Scaling Community Pharmacy and Payer Partnerships for Patient Care

A Resource Guide

Summer 2024

Prepared by Academia-Community Transformation (ACT) Pharmacy Collaborative

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"CPF's Flip the Pharmacy (FtP) program helps community pharmacies transform their practices to deliver patient care services that can be offered in value-based arrangements."

- Kelly Brock, Executive Director, Community Pharmacy Foundation (CPF)

Foreword

By Cody Clifton and Alison Haas, CPESN USA

The survival of community pharmacies depends on their ability to adapt and transform their practices to provide a growing list of patient care services while remaining sustainable amid numerous uncontrollable challenges. In 2019, the Community Pharmacy Foundation (CPF) recognized an opportunity to affect positive change in community pharmacy practice and made a significant commitment to fund its signature program, Flip the Pharmacy (FtP).[1] Flip the Pharmacy is a practice transformation initiative that helps community-based pharmacies move beyond filling prescriptions at a moment-in-time to providing patient care services and longitudinal care for patients over time.[2] In the first five years of the program, CPF invested over six million dollars towards community pharmacy practice transformation through FtP. The FtP program provides tools, resources, and hands on coaching to help community pharmacies transform their practices to deliver patient care services that can be offered in value-based arrangements. Community pharmacies engaging in FtP established and sustained capabilities of providing a diverse set of enhanced pharmacy services and reported them in Pharmacists eCare plans.[3] [4]

The Pharmacists eCare Plan Standard Initiative, a HL-7 clinical documentation tool, has allowed community pharmacies to demonstrate their value in a way that was not possible prior to the adoption of the eCare Plan.[5] The data submitted by pharmacies have been shared with health plans and other collaborators to recognize the value of pharmacist provided patient care. Within the FtP initiative, 1387 Pharmacies have participated in 74 FtP Teams between October 2019 to September 2024. These FtP pharmacies are a subset of CPESN Pharmacies and have submitted 4.1 million eCare Plans within this period. Over 8.1 million eCare Plans have been submitted by CPESN Pharmacies. A study performed in Pennsylvania found that participation in the Flip the Pharmacy practice transformation initiative was associated with greater engagement and completion of encounters within a payer program as compared to pharmacies that had not participated in FtP.[6]

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1 Community Pharmacy Foundation. (2019, June 27). The Community Pharmacy Foundation and CPESN® USA Announce a 5-year Partnership to "Flip the Pharmacy" and Transform Community-based Pharmacy Practice. https://communitypharmacyfoundation.org/insider/email_details.asp?uid=7009FC82-21D7-4D01-96A1-52D1EC7050F2

2 Kondic AMS, Trygstad T, McDonough R, Osterhaus M. Scaling Community Pharmacy Transformation with the 'Flip the Pharmacy' Implementation Model: Program Origins. Innov Pharm. 2020 Jul 31;11(3):10.24926/iip.v11i3.3399. doi: 10.24926/iip.v11i3.3399. PMID: 34007624; PMCID: PMC8075137.

3 Doucette WR, Bacci JL, Coley KC, Daly CJ, Ferreri SP, McDonough RP, McGivney MAS, Smith MG. A taxonomy for community pharmacy patient care services reported in Pharmacist eCare Plans. J Am Pharm Assoc (2003). 2023 Jan-Feb;63(1):173-177. doi: 10.1016/j.japh.2022.08.026. Epub 2022 Aug 30. PMID: 36115760.

4 Ferreri S, et. al., Community Pharmacy Practice Transformation Initiative: Evaluating sustainability of patient care services. Publication in Progress. CPF Grant 234. Grant Synopsis available: communitypharmacyfoundation.org/grants/grants_list_details.asp?grants_id=72091.

5 Community Pharmacy Foundation. (Accessed 2024, Nov 4). Pharmacist eCare Plan Initiative. https://www.ecareplaninitiative.com.

6 Herbert SMC, Herbert BM, Hake KL, McGrath SH. Flip the Pharmacy's impact on comprehensive medication management performance. J Am Pharm Assoc (2003). 2023 Jul-Aug;63(4):1070-1076. doi: 10.1016/j.japh.2023.04.006. Epub 2023 Apr 12. PMID: 37055010.

Figure 1: Total eCare Plans Submitted by CPESN Pharmacies

8,151,736 eCare Plans have been submitted since January 2019 from 2489 pharmacies. Many of these eCare Plans, which entail clinical data for patients, are submitted by CPESN Pharmacies for the purpose of quality assurance. eCare Plans, being structured data, has been valuable to payers and partners to understand clinical data submitted by pharmacies (i.e., interventions), which help to justify payment to pharmacies for services and pharmacies' efforts in improving care.

Though the eCare Plan was never intended to be a way pharmacies bill for services, eCare Plans submitted have paved the way for pharmacies to be paid for services.

One example is a payer program that is in 10 states at the time of this publication, which pays pharmacies for services/interventions for identified patients on a monthly basis with the submission of an eCare Plan with the opportunity for value-based reimbursement after the clinical measurement year.

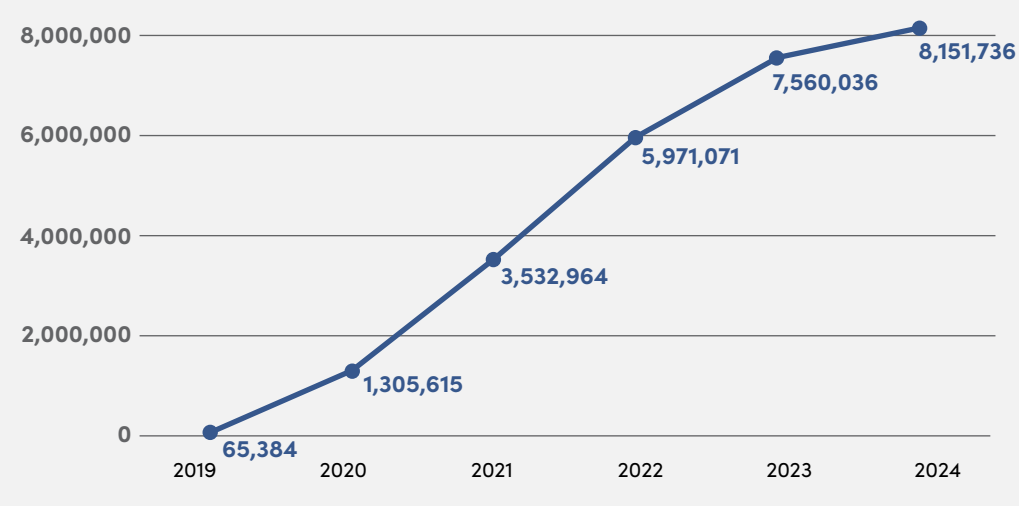

Table 1:
Summary of eCare Plan Data within CPESN USA and FtP

Flip the Pharmacy helped to accelerate the adoption of eCare Plan documentation based on health conditions (e.g., hypertension, diabetes). Over half of the eCare Plans submitted have been by CPESN pharmacies that have participated in the FtP practice transformation initiative.

	CPESN USA	FLIP THE PHARMACY (SUBSET OF CPESN PHARMACIES' DATA)
Total eCare Plans between Jan 2019 – May 2024	8,151,736	4,130,720
Total Pharmacies with at least 1 eCare Plan	2489	1387
Average eCare Plans submitted per pharmacy	3275	2,978
Total eCare Plans since 2019 that included a BP value*	2,023,848	1,144,235
Total eCare Plans since 2019 that included a A1c value*	24,620	9,428

*Eligible for HEDIS validation due to the lab value being structured data via a LOINC code

As the need to transition to a sustainable **service-based** revenue model becomes more apparent, community pharmacies need to contract in value-based arrangements. CPESN USA has been at the forefront of supporting such arrangements since the start of the clinically integrated network and now has had over 300 programs to date. CPESN USA is a clinically integrated, nationwide organization of pharmacy networks structured to advance community-based pharmacy practice. CPESN USA empowers community-based pharmacies that are deeply rooted within their community by fostering their ability to provide high quality, patient-centered enhanced services. CPESN USA originated from a Centers for Medicare and Medicaid Innovation Award to foster new payment models to support service delivery.

Many CPESN thought leaders have been instrumental in the creation of this resource guide. The CPESN care delivery model and its role as a contracting vehicle have proven successful. For example, one CPESN Network generated over $1.6 million in service-based revenue in 2023 through patient care programs. Not all community-based pharmacies are the same, and therefore, not all community-based pharmacies should be paid the same way. CPESN USA has enabled those pharmacies that provide high quality care to aggregate and express their value to the healthcare system through value-based arrangements.

For community pharmacy to succeed, pharmacies must differentiate their value beyond dispensing. This has been proven possible with outcomes data and revenue to pharmacies. To meaningfully participate in value based arrangements, pharmacies should engage in the Flip the Pharmacy initiative, utilizing practice transformation materials from www.flipthepharmacy.com and submitting structured HL-7 formatted data via the eCare Plan Standard, if supported by their technology. Ultimately, this will prepare pharmacies to maximize patient care opportunities and be paid for the value of their enhanced services by health plans.

"A key piece of insight from those operating in the value based contracting space is that we must ensure we are aligning goals across pharmacy, health plans, and patients – and ensure that our patients are always at the center."

– Cody Clifton, CPESN USA

CPESN USA

Pharmacies, payers, purchasers and partners alike rely on these local collaboratives to successfully implement programs, including value-based contracting and service opportunities. As a clinically integrated network, CPESN USA pharmacy providers collectively deliver health services to improve quality of care for patients in their local communities and to lower total cost of care. CPESN incorporates innovation and technology to empower its networks of pharmacies to succeed in an evolving outcomes marketplace. Transparency in value contracting ensures sustainability of independent community pharmacies as they leverage local trust for new provider and payer partnerships.[7] For further information or inquiries for CPESN USA please reach out to support@cpesn.com.

7 https://cpesn.com/index.php/about-cpesn-usa

Acknowledgements

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8 https://communitypharmacyfoundation.org/grants/grants_list_details.asp?grants_id=72152

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Developing the Resource Guide

The ACT Pharmacy Collaborative, CPESN USA, and University at Buffalo School of Pharmacy and Pharmaceutical Sciences (UB SPPS) collaborated on a Community Pharmacy Foundation (CPF) funded grant in response to the evolving landscape of community pharmacy and patient care. The UB SPPS research team led the development of this resource guide for executing contracts involving patient care programs within clinically integrated community pharmacies. The collaboration engaged a spectrum of key stakeholders responsible for the execution of patient care programs.

Through a methodological approach that combined a thorough review of current literature and the development of a semi-structured interview guide based on the PRISM framework, the project team was able to engage stakeholders to capture the breadth of experiences and perceptions around executing patient care programs within community pharmacies. The insights gathered from 14 stakeholders informed the development of this guide, ensuring it is robust and reflective of the real-world challenges and opportunities within community pharmacy practice.

This resource guide's framework is structured around key themes validated by

the research team and stakeholders. These themes include payer engagement, program intervention and design, contract set-up, communication, implementation training, measuring program success, and payment mechanisms for patient care programs. The research team expanded the framework and incorporated feedback from key stakeholders to develop the final resource guide establishing best practices for partnerships and clinically integrated networks of community pharmacies.

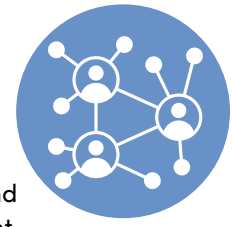
Resource Guide Development Timeline

December 2022	Workgroup meetings
January 2023	Resource guide process development
March 2023	Semi-structured interview guide and survey development
April 2023	Program coordinator (managing network facilitator) recruitment
May 2023	Surveys and semi-structured interviews
June 2023	Results analysis
November 2023	Resource guide drafting process with collaborators
November 2023	Dissemination: ACCP 2023 Annual Meeting
January 2024	Resource guide development
March 2024	Dissemination: APhA 2024 Annual Meeting
April 2024	Re-engage interviewees for additional resources
May 2024	Completion of resource guide full draft with stakeholder input
May 2024	Dissemination: PQA 2024 Annual Meeting
June – July 2024	Resource guide copy editing and creative finalization.
September 2024	Dissemination of Final Product

Utilizing this Resource Guide

This resource guide serves as a versatile tool for enhancing patient care within community pharmacies. It is designed to be broadly applicable, supporting not only community pharmacies but also payers, public health entities, and diverse healthcare associations. Its adaptable framework supports a wide array of patient care programs recognizing the various positions and needs of key stakeholders. It provides a roadmap for establishing, executing, and evaluating patient care programs while acknowledging that every healthcare entity and partnership are unique. Below is an introduction of how to utilize the resource guide for selected healthcare fields.

Community Pharmacy Network



Community pharmacy networks stand to gain significantly from this resource guide by customizing patient care programs to meet the specific needs of their communities and partnerships. This involves strategic development and execution of these programs, ensuring they are both effective and sustainable. The guide provides information and examples on steps involved in planning and executing patient care programs, ultimately facilitating comprehensive community health

improvements. Moreover, the guide encourages networks to expand their reach through collaboration with other healthcare providers, payers, and public health agencies. Such partnerships can lead to the enhancement of service offerings and the integration of pharmacies into the broader healthcare environment.

Payers

For payers, this guide provides a framework for forming strategic partnerships with community pharmacy networks. It provides insights into the capabilities and scope of community pharmacies and what they offer within the healthcare system. By leveraging the information on the scope of community pharmacies, payers can more effectively foster collaborations and optimize the integration of community pharmacies in their network. Additionally, the guide encourages payers to consider innovative care models that community pharmacies can implement. These models not only improve patient outcomes but also contribute to the efficiency and effectiveness of healthcare spending, promoting a value-based care approach.

Public Health Organizations

Public health organizations can utilize this guide to launch and enhance community health initiatives that leverage the accessibility of community pharmacies. By focusing on data utilization, these entities can better understand community needs and tailor their interventions accordingly. The guide can support public health entities in developing policies that incorporate pharmacies into the public health infrastructure, enhancing the delivery of health services. Departments of Health (DOH) can particularly benefit from these strategies, as they often lead efforts in disease prevention and health promotion at the community level.

Healthcare Associations

Healthcare associations play a crucial role in disseminating information and influencing interprofessional collaboration. By promoting this resource guide, healthcare associations can help standardize practices across the field and promote the utilization of community pharmacies to improve patient health outcomes. Furthermore, these associations can use the insights provided in this guide to reinforce advocacy efforts for community pharmacies in the healthcare system and for policy changes that support the expansion of community pharmacy services.

Consider this resource guide a tool not just for executing and managing patient care programs, but also a blueprint for building stronger collaborations across the healthcare spectrum. The framework outlined within the resource guide is designed to establish best practices for partnerships that ultimately enhance patient care and community health outcomes.

Pre-Chapter

By Christopher Daly

Established History of Community-based Pharmacy Patient Care Service Expansion

Community-based pharmacy practice has advanced significantly over the years, transitioning from a focus primarily on dispensing medication to playing a vital role in patient care and public health. As the needs of healthcare and the role of pharmacist expanded, community pharmacies began to provide various clinical services and actively participate in comprehensive health management. Clinical services such as medication therapy management and chronic disease management began to be offered. These services reflected the impact community pharmacies have on patient outcomes beyond traditional dispensing, emphasizing their importance in patient care and public health. This shift towards patient-centered care within community pharmacies was further driven by legislative changes and technological advancements, leading to diverse models and services like the appointment-based model, tele-pharmacy, health screenings, and social needs navigation.

Key Advancements to Community Pharmacy Practice

Clinical services – Community pharmacists are increasingly involved in providing clinical services such as medication therapy management (MTM), chronic disease management and health screenings. These services aim to optimize medication use and improve patient outcomes.
Medication therapy management – Community pharmacies have provided MTM services since 2004 to optimize drug use and therapeutic outcomes.
Immunizations – Community pharmacies have become key providers of immunizations, expanding access for patients.
Point-of-care testing (POCT) – Many community pharmacies offer testing for flu, COVID-19, and cholesterol. This offers a quicker and more accessible way to patients to determine next steps for their healthcare.
Tele-pharmacy – Tele-pharmacy has expanded access to pharmacy services, especially in rural and underserved areas. This service also allowed remote dispensing, counseling, and disease management.
Appointment-based model – The ABM focuses on patient adherence to medications and efficiency within pharmacy operations. The three components include prescription synchronization, monthly call to the patient, and scheduled monthly appointments.
Social determinants of health programs – Community pharmacies are expanding roles and cross training pharmacy personnel to perform health related social needs screenings. A growing number of community-based pharmacy settings employ community health workers to established these key programs.

Community-based pharmacy has moved beyond the traditional role of dispensing medications and expanded its offerings of patient care services. Due to a variety of key factors, community-based pharmacies have become leaders in public initiatives. These key factors include close proximity to all

United States populations including underserved priority populations, little to no wait for access to care, and a cost-effective efficient health care delivery.[9] The exemplary example is community-based pharmacy was responsible for greater than half of the total COVID vaccines provided during the pandemic. This was possible due to their community centric locations, accessibility to patients, and previous expansion of scope practice allowance.

Community-based pharmacies are geographically diverse and are capable of addressing high needs diabetes disease burden as defined by public health entities. Publicly available data focusing on social vulnerability index (SVI) and the potential negative effects caused by external stressors on human health helps to position the need for health care services. The data themes demonstrate socioeconomic status, household characteristics, racial and ethnic minority status, housing, and transportation for specific counties. This aligns with a diverse offering of patient care services where community-based pharmacies help to address the need of greatest disease burden and alignment in both urban and rural settings.

Community-based pharmacy models have adapted to the growing need for patient care services

The increased need for patient care services led to many changes in the model of community-based pharmacy. Overall, there were many high-quality published studies and public projects that demonstrated significant patient care impact. Below is a select sample of these resources. To establish patient care service alongside dispensing activities, one approach led to developing an appointment-based model utilizing the benefits of medication synchronization. At the same time, you had similar interests among community-based pharmacies of different ownership to come together in new models to focus on patient care services.[10] This was occurring at both the state and national levels.

9 Berenbrok LA, Gabriel N, Coley KC, Hernandez I. Evaluation of Frequency of Encounters With Primary Care Physicians vs Visits to Community Pharmacies Among Medicare Beneficiaries. JAMA Netw Open. 2020;3(7):e209132. doi:10.1001/jamanetworkopen.2020.9132

10 Goode JV, Owen J, Page A, Gatewood S. Community-Based Pharmacy Practice Innovation, and the Role of the Community-Based Pharmacist Practitioner in the United States. Pharmacy (Basel). 2019 Aug 4;7(3):106. doi: 10.3390/pharmacy7030106. PMID: 31382690; PMCID: PMC6789634.

