add-on code to the initiating visit, recognizing that establishing the plan of care may require extensive assessment and care planning beyond the usual effort described by the separately billable CCM initiating visit. The code is G0506.
        ii. Beneficiary or patient requirements
            (a) Multiple (two or more) chronic conditions
            (b) Chronic conditions expected to last at least 12 months, or until the patient's death
            (c) Chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline.
        iii. A comprehensive care plan is established by the billing-eligible provider and is implemented, revised, or monitored by the health care team.
        iv. As noted with TCM, CMS provides an exception to incident-to rules of general versus direct supervision and states that the auxiliary personnel need not be a direct employee.
    b. Additional rules
        i. Copayment from beneficiary required
            (a) For dual-eligible patients, state Medicaid is required to pay the copayment.
            (b) For patients with private Medicare supplement insurance, the insurance is required to pay the copayment.
            (c) For patients with a secondary to Medicare full health care insurance plan (e.g., employer-based plan), the insurance is not required to pay the copayment.
        ii. Patient consent must be obtained before furnishing or billing for CCM services. This may be done verbally or it may be written, but it must be documented in the medical record. The consent should include:
            (a) Availability and description of the service and the applicable cost-sharing
            (b) The beneficiary of the right to stop the CCM services at any time, effective at the end of a calendar month
            (c) Only one practitioner can furnish and be paid for these services during the calendar month service period.
    c. Required scope-of-service elements
        i. The patient must have access to the practice for urgent needs 24 hours a day, 7 days a week for CCM services. The patient must be provided a means to make timely contact with health care providers in the practice to address the urgent care needs. The practice should use available enhanced opportunities for communication such as:
            (a) Secure messaging
            (b) Telephone access
            (c) Internet
            (d) Other asynchronous non–face-to-face consultation methods
        ii. Continuity of care with a designated practitioner or member of the care team with whom the patient can obtain successive routine appointments

iii. Care is comprehensive and includes a systematic assessment of the following:
   (a) Patient medical, functional, and psychosocial needs
   (b) Timely receipt of all recommended preventive care services
   (c) Medication reconciliation with review of adherence and potential interactions
   (d) Oversight of patient self-management of medications

iv. An electronic patient-centered comprehensive care plan is created, revised, and/or monitored and shared electronically or by fax outside the practice, and a copy is given to the patient and/or caregiver. The care plan should contain the following elements:
   (a) Problem list
   (b) Expected outcome and prognosis
   (c) Measurable treatment goals
   (d) Symptom management
   (e) Planned interventions and who is responsible for each intervention
   (f) Medication management
   (g) Community/social services ordered
   (h) A description of how services of agencies and specialists outside the practice will be directed/coordinated
   (i) Schedule for periodic review and, when applicable, revision of the care plan

v. Management of all care transitions between and among all health care providers and settings (e.g., other clinicians, emergency department, or facility discharges). This includes the timely creation and exchange of continuity of care documents with other practitioners and providers.

vi. Coordination and communication with home and community-clinical service providers, with note of the patient's psychosocial needs and functional deficits. This must be documented in the EHR.

d. EHR requirement
   i. Ability to fulfill the scope of service and other elements listed earlier
   ii. EHR certified to the edition of certification criteria that is acceptable for the EHR Incentive Programs as of December 31 of the calendar year before the PFS (PFS payment year)
   iii. Meet the final core EHR capabilities (structured recording of demographics, problems, medications, medication allergies, and creation of a structure clinical summary record)

e. May be billed under HOPPS. Required to inform the patient that hospital personnel are providing this service

f. Requirements for the specific CCM codes
   i. Comprehensive Care Management code 99490
      (a) At least 20 minutes of qualified staff time directed by a physician or other qualified health care provider per calendar month
      (b) Only code available to be used by federally qualified health centers and rural health clinics
   ii. Complex Comprehensive Care Management codes 99487 and 99489
      (a) Evidence of moderate- or high-complexity medical decision-making (as described under Documentation earlier)
      (b) For 60 minutes of clinical staff time directed by a physician or other qualified health care professional per calendar month, use code 99487.
      (c) For each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional per calendar month, use 99489 as an add-on code to 99487 only.
      (d) Must meet the time elements to bill each code; cannot use the codes for less time (e.g., 45 minutes instead of 60 minutes) for 99487 or 20 minutes instead of 30 minutes for 99489
   iii. May use only CCM or complex CCM code for any given month; may not use both codes in the same month

