

# Pharmacists' Impact on Quality Measures and Opportunities for Pharmacy Enhanced Services

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**Upon successful completion of this article, the pharmacist should be able to:**

1. Explain the impact of the Merit-Based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs) on providers.
2. Discuss MIPS quality measures and improvement activities upon which pharmacists can have an impact.
3. Describe opportunities for pharmacists to partner with providers to improve patient outcomes using pharmacy resources.

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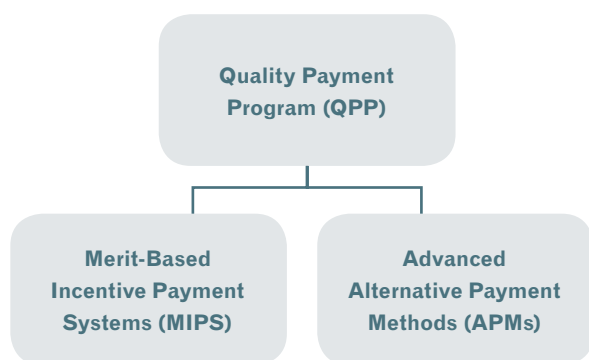


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## INTRODUCTION

The rapidly evolving health care landscape is currently experiencing a major shift from a volume-based, fee-for-service system to a value-based payment system. As such, today's health care system is challenged to improve quality by creating new models of care that decrease both payer and patient costs and improve patient outcomes. The Centers for Medicare & Medicaid Services (CMS) is committed to rewarding quality. On Oct. 14, 2016, the CMS released the Final Rule of the Medicare Access and Children's Health Insurance Program (CHIP) Reauthorization Act (MACRA) of 2015. This rule dramatically changes how providers are compensated for their services under Medicare and will likely pave the way for private payers to follow suit. In the MACRA, two value-based payment tracks are described: Merit-Based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs), collectively referred to as the Quality Payment Program.

Figure 1. Quality Payment Program



Physicians face a severe time crunch due to an influx of patients seeking care, increasing administration requirements, and a looming physician shortage. These challenges add to their pressure to meet patient needs and adjust to value-based reimbursement, creating an opportunity for pharmacists to emerge as indispensable members of the health care team. Pharmacists can help prescribers enhance performance on quality metrics and improve patient outcomes. As the most accessible health care providers, pharmacists increase patient access to care, decrease the overall number of hospitalizations and readmissions, and reduce the total net health care spend.

While MACRA does not directly affect most pharmacists, the value-based payment system that is changing the health care landscape is here to stay. Pharmacists are already experiencing some fundamental elements

of quality-based payment programs in the form of Star Ratings for medication adherence and medication-related quality measures. Pharmacists should be familiar with quality-based payment models to tailor enhanced services that help meet or exceed quality measure standards. Additionally, many of the measures providers are now required to report on can be impacted by popular enhanced pharmacy services including medication therapy management (MTM) and medication synchronization (med sync). It is important to demonstrate to providers how enhanced pharmacy services can impact patients' therapeutic outcomes. This data will also help qualify future opportunities to foster additional pharmacist-administered services. Understanding performance-based reimbursement programs and cultivating relationships with prescribers are avenues of opportunities for pharmacy enhanced services.

## OVERVIEW OF MIPS AND ADVANCED APMS

The MIPS is a new program that measures providers' performance in four weighted categories:

- Quality (60 percent for 2017)
- Cost/resource use (0 percent in 2017, but will increase in subsequent years)
- Improvement activities (15 percent for 2017)
- Advancing care information (25 percent for 2017)

Practitioners' MIPS composite performance score will determine how they will be compensated for the Medicare beneficiaries they care for in the future. Beginning in 2019, payments will be increased or decreased up to 4 percent based on performance during the 2017 reporting year. By 2022, there will be up to a 9 percent payment adjustment.

For the first year of MIPS reporting, providers—including physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, dentists, podiatrists, optometrists, and chiropractors—can choose the amount of 2017 data to submit through MIPS for 2019 payment adjustments. These clinics will begin having payments adjusted for 2017 performance on or after Jan. 1, 2019.