COMMUNITY-BASED PHARMACY MODEL DEVELOPMENTS		
MODEL (YEAR)	**TITLE**	**CONTRIBUTIONS**
Community Pharmacy Integration (2003)	The Asheville Project: long-term clinical and economic outcomes of a community pharmacy diabetes care program	• Clinical and economic impact • One of many to show value
Citation: Cranor CW, Bunting BA, Christensen DB. The Asheville Project: long-term clinical and economic outcomes of a community pharmacy diabetes care program. J Am Pharm Assoc (Wash). 2003 Mar-Apr;43(2):173-84. doi: 10.1331/108658003321480713. PMID: 12688435.		
Pharmacists in Public Health (2011)	Improving Patient and Health System Outcomes through Advanced Pharmacy Practice	• Make long case for pharmacy as public health contributors
Citation: Giberson S, Yoder S, Lee MP. Improving Patient and Health System Outcomes through Advanced Pharmacy Practice. A Report to the U.S. Surgeon General. Office of the Chief Pharmacist. U.S. Public Health Service. Dec 2011		
Establishment of statewide practice network (2011)	Evaluating Pennsylvania Pharmacists' Provision of Community-based Patient Care Services	• Community pharmacists are currently providing robust clinical services and interested in joining statewide network.
Citation: Osborne MA, Snyder ME, Hall DL, Coley KC, McGivney MS. Evaluating Pennsylvania Pharmacists' Provision of Community-based Patient Care Services to Develop a Statewide Practice Network. Innov Pharm. 2011 Dec 1;2(4):61. doi: 10.24926/iip.v2i4.244. PMID: 25405069; PMCID: PMC4232935.		
Pharmacy Appointment Based Model (2013)	Pharmacy's Appointment Based Model: A prescription synchronization program that improves adherence	• To establish a care model through work med sync to improve adherence
Citation: https://www.aphafoundation.org/appointment-based-model https://www.aphafoundation.org/sites/default/files/ckeditor/files/ABMWhitePaper-FINAL-20130923(3).pdf https://www.aphafoundation.org/sites/default/files/ckeditor/files/ABMImplementationGuide-FINAL-20130923.pdf		
Establishment of first national CIN of Community-based Pharmacy (2014)	Care team perspectives on community pharmacy enhanced services	• Organized capacity for care management and medication optimization services, to populations in greatest need. • CCNC Website
Citation: Fay AE, Ferreri SP, Shepherd G, Lundeen K, Tong GL, Pfeiffenberger T. Care team perspectives on community pharmacy enhanced services. J Am Pharm Assoc (2003). 2018 Jul-Aug;58(4S):S83-S88.e3. doi: 10.1016/j.japh.2018.05.009. PMID: 30006190.		

Clinically Integrated Network (CIN)

Two driving forces behind the community-based pharmacy model change were adjusting reimbursement models and practice transformation. A nationally recognized practice transformation effort called, Flip the Pharmacy (https://www.flipthepharmacy.com/), looked to equip pharmacies with best practice on implementation domains to progress workflow significantly aimed to increase patient care activities. Any pharmacy can utilize these resources, however, a pharmacy that participated in the structured accountability programs led to greater success.. Using the pandemic as our exemplary example, COVID Best

Practices (https://www.covidbestpractices.com/) created a central repository of vaccination, testing, treatment, and general workflow resources for community-based pharmacies to receive timely guidance on how to build successful programs on very short notice.

COMMUNITY-BASED PHARMACY NATIONAL COMPANIES	
COMPANY	**NUMBER OF STORES**
CVS Health	9,728
Walgreens Boots Alliance	8,785
Walmart	5,326
Health Mart System (Franchise)	4,734
CPESN USA	3,500
The Kroger Company	2,856
Rite Aid	2,309

Citation: National Retail Federation. (July 5, 2023). Number of stores of the leading drugstores in the United States in 2022. In Statista. Retrieved April 23,2024. https://www.statista.com/statistics/197848/number-of-stores-of-top-drug-stores-in-the-us/

Community-based pharmacies growth through Clinically Integrated Networks

A Clinically Integrated Network (CIN) is a partnership among healthcare providers that is designed to improve the quality and efficiency of care and reduce costs. From a governance standpoint, CPESN USA, as a CIN, is governed by and led by pharmacy providers, which is vital to its success. In the context of community pharmacy and patient care services, a CIN extends the clinical integration beyond the traditional hospital setting and includes community pharmacies as active participants in the coordinated care model. The integration of community pharmacies leverages the accessibility of community pharmacists to enhance patient care, improve medication management, and actively contribute to health outcomes. From a legal perspective, it represents a single signatory option for payers and third parties.

In specific reference to the CPESN USA model, as studied for this guide, participant pharmacies are individually owned and operated. This single signatory authority allows for scalable high-quality services that are locally based. It ranks among the highest number of entities under one umbrella when compared to its national counterparts. Another requirement of the CIN is for participant pharmacies to maintain a minimum service set. These enhanced services are delivered at the discretion of the local community-based pharmacy. However, many pharmacies transcend this basic requirement and offer an entire host of additional services aimed at reducing costs and optimizing patient care.

CPESN USA MINIMUM SERVICE SET https://cpesn.com/pharmacy-support	
Comprehensive Medication Reviews	Offering a systematic assessment of medications, including prescription, over-the-counter, herbal medications and dietary supplements to identify medication-related problems, prioritize a list of medication therapy problems and create a patient-specific plan to resolve medication therapy problems working with the extended healthcare team.
Face-to-Face Access	Providing each patient receiving a dispensed medication from the participating pharmacy ready access to unscheduled face-to-face meeting(s) with a pharmacist employed by the participating CPESN pharmacy during operational hours. For pharmacies not staffing a pharmacist during operational hours, a non-pharmacist involved in the patient's care must be available for the unscheduled face-to-face visit as well as a pharmacist via appropriate telecommunication methods upon request by the patient or the pharmacy staff-person who provides service in support of that pharmacy.
Immunizations	Screening patients for ACIP recommended immunizations, educate patients about needed immunizations and administer immunizations when appropriate.
Medication Reconciliation	Comparing a patient's medication orders to all of the medications that the patient has been taking (active, chronic, as needed and OTC including herbal) to avoid medication errors. This service is especially important during transitions of care when patients are most vulnerable to medication errors or mishaps.
Medication Synchronization Program	Aligning a patient's routine medications to be filled at the same time each month. The pharmacists will provide clinical medication management and monitoring for progression toward desired therapeutic goals during the patient appointment at time of medication pick-up or delivery.
Personal Medication Record	Providing each patient a comprehensive list of current patient medications manually or from dispensing software.

LIST OF EXPANDED PATIENT CARE SERVICES	
CATEGORIES	**EXAMPLES OF SERVICES**
Enhanced Medication management	24 Hour Emergency Service on Call, Dispensing and Non-Dispensing, Compounding - Non-Sterile and Sterile, Specialty Pharmacy Dispensing
Social determinants of health screenings	Multi-Lingual Capability, Nutritional Counseling, Local Community-Based Organization Referrals
Health risk assessments	Hepatitis C. Treatment, HIV PrEP, Standardized Assessments, Mental Health Screenings (e.g. – PHQ-9), Asthma Control Test (ACT)
Comprehensive adherence programs	Adherence Packaging, Targeted Disease State Programs, Vitamin and Nutritional Supplementation
Care coordination	Care Plan Development, Home Delivery, Home Visits, Medication Injections (e.g. – mental health), Transitional Care Management
Pharmacy monitoring services	Clozapine Dispensing and Monitoring, Collection of Vital Signs, Naloxone Dispensing
Point-of-care testing	COVID, Strep, Influenza, A1C, Pharmacogenomics
Priority Populations	Asthma, COPD, COVID, Diabetes, Respiratory disease (COVID, Influenza, Streptococcus), Pediatric patients, Older adults (>65)

CINs are moving towards a new normal as pharmacies are seen as accessible capable places to receive patient centered care. As the distribution of COVID vaccines sought a pharmacy aggregation pathway in the Federal Retail Partner Program (FRPP) there are successes in scaling these models for patient care. CPESN USA participant pharmacies see positive placement in a pharmacy care-oriented market. The SWOT analysis demonstrates the networks' capabilities and strategic abilities in the expansion of these care activities.[11, 12, 13]

11 https://www.pharmacytimes.com/view/pharmacists-play-vital-role-in-health-screenings

12 Fathima M, Naik-Panvelkar P, Saini B, Armour CL. The role of community pharmacists in screening and subsequent management of chronic respiratory diseases: a systematic review. Pharm Pract (Granada). 2013 Oct;11(4):228-45. doi: 10.4321/s1886-36552013000400008. Epub 2013 Dec 20. PMID: 24367463; PMCID: PMC3869639.

13 Kelling SE, Rondon-Begazo A, DiPietro Mager NA, Murphy BL, Bright DR. Provision of Clinical Preventive Services by Community Pharmacists. [Addendum appears in Prev Chronic Dis 2016;13. http://www.cdc.gov/pcd/issues/2016/16_0232e.htm.] Prev Chronic Dis 2016;13:160232. DOI: http://dx.doi.org/10.5888/pcd13.160232

SWOT ANALYSIS FOR CPESN USA CIN MODELS
Strengths
Emphasize personalized, locally sourced, patient-centered care
Participant pharmacies have pulse of local community members and priorities
Flexibility of model allows for more adaptive service designs, compared to larger companies
Collaboration and interdisciplinary care models are promoted in patient care programs
Weaknesses
Smaller-scale community pharmacies may have fewer resources, compared to larger companies
Financial limitations due to decreasing dispensing margins, compared to larger companies
Patient reach will be through combined network overlay
Workforce and staffing challenges face all pharmacy settings
Opportunities
Increase need for individualized whole-person care as provided by local providers
Partnerships with local healthcare organizations and community-based organizations are growing
Pharmacies accessibility and locally based allow for patient advocacy for patients in the community
Threats
Competition for scare health care resources within pharmacy and other healthcare providers
Regulatory changes impacting community pharmacy operations may slow practice transformation efforts
Scalability mandates (e.g. – data infrastructure) required for collaboration may draw on limited resources

Payment Reform is here, and Community-based Pharmacies are Ready

Government plans, Medicare and Medicaid are moving towards value-based payments for providers as established by past initiatives. These payments are made directly in relation to performance metrics set by quality standard boards. One high-level performance metric is diabetes A1C control where a specific metric is medication adherence in the oral diabetes class. Optimizing these complementary measures requires a combination of care coordination and medication optimization services. While a medical provider often orders the A1C, pharmacies can support patients, providers, and health plans by assessing A1C with a point of care test in the pharmacy share back with the care team and health plan. Value-based arrangements enable multiple health care providers to collaborate in delivering comprehensive care to the patient.[14]

CINs like CPESN USA are well-positioned to engage payers with varying priorities, patient populations, and goals. It is this mindset of practice adaptability by which a program can be designed to impact care and reduce costs. This resource guide outlines best practices for implementing patient care programs in collaboration with payers, aiming to scale these services across clinically integrated community pharmacy networks nationwide. The appeal of these materials is expected to positively impact a wide audience ranging from program facilitators with companies or CINs, standard setting organizations (e.g. – PQA), pharmacy associations, and payers.

14 Doucette WR, DeVolder R, Heggen T. Evaluation of financial outcomes under a value-based payment program for community pharmacies. J Manag Care Spec Pharm. 2021 Sep;27(9):1198-1208. doi: 10.18553/jmcp.2021.27.9.1198. PMID: 34464212; PMCID: PMC10390956.

Representative quotes placed throughout are from current managing network facilitators or luminaries and help to reinforce content.

"It's not what you know, it's who you know."

"Here's our [pharmacy location] map. Here's where our NPIs are located. Here's what our pharmacists can do and the services they can provide."

Chapter 1: Engagement

By Stefanie Ferreri

Engaging with payers requires a multi-pronged approach including engaging with those inside your network as well as those outside your network. Many times, the first step in engaging in a new payer partnership outside of your network requires using professional contacts to identify people you can partner with. Connecting with people on social media and at regional and national conferences is an important part of the engagement process. Similarly, pharmacies have to use their internal network to identify when they are ready to engage with external partners or payers for providing patient care services.

This chapter focuses on understanding when the pharmacy network is ready to have payer partner conversations. First and foremost, each network should have a leader who is able to support and encourage pharmacies in the network. Within CPESN this leader is called a Managing Network Facilitator (MNF) or a Luminary. More broadly the leader may be a District Pharmacy Supervisor. Whichever leadership strategy your pharmacy network utilizes, leadership is essential to the success and longevity of the network.

Leadership skills that have resulted in successful external partnerships include those with strong organizational, communication and technical skills. Leaders are responsible for scheduling appointments, following up on contracts, assisting pharmacies with patient enrollment, ensuring program metrics are being met and troubleshooting any billing and documentation questions on various technical platforms. The network leaders should also have a high-level understanding of the strengths and weaknesses of the pharmacies in the network and set a vision for the network.

Leaders must serve as facilitators to improve upon the network's weaknesses and leverage its strengths. One of the first items leaders should be aware of is which pharmacies have participated in workflow transformation, meaning the pharmacies have shifted from a mindset of reactively filling prescriptions at a moment in time to a proactive approach of caring for patients over time. One easy way to capture this data is by knowing which pharmacies in the network participated in a practice transformation initiative such as Flip the Pharmacy (FtP). For those that did not participate in a workflow transformation initiative the network leaders should identify a strategy to encourage peer-to-peer coaching in workflow transformation.

A proactive approach to caring for patients in pharmacy workflow allows for new payer opportunities. In addition to understanding which and how many pharmacies have shifted their workflow transformation, the network should also have a methodological approach to data management, communication, and a grasp of technology needs.

Established pharmacy networks may have a database based on pharmacy National Provider Identifier (NPI) and zip code that assists in identifying strengths of the network. Knowing the strengths of the network prior to engaging with an external partner or payer makes engagement and next steps more likely to be a success. Table 1.1 has examples of data that networks can collect prior to engaging with payers.

TABLE 1.1. TYPES OF PHARMACY DATA COLLECTED BY NETWORKS
Delivery service radius
Medication adherence packaging
Participation in payer contracts
Patient care services offered
Payor mix (e.g. Medicaid, Medicare, Third party)
Percent of prescription volume using medication synchronization
Pharmacy Champion who oversees services
Pharmacist credentials
Scope of the network (state-wide, across state-lines, certain counties in the state, national)
Technical assistance with pharmacy vendors and software

Pharmacies that offer patient care services in their workflow are able to more readily introduce new patient care services into workflow.[15] If the majority of pharmacies in a network offer services, then this signifies the network has the ability to support training programs and provide quality improvement for new programs.

Lastly, a network should have an established communication strategy with participants as explored in Chapter 4. Many networks have newsletters, social media pages, text messaging features, websites and other various forms of communication so pharmacies can learn best practices from one another. The communication strategy not only alerts networks to new opportunities, it also provides a support mechanism to share best practices to take care of patients in the payer programs.

Once network leaders feel they have pharmacies who are transforming their workflow, have data regarding network strengths and a solid communication strategy they are now ready to engage with payers. The number of pharmacies needed for adequate network coverage may depend on the geographic needs of the payer and their scope of work. For example more pharmacies are needed for a statewide contract compared to a regional multi-county contract.

Engaging payers

Congratulations! You have a meeting with an external payer or partner. Setting up that meeting is a step in the right direction. Preparing for the meeting is extremely important. Table 1.2 briefly outlines the questions to consider when engaging with external partners or payers.

15 Bacci JL*, Ferreri SP, Coley KC, Daly CJ, Hake KL^, Herbert SM, Hughes TD, McDonough RP, Roller JS^, McGivney MS, Smith MG, Doucette WR. Qualitative analysis of a community pharmacy practice transformation initiative. J Am Coll Clin Pharm. 2022 Nov 05;1–17. doi:10.1002/jac5.1728

"They [payers] might not realize that pharmacy can give them what they need in other areas that they weren't even thinking we could help them with and move that needle and make their outcomes better."

What

Identifying what the purpose of the meeting is important to answer *Who* needs to be at the meeting. If the intended purpose is exploratory then having leaders attend and share the strengths of the network will be vital. If the purpose of the meeting is to pitch a proposed solution to an already identified problem, then having a subject matter expert who has implemented the solution is essential to attendance. During the course of the meeting, external partners will want to know network strengths and capacity. External partners will also want data regarding prior experiences so they can understand network credibility. No matter the intended purpose of the meeting, network leaders should be ready to share quantitative and qualitative data regarding network capacity and experience.

Who

Network leaders need to know who will be attending the first meeting. Depending on the intended goal of the initial meeting it will be important to decide who needs to be in that meeting from a network perspective. Many times the first meeting is a high-level exploration meeting to decide whether this partnership should proceed. Both parties need to bring people who have an understanding of the strengths of their organizations and the needs they want fulfilled. For example, a payer may have a need to lower hospital readmissions for diabetes patients. A pharmacy network may have 15% of their network who offer a diabetes prevention program. If both parties know the need pertains to diabetes then inviting people to the meeting who can describe the strengths from both sides is essential.

Prior to the initial meeting ask who the payer intends to invite. Will someone from the medical benefit be present in addition to someone from the pharmacy benefit? Will an actuary be present? Who from the payer mix will be present? Will it be a Part D payer, a third party payer, or an Accountable Care Organization (ACO)? Or perhaps a combination of all of the above? Understanding the organizational structure of the payer will be essential to know in advance of the initial meeting.

When

Once the what and who are discussed, both parties should agree when the meeting will occur. Does the timing of the meeting align with the end of the fiscal year for the payer or a time when a new contract or program would be likely to begin? Does it align with the new benefits rolled out for pharmacies? Understanding the "why" behind the timing of the meeting will determine the urgency of the meeting to occur. Agreeing to whether the meeting occurs during normal business hours, at the start of the day or the end of the day will also have implications for some pharmacies.

Where

When starting new relationships, face-to-face meetings allow for trust to form quicker than a virtual environment. Identifying who will host the first in-person meeting and where it will occur is important. Make sure a friendly, clean environment with adequate parking is a nice suggestion for a first meeting. After an initial meeting determine whether continued face-to-face meetings will occur or if a virtual or hybrid option will be best. If hybrid or virtual are selected, have an upfront conversation about whether cameras will be on or off for the meetings.

How

Identify how the meeting structure will be organized. For example, who will lead the meeting? Which party takes the lead or is it a shared approach? Identify how the parties want to execute on the meeting (e.g. a digital agenda, working groups, PowerPoint presentations).