G. Community Pharmacy – Part D MTM Services
   1. As a result of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Medicare contracts with PDPs to provide MTM services.
   2. PDPs then contract with pharmacists and/or pharmacies to provide these services or may provide these services with internal staff.
   3. May or may not use MTM codes
   4. Requirements updated yearly in the CMS call letter, usually released in the spring before the year the regulations are implemented. The following are a summary of the 2018 requirements for Medicare Part D MTM services:
      a. Eligible beneficiaries to have an annual comprehensive medication review (CMR)
         i. Interactive person-to-person visit
         ii. Telehealth consultation
      b. Eligible beneficiaries should have at least quarterly targeted medication reviews (TMRs) with follow-up interventions when necessary
      c. Opt-out only. All eligible beneficiaries are to receive these services unless they decline to participate.
      d. May be furnished by a pharmacist or other qualified provider
      e. May distinguish between services in ambulatory and institutional settings
      f. Must be developed in cooperation with licensed and practicing pharmacists and physicians
      g. Measure outcomes of MTM program
         i. Examples of drug therapy problem recommendations made as a result of MTM
         ii. Examples of drug therapy problem resolutions made as a result of MTM recommendations
   5. Eligibility for MTM services under Medicare Part D
      a. Minimum threshold of two to three chronic health conditions
      b. Five of nine core chronic conditions
      c. Minimum threshold of two to eight Part D medications
      d. Likely to incur Part D drug costs of $3967 or greater

H. MTM CPT Codes
   1. 99605: New patient, face-to-face visit: Initial 15 minutes
   2. 99606: Established patient, face-to-face visit: Initial 15 minutes
   3. 99607: Face-to-face visit
      a. For each additional 15 minutes
      b. Used only in addition to 99605 or 99606
      c. List separately.
   4. Summary of current use
      a. Lack of universal reimbursement for codes
      b. Used in some state Medicaid programs and some prescription drug benefit programs
      c. Potential to use in private contract reimbursement

I. Private Payers
   1. Contractual relationships in which all aspects of the service are negotiated between the pharmacist and the payer
   2. Can be done with the following:
      a. Commercial payers
      b. Self-insured employers
      c. Health care organizations

J. State-Based Programs that have reimbursement for patient care services under Medicaid. For pharmacists practicing in these states, the state requirements should be reviewed to determine the reimbursement opportunities. (Correspondence with Krystalyn Weaver, national Alliance of State Pharmacy Associations June 2, 2017).
   1. California
   2. Colorado
   3. Georgia
   4. Iowa
   5. Kansas
   6. Michigan
   7. Minnesota
   8. Missouri
   9. New Mexico
   10. North Dakota
   11. Ohio
   12. Oregon
   13. Washington State
   14. Wisconsin

K. Self-Paying Patients: Depends on the fees established for services and ability to pay by your customers

L. MACRA: Payment under MIPS will begin in 2019 and will be based on provider performance as described above under Quality. Payment may be above, at baseline, or below baseline, depending on the provider's performance under MIPS. Providers eligible for APMs as noted previously will automatically receive a 5% lump sum bonus over Medicare Fee-for-service billing starting in 2019. (Figure 3)
   1. Key provisions of the act
      a. Repeals the Sustainable Growth Rate (SGR) formula
      b. Changes the way that Medicare pays clinicians under Medicare Part B and establishes a new payment framework that rewards value over volume.
      c. Streamlines Medicare quality reporting programs into two options for providers
         i. MIPS
         ii. APMs
   2. It is anticipated most practitioners will be subject to MIPS because most will not be eligible for Advanced APMs participation because of the required qualifications.
      a. MIPS will have four components that will determine provider payment
         i. Quality 50% of reimbursement. Streamlines existing programs into one (PQRS, meaningful use)
            (a) Must select six measures that includes one outcome measure, one cross-cutting measure or other high-priority measure
            (b) Specialties may select specialty-specific measure set
         ii. Resource use 10% of reimbursement. Replaces RBRVS.
         iii. Clinical practice activities, 15% of reimbursement. Must select at least one from the 90-plus proposed activities. If the organization is a recognized PCMH, it receives full credit and half credit if it is participating in an alternative payment model.
         iv. Advancing care information, 25% of reimbursement. Replaces the EHR incentive program. Scoring will be based on health IT interoperability and information exchange. Focus will be promoting care coordination that yields improved patient outcomes.