The other value-based track, Advanced Alternative Payment Models (APMs), is a payment approach which incentivizes quality and value, and is subject to additional requirements. Advanced APMs include the Next Generation Accountable Care Organization Model, the Oncology Care Model, and the Shared Savings Program. Qualifying participants must have 20 percent of their patients or 25 percent of their payments through an advanced APM to be excluded from MIPS. These eligible

clinicians will receive a 5 percent lump sum bonus beginning in 2019 but must share financial risk.

Due to the additional requirements with advanced APMs, it is expected that most providers will be reporting under MIPS and very few practices will initially participate in the Advanced APM track. Therefore, pharmacists may currently find more opportunities to collaborate with prescribers who are participating in the MIPS track.

### BREAKING DOWN MIPS

Value-based reimbursement models like the MIPS are becoming increasingly widespread. Thus, it is important for pharmacists to understand value-based payment systems and learn the language of MIPS to help prescribers meet performance-based goals. The MIPS category with the most potential for immediate pharmacist impact, and the only place in which pharmacists are specifically mentioned in the MACRA, is improvement activities.

**Table 1. Potential Improvement Activities for Pharmacists**

Improvement Activity	Pharmacists' Role	Action Steps
Consultation of the Prescription Drug Monitoring Program (PDMP)	Assist prescribers in identifying polypharmacy, doctor shopping, and potential opioid misuse or abuse.	<ul style="list-style-type: none"> <li>• Ensure patients with prescriptions for opioids are documented in the PDMP.</li> <li>• Consult PDMP before filling and inform prescribers of any inconsistencies.</li> </ul>
Implementation of integrated patient centered behavioral health model	Facilitate regular communication between prescribers in primary care and behavioral health.	<ul style="list-style-type: none"> <li>• Have employees obtain mental health first aid certification.</li> <li>• Use evidence-based screening to identify patients at risk and in need of services.</li> <li>• Conduct regular reviews for at-risk, unstable, or patients not responding to treatment.</li> </ul>
Implementation of medication management practice improvements	Integrate pharmacists into care teams and designate "clinic" time.	<ul style="list-style-type: none"> <li>• Conduct periodic, structured medication reviews.</li> <li>• Reconcile and coordinate medications across transitions of care.</li> <li>• Identify and resolve drug utilization issues.</li> <li>• Adjust strength, dosage form, or suggest therapeutic substitutions as needed.</li> </ul>
Implementation of antibiotic stewardship program	To ensure prescribing meets guidelines for proper antibiotic use, duration of therapy, and avoidance of drug-drug interactions	<ul style="list-style-type: none"> <li>• Identify overuse/underuse of antibiotics and assess dose appropriateness.</li> <li>• Utilize rapid diagnostic testing to diagnose influenza and streptococcus in the pharmacy under a collaborative practice agreement (CPA).</li> </ul>
Implementation of fall screening and assessment programs to identify patients at risk for falls and address modifiable risk factors	Counsel patients receiving high risk medications and use fall risk assessment scales during comprehensive medication reviews (CMRs).	<ul style="list-style-type: none"> <li>• Remind patients of why their medication is considered high risk.</li> <li>• Counsel on lifestyle interventions and help family modify environment.</li> <li>• Perform risk assessments in patients' homes with delivery drivers.</li> </ul>
Proactively manage chronic and preventative care for patients	Utilize evidence-based protocols to guide treatment for chronic conditions (i.e., hypertension, diabetes, depression, asthma, heart failure); and provide chronic care services.	<ul style="list-style-type: none"> <li>• Individualize care plans and educate patients.</li> <li>• Enroll patients in med sync.</li> <li>• Screen for comorbid conditions.</li> <li>• Perform routine medication reconciliations.</li> </ul>

## EXAMINING IMPROVEMENT ACTIVITIES

More than 90 improvement activities have been defined for the MIPS. The major subcategories of these improvement activities are expanding practice access, population management, care coordination, beneficiary engagement, patient safety and practice assessment, achieving health equity, integrating behavioral and mental health, and emergency response and preparedness.