TABLE 1.2. QUESTIONS TO CONSIDER WHEN ENGAGING WITH EXTERNAL PARTNERS OR PAYERS

What	What is the intended purpose/outcome of the meeting?
Who	Who needs to attend this meeting? Who will lead the meeting?
Where	Will the meeting be in-person or virtual?
When	What is the frequency of the meetings?
How	Who is on point to create the agendas for the meetings? What is the meeting structure (e.g. conversational, presentations)? How will the meeting be executed (e.g. working groups)?

Post-engagement

You had a successful first meeting. Now what? Be sure that the meeting ends with an agreement about when follow-up will occur. The follow-up meeting date, time and location can be included in a meeting summary. Be sure to leave the meeting with Specific, Measurable, Achievable, Relevant, and Time-bound (SMART) goals completed. What does each stakeholder need to do? And in what timeline? Decide whether the next meeting will be in-person, virtual, or if emails are sufficient. Decide who is the minute taker and who will be on point to make sure all parties follow through with their action items.

Chapter 2: Program Intervention Design

By William Doucette

A vital part of your program is to design the interventions that will be performed by the network pharmacists. Some key decisions are needed to determine the scope of the program, including selecting what services are to be delivered, identifying what pharmacies will be involved in the program and which patients will participate in it. For example, an intervention might focus on a particular disease or medication type, or it could be broad-based and be concerned about managing all medications to affect total healthcare utilization and costs. Similarly, a program could be focused on patients with a particular condition (e.g. diabetes) or could be much broader for all patients with a particular healthcare coverage or employer. Key variables for scope of a program or intervention are shown in the following table 2.1.

TABLE 2.1. KEY VARIABLES OF PROGRAM INTERVENTION

SCOPE COMPONENT	EXAMPLE
Financial	Maximum total payments; Payments per patient/activity/ performance level
Clinical	Providing comprehensive medication management services; Diabetes management
Geographical	Communities; Counties or regions
Number of patients	Total number of covered lives; Number of patients attributed to each pharmacy
Health equity	Screening for social determinants of health; Referrals to social services/resources
Network capacity needed	Number of pharmacies needed; Time and skills needed to deliver services; Personnel ready and able to provide care

"We come back to our luminaries and say, 'Here's the service set that aligns with this need. Here is a proposed reimbursement payment model. What do you think? Does this work? Can you sustain it in your practice? Does the amount of work, or does the payment justify the amount of work that needs to be done?"

As the scope of the program is being worked out, the network representative should try to align the services to meet the needs of the payer. One issue for alignment is to match the level of payment with the services being delivered and their expected effects. An initial consideration here is covering the costs of service delivery and some profit. To reliably estimate cost of service, the typical amount of staff time should be determined – perhaps through discussions with luminaries/practitioners or from published literature. Another consideration with financial alignment is the expected benefits to the payer, which might derive from reduced healthcare utilization by the patients, meeting some payment-based metric or some other means. If these considerations are viable, then higher payments might be discussed.

A second alignment issue is to clarify the type and intensity of patient engagement by network pharmacists. The payer likely will have a group of patients targeted for the program. The network should clarify how the pharmacies will know which patients to serve under the program. For example, will they receive a list of attributed patients, or will the program be more open? Can a pharmacist or other provider refer anyone to the program? Also, the frequency of pharmacist services in the program should be established. For example, will there be an initial visit along with multiple follow-up visits? Are regular visits (e.g., monthly or quarterly) expected. Is there a stated expectation for how long a pharmacist will be with a patient during a care visit? If so, what

is it? In addition, some discussion is needed to determine what information the payer wants and the pharmacy can provide about the care being provided. For example, does the pharmacist complete an eCare plan and submit it? Are there any specific measures the pharmacy needs to report other than dates of service? Finally, there should be agreement about any training the pharmacists should receive to be able to participate in the program. This could relate to the clinical aspects or to other issues such as documentation processes.

Another key topic for discussion is the timeline for the program. A basic question is the length of the program. Will it be one year or multiple years? When is the targeted start date for the program. It is important to give the network sufficient time to prepare, train and onboard pharmacies to deliver the program services. Implementing a new program can readily take 6-9 months, depending on the readiness of the network pharmacies. Activities during program implementation could include credentialing, training and determining patient numbers for network pharmacies. Once the program has launched, will continuous quality improvement be conducted to assess engagement, quality of program delivery, early milestones, and outcomes?

After a program has operated for the planned period, there can be an evaluation of it. Collection of data for such an evaluation could occur during the time of operation of the program. For example, pharmacists could collect PHQ-9 measures several times over 12 months as part of an evaluation of effects of an antidepressant adherence program. Timing of data generation by the program, data collection by evaluators and timing of the actual evaluation activities should be discussed to assure a viable evaluation gets done in a timely fashion. Considerations for who will do the evaluations should be discussed and whether that is included in the payment.

The payment model for the program should be discussed during this planning and implementation. See Chapter 7 for more details about payment mechanisms. Some payment mechanisms include fee-for-service (FFS), value-based and capitation (e.g., per member per month). FFS pays a set amount for a given service delivery. Value-based payment typically uses performance metrics to determine how much is paid for the care during a set period for a given group of patients. Capitation is payment of an amount, often per member per month (PMPM) – for each patient being served by the program.[16] In addition to payments for service delivery, there should be discussion about payment for the network administering the program. Another issue here is establishing the frequency of payments from the payer. For example, a payer might want to pay every 6 months, while the pharmacies might want monthly payments. Ideally, payment for network/program administrative activities will be included in the contract. These activities include tracking pharmacy and network performance, monitoring billing and payments, communicating with network pharmacies and the payer, preparing various materials (e.g. forms, tools, patient education pieces), coaching on technology use and planning and coordinating evaluation of the program. Please review the additional resource supplied outlining the typical onboarding process and example proposals.

16 Doucette WR, DeVolder R, Heggen T. Evaluation of financial outcomes under a value-based payment program for community pharmacies. J Managed Care Pharmacy. 2021;27(9):1198-1208

ADDITIONAL RESOURCES
(provided by program coordinators)

Appendix 1: Example Onboarding Email

Appendix 2: Cardiovascular Disease Grant Proposal

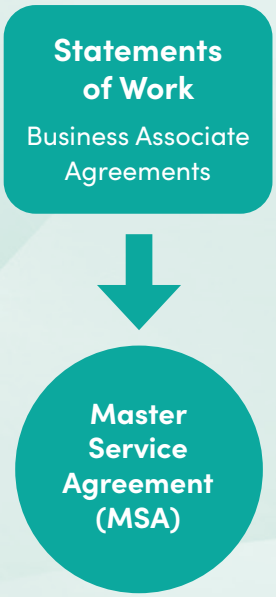
Appendix 3: Diabetes Focused Grant Proposal

Appendix 4: Vaccine Gap Screening and Enhanced Services Proposal

Payer Perspective – Important Insights from Payers

- Pharmacy measures that tie back to existing health plan incentives provide the easiest business case to make to payers – pharmacy-specific measures that aim to improve medication use more broadly and reduce total cost of care may be more challenging to pitch.
- For timelines, allowing sufficient time (at least 3 months) for contracting prior to starting work (or having mutually understood good-faith work occurring during contracting, as appropriate or possible) is strongly recommended.
- Carefully consider what timeline to show impact is reasonable, especially if tied to monetary incentives. Consider evaluating literature or comparing it to previous experience to create reasonable estimates of timeline to impact.

Chapter Disclaimer: *Many of the details located within a payer contract are proprietary and confidential and only for the parties defined within. This chapter looks to explore the approach and relationship of a clinically integrated network with prospective payers. By no means does this offer legal advice, and expert legal counsel should be sought in these scenarios.*



Chapter 3: Contract Set-up

By Cody Clifton, Christopher Daly and Alison Haas

Clinically integrated networks of community pharmacies looking to offer patient care services will need to enter into legal binding arrangements with a prospective payer that considers many factors including pharmacy and patient population characteristics. As discussed in previous chapters, these factors for consideration vary greatly dependent on payer, which may include details about patient populations, targeted outcomes, and various terms of the agreement. Other third-party administrators may need to be considered as essential to this process as well. Within the agreement, list reimbursement methodologies (e.g. – fee-for-service, value-based, etc.), services provided, data sharing, and other details.

Essential legal documents from the perspective of a clinically integrated network may include: Master Service Agreement (MSA) and Statement of Work (SOW) comprising the overall contracts. All have unique elements to drive implementation and sustainability for the program duration. Developing these documents requires all parties involved to ensure all pertinent information is included to ensure clear expectations and avoid confusions. All patient-centered programs are unique, and documents should be tailored accordingly. This resource guide will review the different components needed for the documents. Importantly, structures are needed to help meet unique elements for legal and compliance, which include, but are not limited to, data security, contract management, and program operations.

The **Master Service Agreement (MSA)** provides a structure, or legal framework, for contracts between the involved parties for long-term projects. A MSA includes the general roles and responsibilities of each party to reduce the need to discuss every activity or step in the process of completing the program. It also entails any recurrent services or activities for the project. The MSA structure is broad compared to the SOW, which is extremely detailed. Table 3.1 overviews suggestive key terms and considerations when establishing a payer contract. It is important to consult legal counsel when reviewing, understanding, and negotiating these components.

TABLE 3.1. POTENTIAL MSA COMPONENTS
Confidentiality
Dispute resolution
Geography
Intellectual property rights
Limitations of liability
Payment terms
Product delivery
Venue of law
Warranty
Work standards

A **Statement of Work (SOW) i**s a document or section that outlines detailed information for all involved parties.[17] The goal of a SOW is to ensure that there is a shared understanding of the expectations and responsibilities. It is important to have sufficient information within the SOW to conduct and evaluate programs/projects.

The following are recommended elements with pertinent details to be included for successful project completion:

17 https://legal.thomsonreuters.com/blog/what-is-a-sow/

- **Overview of project:** A brief yet specific description of the project highlighting the target populations, scope of interventions or services, expected outcomes, and timeline of program.
- **Scope of work:** Details of what needs to be accomplished for the project to be complete. This includes activities completed by involved parties and who will be completing them.
- **Training of Key Personnel:** Best practice is to outline the responsible parties required to offer, track, and monitor program training. Can be more than one party responsible.
- **Workflow of Intervention:** A thorough description of the process of the services offered, naming specific personnel and outcomes to be collected. Sometimes, these are mapped to a standard patient care process (e.g. – PPCP). Visual representation often helps to augment a description if complex.
- **Deliverables:** The action items or milestones that need to be completed for payments to occur. This includes reports, patient health outcomes, patient outreach, etc. The timeline and payment amount at each deliverable should be specified in the SOW.
- **Timeline:** Sets deadlines for milestones and what needs to be completed for payments. Timelines should be clear and realistic.
- **Payments:** Ideally these accompany the deliverable section if completed at regular time intervals. If ongoing payments for volume-based activities (e.g. – number of screenings) details to be spelled out here.
- **Outcome measures:** Specifically defined measures based on target population and services provided. The outcomes measure in most cases is tied to the deliverable and payment.
- **Data analysis:** A description of the formal process by which both parties will agree to an assessment of the intervention and associated outcomes. Best practice should focus on details that both parties agree to at onset knowing the resources needed to be in place (e.g. – data collection process, personnel (analysts), and methodology).
- **Data collection/sharing:** This section details the process by which the network of pharmacies and payer will engage in data collection and sharing. A detailed description is needed along with potential various legal riders (e.g. – business associate agreement) to be in place for the sharing of personal health information.

The overarching **contract agreement** will be between the various parties as defined within.[18] The subcontract may be a more appropriate term if there are more than two parties involved what are needed for the various tasks to execute.

Table 3.2 lists potential contract components. Again by no means does this look to be comprehensive where other legal expertise is needed to fully develop this document. The typical process is for one of the parties to establish the baseline document. This is based off past similar contracts. Then legal counsel on both sides engages in back-and-forth revisions to meet a standard for agreement.

Clinically integrated networks (CINs) have become engaged in value-based

18 https://www.ama-assn.org/system/files/payor-contracting-toolkit.pdf

contracting for patient care services. They have made progress in developing and executing on these contracts. Key administrative support within CINs have many years of knowledge and experience performing these activities and can leverage in next steps. The administrative support shares that it is important to share value and benefit with payers looking to engage in value-based contracts.[19] It is important that data submission triggers the payment processes for pharmacies. Details of this will be covered in a later chapter but the contract needs to clearly spell out these details.

TABLE 3.2. POTENTIAL CONTRACT COMPONENTS

- Effective date
- Parties involved
- Funding received
- Mutual agreements

Availability of funds, Compliance with laws-regulations-prime contract, Conflicts of interest, Cost or pricing data, Covenant against interference with contractual relations, Disputes, Dissemination-publication-distribution of data, Indemnification, Intellectual property, Limitation of liability, Media releases, No warranties, Non-disclosure of commercial and medical information, Payment, Records and audits, Relationship of parties, Statement of work, Survival, Term, Termination, and Waiver and severability

As more contracts are developed with CINs it is important to be aware of the evolving scope expansion of pharmacist provider status. Provider status may lead to credentialing of these pharmacists to provide set services. Processes are developed in states like Pennsylvania, Minnesota, Ohio, Oregon and Washington where a pharmacist may become credentialed with the state Medicaid program where they can be paid as pharmacists to provide defined services. This evolving trend will eventually play into the contracting phase and how pharmacists would onboard with payers. Currently credentialing is not a typical process completed for payer programs at this time.

Another element that is vital to the contracting process and covered in another chapter is the training needed to complete the patient care program. During the contracting phase it is important to establish training requirements for participation. It is also important to determine which party will document when training is complete. This is a key best practice to outline details up front.

Lastly, the process of drafting these documents and the revisions needed is a collaborative process. Best practices tell us to work on core documents first and allow for back and forth to satisfy both parties. Having regular check-in meetings is key to forward progress. It is possible for this process to take months therefore regular conversation is needed.

Payer Perspective – Important Insights from Payers

Agreement in theory may be sufficient in early stages, but before contracting is finalized, agreement on precise specifications is critical and requires significant time for review and consideration by both sides.

19 https://www.pqaalliance.org/pqa-measures

"If there are pharmacies that are receiving opportunities but not completing them or not completing a lot of them, you might want to reach out to them."

Chapter 4: Communication Across Program Collaborators

By Wesley Nuffer

Bi-directional, coordinated communication is a critical element for a successful payer/clinically integrated network partnership. Depending on the intended services to be provided, there can be several moving parts involved to successfully meet or exceed contract expectations, all of which come in addition to any individual pharmacy's daily scope of work. The pharmacy network facilitator has an important role in monitoring the clinically integrated network's progress, providing education, resources, and support to pharmacies who are not performing or underperforming, and making sure that the goals, services, and documentation processes of the contract are understood and successfully being completed in a timely fashion. Since these patient care services require additional work from pharmacies beyond their usual daily business, regular check-ins that provide support, encouragement, and keeping the initiatives as a priority are essential. The pharmacy network facilitator serving as a "peer coach" to the participating pharmacy network can greatly enhance productivity and results.[20]

Communication should start with a solid foundation of the project and organized meeting to launch the initiative. The essential role of communication in facilitating implementation of new initiatives has been well established.[21, 22] Key modes of communication should be outlined during this meeting and reiterated throughout. Table 4.1 lists some example communication strategies that could be employed by the pharmacy network facilitator.

TABLE 4.1: KEY STRATEGIES FOR COMMUNICATION
Pharmacy network facilitator holds key role with information flow
Scheduled meetings including all contracted pharmacies should occur at set intervals
Resource center should be established with key documents that can help with implementation/ recruitment
Establish reporting interval with payers, use this time to highlight successes and explore other opportunities
Pharmacy network facilitator should prioritize time to pharmacies which need the support and assistance
Regular performance updates shows all pharmacies how they are doing compared to others in the network
Underperforming pharmacies should be supported and possibly relocated if they are unlikely to improve

20 Turco E, Carroll JC, McGivney MS, McGrath SH, Herbert SMC, Firm A, Coley KC. Coaching strategies for the Flip the Pharmacy practice transformation initiative in Pennsylvania independent community pharmacies. J Am Pharm Assoc (2003). 2023 Jan-Feb;63(1):164-168. doi: 10.1016/j.japh.2022.07.013. Epub 2022 Aug 6. PMID: 36031545.

21 Albright K, Navarro EI, Jarad I, Boyd MR, Powell BJ, Lewis CC. Communication strategies to facilitate the implementation of new clinical practices: a qualitative study of community mental health therapists. Transl Behav Med. 2022 Feb 16;12(2):324-334. doi: 10.1093/tbm/ibab139. PMID: 34791490; PMCID: PMC9127548.

22 Galli, B. J. (2022). The Role of Communication in Project Planning and Executing. International Journal of Applied Management Sciences and Engineering (IJAMSE), 9(1), 1-20. http://doi.org/10.4018/IJAMSE.302902

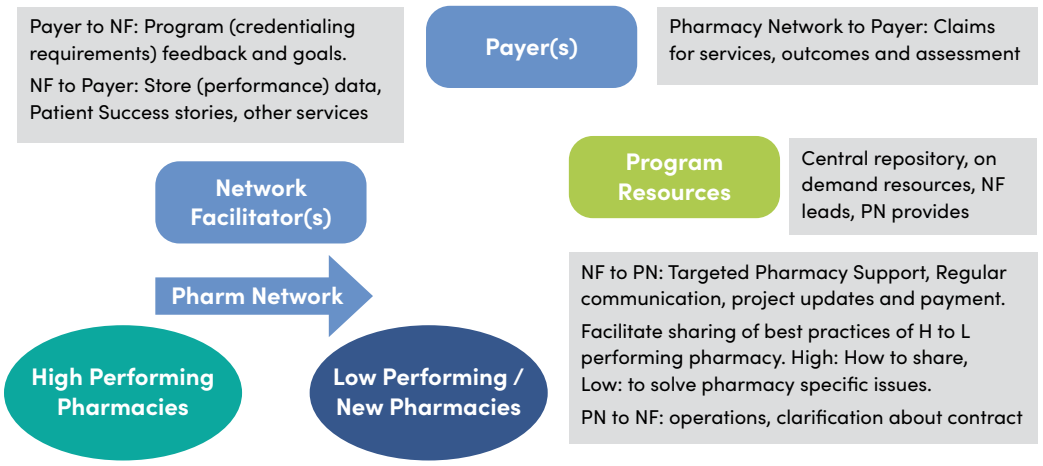
Communication flow should go between all groups within the contract to differing extents depending on the size of the project and the desired involvement from the payer's side. Figure 4.1 represents a schematic of the information flow and potential modes of communication. Note that for most situations, the pharmacy network facilitator serves as the intermediary controlling information flow between partners. This representative manages data, serves to answer questions, monitors the progress of the project, prioritizes support to the pharmacies, provides resources, and updates the payer on successes and challenges throughout. That said, there can be direct communication between payers and the participating pharmacies, both in the forms of claims for reimbursement for services, as well as data reporting and other information.