b. Affects physicians (MD/DO), dentists, physician assistants, nurse practitioners, clinical nurse specialists, and nurse anesthetists the first year of implementation and a list of other eligible Medicare Part B at year three of implementation.
c. Certain groups are not subject to MIPS.
    i. Providers in their first year of Medicare Part B participation
    ii. Providers who bill less than or equal to $10,000 and provide care to 100 or fewer Medicare patients in one year
    iii. Providers eligible for APMs described in the following text.
d. Payment under MIPS will begin in 2019 and will be based on provider performance in the year 2017. Thus, providers must be aware of meeting MIPS requirements starting in 2017. Payment may be above, at baseline, or below baseline, depending on the provider's performance. (See Figure 3). If providers under MIPS work under alternative payment models that are not eligible for APMs described below they will be eligible for added financial rewards under MIPS.

3. Advanced Alternative Payment Models (APMs)
    a. As defined by MACRA, includes the following:
        i. CMS Innovation Center model
        ii. Medicare Shared Savings Program
        iii. Health Care Quality Demonstration Program
        iv. A demonstration program required by federal law
    b. APMs must meet the following criteria to participate in this arm of MACRA
        i. Use certified EHR technology
        ii. Quality performance payment program is comparable to those in MIPS
        iii. Must have one of the following:
            (a) More than a nominal financial risk for monetary losses
            (b) Be a Medical Home Model expanded under Center for Medicare and Medicaid Innovation authority.
        iv. Have a certain percent of patients or payments through an Advanced APM.