While there are numerous improvement activities in which pharmacists can have a positive impact, a select few have been specifically identified by the Pharmacy Quality Alliance (PQA). These are activities pharmacists are often already practicing in various settings that may lend themselves to easy integration in a team-based pre-

scriber's practice. Identification of improvement activities such as these will provide pharmacists the ability to cultivate pharmacy enhanced services. Provided in Table 1 is a selection of improvement activities from PQA's listing. In accordance with each activity, there are action steps for pharmacists to use when building pharmacy programs that support providers.

## CONSIDERING QUALITY

In 2017, the quality category holds the most weight under the MIPS. However, it will gradually lose weight as the other categories increase in significance in the subsequent years. The quality category is a holdover of the nine measures providers used to participate in the Physician Quality Reporting System. In the quality cate-

**Table 2. Potential Quality Interventions for Pharmacists**

Quality Sub-Category	Pharmacists' Role	Action Steps
Patient Safety	Address processes and procedures designed to help reduce the risk of adverse events.	<ul style="list-style-type: none"> <li>Partner with providers to offer CMRs and medication reconciliation post-transitions of care.</li> <li>Call patients started on new medication within first three days to address any lingering questions.</li> </ul>
Person and Caregiver-Centered Experience and Outcomes	Address patient-centered care and quality care processes, including collection of patient-reported data and involvement of family members in patient's care plan.	<ul style="list-style-type: none"> <li>Include patients and family members in any clinical service activity.</li> <li>Gather patient-reported experiences and outcomes that reflect greater involvement of patients and families in decision making, self-care, activation, and understanding of their health condition and its effective management.</li> </ul>
Communication and Care Coordination	Address sharing of information and coordination of clinical and preventative services among patients, caregivers, and multiple health care professionals.	<ul style="list-style-type: none"> <li>Set up a CPA to help providers' document patient care activities using chronic care/transitional care management codes.</li> <li>Document clinical and preventative services and notify prescribers, so the patient's record is up-to-date.</li> <li>Send over an updated medication and fill record to prescriber's office quarterly.</li> </ul>
Effective Clinical Care	Address use of evidence-based prescribing guidelines for specific disease states	<ul style="list-style-type: none"> <li>Use CMRs, MTM, chronic care/transitional care management interventions to ensure appropriate prescribing and monitoring parameters are met.</li> <li>Use evidence-based guidelines and focus on measurable patient outcomes.</li> </ul>
Community/Population Health	Address population health such as screening and primary disease prevention.	<ul style="list-style-type: none"> <li>Provide point-of-care (POC) testing and screening services in the community pharmacy to improve accessibility of HIV and HCV screening tests.</li> <li>Screen for and refer patients for other diseases such as diabetes, hypertension, and osteoporosis.</li> </ul>
Efficiency and Cost Reduction	Address efforts to decrease costs, improve outcomes, and reduce errors.	<ul style="list-style-type: none"> <li>Enroll patients in adherence programs.</li> <li>Consider establishing a transitions of care program.</li> </ul>

gory, providers will choose six quality measures from a list of over 271 subcategories. Of the six quality measures chosen, one must be a high priority measure such as an outcome measure and one must be applicable to all provider specialties, also known as a “cross-cutting” measure. Because of the weight, providers’ focus will likely weigh heavily on the quality measure category for the MIPS reporting. Pharmacists should consider which of the subcategories in which they can be the most impactful. Examples for consideration outlined in Table 2.