The central role of the pharmacy network facilitator in communicating across the clinically integrated network is critical for successful contract completion, particularly if the pharmacy group may be involved in several initiatives simultaneously. Programs may evolve during the implementation of the patient care services, and pharmacies need to be updated to the clinically integrated network's performance, including any changing expectations or potential new services. Solid communication flow between participating stores, program champions, and pharmacy network facilitators has been highlighted as a key element for success in meeting specified pharmacy-level goals.[23] Establishing a specific feedback process for pharmacies can be helpful to share the clinically integrated network's performance, encourage competition across pharmacies, and highlight the efforts of high performing teams. This can also help those pharmacies who may be underperforming recognize where they fall in comparison to their peers, which may lead to increased participation. Performance sharing can be accomplished through a central dashboard or spreadsheet that is accessible in real time by the pharmacies but should also include regularly scheduled notifications. These scheduled emails emphasize successes and identify challenges, celebrate the pharmacies' victories, and keep the project(s) fresh in everyone's minds. This can help to keep the clinically integrated network initiatives fresh and current as day-to-day pressures may sometimes de-prioritize clinical initiatives over time. Scheduling live group video meetings or conference calls are another important strategy to provide updates, receive feedback from the pharmacies on any difficulties or confusion that may be occurring, and strengthen the team mentality of the clinically integrated network. Facilitators will sometimes engage a specific pharmacy champion to speak during these calls to highlight a success or meaningful encounter. These personal success stories can go a long way towards motivating team members to try to achieve goals during an already taxing work week and build camaraderie across pharmacies.

23 Bacci JL, Ferreri SP, Coley KC, Daly CJ, Hake KL, Herbert SM, Hughes TD, McDonough RP, Roller JS, McGivney MS, Smith MG, Doucette WR. Qualitative analysis of a community pharmacy practice transformation initiative. J Am Coll Clin Pharm. 2022 Nov 05;1–17. doi:10.1002/jac5.1728

Figure 4.1 Communication Flow of a Patient Care Program

NF - Network Facilitator
PN - Pharmacy Network



Establishing a communication process for pharmacies to access information and request support reduces the time commitment required for personnel to implement contract initiatives. Pharmacies need to know how to access additional resources when needed, whom they should direct questions to regarding the payer contract, reporting, or specific services they are providing, and should be clear on what is required of them. This can be accomplished through initial planning and orientation, establishing a communication process, and regular check-ins throughout the project. For larger projects, it may be useful to establish peer-to-peer relationships across the participating pharmacies. Pharmacies could be paired or grouped strategically geographically or potentially pairing higher performing pharmacies with low or new additions. These peer groups could provide support to each other and serve as an accessible resource during the training and initial implementation phases. Across participating pharmacies, the method for enrolling patients or recruiting participants into the programs needs to be clear to all personnel within the pharmacy. A clinically integrated network will have very different needs at different times, and the pharmacy network facilitator should prioritize and identify what pharmacies may need additional support and assistance at which times, in order to optimize performance production with the limited hours devoted to a specific contract. Likewise, the facilitator has a key role in identifying pharmacies who are not meeting performance criteria. They can provide help to analyze workflow, identify pharmacy personnel who may be able to assist on the project, better clarify what is required from the pharmacy team to meet the contract criteria, and in some cases decide whether to re-allocate the contract to a different pharmacy. Sometimes, changing circumstances or personnel could make it unlikely for a pharmacy to be successful in the project.

Another essential communication process is between the pharmacy network facilitator and the third-party payer who partnered in the contract for pharmacy services, as demonstrated in Figure 4.1. After the initial contract is established and implemented, the pharmacy network facilitator needs to gain an understanding of how much contact and information the payer would like to receive, and at what intervals. Payers may vary widely in how involved they would like to be in a particular program, and how they would like to receive data regarding performance. In addition to any direct "claims" or notes that

"What has seemed to help the most, but not all the time is finding a buddy and pairing them up with another pharmacy that is somewhat comparable in size and pharmacy management system, so that they can kind of communicate best practice [and] what's worked."

may come from individual pharmacies, the pharmacy network facilitator should assemble regular performance reports to update the payer on the clinically integrated network's progress. Any clarifications or queries that an individual pharmacy may have regarding the process of submitting data for patients should have a specified workflow, again to minimize the time required to successfully meet contract outcomes. Including some personal examples with aggregate data sent to the payer(s) can also provide a positive, humanistic side to the project, demonstrating how people's lives are positively impacted by the contracted work. Time intervals for payer engagement should be worked out early in the contract to communicate progress, ensure that the goals for the program are being met, address any concerns or questions the payer may have, and continually update them on the clinically integrated network's work. These touch points may also provide opportunities to explore other potential areas where the pharmacies could help improve members' health, leading to further or expanded contracts and facilitating continued partnerships. Finally, the payer can inform the pharmacy network facilitator about any feedback their members may have provided regarding pharmacy services, and whether there is a need for improvements or changes in the care delivery.

Most clinically integrated networks have a central or managing network facilitator, particularly if the pharmacies within the clinically integrated network are involved in several different patient care contracts. This creates an opportunity for discussions within network leadership to prioritize various projects and divide up work in supporting and optimizing production from the pharmacies. There could be synergistic projects across the network where specific pharmacies could be well positioned to implement several contracts with similar types of outcomes, such as working with patients diagnosed with diabetes and/or cardiovascular disease. As the numbers of contracts and participating pharmacies increase, the pharmacy network facilitation should also grow accordingly to help manage these increasing complexities. Likewise, pharmacy network facilitators may identify various luminaries from high-performing pharmacies to function as a focus group, providing feedback about the various contracted initiatives and potential challenges or opportunities that may arise.

As the contract progresses, the support and communication transitions to maintenance and optimization. Data generated across the pharmacies guides the pharmacy network facilitator(s) in their outreach and follow-up. This communication can take many forms, including highlighting pharmacy successes, clarifying common questions or pitfalls, supporting pharmacies who may be falling behind in their efforts, and re-energizing pharmacies to the project goals or bringing the project back to the front of priorities. This can be accomplished in several ways. The clinically integrated network performance is dynamic and changing, and the pharmacy network facilitator should be fluid in adjusting to various needs from all participants, consistently working to optimize outcomes, participation, and data generation to demonstrate success to the payer.

Finally, it is useful for the pharmacy network facilitator(s) to establish various resources that can be accessed by participating pharmacies during the contract period. These could include sample marketing materials that could be given to patients or providers describing the program(s), recruiting strategies that could be implemented at the pharmacy level, or various promotional referral pads, pharmacy posters, or bag stuffers. An organizational chart could be drafted to show the pharmacies' points of contact information for different requests, and

"We look at engagement. 'Are there areas of the state where we are seeing great engagement and areas where we need more engagement.'"

where to locate important information regarding the contract. This chart could list participating pharmacies within a project, to create a peer support network and to better clarify the scope and nature of the project itself. As programs evolve over time, sample best practices and various forms or tools created by high-performing pharmacies should be collected and shared to benefit the entire clinically integrated network. Providing a wealth of resources to help personnel implement the services demonstrates the commitment of the network towards each pharmacy's success within the contract. Please view additional resources in support of program communication.

TABLE 4.2: POTENTIAL PROJECT NON-HIPAA COMMUNICATION TOOLS
Video-teleconference meetings (Zoom, Teams, Google Meet, Skype)
Created email group
Cell phone texting group
Telephone conference calls (voice only)
Messaging Apps (Slack, Connecteam, Haiilo, Teams)
Project dashboard (Basecamp, ClickUp, Monday, Smartsheet)

ADDITIONAL RESOURCES
(provided by program coordinators)

Appendix 5: Vaccine Gap Closure Online Workgroup Invite

Appendix 6: Vaccine Gap Closure Program Enrollment Steps (internal)

Appendix 7: Vaccine Gap Closure Pharmacy Intervention & Income Totals

Payer Perspective – Important Insights from Payers

Recommend standing meetings at a reasonable cadence (e.g., monthly) between project champions on pharmacy (perhaps the network facilitator) and payer side. These champions should be focused on mutual success in the project. Consistently evaluate whether data exchange, early measure reporting, and other project aspects are behaving as planned.

"Training needs to be flexible and something that can be done on their own time."

Chapter 5: Preparing for Service Implementation

By Megan Smith

After the approval of the network contract by both parties, the subsequent phase involves the rollout of the program to eligible pharmacies. The program's design may encompass mandatory credentialing or specific training requirements. Before launching the program, it is crucial to identify the responsible party tasked with designing, delivering, and tracking the completion of required training or credentialing. Based on the success of various programs, it was observed that the pharmacy network often assumed the responsibility for delivering, collecting, and reporting the status of required training or credentialing to the payer.

TABLE 5.1. EXAMPLES REQUIRED TRAINING AND TRACKING MECHANISMS	
Required webinars - attendance reports webinar client	Attestations - self-attestation or site visits by network staff
Certificate program completion	Continuing Education credit

Networks should consider additional training or implementation support that enhances the program's success without necessitating specific tracking or reporting to the payer. This may involve baseline knowledge refresher programs and the identification of all personnel requiring training and/or orientation to the program. Successful programs typically involve multiple staff members with divided responsibilities. Developing a flow chart or table outlining example roles and responsibilities for the specific service can be helpful (See Figures 5.1 and 5.2 at the end of this chapter.) Program/service-specific supplements may encompass equipment, a list of helpful resources and links, patient-facing materials, documentation requirements with examples, and guidance on navigating reports and dash-boards (e.g., patient lists, tracking dashboards). An additional example of an im-plementation guide can be found in additional resources at the end of this guide.

During the creation and compilation of training materials and references for program participants, it is advised to explore similar models or training programs available from professional organizations. While not everything needs to be newly created by the network, consolidating the most useful resources tailored to a specific program will be the most efficient approach. For clinical services, examples include disease state guidelines, drug references and Pharmacist's Letter. For practice transformation tools, the transformation initiative Flip the Pharmacy (www.flipthepharmacy.com) provides publicly accessible templates and workflow solutions. Finally, for documentation purposes, the organization CPESN USA offers various resources on e-care planning using pharmacy software and standardized coding for CPESN participant pharmacies.

The initiation of successful program training should commence with a launch meeting. See Table 5.2 for an example agenda. Whether delivered live or virtually, recording the meeting is advisable for future reference by new participants. An example of a pharmacy onboarding process is available as an appendix as an additional resource. It is imperative to centralize materials, trainings, and supportive resources in an easily accessible location. Avoid relying solely on email for communication; a more robust system ensures effective dissemination and utilization of these resources.

TABLE 5.2. INITIAL PROGRAM LAUNCH MEETING AGENDA
Objectives of the program/service
Metrics and key performance indicators for the program
Patient eligibility
Payment model with examples
Example service workflow
Billing requirements
Documentation requirements with examples
Training and resources - outline required vs supportive materials
Timeline of rollout and communications
Q&A
Post-Launch Readiness
Post-Launch Follow-up
Create and send readiness checklist for participating in the program
Send recording of Launch meeting
House all materials in an easily accessible central place - shared network drives, website
Consistent follow up with reminders on how to access resources

After Initial Training/Launch

Encourage each pharmacy to designate a pharmacy champion for the project. The champion is the point person for the pharmacy and liaison to the network leadership. Within the pharmacy, the champion shares the project goal, interventions, and progress with all pharmacy staff and leadership. This assures local staff have a direct resource to ask questions and helps in recruiting and redirecting patients. Peer-to-peer coaching utilizing the pharmacy champions can successfully support program implementation as well. For liaising with the network leadership, design a strategy for continuous education and updates to keep the pharmacy champion and appropriate pharmacy staff abreast of the latest developments. This may involve regular webinars, newsletters, or access to online resources. Consider implementing feedback mechanisms that allow participants to provide insights and suggestions. Sharing these insights and best practices across participating sites throughout the project enables real-time course correction and continual improvement. These two strategies foster a collaborative environment where successes and challenges are promptly addressed. Regularly exchanging insights helps standardize high-quality practices, ensuring that all sites benefit from collective experiences, ultimately enhancing overall engagement.

Finally, acknowledge and celebrate milestones achieved by participating pharmacies. Implement a system of recognition and incentives to motivate and reward exemplary performance. This can include acknowledging high-performing pharmacies in newsletters, highlighting patient success stories, recognizing pharmacies that submit their first intervention, and sharing overall performance of the network. Recognizing and incentivizing success not only boosts morale but also creates a positive competitive spirit within the network, encouraging sustained dedication to the program's goals.

Figure 5.1 Example Flowchart of Workflow

Example Behavioral Health Services Workflow

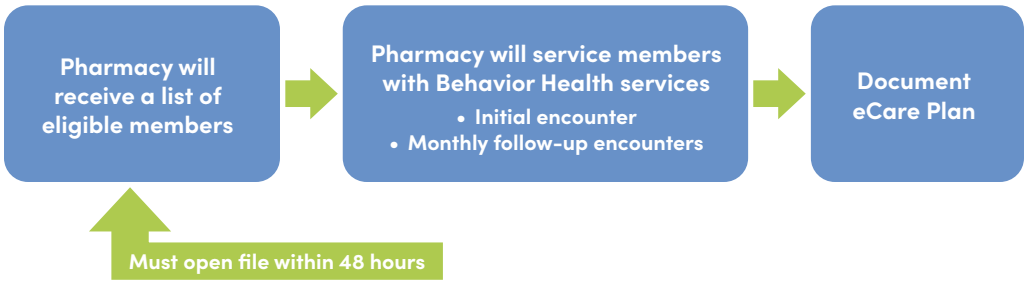
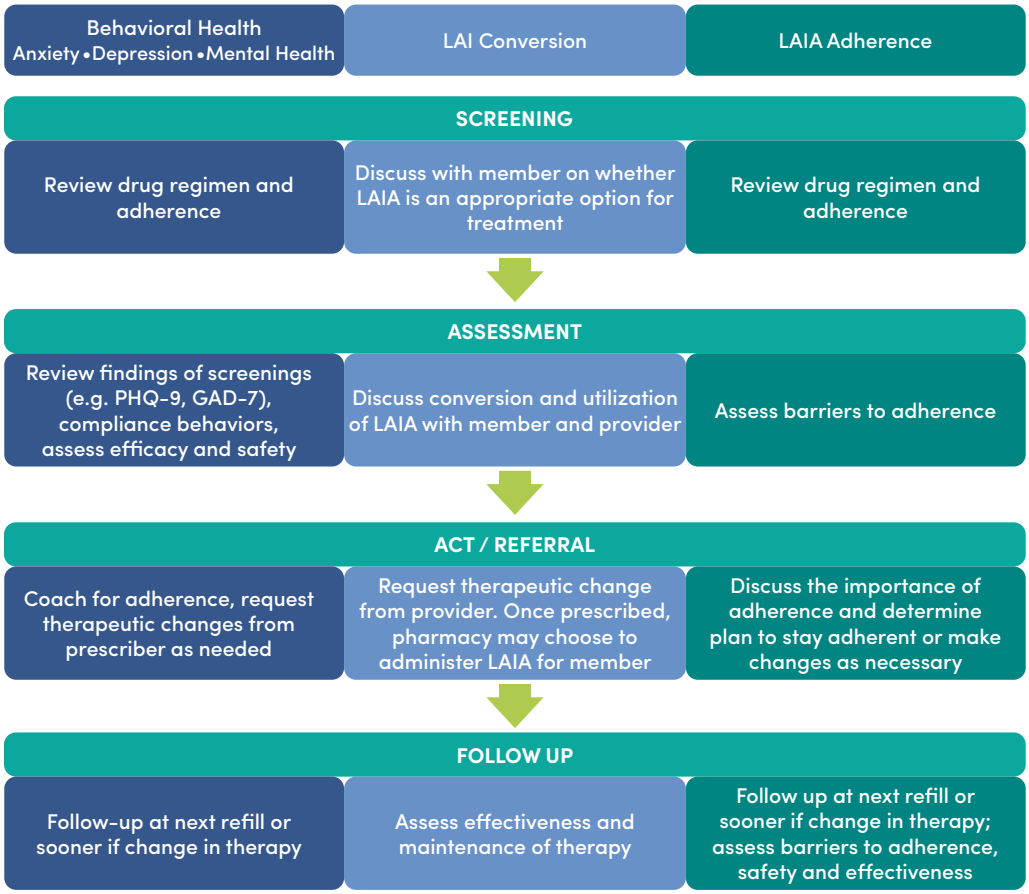


Figure 5.2 Example Workflow of Patient Care Service Intervention

Workflow for Each Category



*LAI - Long-acting injectable; LAIA- Long-acting injectable adherence

ADDITIONAL RESOURCES
(provided by program coordinators)

Appendix 8: Vaccine Gap Closure Program – Getting Started and Onboarding

Payer Perspective – Important Insights from Payers

Consider sharing best practices across participating sites (e.g., pharmacies within the CIN) – not just at the end but during project to enable course correction and continual improvement.

Chapter 6: Measuring Program Success: Data Collection and Outcomes Assessment

By Jennifer Bacci, Kim Coley, and Sophia Herbert

Data is essential to demonstrating the value and effectiveness of patient care programs in community pharmacy to payers. Data allows measurement of program success and offers insights into various aspects of patient care, financial performance, and operational efficiency. Thus, data are crucial when securing a new payer contract and when maintaining an existing payer contract. The first step in measuring program success is to identify the audience or stakeholders (i.e., payers) and purpose in collecting data (i.e., new contract or existing contract). Identifying the purpose is important because the data needed to make the case for a new program, to sustain an existing program, and for internal quality assurance related to payer programs differ. Table 6.1 outlines example data elements collected in the different phases of engagement.

TABLE 6.1 – EXAMPLES OF DATA FOR SECURING A NEW CONTRACT, MAINTAINING AN EXISTING CONTRACT, AND INTERNAL QUALITY ASSURANCE.

New Contracts: When meeting with payers to secure new contracts, it is helpful to bring data that shows the potential impact of the program and the pharmacies' capacity or readiness to deliver the program.
• Map of community pharmacy locations to show spread across a geographic area • Demographics of the communities and populations the pharmacies serve • Quantities and types of existing patient care programs at the pharmacies • Data from existing programs within your clinically integrated network (CIN) or similar programs from the literature
Existing Contract: When meeting with payers to renew existing contracts, it is helpful to bring data that highlight the difference the program is making.
• Program adoption or utilization rates by eligible patients and pharmacies • Numbers and types of interventions provided at pharmacies • Changes in patient health outcomes (e.g., medication adherence, disease management, or overall health metrics) • Cost savings resulting from the program (e.g., decreased hospitalization or emergency department utilization)
Quality Assurance: Routine data collection to monitor network operations supports the CIN's readiness to participate in and that the CIN is a good steward of payer contracts.
• Participant pharmacy compliance with CIN requirements (e.g., minimum service sets) • Pharmacy engagement in CIN programs • Pharmacy adherence to CIN protocols and standard operating procedures • eCare plan documentation accuracy • Pharmacy receipt of payment from payer contracts

"Were the outcomes met? Is the health plan generally satisfied with the partnership as well? Did we achieve the target PDC score as a network or how are we progressing towards seeing blood pressure control?"