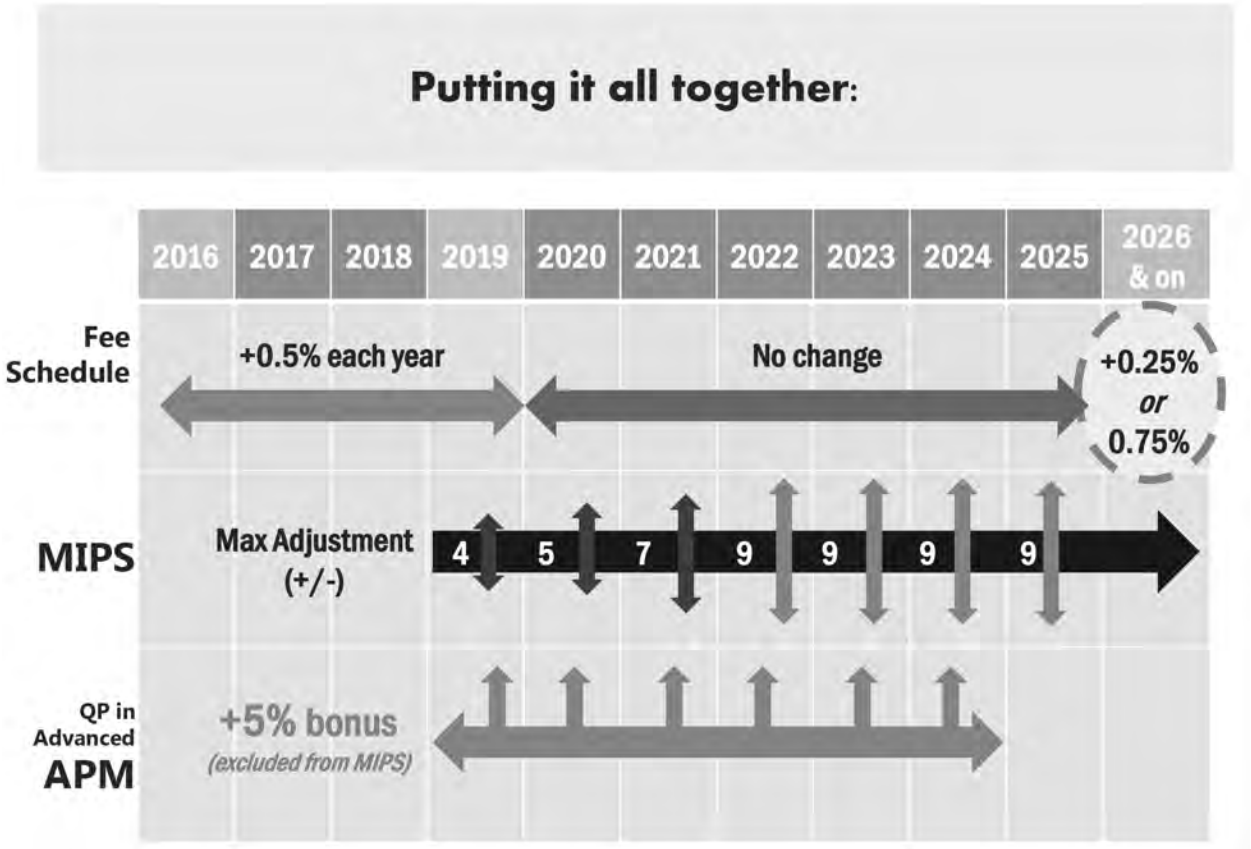

Figure 3. CMS training slide set. www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Quality-Payment-Program-MIPS-NPRM-Slides.pdf

QP= qualified practitioner.

Practice Case 4

Your site is pleased with the services you are providing. Administration is interested in investigating billing for your services. You present to administration and the medical staff the options for pharmacist billing in the physician-based office setting. These include "incident to" physician billing, transition-of-care participation and billing, chronic care and complex chronic care management billing, and billing pharmacist-conducted follow-up wellness visits. The compliance officer is not comfortable with the incident to billing of your services because they are titled MTM, which is not a covered benefit under Part B Medicare. In addition, the reimbursement rate may not be worth the effort. The office prefers to prepare for MACRA. However, the office is currently struggling with physician schedules for hospital-discharged patients to be seen in the 7-day higher-reimbursed time. A proposal is developed to use pharmacy services to complete most coordination and transition work within 72 hours post-discharge, either by telephone or within 30 minutes before the physician visit. Reducing time spent by the physician for discharge visits would create the needed physician visit slots within the 7-day period. Removing follow-up wellness visits would also create more visit slots in physician schedules. A plan is created to expand pharmacy services for transition-of-care and wellness visits.

During the past several years, several new opportunities well aligned with pharmacist services have become available to provide revenue generation to help support pharmacist patient care programs.

VII. SUSTAINING YOUR PRACTICE FOR THE FUTURE

A. Planning for Growth
   1. Using structure-related measures (remember the balanced scorecard), monitor the growth of your service at least quarterly.
      a. Number of referrals
      b. Number of patients in your clinic
      c. Number of visits
      d. Complexity of patients
      e. Swing patterns of the above measures
      f. Non–patient care workload
         i. Quality assurance or pay-for-performance measurement
         ii. Research activities
         iii. Administrative tasks
            (a) Committee work and meetings
            (b) Teaching
   2. At 90% capacity, have a plan for hiring additional staff.
      a. Know the timeline for hiring in your organization.
      b. Know the timeline and availability of qualified pharmacists and other staff in your community.
   3. Managing growth
      a. Short-term solutions
         i. Review processes and shift any work that you can to ancillary staff. May be easier to add ancillary staff, if needed, to your team.
         ii. Close your service to new referrals, or refer the patient back to the referring provider for continued management until you can secure the needed staffing for growth (least desirable).
         iii. Redistribute responsibilities in the non–patient care duties for the short term.
      b. Long-term solutions
         i. Consider cross-training other pharmacists in your organization to assist in coverage during high-volume periods.
         ii. Hire additional practitioners.

B. Strategic Planning. A management activity used to set priorities and direction for your clinic or organization so that you are adapting constantly to the environment and any changes foreseen
   1. Review your current situation and your business plan. Is this the direction you are going? Is it the direction you want to go? Change what has to be changed.
      a. Mission and vision
      b. Environmental scan
      c. Strengths, weaknesses, opportunities, threats (SWOT) analysis
      d. Quality program and balanced scorecard
      e. Identify what is needed to achieve excellence in your practice.
      f. Reset goals and objectives to achieve the desired level of practice.
   2. Setting the time interval. Many strategic plans use a timeline such as 5–10 years. Practice and health care is a rapidly changing environment, so the strategic planning document may be ongoing and visited regularly.