### **OTHER MIPS CATEGORIES**

The advancing care information category expands the Meaningful Use program and emphasizes using technology to streamline patient care processes. This includes the ability to prescribe electronically, send and receive secure messages, and share information with others involved in the patient’s care. The advancing care information initiative expands on meaningful use to include protecting health information, increasing patient access to electronic records, creating more patient engagement, leading coordination of care efforts, and utilizing electronic prescribing and health information exchange. Pharmacists can leverage the physician’s need to meet the measures in this category and request access to the provider’s electronic health record (EHR). The ability to obtain patient EHRs can significantly improve patient care and quality. Pharmacists with access to the patient EHR either directly or through the sharing of electronic care plans can save both the health care system and patient money by leveraging their better understanding of patient needs with the additional information within a patient’s medical record to improve patient care. Importantly, pharmacists are increasingly able to create eCare Plans themselves that can be shared with other providers and improve patient care.

Lastly, the Cost/Resource Use category does not require reporting by physicians, but instead is pulled from Medicare claims data submitted throughout the year. Part of the goal of this measure is to encourage health care professionals to help beneficiaries understand their benefits and make medical decisions accordingly.

### **PRESCRIBER DETAILING**

Before a pharmacy can take advantage of all the opportunities presented by MIPS, the pharmacy must present their value case to prescribers. The first step in fashioning collaborative opportunities is building the relationship with the provider. By recognizing the objectives of the MIPS, pharmacists can reach out to prescribers to begin conversations around helping them meet quality benchmarks. Best practices identified by community pharmacists include:

- Identify prescribers who share mutual patients that already are familiar with your pharmacy. If possible, share a personal story of how the pharmacy has been able to help a mutual patient through enhanced services (such as adherence packaging and POC testing).
- Establish a relationship with the “gatekeeper” or office manager. This person is responsible for scheduling appointments and can let you know when scheduled down time is available.
- Call local providers’ offices where you have an existing relationship and set up an in-person appointment with the provider and staff, if possible. If they feel comfortable sharing, ask them which benchmarks they have chosen to submit data on.
- Be prepared to explain how your pharmacy’s existing services can help them meet their MIPS performance goals. Services like CMRs, medication therapy management, and adherence services could prove valuable for MIPS improvement. Medication synchronization, adherence packaging, and home delivery are all strategies to improve patient adherence, a key component when looking at quality and improvement activity measures.
- Focus on ways the pharmacy could streamline prescriber workflow. For example, med sync programs can decrease the administrative challenges of refill requests. If a pharmacy initiates a refill request 5-7 days before the patient needs the medication, the prescriber’s office has more time to pull the file, review the request, and send over the authorization in advance of the patient running out of medication.

The process of building collaborative relationships is key to the success of pharmacy enhanced services. Explain how you can help them meet expectations and care for their patients. The following clinical service programs are some revenue-generating opportunities pharmacists have for improving patient outcomes.

### **COLLABORATIVE PRACTICE AGREEMENTS**

One way to facilitate efficient patient care for patients with chronic conditions or minor acute illnesses is through a collaborative practice agreement (CPA). A CPA, sometimes referred to as a collaborative drug therapy agreement, is a formal relationship between a prescriber and a pharmacist that delineates and legalizes functions a pharmacist can perform beyond their typical scope of practice. Collaborative practice agreements are generally between a pharmacist and physician, but in many states are also allowed with nurse practitioners or other prescribers. CPAs can increase patient access to care and minimize workflow disruptions both in the pharmacy and provider’s office.

Entering into CPAs allow pharmacies to offer additional enhanced services that may help prescribers be successful in the MIPS program. Examples of pharmacy services that generally require a CPA include POC testing, refill authorizations, and therapeutic interchange. CPAs open lines of communication because roles and goals are clearly defined. They also allow pharmacists to tap into additional sources of revenue. Because collaborative practice acts vary from state to state, refer to your state's current laws to determine what agreements and functions can be performed. Sample agreements and more information can be found at [www.ncpanet.org/collaboration](http://www.ncpanet.org/collaboration).

### **POINT-OF-CARE TESTING**

Point-of-care testing services are anticipated to surpass immunizations as drivers of revenue for community pharmacies and clinics, based on research by Deloitte. Pressure from payers to detect high-cost diseases early will help speed up the growth of pharmacy-based diagnostic screening services. Offering POC testing at the pharmacy increases access to pharmacy care and also can improve population health.