Clearly specifying the goal or objective serves as the foundation for determining the outcomes and measures that should be used to evaluate the success of the program. This clarity ensures the evaluation process is aligned with the intended purpose of the program and the needs of program stakeholders. Process measures and outcomes measures are commonly used to evaluate programs in community pharmacies. Outcome measures focus on the results or impact of a program and include clinical, economic, and humanistic measures. On the other hand, process measures concentrate on the processes and activities that lead to the overall impact of the program. It is important to consider which measures are feasible to assess and can reasonably reflect the impact of the program. For example, it is difficult to measure and quantify the direct impact of a community pharmacy program on reducing opioid overdose deaths in a population or geographic area. A feasible and impactful alternative could be to measure naloxone access or distribution resulting from the community pharmacy program. Furthermore, process measures often show meaningful changes in a shorter time frame compared to outcome measures allowing for more immediate insights and the potential for timely program adjustments or improvements. Table 6.2 maps example pharmacy process measures as it relates to payer outcome measures. It is important to align available data sources when assessing the outcomes of existing and prospective programs. Appendix 9 presents example pharmacy processes called encounters and how they align to outcomes shown as SNOMED codes.

TABLE 6.2 MAPPING PHARMACY PROCESS TO PAYER OUTCOME MEASURES

Pharmacy Process Measures	Payer Outcomes Measures (Based on HEDIS*)
Adherence programs (e.g. – medication synchronization)	Statins (diabetes and cardiovascular), Asthma Medication Ratio
Vaccination programs (e.g. – gap closure/social needs screenings)	Child, Adolescent, Adult Immunizations Status (various)
Disease state monitoring, (e.g. – diabetes, hypertension, opioid use disorder)	Diabetes (glycemic status, blood pressure, statin), Transitions of Care, Opioid Use Disorder, etc.

*https://www.ncqa.org/hedis/measures/

It is ideal to utilize existing data and/ or automatic data collection processes when available to minimize additional workload for the network or pharmacy staff. When new data or manual data collection processes are needed, the potential additional workload and expense for the network and pharmacies needs to be carefully considered. It can be helpful when designing the evaluation plan to learn from what is published in the literature. Please see Table 6.3 for select examples of program evaluations in community pharmacy practice. Identifying similar initiatives including what outcomes and data sources have been used by others will facilitate evaluation design.

TABLE 6.3. SELECT EXAMPLES OF PROGRAM EVALUATION IN CLINICALLY INTEGRATED NETWORKS OF COMMUNITY PHARMACIES IN THE PRIMARY LITERATURE
Bacci JL, Ferreri SP, Coley KC, et al. Qualitative analysis of a community pharmacy practice transformation initiative. J Am Coll Clin Pharm. 2022;5(12:1236-152. doi:10.1002/jac5.1728
Clifton CL, Branham AR, Hayes HH Jr, Moose JS, Rhodes LA, Marciniak MW. Financial impact of patients enrolled in a medication adherence program at an independent community pharmacy. J Am Pharm Assoc. 2018;58(4S):S109-S113.
Doucette WR, DeVolder R, Heggen T. Evaluation of financial outcomes under a value-based payment program for community pharmacies. J Manag Care Spec Pharm. 2021;27(9):1198-1208. doi:10.18553/jmcp.2021.27.9.1198
Herbert SMC, Herbert BM, Hake KL, McGrath SH. Flip the Pharmacy's impact on comprehensive medication management performance. J Am Pharm Assoc. 2023;63(4):1070-1076. doi:10.1016/j.japh.2023.04.006
Huang C, Doucette WR, Andreski M, Pudlo A. Patient Experiences at Enhanced-Service Pharmacies in Iowa. Innov Pharm. 2019;10(2):10.24926/iip.v10i2.1530. Published 2019 Aug 31. doi:10.24926/iip.v10i2.1530
Renfro CP, Turner K, Seeto J, Ferreri SP. Medication synchronization adoption and pharmacy performance. Res Social Adm Pharm. 2021;17(8):1496-1500. doi:10.1016/j.sapharm.2020.11.009
Urick BY, Bhosle M, Farley JF. Patient Medication Adherence Among Pharmacies Participating in a North Carolina Enhanced Services Network. J Manag Care Spec Pharm. 2020;26(6):718-722. doi:10.18553/jmcp.2020.26.6.718

All pharmacies can utilize their prescription dispensing records as a data source. This source might be sufficient for process outcomes such as whether vaccines or a particular medication (e.g. naloxone, asthma maintenance medication) were provided. It is always recommended for pharmacies to work with their vendors to understand the reporting capabilities of the dispensing software. Some CPESNs have technology support leads for the most common vendors who can offer advice on extracting data and reports. Pharmacist eCare Plan (PeCP) data are also a good source to assess outcomes - particularly process outcomes. It is helpful to become familiar with the data fields that are populated for documenting care as well as those fields that can be readily extracted for reporting purposes. PeCP data aims to report on the specific interventions being performed (e.g. medication synchronization, health assessment, home visit) because standard codes (i.e. SNOMED CT) are often used. When analyzing an existing payer program, that payer might be willing to assist in assessing outcomes or share their claims data for analyses. Please see the PeCP call out and both Appendices 9-10 for additional resource on this topic.

It is recommended to have a Data Use Agreement (DUA) between organizations that are sharing data. DUAs are contractual agreements that enable sharing of data that is nonpublic or subject to certain use restrictions across organizations. Irrespective of the source, the data that you receive usually requires further cleaning and management. It is recommended to always verify your data after manipulating it by conducting and evaluating descriptive statistics as well as examining the original data to confirm accuracy of the changes. It is always an option to ask the pharmacies to prospectively collect data to assist in evaluating the outcomes of a program. This can be accomplished through surveys and other types (e.g. JotForm) of data collection forms. However, when doing so, it is important to keep data collection simple for the pharmacy staff and to ensure there is a plan for data security. Finally, collecting and sharing short case

"The payer housed all the data so they could see the numbers. It was health risks and screenings, so they could see when our pharmacies were completing them, and they could watch it grow. They were really driven by the numbers that they were seeing."

vignettes and/or patient stories are also an effective way to highlight impactful care provided as part of a payer program. These vignettes or stories are an excellent supplement to quantitative data for demonstrating program outcomes.

Effective communication of the project outcomes at the beginning of a new program is a vital step for successful payer engagement. Sharing the results of program initiatives can take different forms and should be tailored to the audience. For example, the type and amount of detail shared with participating pharmacies may differ from what would be shared with a payer. Pharmacies may benefit from more granular data so that they can improve their performance. Additionally, benchmarking data may be shared across a network of pharmacies so that pharmacies can assess their performance in relation to the network. For payers, sharing higher level results that highlight the most impactful outcomes may be a more effective approach. Infographics are one method that can be used to help visualize outcome data.

ADDITIONAL RESOURCES (provided by program coordinators)

Appendix 9: Example Pharmacy Processes (Encounters) and Outcomes (SNOMED Codes)

Appendix 10: Pharmacy Documentation Data Collection

Appendix 11: Pharmacist eCare Plan Example – Diabetes Program

Appendix 12: Pharmacist eCare Plan Example – Asthma Program

Appendix 13: Pharmacist eCare Plan Example – Heart Failure Case

Payer Perspective – Important Insights from Payers

- For any data to be exchanged and reporting of results, recommend mutually agreed upon templates. Receiving data in unexpected formats, or measure results that are challenging to parse or verify, can cause friction and increased effort from both sides.
- PQA specifies required fields versus optional/desirable fields, as well as expected code types or allowable values. When these templates are used properly, the analytic burden is greatly reduced by all parties.
- When considering existing versus new generation of data, existing data are typically easier. When new data fields are generated, use existing data terminologies and frameworks (e.g., new collection of specific SNOMED codes as mentioned above) where possible.
- CINs must work with technology vendors to align their capabilities with what's relevant to payers. Similarly, when building processes to capture new data, collaborate with payers or consult with measurement experts to understand the best approach to capturing data in ways that are valuable to pharmacies and payers. Payer metrics and incentives, for example, may be satisfied by specific codes, so understanding that is helpful.
- DUAs will generally have to be in place prior to any exchange of data, so they should also be approached well in advance of when work is intended to begin.
- Consider any need to exchange personally identifiable information and ensure that systems are in place to appropriate manage/exchange that information.

Pharmacist eCare Plan

WHAT IS IT?

The Pharmacist eCare Plan (PeCP) is an interoperable, HL-7 clinical documentation tool that allows pharmacists to exchange information related to patient care including goals, health concerns, medications, lab results, vitals, and billing information.

WHAT IS THE VALUE?

Streamlines Data Collection and Sharing

- Currently the only interoperable standard, focused on medication use optimization.
- Streamlines healthcare information across multiple data types, different computer systems, and diverse healthcare settings.
- Ensures consistent communication optimizing care coordination and patient outcomes.

Supports Claims Submissions

- Includes payer information and billing details, which streamlines claims submission process.
- Patient care activities and interventions can be documented and submitted.
- Detailed documentation of patient care provided by pharmacists supports value-based reimbursement models.

Enhances Patient Care and Health Outcomes

- Documenting and sharing care delivery information, the eCare Plan helps pharmacists provide more targeted and effective patient care.
- Supports chronic disease management and facilitates continuous monitoring and following up.

The Pharmacist eCare Plan, the only interoperable system, has demonstrated the value of community pharmacy provided patent care by sharing submitted data with health plans and collaborators.

Available Resources:

- Pharmacist eCare Plan Initiative
- CPESN eCare Plan Education
- See Case Examples in Appendix as provided as additional resources at the end of the chapter.

Chapter 7: Payment Mechanisms

By Jessica B. Finke and Sophia Herbert

In growing numbers, community-based pharmacies are receiving payments for patient care services, departing from the historical reimbursement model tied solely to drug sales. Pharmacy benefits have traditionally covered prescription drugs, with expansion of coverage for select services like Medication Therapy Management (MTM) in the 2000s. As recognition for pharmacists' impact on health outcomes beyond prescription drug utilization has grown, new methods have been developed to compensate pharmacies for services. In instances where legislation supports pharmacists' status as healthcare providers, direct medical billing like other healthcare providers is possible for pharmacists. However, regardless of "provider status", payers for healthcare services and pharmacy organizations have found ways to implement payment for pharmacy services. Based on state laws and other considerations, this can include payment direct to the pharmacist, and in others it may include payment to the pharmacy as a business entity. CINs have played a large role in contracting on behalf of networks of pharmacies with payers for reimbursement for patient care services.

These contracts with pharmacies or CINs of pharmacies can utilize several different payment structures, including fee-for-service, value-based payments, per member per month, or combinations. The following payment structures all allow pharmacies to be compensated for services they provide regardless of state-level pharmacist provider status. Rather, compensation for services is dependent on terms of the contract or SOW (see Chapter 3).

Regardless of payment mechanism, these contracts with CINs of pharmacies should also include administrative support for the network (see Chapter 3). Administrative costs should be built into any program structure to support the implementation of the program. This work includes design of the program, development of training, launch of the program, and provision of ongoing support by the network to participating pharmacies. Administrative costs are typically structured based on the SOW, resources, and finances of the program. Costs can be distributed as either a lump sum or tied to individual deliverables or program outcomes. Examples of payment models including advantages, disadvantages, general examples, and resources for additional learning are outlined below in Tables 7.1 and 7.2. Regardless of payment model employed, the network and payer should predetermine which billing codes are to be used for the program. The network should communicate these codes to participating pharmacies and provide training on documentation and billing processes for the payer program.

Combinations and Other Models

Each of the above payment structures can be combined, such as integrating fee-for-service (FFS) and a value-based care model (VBM). For instance, this may entail a set payment structure for provision of individual enhanced services, as well as bonus payments for achieving specific program outcome goals, such as reaching target outcome goals of average reduction in A1C or blood pressure. Another combination example is the per-member-per-month (PMPM) model with the VBM, offering steady payments to pharmacies for member care and larger bonuses at intervals for meeting designated metrics for the program. Utilizing multiple payment structures within one program can optimize benefits

while leveraging and incentivizing high-quality care. Additionally, grants can fund new programs or payment models to facilitate enhanced community pharmacy services. Grants can be helpful in launching new programs, trialing innovative ideas and services, and increasing access to patient care services in underserved areas; however, they should not be looked to as a long-term solution for sustaining programs.

Table 7.1 Payment Models

Fee-for-Service

OVERVIEW

- A regular, set payment delivered to the pharmacy for a one-time service provided to the member.
- The set payment amount is dependent on the service being delivered or provided to the member.
- Types of services are moments in time with a patient versus care over time.

ADVANTAGES

- Pharmacies are compensated for each discrete service via contract.
- Reimbursement for time spent on the service is transparent and known by pharmacy prior to completing service.
  - Thus, allows for efficient and timely management of staffing demands and budgets

DISADVANTAGES

- A transactional, moment in time experience for patient and pharmacist.
- Lacks ability to promote longitudinal patient care.
- Lacks pharmacy incentive for further participation in health plan.
- Lacks ability to incentivize patient behavior.

GENERAL EXAMPLES

- Pharmacies are paid to complete a service. Examples of services include measurement and documentation of blood pressures or A1cs, completion and documentation of Comprehensive Medication Reviews (CMRs), Medication Therapy Management (MTM) encounter, vaccine administration, and screening completion of Patient Health Quetionnaire (PHQ-9), General Anxiety Disorder (GAD-7), and Social Determinants of Health (SDoH).

RESOURCES FOR EXPANDED LEARNING

1. Prasad A. Revenuexl: Accelerating Healthcare Revenues. Value-based Care vs. Fee-for-Service: What's the difference? https://www.revenuexl.com/blog/fee-for-service. [Accessed 1, March 2024].
2. PrognoCIS. What is fee for service in healthcare? https://prognocis.com/what-is-fee-for-service-in-healthcare/. [Accessed 1, March 2024].

Table 7.1 Payment Models (cont.)

Value-based Service

OVERVIEW

- Payments provided to the pharmacy are dependent on the quality of care delivered to a member.
- Services and care provided to members focuses on care over time and the member's positive change in health outcomes (typically associated with HEDIS measures).

ADVANTAGES

- Pharmacies enrolled in program collectively participate at the same minimal quality service level.
- Overall network performance minimizes inconsistency of individual pharmacy performance levels.

DISADVANTAGES

- Reduced payments may result if goal outcomes are not achieved.
- Penalization for factors and outcomes out of pharmacies and networks control to be tied to performance assessment.
- Overall network performance could be negatively impacted by low performing pharmacies.

GENERAL EXAMPLES

- Payer programs which pay pharmacies and networks based on performance of delivery value-based care which aims in improving HEDIS gap closures and in-person patient counseling engagement.
- If the Network Level Performance Goal is met, each pharmacy in the network will receive a payment per eligible encounter.
- Additional payments can be distributed at the end of a period based on gap closure and network performance.

RESOURCES FOR EXPANDED LEARNING

1. Centers for Medicare and Medicaid Services (CMS). What are the value-based programs? https://www.cms.gov/medicare/quality/value-based-programs. [Accessed 1, March 2024].
2. Cosentus. Value Based Healthcare Revenue Model: Guide For Success. https://cosentus.com/value-based-healthcare-revenue-model-guide-for-success/. [Accessed 1, March 2024].
3. Elevance Health. Value-Based Payment Programs in Healthcare and Their Application to Pharmacies. https://www.elevancehealth.com/public-policy-institute/value-based-payment-programs-and-their-application-to-pharmacies. [Accessed 1, March 2024].
4. Medical billers and Coders (MBC). Value-Based Care Vs Fee-for-Service. https://www.medicalbillersandcoders.com/blog/value-based-care-vs-fee-for-service/. [Accessed 1, March 2024].

Table 7.1 Payment Models (cont.)

Per Member Per Month (PMPM)

OVERVIEW

- Includes a regular, set payment amount to be provided to the participating pharmacies for each attributed member per month.
- This set amount is provided regardless of services rendered to a member in a given month.
- Provides a "population health" approach to enhanced community pharmacy services.

ADVANTAGES

- Steady revenue for care provided incentivizes up front, continuous, and consistent pharmacy team effort to provide enhanced services.
- Allows clinicians to focus resources on the patients who need them most in a given month without concern for fluctuations in compensation for care provided.

DISADVANTAGES

- There is a risk for "under-payment" for high care utilizers and for "over-payment" for low care utilizers.
- Determining scope of work within PMPM payment structures can be difficult (risk of scope of work being too wide or too narrow to make desired effect on outcomes).

GENERAL EXAMPLES

- A Medicaid MCO provides $ per-member-per-month to pharmacies in the network based on the number of members attributed to each pharmacy to provide comprehensive diabetes services because diabetes healthcare expenditure is a priority area for the plan.
- A small Medicaid MCO provides $ per-member-per-month to pharmacies in the network to provide medication management services including medication reconciliation, medication synchronization, medication adherence packaging, and home hand delivery because the plan wants to improve proportion of days covered for chronic medications dispensed.

RESOURCES FOR EXPANDED LEARNING

1. Clement C. OpenLoop. Understanding the Per Member Per Month (PMPM) Model: A brief overview of PMPM, its many benefits and tips for successful implementation. https://openloophealth.com/blog/understanding-the-per-member-per-month-pmpm-model. [Accessed 1, March 2024].

Chapter 8: CPESN Patient Care Program Case Studies

By Durdana Iqbal with CPESN USA and program coordinators

This chapter presents a selection of case studies from a growing network of diverse patient care programs that have been integrated into community pharmacies at local, state, and national scales. These programs, supported by an array of care models and payers including government (Medicare/Medicaid), grants, and commercial, exemplify the dynamic and adaptable nature of community pharmacy practice in enhancing clinical outcomes and healthcare service delivery. In compiling these case studies, care has been taken to de-identify specific details, ensuring confidentiality while providing the fullest account possible. Each included case study offers a glimpse into the intervention, goals, and outcomes of patient care programs, reflecting the uniqueness of each program. These examples illustrate the pivotal role of community pharmacies in improving patient health outcomes through innovative care and collaborative efforts, serving both as a valuable resource and source of inspiration.