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ANSWERS AND EXPLANATIONS TO SELF-ASSESSMENT QUESTIONS

1. Answer: B

Pre-visit planning—including ordering need test before seeing a provider or alerting providers to current issues, new or on-going—with patients increases efficiency and work flow in primary care visits (Answer B is correct). Although it would make sense that technology and alerts would also improve visits, thus far this has not been shown primarily because of inconsistent use of technology by providers even when it is available (Answer C is incorrect). As patients' needs and issues are so highly variable, and we know that being patient centered improves care, it is difficult to meet those goals when policies and procedures do not provide enough latitude to adjust to individual patient needs and desires (Answer A is incorrect). The same concern makes a consistent time frame very difficult to manage if the goal is to improve patient-specific outcomes (Answer D is incorrect).

2. Answer: A

Making sure the providers are trained in correct blood pressure technique is a measure of your clinic structure, making sure blood pressure is documented at each visit is a process measure, achieving a blood pressure goal is an outcome, and knowing how that influences the organization's financial status is an important financial measure, thus meeting the four key elements of the balanced scorecard: structure, process, outcomes, and financial measurement (Answer A is correct). Answer B is lacking a structure measurement. Usability of the CPOE system would be a structure measure that could be used in this case to meet a balanced scorecard with the other measures listed. Answer C does not have a financial measure component. Answer D does not have an outcome measure component.

3. Answer: D

The Medicare shared savings program was established by CMS under the Affordable Care Act, as a new approach to health care delivery and to facilitate coordination and cooperation among providers to improve quality of care for Medicare beneficiaries and reduce unnecessary costs. To participate in the Medicare shared saving program, providers should either be or participating in an accountable care organization (ACO). Participants must report on the 33 ACO quality measures established by CMS (Answer D is correct). PQRS and meaningful use are measures for Medicare Part B, which, in 2016-17, is a fee-for-service model (Answers B and C are incorrect). HEDIS is a measure set for commercial plans (Answer A is incorrect).

4. Answer: C

Although BCACP status, PGY-2 training and MTM certification all may be desired credentials, they within themselves do not guarantee the hire will meet the needs of your organization nor be at the same skill level as you, the organization's current patient care pharmacist. (Answers A, B and D are incorrect). The trust for that individual will be on his or her performance, thus making peer review of services the best option for building the needed trust and confidence (Answer C is correct).

5. Answer: C

Under the Hospital Outpatient Prospective Payment System (HOPPS), all mid-level providers who are employees of the hospital and meet "incident to" rules bill at the same facility fee code. The current revenue for that code is a reasonable reimbursement (Answer C is correct). Medication therapy management codes are currently not recognized or payable under Medicare, making A an incorrect answer. Answer B is incorrect because "incident to" E/M codes are no longer recognized under HOPPS. Although the codes for chronic care management in answer D may be used, it is only for those patients who meet the criteria established by CMS. Additionally the reimbursement for CCM codes currently significantly less than the facility fee.

6. Answer: B

Medicare relaxed the "incident to rules" of direct supervision for aspects of the chronic care management and transitional care management requirements that may be done by auxiliary personnel within their scope of practice (includes pharmacists) to bill these particular codes. General supervision is felt sufficient because the Medicare-approved provider in these cases would be setting, sharing, and reviewing the patients' plans of care, thus providing general supervision (Answer B is correct). Answers C and D are incorrect because they require direct supervision; and MTM is not a recognized billing code under Medicare (Answer A is incorrect).

7. Answer: A

Although at this writing we do not know the final ruling, CMS has stated that the majority of the reimbursement under MIPS will be for the six measures required for each provider. Answer C, although true, is not applicable in this case because PCMH status automatically would have the provider meet the practice improvement portion based on the proposed rules. Although patient engagement, Answer B, and improved coordination of care, Answer D, are important within CMS's quality improvement plan, at this point it is not clear how those activities will play into the reimbursement formula. Your best strategy at this point is to make sure your services contribute to the six core measures that the provider/practice must choose (Answer A is correct).