Point-of-care tests are lab tests designed to be rapid, reliable, and performed at the point of service where the specimen is taken from the patient, such as when a patient presents to the community pharmacy. Commonly used POC tests in community pharmacies include (but are not limited to) cholesterol screenings, Group A streptococcal infection rapid diagnostic testing, *H. pylori* rapid diagnostic testing, A1c testing, influenza A and B rapid diagnostic testing, international normalized ration testing, and serum chemistry (such as serum creatinine and electrolytes). Any POC test that can be performed in the home by the patient is also considered to be Clinical Laboratory Improvements Amendments (CLIA)-waived.

For a pharmacy to become a CLIA-waived lab, certain requirements must be met. A pharmacy must enroll in the CLIA program, pay applicable certificate fees biennially, and follow manufacturers' test instructions. More information on CLIA waivers can be found at [www.cms.hhs.gov/clia](http://www.cms.hhs.gov/clia). States may have additional requirements or restrictions, so pharmacies should also consult their state pharmacy practice acts. Since its inception in 1992, the program has grown from eight CLIA-waived tests to more than 100 tests as of March 2017. Point-of-care testing services are usually offered as cash-based services, unless the pharmacy has a physician's order for lab work.

### **CHRONIC CARE MANAGEMENT**

Beginning in 2015, CMS started paying for a new program focused on the monthly management of chronic

conditions. The agency created chronic care management billing codes—99490, 99487, and 99489—that reflect varying degrees of complexity and time spent. However, the main tenant of the program is at least 20 minutes of non-face-to-face coordinated care directed by a physician or other qualified health care professional, per calendar month.

There are many criteria that must be met and documented to bill for chronic care services. These include creation of a comprehensive patient care plan, ability to share information to be uploaded in the patient's medical record, and patient access to a provider around the clock. Because pharmacists are not eligible to bill CMS directly for this service, pharmacists offering chronic care services to patients need to be contracted with a provider to bill incident-to the provider's referral. These contracts often designate the pharmacist as an independent contractor of the physician or the physician practice but other employment contracts can be created. Pharmacists working incident-to a physician for chronic care management must share all documentation from patient interaction back to the provider to be uploaded into the patient's medical record.

### **TRANSITIONAL CARE MANAGEMENT**

Transitional care management includes services provided to a Medicare patient who's requires moderate or high-complexity medical decision-making during transitions in care from an inpatient hospital setting, partial hospital, observation status in a hospital, or skilled nursing facility/nursing facility to the patient's community setting. These services are billed using codes 99495 and 99496.

The services are intended to be used by a physician's clinical staff member for two patient encounters immediately following a transition of care. Much like the chronic care services, a pharmacist who is a contracted employee of the physician with EHR access can provide a portion of the service. There are two touch points that must be completed before providers may bill for transitional care:

1. Within 48 hours post-discharge, a follow-up communication.
2. A seven to 14 day post-discharge face-to-face follow up with the provider.

Pharmacists can independently manage the 48-hour post-discharge touch point via call or interaction with the patient or family members. The pharmacist should contact the patient to discuss post-discharge plans and medication changes or additions. The second touch

point must be provided face-to-face and must include an evaluation and management visit with the provider. While the prescriber will perform the service, pharmacists may assist in this second touch point by scheduling the visit, completing the post-discharge medication reconciliation, updating the care plan, and arranging for patient supportive services as necessary. Both chronic care and transitional care billing have specific requirements including a description of the type of supervision required available on the CMS Medicare Learning Network at [www.cms.gov/mlnproducts/](http://www.cms.gov/mlnproducts/). Community pharmacy resources for chronic care and transitional care management can be found at [www.ncpanet.org/collaboration](http://www.ncpanet.org/collaboration).