Case Study #1

Region	Midwest
Program Name	Vaccine Immunization Gap Closure[24]
Payer Type	Medicare/Medicaid
Collaborators/Partners	Quality Innovation Network – Quality Improvement Organizations (QIN – QIO)
Payment Model	Fee-for-service, value-based-care, and reimbursement from plans
Target Population	Long-term care (LTC) residents
Intervention	Administer Covid, Pneumonia, Influenza, and RSV vaccines
Goal of Program[22]	Close immunization gaps
Duration of Program	February 2024 – August 2024
Number of Participating Pharmacies	~ 100 across 4 states
Number of Interventions	See program results
Outcome Evaluation Strategy	Gap closure rates, facility & pharmacy surveys
Program Results	194 total vaccine clinics - 119 (61.3%) completed clinics - 51 (26.3%) canceled due to locating another source - 24 (12.4%) pending clinics Total Vaccines Administered (3/21/24 to 8/22/24): 5,177 - COVID LTC Residents: 2,992 - Pneumonia: 1,041 - Respiratory syncytial virus (RSV): 914 - COVID Staff: 128 - Influenza: 102* *Only adminstered March/April 2024 Areas of high Social Vulnerability (SVI) had an increase in vaccine uptake (>26%) above national data.
Program Impact & Lessons Learned	Partnering with QIN – QIO as an intermediary with the long-term care (LTC) facilities and pharmacies has helped prepare and educate facility staff for vaccine events. The funding from QIN – QIO has also enabled pharmacies to be willing to say yes to LTC facilities that may need assistance that have been understaffed and unable to complete these vaccines for those most vulnerable. The vaccine clinics allow the LTC facilities improve their vaccine rates which helps them stay in compliance with CMS.

24 Program Results and Summary

Case Study #2

Region	Midwest
Program Name	Elevance Health Value Based Care[25, 26]
Payer Type	State Medicaid MCO
Collaborators/Partners	Elevance Health
Payment Model	Per-engaged-member-per-month (PEMPM)
Target Population	Clinically high-risk Medicaid members with asthma, COPD, mental health, and opioid use disorders
Intervention	Provide pharmacist led health screenings (GAD-7, PHQ-9, ACT, etc.), and wellness coaching.
Goal of Program	Improve health outcomes and reduce total cost of care for high-risk members attributed for behavioral health, opioids, or chronic respiratory conditions
Duration of Program	2 years
Number of Participating Pharmacies	18
Number of Interventions	Over 5,000
Outcome Evaluation Strategy	Medical service utilization and medication adherence
Program Results	800 program participants were analyzed: Medical Service Utilization – There was a decrease in utilization in all categories of medical services including 30.1% decrease in inpatient admissions and 17.9% decrease in emergency department use. Medication Adherence – Among program participants, 29.2%, 44.6%, and 45.1% of non-adherent patients achieved adherence for anti-anxiety, anti-psychotic, and anti-depressant medication therapy, respectively. There was an 8% decline in rescue inhaler use among COPD patients. Respiratory Therapy Measures – There was an 8.1% decline in rescue inhaler use among COPD patients and over 41% demonstrated an improvement in their Asthma Medication Ratio (AMR) or reached their AMR goal.
Program Impact & Lessons Learned	Engaged program members demonstrated improvement in combined medical/pharmacy costs suggesting better adherence to medications and improved chronic condition management.

25 PBM and Community Pharmacy Partnerships (Full Report within)

26 Outcomes in Medicaid Members Engaged in Health Plan, PBM, and Community Pharmacy Collaboration (Full Report within)

Case Study #3

Region	Northeast
Program Name	Medicaid MCO Multi-Service Program
Payer Type	Medicaid MCO
Collaborators/Partners	Medicaid MCO
Payment Model	Fee-for-service
Target Population	Medicaid members
Intervention	Provided 10 patient care services including COVID-19 vaccine gap closure, health risk assessment, naloxone dispensing & education, medication synchronization, medication reconciliation, adherence packaging, home hand delivery, SDoH assessment, and SDoH referral
Goal of Program	Engage patients to close COVID-19 vaccine gaps and provide diverse patient care services to enhance health outcomes
Duration of Program	1 year
Number of Participating Pharmacies	96
Number of Interventions	29,445 patient encounters for 6,578 unique patients including 2,059 health risk assessments and 398 COVID-19 vaccinations.
Outcome Evaluation Strategy	Number of patients engaged, and patient care services provided.
Program Results	Accomplished all 2023 program goals: Medication Reconciliation – 474% Naloxone – 136% SDoH Referral – 765%
Program Impact & Lessons Learned	Community pharmacists can successfully engage patients in high quality, value-based services, improving health outcomes. Health plans see value in pharmacist services. This program was expanded in 2024 to also include influenza and RSV vaccinations, demonstrating how health plans value pharmacist provided patient care services.

Case Study #4

Region	Midwest
Program Name	Vaccine Gap Closure with SDoH Sub-Focus
Payer Type	Grant
Collaborators/Partners	Department of Health and Senior Services Bureau of Immunizations State Pharmacy Association CPESN Health Equity
Payment Model	Fee-for-service
Target Population	Adults over 18 years
Intervention	Provide vaccine education, assess vaccine gaps, administer vaccines, and conduct SDoH screenings and referrals
Goal of Program	Increase vaccination rates with a focus on impacting vulnerable and high-risk populations
Duration of Program	In progress (As of Q4 2024), Expected one year in duration
Number of Participating Pharmacies	100
Number of Interventions	N/A (program ongoing)
Outcome Evaluation Strategy	N/A
Program Results	N/A (program ongoing)
Program Impact & Lessons Learned	N/A (program ongoing)

Case Study #5

Region	Midwest
Program Name	Immunizations for Homebound Adults
Payer Type	US Aging Grant
Collaborators/Partners	Local Agency on Aging
Payment Model	Fee-for-service
Target Population	Homebound adults
Intervention	Administered vaccines in patients' homes or care facilities
Goal of Program	Expand immunization services to older and homebound adults with barriers to transportation and access to healthcare
Duration of Program	6 months
Number of Participating Pharmacies	1
Number of Interventions	Over 100
Outcome Evaluation Strategy	N/A
Program Results	N/A
Program Impact & Lessons Learned	This program highlights how pharmacies can provide services in non-traditional settings, which is important for local organizations to understand. It facilitated the expansion of new mass immunization clinics, including annual drive-thru clinics. The experience gained from this program highlights the necessity of an organized system for patient intake, scheduling, and coordination of nurse/pharmacist to be deployed into community. Additionally, a lesson learned was that establishing routes in "quadrants", particularly in rural areas, reduces drive times maximizing efficiency.

Chapter 9: Program Growth and Sustainability

By Randy McDonough and Melissa McGivney

Several trends and characteristics have emerged as successful strategies of patient care programs, as discussed throughout this resource guide. This chapter builds on those foundational elements.

Clinically Integrated Networks (CINs) and their Role

Clinically Integrated Networks have proven to be a strategic model for organizing and delivering pharmacy-provided patient care services, including securing payments. The CIN structure allows the network administration to represent the participant pharmacies in contract discussions with payers and single signage of contracts. An effective CIN establishes quality standards for participation and requires clinician leadership.[27, 28] These networks have specific participation criteria, shared information technology for ongoing quality improvement, established mechanisms for contracting and payment, and legal oversight. High standards of performance are maintained within the network, as the overall strength depends on each participant's contributions. By adhering to these standards, individual pharmacies can improve their financial viability and offer enhanced clinical services to their patients. These innovative approaches opens non-dispensing revenue through value-based contracts and sharing of best practices around other potential opportunities (e.g. - cash-only services, direct contacts with local employers). For further insights on financial benefits and contracts, refer to Chapter 3.

"We have to have standards for quality assurance. So, making those standards really clear and transparent across the entire network, nobody gets special treatment. Everyone has to go through this process."

Demonstrating Outcomes

Collecting robust evidence to support outcomes and demonstrate the positive impact of the network is crucial. Outcomes of interest may include the ability to engage patients, consistency of care, impact on key metrics, and connecting patients to other services offered by health plan payers. Ensuring all participant pharmacies meet these outcomes involves readiness assessments, education, and implementation programs like "Flip the Pharmacy". Regular reporting and interactive dashboards help monitor and improve performance. Refer to Chapter 6 for detailed methodologies on outcome measurement and reporting.

"I try to think about outcomes in the forefront. So, what is something that is measurable that we can determine success from?"

Network Performance and Communication

Performance elements of network quality include approaches of sharing data. For the network to perform maximally, each pharmacy participant needs to commit, engage, and hold themselves accountable to the network creating a culture of inclusion. One strategy includes sharing back performance 'Dashboards' with pharmacies to promote positive feedback of completed patient encounters. Communication involving frequent, open touch points between networks and payers to ensure expectations and milestones are being met is key. Templated, consistent communication to be utilized by the payer or network to disseminate to pharmacies is important. Refer to Chapter 4 for additional content.

27 American Medical Association. https://www.ama-assn.org/system/files/private-practice-checklist-cin-considerations.pdf

28 https://www.beckershospitalreview.com/hospital-physician-relationships/the-7-components-of-a-clinical-integration-network.html?oly_enc_id=7598E9324667D1B

Network Infrastructure and Leadership

Creating the necessary network infrastructure by including practicing pharmacists who have experience working with community pharmacies is a critical element. The specific organization of the CIN must include the key elements of a CIN notable above, but the layout, size and depth of the leadership will evolve over time. Most local chapters at the state level are self-governing and have the necessary elements to perform as a CIN. Leaders within these networks are program coordinators and key opinion leaders. Within the CPESN networks, there are managing network facilitators and luminaries, who are pharmacist owners and leaders. The managing network facilitator responsibilities include main liaison between the network and payer, main communicator for network, and holds individual pharmacies accountable.

The key opinion leaders (luminaries) function as a sounding board for the managing network facilitator and assist in the management of network pharmacies.

Payment Accelerates Practice Transformation

Alongside network growth and maturity, payment for services is a significant driver for patient care programs. Expanded payment options for both payers and pharmacies accelerate the adoption and expansion of these programs. However, practice transformation must also be prioritized, with new revenues supporting the sustainability of patient care activities. Ensuring pharmacy readiness through infrastructure assessment and workflow optimization is essential. This includes evaluating practice culture and staff readiness to implement and sustain clinical services. Equally as important is practice readiness to support pharmacists/technicians' delivery of service. Workflow efficiencies need to be established within the site (e.g. medication synchronization, technician driven dispensing, appointment-based model). Optimizing the use of pharmacy support staff and technology improves the ability of the pharmacy to provide clinical services and perform at a high level consistently. Also, the site needs to be assessed for its' practice culture to determine if the staff is ready to commit, engage, and be held accountable to network activities/payer programs. This includes the site's willingness to assess all staff (pharmacists included) to determine their readiness to implement clinical services and being critically evaluated for their performance.

"The daily activities and core functions of the community pharmacy are shifting to support intervention-based services."

Pathways of Program Sustainability

Sustainability in community pharmacies involves focusing on patient care programs that withstand current healthcare challenges and set new standards for patient care, community health engagement, and enhancing public health. This requires a shift in the pharmacy's operational mindsets to prioritize patient care programs as the central focus of services. Community pharmacy sustainability translates into the capacity to manage the increased workload that comes with enhanced patient care services, while transitioning from purely traditional dispensing services. This requires training and development for pharmacy staff, ensuring team members are not only competent in new roles but are also advocates for evolved practice models and feel empowered to make changes.

Financial models need to be structured in a way that services are reimbursed adequately and allow for bonuses based on performance ensuring that pharmacies are compensated fairly for their contributions to improving healthcare outcomes.

Community pharmacists are some of the most accessible healthcare providers in the community. Their extensive training in pharmacology and therapeutics make community pharmacists key members of the patient's health journey by identifying and resolving medication-related problems. This goes far beyond just dispensing medication, but rather providing ongoing follow-up and monitoring of patients to ensure that they are achieving a therapeutic outcome with safe and effective medications. To provide this level of care, financial models must ensure community pharmacies are adequately compensated for dispensing medications (both brand-name and generics) through the pharmacy benefit, while also enabling pharmacists to bill for clinical services under the medical benefit.

From the payer perspective, sustainability is closely tied to health outcomes, reimbursement models, and return on investment (ROI) patient care programs deliver. Payers are focused on achieving significant improvements in population health outcomes and community pharmacies are ideal partners in this endeavor. Programs that enhance health outcomes and reduce healthcare utilization and cost are extremely valuable. Payers are more likely to continue collaboration with pharmacies if they see value being added. For example, a payer instituted a value-based payment pilot program at a single pharmacy in Iowa to determine if their beneficiaries using the pharmacy benefited. That pilot project resulted in a lower total cost of care and improved medication adherence for the beneficiaries associated with the pharmacy.[29] This led to the payer instituting a value-based pharmacy program (VBPP) with 73 pharmacies. The results of that program also showed significant reductions in total cost of care for the beneficiaries using the pharmacies associate with the VBPP.19 Anecdotally, discussions with payers and self-insured employers have indicated that they would explore a breakeven model if they believed that beneficiaries health and satisfaction with services improved.

Community pharmacies are vital access points in public health networks, providing essential services that extend far beyond traditional pharmacy roles. Financial and structural support from public health entities can empower pharmacies address broader public health challenges effectively. Sustainable strategies for managing disease outbreaks, supporting underserved populations, or addressing health-related social needs are critical. By enhancing collaboration between pharmacies and public health organizations, these efforts can amplify the impact of community pharmacies in improving overall public health outcomes.

This resource guide offers a comprehensive framework for enhancing patient care programs through clinically integrated networks (CINs) in community pharmacies. It outlines strategies for establishing effective CINs, emphasizing the importance of high standards, practice readiness, and robust infrastructure. The guide details how to leverage payment models, optimize workflow efficiencies, and ensure consistent performance through transparent data sharing and accountability. Additionally, it highlights the critical role of community pharmacies in public health, advocating for sustainable practices and collaboration with health payers to improve health outcomes. By following these best practices, pharmacies can transform their operations, secure appropriate payments, and deliver high-quality, patient-centered care.

"Any interest in connecting with CPESN USA or any local state chapter, please reach out to support@cpesn.com."

29 Doucette WR, DeVolder R, Heggen T. Evaluation of financial outcomes under a value-based payment program for community pharmacies. J Manag Care Spec Pharm. 2021 Sep;27(9):1198-1208. doi: 10.18553/jmcp.2021.27.9.1198. PMID: 34464212; PMCID: PMC10390956.

Scaling Community Pharmacy and Payer Partnerships for Patient Care

A Resource Guide

Appendices

Appendix 1

Example Onboarding Email

From: Network Leadership
To: Network Pharmacies
Subject: Welcome to CPESN!
Date: Monday, February 26, 2024 10:42:27 AM
Attachments: Participant Packet.pdf

To the Pharmacy team:

Congratulations on becoming a CPESN Participating Pharmacy and welcome to CPESN (State)! On behalf of CPESN (State) leadership, it is exciting to add to our network of community pharmacies offering enhanced clinical services in value-based care delivery. Attached your will find our CPESN (State) participant packet. In this packet you will find our Luminary leaders and our Regional Facilitators, who can support sharing and searching for resources, contacts, etc. in addition to myself.

I am sure that your pharmacy is eager to get started. We are sharing the following resources and onboarding steps attached to this email. Below are the steps to complete your enrollment with CPESN (state) and make sure you are getting the most out of your participation

Complete our local chapter agreement through DocuSign: Local Link Provided

Look out for an invite from (online platform) to join our network wide page. This can also be accessed by going to our website (link) and clicking on the Network Login button in the top right corner. If there are additional pharmacy staff, including pharmacists, technicians, or CHWs, that you wish to add to this page, please email first & last name and email address to get them added.

When convenient, please complete this Pharmacy Landscape Assessment survey

The first question most new pharmacies ask is "Where do I start?" – I am happy to answer this question in a quick virtual meeting to introduce the plethora of opportunities with CPESN and break them down into where to start and where you can go. Please let me know what your schedule looks like over the next couple weeks to get that scheduled. The top three areas of focus for pharmacies asking this question are:

1. **Review your Med Sync process.** Our goal with current (and future) services and opportunities is to incorporate billable services into your pharmacies workflow without overburdening you or your pharmacists and incorporating your entire staff and your current pharmacy management software. I can share a self-assessment resource and we have additional resources, support, and more on developing and expanding on robust sync programs to create longitudinal care processes without the burden.
2. **Enroll pharmacists as providers in the state.** There are expanded services we can already provide to patients through the state that many pharmacies are not taking advantage of. CPESN (state) is focused on changing that and providing resources and tools for our pharmacies on this priority. You can find these resources on the online platform once you join and our Regional Facilitators are all able to support you through this process as well.
3. **Consider training your technician workforce as Community Health Workers (CHWs).** Pharmacy technicians have scholarships available right now to support enrolling in a course specifically designed for pharmacy teams through www.ceimpact.com/chw. Additionally, we have programs related to pharmacist + CHW/tech teams and have expanded our partnerships and future opportunities through a focus on health equity and pharmacy teams addressing social determinants of health. More information is available on Basecamp, through your Regional Facilitator, or me.

We look forward to working together to improve patient care. As your Lead Network Facilitator, I encourage you and your team to reach out to me should you have any further questions now or in the future! I am also happy to connect further on opportunities in our network. If you would like to set up an introductory call with myself or one of our luminary leaders, let me know!

Thank you!

Sincerely,

Managing Network Facilitator Name and Contract Information

Appendix 2

Cardiovascular Disease Grant Proposal

Developed on: Q4 2023
Developed by: Lead Network Facilitator
Intervention: Addressing Health Equity and Blood Pressure Gap Closures utilizing Pharmacist and CHW teams
Pharmacy Partners: Network Pharmacies

Background:

Community Pharmacy Enhanced Services Network (CPESN) is a clinically integrated network committed to offering enhanced patient services through community-based pharmacies, addressing patients' unique medication use needs and co-managing patients in collaboration with an integrated care team, ensuring positive health outcomes and reducing overall health care costs. All CPESN pharmacies offer Medication Synchronization as a minimum service which includes a regular (typically monthly) call with each patient enrolled in their program to review medication lists, provide education, and address potential barriers to adherence and medication management, communicate with providers for refills or medication changes or refer for additional care as needed. Patients have a routine pick-up date each month where there may be additional interaction and counseling by the pharmacist and team and additional clinical services, including immunizations, can be provided at this set pick-up time.

Through the medication synchronization process, the pharmacy and patients already have an established relationship and rapport. This program will 1) create workforce development and training specific to self-monitoring blood pressure (SMBP) for the pharmacy team to support Community Health Workers (CHW) with health equity expertise and then 2) layer on CHW services through credentialled pharmacy technicians as well as provide SMBP initial and follow-up education interventions tied with the med sync process' longitudinal check-ins during monthly calls and pick-ups. Additionally, they have training and resources to provide a more robust clinical pharmacy program, to layer in pharmacist's providing more in-depth medication management services. Both SMBP and Medication Management Services are associated with billable Current Procedural Terminology (CPT) codes with pharmacists eligible to enroll as providers and have ability to bill.

Process Outline:

Phase I: Workforce Development, Training, and Onboarding

1. Develop CHW continuing education module(s) for providing SMBP initial and follow-up interventions overseen by pharmacist.
2. Review and test documentation forms, templates, and other resources for best practice development.

Phase II: Intervention Implementation

1. Pharmacist screens patient eligibility prior to monthly care call. Eligible paitents include adult ages 18-85 years old who are currently on at least 1 antihypertensive medication.
2. Community Health Worker (CHW) performs initial assessment, including social determinants of health (SDoH) screening, and provides initial SMBP education intervention during monthly care call and at patient pick-up, if needed.
3. CHW performs follow-up SMBP interventions and education provided during routine monthly care calls following initial education and assessment.
4. CHW refers to pharmacist for additional education regarding blood pressure or related medications. Pharmacist provides medication management services on per patient basis.

Phase III: Scalability Resource Development

1. Review resources, tools, and templates from a scalability perspective and organize for sharing with expanded number of pharmacy sites.

Data Collection Process:

- SDoH screening, assessments, and referrals
- Intervention target: Blood pressure readings <140/90 mmHg for patients 18-85 years old (based on HEDIS quality measure)

Recommended Rates of Interventions:

CHW SMBP Education Intervention:

- Initial SMBP Education (based on CPT code 99473): $ (billed once)
- Follow-up SMBP Education (based on CPT code 99474): $/intervention (provided monthly)

Pharmacist Medication Management Services CPT codes (provided monthly):

- 99605 – Medication therapy management service(s) provided by a pharmacist, individual, face-to-face with the patient, with assessment and intervention if provided; initial 15 minutes, new patient. This code is payable only one time per participant per lifetime.
  - Rate of Intervention: $
- 99606 - Medication therapy management service(s) provided by a pharmacist, individual, face-to-face with the patient, with assessment and intervention if provided; initial 15 minutes, established patient.
  - Rate of Intervention: $
- 99607 – each additional 15 minutes (List separately in addition to code for primary service) Maximum of four 15-minute increments (60 minutes) per provider per patient per calendar month.
  - Rate per Intervention: $

Proposed Budget:

CHW Interventions: Assuming the average patient will require initial SMBP + 5 follow-up interventions performed by the CHW during care sync calls, total budget per patient is $. Anticipating 100 patients over the course of 6 months to receive SMBP interventions, budgeting $.

Pharmacist Interventions: Every patient referred to pharmacist for medication management services would budget for $/first month intervention with $/month for 3 months on average for follow-up, total of $ per patient over the 6 month timeframe. Anticipating (number) patients over the course of 6 months to receive medication management services provided by the pharmacist, budgeting $.

LINE ITEM	BUDGET
Phase I: Pharmacy Training and Onboarding	$
Phase II: Intervention Implementation (6 month time frame)	$
Phase III: Scalability Resource Development	$
Admin/Personnel Time	$
Indirect	$
TOTAL	$

Appendix 3

Diabetes Focused Grant Proposal

Developed on: Q1 2023
Developed by: Lead Network Facilitator
Intervention: Addressing Health Equity and Diabetes-related Gap Closures utilizing Pharmacist and CHW teams
Pharmacy Partners: TBD (Specification: Currently accredited DSMES* pharmacy)
*Diabetes Self-Management Education and Support
Pharmacy 1
Pharmacy 2
Pharmacy 3

Background:

Community Pharmacy Enhanced Services Network (CPESN) is a clinically integrated network committed to offering enhanced patient services through community-based pharmacies, addressing patients' unique medication use needs and co-managing patients in collaboration with an integrated care team, ensuring positive health outcomes and reducing overall health care costs. All CPESN pharmacies offer Medication Synchronization as a minimum service which includes a regular (typically monthly) call with each patient enrolled in their program to review medication lists, provide education, and address potential barriers to adherence and medication management, communicate with providers for refills or medication changes or refer for additional care as needed. Patients have a routine pick-up date each month where there may be additional interaction and counseling by the pharmacist and team and additional clinical services, including immunizations, can be provided at this set pick-up time.

Through the medication synchronization process, the pharmacy and patients already have an established relationship and rapport. This program will 1) create workforce development and training specific to DSMES for the pharmacy team to support Community Health Workers (CHW) with health equity expertise and then 2) layer on CHW services through credentialled pharmacy technicians as well as provide DSMES initial and follow-up education interventions tied with the med sync process' longitudinal check-ins during monthly calls and pick-ups. Additionally, they have training and resources to provide a more robust clinical pharmacy program, to layer in pharmacist's providing more in-depth medication management services. Both DSMES and Medication Management Services are associated with billable Current Procedural Terminology (CPT) codes with pharmacists eligible to enroll as providers and have ability to bill.

Process Outline:

Phase I: Workforce Development, Training, and Onboarding

1. Develop CHW continuing education module(s) for providing DSMES initial and follow-up interventions overseen by pharmacist.
2. Review and test documentation forms, templates, and other resources for best practice development.

Phase II: Intervention Implementation

1. Pharmacist screens patient eligibility prior to monthly care call.
2. Community Health Worker (CHW) performs initial assessment, including social determinants of health (SDoH) screening, and instructs DSMES classes under pharmacist supervision.
3. CHW performs DSMES education follow-up interventions and education provided during routine monthly care calls following initial education and assessment.
4. CHW refers to pharmacist for additional education regarding clinical questions over patient's diabetes or related medications. Pharmacist provides medication management services on per patient basis.

Phase III: Scalability Resource Development

1. Review resources, tools, and templates from a scalability perspective and organize for sharing with expanded number of pharmacy sites.

Recommended Rates of Interventions:

CHW DSMES Education Intervention:

- SDOH Screening and Longitudinal Diabetes Education through Med Sync Program: $ per 15 minutes per patient

Pharmacist Medication Management Services CPT codes (provided monthly):

- 99605 – Medication therapy management service(s) provided by a pharmacist, individual, face-to-face with the patient, with assessment and intervention if provided; initial 15 minutes, new patient. This code is payable only one time per participant per lifetime.
  - Rate of Intervention: $
- 99606 - Medication therapy management service(s) provided by a pharmacist, individual, face-to-face with the patient, with assessment and intervention if provided; initial 15 minutes, established patient.
  - Rate of Intervention: $
- 99607 – each additional 15 minutes (List separately in addition to code for primary service) Maximum of four 15-minute increments (60 minutes) per provider per patient per calendar month.
  - Rate per Intervention: $

Proposed Budget:

CHW Interventions: Anticipating (number) patients given SDoH screening and longitudinal education and support tied to Med Sync care calls over the course of 6 months, budgeting $.

Pharmacist Interventions: Every patient referred to pharmacist for medication management services would budget for $/first month intervention with $/month for 3 months on average for follow-up, total of $ per patient over the 6 month timeframe. Anticipating 50 patients over the course of 6 months to receive medication management services provided by the pharmacist, budgeting $.

LINE ITEM	BUDGET
Phase I: Pharmacy Training and Onboarding ($ per pharmacy)	$
Phase II: Intervention Implementation (6-month time frame)	$
Phase III: Scalability Resource Development ($ per pharmacy)	$
Admin/Personnel Time	$
Indirect	$
TOTAL	$

Appendix 4

Vaccine Gap Screening and Enhanced Services Proposal

Developed on: Q1 2023
Developed by: Lead Network Facilitator
Intervention: Vaccine Screenings and Longitudinal Counseling for Eligible Patients on Pharmacy Med Sync Program

Background:

Community Pharmacy Enhanced Services Network (CPESN) is a clinically integrated network committed to offering enhanced patient services through community-based pharmacies, addressing patients' unique medication use needs and co-managing patients in collaboration with an integrated care team, ensuring positive health outcomes and reducing overall health care costs. All CPESN pharmacies offer Medication Synchronization as a minimum service which includes a regular (typically monthly) call with each patient enrolled in their program to review medication lists, provide education, and address potential barriers to adherence and medication management, communicate with providers for refills or medication changes or refer for additional care as needed. Patients have a routine pick-up date each month where there may be additional interaction and counseling by the pharmacist and team and additional clinical services, including immunizations, can be provided at this set pick-up time.

Through the medication synchronization process, the pharmacy and patients already have an established relationship and rapport. This program will layer on CHW services through credentialled pharmacy technicians as well as provide vaccination screenings tied with longitudinal check-ins and counseling for underserved or high-risk patients on recommended vaccinations. CPESN pharmacies provide medication synchronization programs as a required service to participate in the network. Additionally, they have training and resources to provide a more robust clinical pharmacy program.

CPESN Health Equity is Special Purpose Network, or sub-group, of CPESN pharmacies equipped with the expertise to address the growing health inequity crisis. This clinically integrated network of pharmacies has health equity and social determinant of health (SDoH) expertise within every pharmacy, including community health workers. Additionally, CPESN Health Equity pharmacies can provide medication optimization services, utilize best practice patient safety and quality initiatives, and can aggregate performance reporting on standardized quality measures.

Process Outline (at a minimum):

This intervention is to be conducted in an already operational Medication Synchronization program in a CPESN community pharmacy:

1. Eligible patients are screened by the pharmacist for all vaccinations prior to monthly care call.
2. Patients are counseled initially on appropriate vaccinations by the pharmacist during their medication synchronization monthly care call or in-person during their monthly pick-up date. Initial standardized patient intake form competed including SDoH screening, allergy update, address, race, ethnicity, etc. data collected.
3. Community Health Worker (CHW) in the pharmacy connects with patients through additional outreach who initially refuse the appropriate vaccine to address hesitancy or access issues (especially those related to SDoH) during medication synchronization monthly care calls. CHW will also refer to pharmacist for additional vaccine counseling, as needed.
4. Pharmacy submits data for invoicing/payment monthly which is processed and reviewed by CPESN Health Equity.

Sustainable payment structure:

The following CPT codes are billable to state Medicaid – the pharmacies will enroll and be trained to bill Medicaid if eligible Medicaid patient, and will bill the grant, if not. Rates included are similar to fee-for-service rates.

CPT codes:

- G0310 - Immunization counseling by a physician or other qualified health care professional when the vaccine(s) is not administered on the same date of service, 5-15 minutes.
  - Proposed Rate per Intervention: $

Proposed Budget:

While this program will initially be open to all CPESN (state) Pharmacies, a projected (number) pharmacy locations will participate:

BUDGET LINE ITEM	DESCRIPTION	AMOUNT
Pharmacy Stipend	Stipend for initial review, revamp, and maintaining a robust Med Sync program and additional data collection requested: $ per pharmacy x 75 pharmacy sites	$
Patient Interventions	Goal of 20,000 interventions (average of 2 interventions per patient = approximately 10,000 patients touched) x $/intervention	$
CPESN Health Equity (Special Purpose Network)	To support the development of training and onboarding, implementation design, and customized reporting	$
CPESN (State)	To support the development of training and onboarding, implementation design, and recruitment, facilitation, and success of pharmacies participating	$
Admin/Personnel	Included in the current grant budget	$
	TOTAL	$

Appendix 5

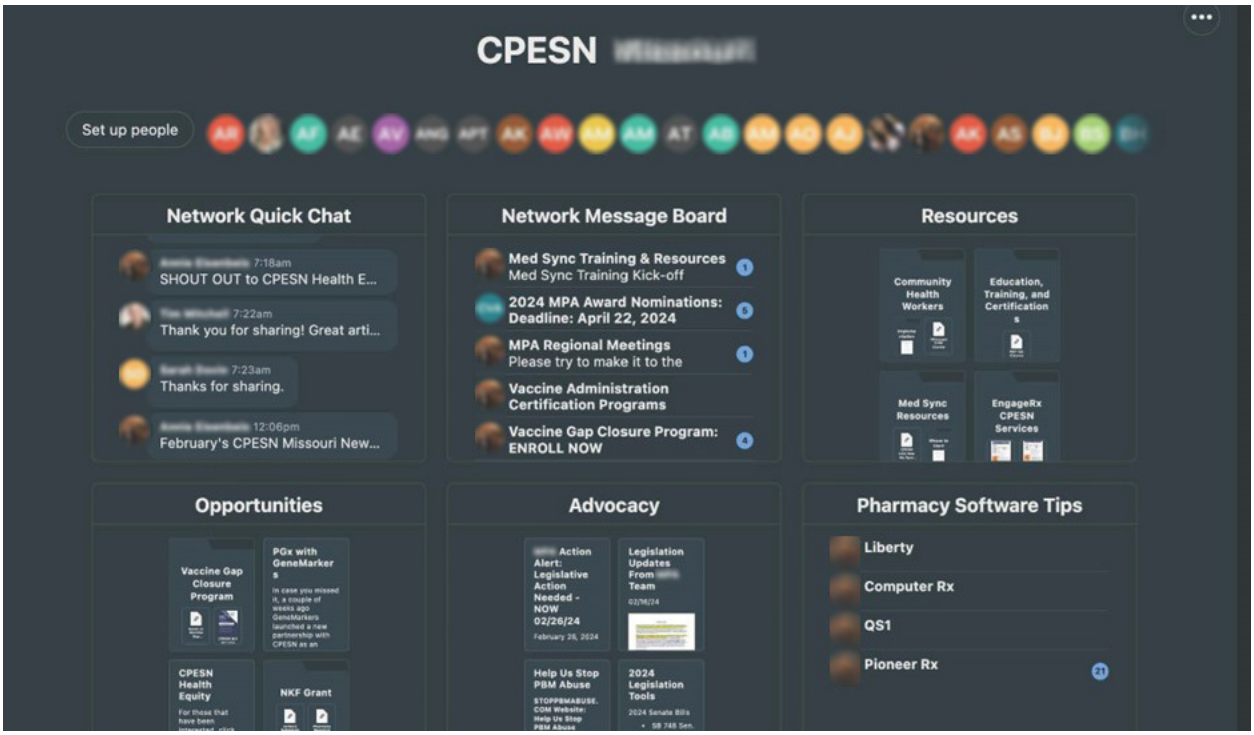
Vaccine Gap Closure Online Workgroup Invite

This page will hold the required onboarding training in addition to serving as a platform for asking questions, resource, and best practice sharing. We recommend that you download the (online platform) app (Link) because if you are solely viewing the content through email notifications, you are missing many of the resources and follow-up posts. Additionally, we hope that Basecamp can serve as hub for information and FAQs so that you can decrease the number of emails in your inbox.

Please email Lead Managing Network Facilitator (email) to add any additional team members who are supporting your pharmacy in this program. Include their first and last name, title (Ex: pharmacist or CHW) and email address.

Thank you!

Lead Contact Name and Information



Appendix 6

Vaccine Gap Closure Program Enrollment Steps (internal)

1. **Pharmacy enrolls:** Pharmacy completes enrollment/opt-in Jotform.
2. **Eligibility confirmed:** Confirms eligibility including CPESN pharmacy, CPESN Health Equity pharmacy.
3. **Training completed:** If meet eligibility criteria pharmacy that next steps include joining Basecamp and completing the training and attestation.
4. **Providers enroll:** Provider enrollment link shared with the pharmacy team automatically when Jotform attestation of training complete is submitted.
5. **Interventions start** (training stipend included on invoice with first intervention submitted)

Appendix 7

Vaccine Gap Closure
Pharmacy Intervention & Income Totals

(AS OF MARCH 2024)

PHARMACY NAME	FEB 2024 INTERVENTIONS SUBMITTED	FEB 2024 INCOME GENERATED
Pharmacy 1	20	$
Pharmacy 2	2	$
Pharmacy 3	49	$
Pharmacy 4	18	$
Pharmacy 5	79	$
Pharmacy 6	98	$
Pharmacy 7	22	$
Pharmacy 8	51	$
Pharmacy 9	25	$
Pharmacy 10	16	$
Pharmacy 11	22	$
Pharmacy 12	593	$
Pharmacy 13	26	$
Pharmacy 14	313	$
Pharmacy 15	182	$
Totals	1516	$

*Intervention is paid per successful intervention.

Appendix 8

Vaccine Gap Closure Program – Getting Started and Onboarding

Phase 1: Med Sync Patients &

Phase 2: Longitudinal Care Patients

Phase 1 includes patients currently enrolled in the pharmacy's Medication Synchronization (Med Sync) Program. Phase 2 includes all other patients who utilize your pharmacy but are not able to be added to the Med Sync program. In both phases, the pharmacy team will utilize processes already in place (in both workflow and pharmacy software) to integrate enhanced services in a stepwise approach. This program also focuses on including the entire pharmacy team.

Team Members

RPh – pharmacist enrolled as provider with a unique Jotform provider link for submitting data on patient interventions

CHW – for the purpose of this document, the CHW will refer to a pharmacy technician who is also fully trained and certified as a Community Health Worker, currently enrolled in a CHW course, or who has completed the Social Determinants of Health (SDoH) Specialist training through CPESN Health Equity; will also have a unique Jotform provider link for submitting data

Pharmacy Tech – Additional team members, including all other pharmacy technicians without formal CHW or SDoH training, who will NOT have a unique Jotform provider link for submitting data

Step 1: Infrastructure Considerations

A. Med Sync Program Self-Assessment: Conduct a self-assessment and review of your pharmacy's current Medication Synchronization Program.

- Do you have a "robust" Sync program?
- Best practice: At least 30% of your patients are on your Med Sync program.
- Does your program have a way to check-in (preferably via phone) with patients prior to their pick-up date/time?
- Do you have a system for scheduling appointments for pick-ups that include additional counseling or services?
- A goal to consider for your Sync program (for Phase 2 of this program): Could you add patients to this program who are not on any chronic medications and provide longitudinal education or follow-up?

B. Overall Process Review & Design: Consider the process that will work best for your pharmacy's team and workflow. Keep in mind, interventions for Phase 1 and 2 of this program include a 5-15 minute check-in with patients during a monthly call prior to their pick-up date/time. Data will be provided electronically utilizing Jotform which will also be how interventions are tracked and reimbursed monthly.

- After a review of your Med Sync program and patients, determine who and how many patients to start with. Additionally, consider how you will choose the initial patients and layer in additional patients currently on your Sync program.
- Assign tasks to each team member with defined expectations and steps including pharmacy technicians, CHW/SDOH specialists, and pharmacists.
- Identifying any improvements or updates needed for your Sync program to be successful for both Phase 1 and to layer in a longitudinal care process for all patients in Phase 2.