### **MEDICATION ADHERENCE**

Adherence is one of the best predictors of patient outcomes. Per a study done by the World Health Organization, “increasing the effectiveness of adherence interventions may have a far greater impact on the health of the population than any improvement in specific medical treatments.” The study also found that among patients with chronic illness, approximately 50 percent do not take medications as prescribed. Poor adherence to medication leads to increased morbidity and death and is estimated to incur costs of approximately \$290 billion per year. Community pharmacies have implemented robust patient monitoring programs to improve patient adherence. Common components include med sync, compliance packaging, and home or work place delivery.

Medication synchronization, also known as the appointment-based model, improves patient adherence and streamlines pharmacy operations. In this model, community pharmacies align all of a patient’s medications to come due on the same day, which is known as the “appointment date.” The pharmacy reviews the medications to be refilled with the patient ahead of the appointment to address any barriers in adherence. The appointment date is commonly used to answer patient questions or conduct MTM services. Coordinating patients’ medications allows the pharmacy to manage the dispensing process, increase inventory turnover, and add enhanced services based on the added time-efficiencies. More information can be found at [www.ncpanet.org/adherence](http://www.ncpanet.org/adherence).

For chronically ill patients, yearly visits to the pharmacy outnumber visits to the prescribers’ offices by six-fold. Per NCPA’s National Report Card on Medication Adherence, the greatest predictor of medication adherence is a patient’s relationship with the pharmacy staff. Increased accessibility and levels of patient engagement create opportunities for pharmacist intervention and documentation of enhanced pharmacy services.

### **OTHER CONSIDERATIONS**

Offering enhanced pharmacy services that help providers achieve quality measures and improve patient outcomes is a relatively new market segment. The marketing challenges associated with enhanced pharmacy services are mostly related to educating the market. This is a challenge that must be met before being able to market the service well. For instance, you may need to explain to a provider what MTM is before you can ask them for patient referrals. Also, providers may or may not be fully aware of the changes to the Quality Payment Program. Some may adopt a proactive approach to achieving measurement goals, while others may take a more hesitant “wait and see” approach. Pharmacists can help providers prepare for the fundamental value-based shift by partnering with them in innovative collaborative partnerships.

When starting an enhanced pharmacy service, it is important to streamline processing to ensure optimal use of pharmacy resources. It is not required that the pharmacist be involved in every aspect of these enhanced clinical services. Pharmacy support staff utilization is key to providing a good return on investment. Workflow issues specifically regarding staff training and process efficiency are key to identifying which enhanced services your pharmacy can offer. Training staff members to help run the clerical aspects of the enhanced service is key to making the service profitable.

For many services, billing may be out-of-pocket with a patient option to submit charges to their health insurance plan independently. Patients will likely be paying cash for certain services such as POC testing and any one-on-one consulting outside of using electronic MTM platforms. Pharmacists can fill out an itemized form for rendered services for patients to submit to their insurance to see if the services are covered. For Medicare beneficiaries, patients can submit a claim with form CMS-1500. With the emergence of high deductible health plans, patients may be more inclined to pay for pharmacy services to save money down the line. For example, a patient in a high deductible plan and experiencing flu-like symptoms would likely be willing to pay for an influenza POC test if the community pharmacy had a CPA in place with a prescriber that allowed the patient to receive oseltamivir at the pharmacy without ever visiting the prescriber’s office.

Consider the costs of licensing, certification, supplies, and the staff coverage needed to administer any new service. Drafting a proposal or a business plan is a good way to identify some expected expenses and consider

calculating expected return on investment building the services. Documentation and demonstration of value through data collection can help illustrate the value of pharmacist-led enhanced services. Make sure to document any services in as much detail as possible.

### CONCLUSION

Understanding how quality is being measured in the processor space gives pharmacists insight into prescribers' motivating factors and allows for constructive collaborative relationships. Developing robust CPAs to offer enhanced services that align with the goals of both the Merit-Based Incentive Payment System and the Advanced Alternative Payment Models could prove a mutually beneficial relationship for providers and pharmacies as well as improve patient outcomes.