- Review all available resources:
  - Pharmacy Documentation One-pager Print-out – this can be used to collect patient information and notes in the initial assessment and follow-up interventions and then transfer the information to the electronic Jotform. Consider where you will store these documents as they can easily be used each month to review prior patient conversations.
  - Clinical Documentation Jotform – this form is unique to each provider, please only use the link provided to you individually; this will be how interventions are tracked for reimbursement as well.

C. Additional Considerations:

- Tracking Time: You will need to track the total time for each intervention. This is included on the Pharmacy Documentation One-Pager Print-Out and on the Clinical Documentation Jotform. Recommended average time for each intervention is 5-15 minutes.

Step 2: Completing the Initial Assessment

The initial assessment includes collecting patient health and demographic information, the CHW conducting a social determinants of health screening, and the pharmacist reviewing and providing information on the vaccinations the patient is eligible for.

Patient Health & Demographic Info (CHW or Pharmacy Tech): Initial demographic and past medical history can be collected by the CHW or pharmacy technician during the patient call.

SDoH Screening (CHW): The CHW will conduct a SDoH screening during the initial assessment call. Add any notes for follow-up during future monthly calls.

Vaccine Eligibility (RPh): The pharmacist will review and determine which vaccinations the patient is eligible for. The pharmacist will review and determine which vaccinations the patient is eligible for. If questions regarding eligibility, determining vaccine recommendations must be made by the pharmacist.

Step 3: Monthly Follow Up Assessment(s)

The follow-up calls will be added onto the monthly Sync program patient calls.

- **Identify Changes/Updates from Prior Month (CHW or Pharmacy Tech):** Identify if there have been any changes since the last call (health conditions, allergies, insurance, etc).
- **Vaccinations Received (CHW or Pharmacy Tech):** Obtain patient-reported of vaccines received since the previous call (may also be able to check the pharmacy system, if received at your pharmacy).
- **Review Eligible Vaccine(s) and Discuss Hesitancy (CHW – may refer to Pharmacist, if applicable):** Start a discussion over eligible vaccines, vaccination hesitancy, and any other barriers. Keep in mind, this may require multiple conversations for one vaccine to build rapport and understanding of barriers.
  - The CHW may choose one vaccine the patient is eligible for as identified by the pharmacist's initial assessment and utilize motivational interviewing to discuss vaccination hesitancy and barriers to that specific vaccine or the CHW may talk in general about vaccination hesitancy and barriers, not referring to any specific vaccine, and allow the patient to dictate overall barriers and vaccine specific barriers.
- **Address SDoH Barriers (CHW):** The CHW should identify any SDoH-related barrier(s) and connect the patient with resources in the community to overcome them.
  - Example: Patient has transportation access issues and financial issues. The CHW schedules a community shuttle to pick up the patient from their home and bring them to the pharmacy and assists the patient in applying for a manufactures program to receive a patient specific dose.
- **Finalize Assessment & Plan:** The CHW should complete the assessment by listing out any details regarding the conversation on vaccine hesitancy and barriers; this should essentially be a summary of what the patient stated were barriers or causing hesitancy. Best practice would be to say "What I heard you say is..." to show active listening. Then, the CHW should complete the plan and follow up by stating what plan was made to overcome the barriers posed by the patient, or what resources were offered to the patient. Best practice would be to repeat this to the patient with the designation of responsibility ("I will do...", "You will do...", "We will do...").

Appendix 9

Example Pharmacy Processes (Encounters) and Outcomes (SNOMED Codes)

INITIAL ENCOUNTER REQUIREMENTS	
Core Services	**Intervention SNOMED Description and Code**
Medication Reconciliation**	Medication Reconciliation (430193006)
Medication Synchronization**	Medication synchronization/synchronization of repeat medication (415693003)
Home Hand Delivery (optional)	Private Home Delivery Booking (169624005)
Adherence packaging (optional)	Promotion of adherence to medication using pill dose dispenser (710153008)

ASTHMA
Encounter Reason SNOMED Code
Asthma Medication Review (394720003)
Intervention
Asthma Education (401135008)
Asthma trigger education (428511000124103)
Asthma action care planning (716542004)
Demonstration of inhaler technique (736601004)
Assessment using Asthma Control Questionnaire (763078008)

ANTI-DEPRESSANT POOR ADHERENCE
Encounter Reason SNOMED Code
Depression medication review (413974004)
Intervention
Depression education (428901000124105)
Monitoring adherence to medication regimen (713116003)
Medication education (967006)

ANTIPSYCHOTIC POOR ADHERENCE
Encounter Reason SNOMED Code
Mental health medication review (413143000)
Intervention
Monitoring adherence to medication regimen (713116003)
Medication education (967006)

HEALTH RELATED SOCIAL NEEDS SCREENINGS AND REFERRALS	
Encounter Reason SNOMED Code	
Assessment of health and social care needs (710824005)	
Social needs met (736691007)	
Coordination of resources to address social needs (1268662008)	
Assessment of social care needs (1085651000000100)	
Referred by community health worker (12261000175100)	
Referral to community health worker (464131000124100)	
Findings / Problem Observation	**Intervention**
Food insecurity (733423003)	Referral to State Funded Food Assistance Program (663081000124100)
Unsatisfactory living conditions (308899009)	Referral to subsidized housing service (472041000124108)
Inadequate clothing due to limited financial resources (1230283000)	Provision of clothing (1268695002)
Education about child care financial assistance program (651341000124104)	Referral to child care assistance program (621411000124107)
Financial insecurity (1184702004)	Referral to financial assistance program (1254705007)
Housing insecurity (611531000124109)	Referral to housing support program (472161000124106)
Unable to afford medication (454061000124102)	Enrollment in medication assistance program (451611000124107)
Unable to afford visit copayment (5311000175103)	Referral to financial assistance program (1254705007)
Inadequate healthcare resources (423593006)	Referral to financial assistance program (1254705007)
Inability to access health care due to transportation insecurity (551731000124103)	Assistance with application for Medicaid transportation program (611011000124107)
Employment problem (75148009)	Referral to Fair Employment Practice Agency (662891000124100)

Source: https://www.findacode.com/snomed/

Appendix 10

Pharmacy Documentation Data Collection

BASIC PATIENT INFORMATION

Name:_____ DOB: _____/_____/_____

Patient Zip-Code: _____ Patient Phone Number: _____

INITIAL ASSESSMENT # 1

Demographics:

Gender at Birth: M / F **Identify:** M / F / Transgender / Non-Binary / Unknown/ Prefer Not to Answer

Sexual Orientation: Heterosexual / Homosexual / Bisexual / Asexual / Unknown / Prefer not to Answer

Race: White / Black / Asian / Pacific Islander /American Indian or Alaskan Native / Hawaiian /Unknown/

Other: _____

Ethnicity: Hispanic/Latino OR Not Hispanic/Latino

Preferred Language: English / Spanish / Other (list): _____

Did the patient identify as having a disability? YES / NO
(i.e. hearing / vision/ cognitive / self-care difficulty / independent living difficulty)

If YES, please list: _____

Health Conditions:
(Please mark any health conditions the patient has)

- ☐ Alzheimer's Disease
- ☐ Anxiety
- ☐ Asthma
- ☐ Cancer
- ☐ COPD
- ☐ Diabetes
- ☐ Depression
- ☐ Falls in Elderly
- ☐ GERD
- ☐ Heart Failure
- ☐ HIV
- ☐ Hypertension
- ☐ Liver Disease
- ☐ Multiple Sclerosis
- ☐ Obesity
- ☐ Organ Transplant
- ☐ Osteoporosis
- ☐ Stroke
- ☐ Other:_____

Insurance Type:

- ☐ Medicaid Only
- ☐ Medicare Only
- ☐ Commercial
- ☐ Self-Pay
- ☐ Dual Eligible
- ☐ Uninsured
- ☐ Unknown
- ☐ Other: _____

Health-Related Social Needs:

- ☐ Access to Care
- ☐ Financial Insecurity
- ☐ Inadequate Housing
- ☐ Lack of Adequate Food
- ☐ Problems Associated with Health Literacy
- ☐ Problems related to health literacy
- ☐ Transportation Insecurity
- ☐ Other: _____

Other: (if applicable)

Allergies: YES / NO if YES, describe: _____

Is the patient pregnant? YES / NO if YES, list trimester: _____

Weight: _____lbs.

Intervention:

Date of Intervention: ___/_____/_____

Start Time: _____:_____ End Time: _____:_____

Place of Service: _____

IMMUNIZATION INTERVENTION:

The patient is eligible for the following: (RPh Only):

	Dose 1	Dose 2	Dose 3	N/A	Contraindicated
Influenza					
COVID-19					
PCV15/PCV20					
RSV					
Td/DTap					
Hep B					
Shingles					
HPV					

Assessment: (Please enter the provider's assessment of the vaccine hesitancy conversation using SOAP format (i.e. subjective, objective, assessment, plan)

Plan & Follow-Up:
(Please enter the provider's plan, follow-up and recommendations based on the conversation)

PATIENT INFORMATION FOLLOW-UP ASSESSMENT:

Name:_____ DOB: _____/_____/_____

Patient Zip-Code: _____ Patient Phone Number: _____

Date of Intervention: ___/_____/_____ Start Time: _____:_____ End Time: _____:_____

Place of Service: _____

IMMUNIZATION INTERVENTION

The patient received the following vaccines since the last intervention
(include vaccine dose, and date administered below):

_____

_____

The following vaccinations were reviewed with the patient to address any vaccination hesitancy or other barriers:

	Dose 1	Dose 2	Dose 3	N/A	Contraindicated
Influenza					
COVID-19					
PCV15/PCV20					
RSV					
Td/DTap					
Hep B					
Shingles					
HPV					

Assessment: (Please enter the provider's assessment of the vaccine hesitancy conversation using SOAP format (i.e. subjective, objective, assessment, plan)

Plan & Follow-Up: (Please enter the provider's plan, follow-up and recommendations based on the conversation)

Appendix 11

Pharmacist eCare Plan Example – Diabetes Program

Pharmacist eCare Plan

DIABETES PROGRAM

Dr. Smith referred Susie who is a 67 year old white female to the local pharmacy's diabetes management program. The pharmacist scheduled an appointment with Susie to review her history and current symptoms. Susie has a history of CAD (6 months post-MI), HTN, depression, COPD, type 2 diabetes, and insomnia. SS reports tobacco use with being a 1PPD smoker with willingness to quit. Susie reports that she has problems remembering to take her medications sometimes. Susie states she lives alone and had difficulty getting to her previous pharmacy and has difficulty getting to her primary care physician appointments.

Patient reported vitals/labs - Ht:5'5". Wt. 200lbs. Patient does not check blood glucose or blood pressure at home. Provided lab report from last physician visit 9 months ago for A1C: 8.5%.

Pharmacy-reported vitals/labs: FBG: 160 mg/dL ; BP: 134/84 mmHG

Immunizations: Influenza 3 months ago. No history of pneumococcal vaccine (Prevnar administered today).

Referral From:

Referred by Doctor

309014007

Encounter Reason and Type:

Diabetes Medication Review

394725008

Device Education

362978005

Initial Assessment

315639002

Medication List:

Metformin 500 mg twice daily
Omeprazole 20 mg daily
Clopidogrel 75 mg daily
Aspirin 81 mg daily
Sertraline 100 mg daily
Lisinopril 5 mg daily
Zolpidem 5 mg PRN nightly
Spiriva Handihaler 1 puff daily
Ventolin HFA 1-2 puffs every 4-6 hours as needed
Metoprolol succinate ER 50 mg daily
Glucometer with strips to be used once daily
Chantix Starter Pack

Patient Goals

- Check blood sugar daily.
- Set quit date and begin Chantix starter pack 7 days before quit date.
- Schedule a physician's appointment within next month.

Free Text

Drug Therapy Problems

- Diabetes not controlled with low current Metformin dose

Medication dose too low SNOMED code: 448152000

- Needs a statin for cardio protection.

Recommendation to start drug treatment SNOMED code: 306807008

Interventions

Pharmacist Assessment & Documentation

- Educated patient on use of glucometer.

Medical equipment or device education SNOMED code: 362978005

- Recommend increase in dose of metformin to MD

Recommendation to increase medication dose SNOMED code: 428811000124101

- Diabetes medication review

Diabetes medication review SNOMED code: 394725008

- Started patient on Medication Synchronization program

Medication synchronization SNOMED code: 415693003

- Pharmacist administered pneumococcal vaccine

Administration of substance to produce immunity,either active or passive (procedure) and pneumococcal vaccination (procedure) SNOMED codes: 127785005 12866006

Care Coordination Note

Enrolled patient in medication adherence program and educated on glucometer device.

Free Text

Appendix 12

Pharmacist eCare Plan Example – Asthma Program

Pharmacist eCare Plan

ASTHMA PROGRAM

Dr. Smith referred Timmy to the local pharmacy's asthma management program. The Pharmacist scheduled an appointment with Timmy's mother to review his history and current symptoms. Timmy is a 7 year old boy with moderate persistent asthma and a dust mite allergy. He likes playing soccer and running around at recess, but his asthma symptoms keep him home from school at least 2 days per month, and he has gone to the ED for uncontrolled asthma symptoms 4 times in the past 6 months. Timmy is on a low dose of fluticasone plus montelukast and an albuterol inhaler as needed. He uses his albuterol 3-4 times a week according to his mom. He does use a spacer with his inhalers and has appropriate technique and good adherence to his chronic meds, but you find out that his peak flow meter got lost about 3 months ago when the family moved. He lives at home with his parents, and you discover that his uncle, who smokes cigarettes in the house, is also living with them.

Referral from:

Referred by Doctor

309014007

Encounter Reason and Type:

Asthma Medication Review

394720003

Asthma Education

401135008

Initial Assessment

315639002

Medication List:

Fluticasone 44mcg oral inhalation twice daily

Albuterol 90mcg/inh oral inhalations every 4-6 hours as needed for asthma

Montelukast 5mg chewable oral tablet once daily

Patient Goals

- Less sick days from school because of Timmy's asthma
- Less trips to the emergency room for Timmy's asthma
- Limiting Uncle John from smoking inside the house

Free Text

Drug Therapy Problems

- Asthma symptoms not controlled with low dose fluticasone

  Medication dose too low SNOMED code: 448152000

- Overuse of albuterol inhaler

  Medication overuse SNOMED code: 6071000124102

Interventions

Pharmacist Assessment & Documentation

- Request new RX for peak flow meter from MD

  Medical equipment or device education SNOMED code: 362978005

- Recommend increase in dose of fluticasone to MD

  Recommendation to increase medication dose SNOMED code: 428811000124101

- Asthma medication review

  Asthma medication review SNOMED code: 394720003

- Educate Timmy's mom about second hand smoke and asthma (see if Uncle John can smoke outside)

  Asthma education SNOMED code: 401135008

- Educate Timmy's mom on techniques to minimize dust mite exposure

  Asthma education SNOMED code: 401135008

Care Coordination Notes

Second hand cigarette smoke in the home, no peak flow meter

Free Text

Appendix 13

Pharmacist eCare Plan Example – Heart Failure Case

Pharmacist E-Care Plan: Heart Failure Patient Case

Patient Case: TL is a 78 year-old African American male with a 9-month history of heart failure (HF). TL was recently discharged from the local hospital after being admitted for an acute HF exacerbation. Upon discharge, the patient remained on maintenance medications and started furosemide 40 mg QD. He was referred to his PCP for follow-up within 2 weeks post discharge.

TL was contacted by care management and agreed to enroll in disease state management. His personal goals include returning to his baseline activity as much as possible. (Before this hospitalization, TL was active maintaining his home, two apartments and a large flower and vegetable garden.) During a routine phone call, the care manager discovers that the patient has yet to pick up his post-discharge prescriptions from the pharmacy. The care manager contacts the pharmacist to identify possible barriers to care and works with the pharmacist to schedule a convenient pick up time for the patient. Upon further investigation in providing medication reconciliation, the pharmacist notices that the prescription for carvedilol is written for once daily, when typically the prescribed dose is BID for HF patients. The pharmacist calls the prescriber and the prescription is changed to reflect BID dosing.

When TL arrives at the pharmacy, the pharmacist performs an initial encounter. The pharmacist counsels him and his wife on medication adherence and heart failure management. Upon discussion with TL, the acute HF exacerbation seemed to have been triggered by drinking >2 L of fluid per day and eating fast food with high amounts of sodium. TL weighed 1 day earlier before the intial encounter with a weight of 180 lbs. Today he weighs, 184 lbs. Pharmacist will follow-up with PCP to discuss TL's weight gain. TL admits he has trouble remembering to take his chronic medications and isn't sure how he is going to remember to take them on time. The pharmacist suggests adherence packaging and helps TL set alarms on his cellphone.

The pharmacist also reviews reading nutrition labels with the patient and it becomes clear that TL is very overwhelmed by all the values. The pharmacist spends additional time counseling the patient. Also, the pharmacist discussed and implemented a follow-up plan with TL which includes a patient-specific weight capture process.

Pharmacist eCare PLAN INITIATIVE

Encounter Reason and Type:
- Heart failure medication review: 473226007
- Heart failure education: 423475008
- Initial assessment: 315639002

Medication List:
- Lisinopril 40 mg QD
- Carvedilol 3.125 mg BID
- Spironolactone 12.5 mg QD
- Furosemide 40 mg QD

Vitals:
- Body weight: 29463-7
- 184 lbs (4 lb increase in 24 hours)

Patient Goals:
- Being able to garden and complete normal activities after hospitalization
- Reduce caregiver burden on family
- Minimize trips to the emergency room for heart failure exacerbation

Referral from Transition Care Nurse: 306045005

Penicillin Allergy: Rx Norm - 70618

Drug Therapy Problems/Problem Observation:
- Medication non-adherence: 702565001
- Medication dose too low: 448152000
- Dietary sodium high: 162528004
- Noncompliance with fluid volume management: 129833008

Interventions:
- Educated patient and patient's wife on nutrition label reading and how to cook a low sodium diet: 61310001
- Educated patient on how to appropriately self-monitor weight and symptoms: 423475008
- Reviewed heart failure medication and confirmed dose of beta blocker with prescriber: 473226007
- Obtained new prescription from provider for beta blocker in order to comply with treatment guidelines: 428821000124109
- Counseled patient on the importance of medication adherence and offered blister packaging services to patient: 410123007
- Low salt diet education 183063000

Care Coordination Notes:
- Referral to physical therapy to help TL reach goals
- Contact PCP about furosemide dose
- Pharmacy to follow-up with patient in 2 weeks