As the most accessible health care provider, pharmacists can impact population health through POC testing, improve patient outcomes through chronic care and transitional care management, and improve medication adherence through implementation of a med sync program. Pharmacists actively searching for new revenue-generating opportunities should seek providers who support pharmacy involvement in clinical service activities. Reach out to your local high-volume prescribers and request an appointment to discuss these changes and their challenges. Share your pharmacy's commitment to supporting them in this new performance-based reimbursement landscape. ■

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**Editor's Note:** For the list of references used in this article, please contact *America's Pharmacist* Managing Editor Chris Linville at 703-838-2680, or at [chris.linville@ncpanet.org](mailto:chris.linville@ncpanet.org).

## Continuing Education Quiz

Select the correct answer.

1. What law created the Quality Payment Program?
  - a. Medicare Access and CHIP Reauthorization Act
  - b. Affordable Care Act
  - c. American Health Care Act
  - d. Medical Improvement Act
2. Which of the following are value-based tracks under MACRA?
  - a. MIPS
  - b. Advanced APMs
  - c. All the above
  - d. None of the above
3. The MIPS measures performance in how many categories?
  - a. One
  - b. Two
  - c. Three
  - d. Four
4. In 2017, which measure category accounts for most of the physician's MIPS score?
  - a. Quality
  - b. Cost/resource use
  - c. Improvement activities
  - d. Advancing care information
5. Which is an example of pharmacist engagement in improvement activities?
  - a. Dispensing a prescription for a narcotic without consulting the PDMP.
  - b. Identify medications that may put a patient at a high risk for falls.
  - c. Filling every prescription for the same antibiotic from a prescriber without assessing appropriateness.
  - d. Recommending treatment to a patient without notifying the patient's provider.
6. Which of the following is true of collaborative practice agreements (CPA)?
  - a. Laws surrounding CPAs vary from state to state.
  - b. CPAs are formal relationships between a prescriber and a pharmacist that delineates and legalizes functions a prescriber can perform beyond their typical scope of practice.
  - c. Both A & B.
  - d. None of the above.



**7.** Which offering could a pharmacist provide that would most impact a physician's quality measure category under MIPS?

- a. Automatic refills for patients
- b. Refill reminder notifications
- c. Comprehensive medication review
- d. Communicating with the prescriber's non-clinical staff

**8.** Which MIPS category is pulled from CMS data and therefore cannot be directly impacted?

- a. Improvement activities
- b. Quality
- c. Advancing care information
- d. Cost/resource use

**Case Example (Use For Questions 9–12)**

Family Pharmacy has an existing relationship with Dr. Smith's primary care practice half a mile from the pharmacy. Many of the patients at Family Pharmacy are also patients of Dr. Smith. Family pharmacy is interested in collaborating with Dr. Smith's office to improve patient outcomes.

**9.** Family Pharmacy would like to meet with Dr. Smith and his staff to discuss ways to collaborate. Which of the following strategies would most likely be successful in setting up a meeting to make the pharmacy's pitch?

- a. Send a promotional fax.
- b. Establish a relationship with the "gatekeeper."
- c. Show up at the prescriber's office unannounced.
- d. Keep it professional and show no interest in the provider's staff.

**10.** Dr. Smith is concerned about the new quality reporting system. Which of the following activities demonstrates a way Family Pharmacy can help provide value for Dr. Smith in his MIPS reporting?

- a. Dispense medication using an automatic dispensing robot.
- b. Offer travel health products in the front end.
- c. Ensure that Dr. Smith is aware of medications that a specialist may have prescribed.
- d. Refer the patient to another provider for primary care.

**11.** Which of the following traditional pharmacy services would Dr. Smith least likely be interested in hearing about?

- a. Med sync program and adherence packaging
- b. Monthly diabetes education classes
- c. MTM cases
- d. Charge accounts

**12.** Family Pharmacy and Dr. Smith agree to enter a contractual relationship to manage the chronic care for their mutual patients. To bill for CMM services, at least \_\_\_\_\_minutes of care coordination services must be provided to a patient.

- a. 10 minutes
- b. 20 minutes
- c. 30 minutes
- d. 60 minutes