Opportunities for Sustainable Pharmacy Services in Federally Qualified Health Centers (FQHCs)
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The intent of this resource document is to introduce opportunities for pharmacy services and billing in an FQHC. This document provides information about various billing opportunities available in an FQHC, with some billing guidance, and also ***highlights*** practice sites currently providing and billing for services in an FQHC. If you would like more information on how a practice site implemented or bills for a service or have additional questions, please contact the site directly via the contact information specified.

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Introduction to Federally Qualified Health Centers (FQHC)

What is an FQHC?

FQHC's are "safety net" providers, and include:

- Community health centers
- Public housing centers
- Outpatient health programs operated by a tribe/tribal organization, or by an urban Indian organization
- Programs serving migrants and the homeless

Their primary purpose is the provision of primary care services in underserved urban and rural communities.

What requirements for FQHC's are different from other traditional practice models?

- FQHCs must offer a sliding fee scale (for patients with incomes below 200% of the Federal poverty guidelines), provide comprehensive services, have an ongoing quality assurance program (including an annual review), and have a governing board of directors.[1]
- An FQHC is unique only in the way it is paid for services eligible for an encounter payment, not by the scope of coverage for which it is paid.[1]
- Participating FQHCs receive an encounter payment under the FQHC Prospective Payment System (PPS) from the Centers for Medicare & Medicaid Services (CMS) that includes medical services (including qualified preventive health services), supplies, and the overall coordination of the services provided to the agency client. This amount is based on reasonable costs as reported on its annual cost report and is different at each FQHC.[1]
- Since payments to FQHC's come from CMS, only those practitioners who are recognized as "Health Care Providers" by CMS can bill directly for services. The Centers for Medicare & Medicaid Services has clarified that physicians may bill Medicare for a Part B covered service provided by a pharmacist in the practice as long as all of the incident-to rules are otherwise met.[2] Therefore, while pharmacists can provide services such as Annual Wellness Visits (AWV's) at FQHC's, they must be billed by the physician in order to be reimbursed. This is similar to the process utilized with medical residency programs where medical residents see the patients with Medicare insurance, but the attending physician (who is the recognized provider by CMS) also goes in to briefly talk with the patient during the visit, provides general supervision to the visit, and is then the provider who bills for the visit.
- Additionally, CMS includes pharmacists as auxiliary staff who may provide care management services (transitional care management, chronic care management, behavioral health integration, and psychiatric collaborative care) under general supervision by the primary care practitioner (PCP). Once the PCP determines that the criteria for care management services is met, the pharmacist can furnish the services under supervision but the PCP is not required to be immediately available or present in the same building.[2]

References:

1. Centers for Medicare and Medicaid Services. Medicare Learning Network Booklet: Federally Qualified Health Center (January 2021). https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/fqhcfactsheet.pdf (accessed 2021 Dec 10).
2. Centers for Medicare & Medicaid Services (CMS). Care Management Services in Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) Frequently Asked Questions (December 2019). https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/FQHC-RHC-FAQs.pdf (accessed 2021 Dec 10).

Additional Resources/Information on FQHC's:

- https://www.cms.gov/Center/Provider-Type/Federally-Qualified-Health-Centers-FQHC-Center
- https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE0441.pdf
- https://bphc.hrsa.gov/programrequirements/
- https://www.nachc.org/about/about-our-health-centers/what-is-a-health-center/
- https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/FQHC-RHC-FAQs.pdf

Medication Therapy Management (MTM)

Background

Medication therapy management (MTM) services can optimize medication use, improve health outcomes, and reduce costs. Medicare Part D plans are required by CMS to include MTM as a covered service to beneficiaries who qualify. As part of the Medicare Part D MTM program provided to eligible patients, CMS requires an annual comprehensive medication review (CMR) and quarterly targeted medication reviews (TMR), identified through the Targeted Intervention Program (TIP™) in some platforms. The CMR must be completed through direct patient interaction, and result in the patient receiving a personal medication record and medication-related action plan to resolve active or potential medication-related problems.

Billing

Since the introduction of the Medicare Part D MTM program, MTM-specific current procedural terminology (CPT®) billing codes were created. Providers of MTM and plan sponsors can contract with software vendors such as OutcomesMTM® or RxCompanion™ to facilitate referrals, documentation, bill for services, and issue reimbursement. For more information, please visit: https://www.outcomesmtm.com/ or https://sinfoniarx.com/mtm-solutions#services4.

CPT codes for pharmacist-provided MTM

99605	MTM encounter with new patient. Initial 15 minutes.
99606	Subsequent or follow-up MTM encounter with the same patient. Initial 15 minutes.
99607	Add-on code to 99605 or 99606 for each additional increment of 15 minutes.

National vs. State

Medicare Part D plan sponsors are required to provide MTM and can utilize their own criteria to select eligible patients for MTM. The criteria must include having multiple chronic disease states, taking multiple medications, and the likelihood of meeting or exceeding the annual CMS threshold of medication costs. Completion rates of CMRs is a CMS Star quality measure to incentivize plans to prioritize MTM services. Some state Medicaid and other non-Medicare third party payers have opted to offer MTM as a covered service.

Examples in Practice

Health Partners of Western Ohio (HPWO)
Lima, OH
Diane Russell, PharmD
Director of Pharmacy
drussell@hpwohio.org

How is this service being used in your practice?
MTM services are incorporated into both our clinical pharmacy practice and our in-house dispensing pharmacy practice. All pharmacists are using the OutcomesMTM portal for billing.

Clinical Pearls
You must get leadership support, provider champions, and meet patients where they are. Ask where patients and providers want help and grow from there. It is about building relationships and working as a team with the patient to reach health goals.

Roadblocks
The hardest part was integration into the traditional care team. Once the providers have a pharmacist on their care team, they do not want to go a day without them.

Role of Resident and Students
We host students on rotation in both community pharmacy and ambulatory care experiences. Each new student needs training on our system each month which does take some time away from patient care. However, Outcomes has streamlined their system to be user-friendly and straight forward and we have found students to be able to pick it up easily.

Role of Pharmacy Technicians
Pharmacy technicians can utilize the Outcomes platform under the guidance of a pharmacist. Technicians play a useful role in addressing the TIPs component of Outcomes by contacting providers and advising patients on ways to increase adherence. A trusting relationship needs to be established with the pharmacist and technician.

Recommended Resources
There are numerous resources for Medication Therapy Management training programs online or in person and the Outcomes portal itself has a training program.

PrimaryOne Health
Columbus, OH

Alexa Sevin Valentino, PharmD, BCACP
Assistant Professor of Clinical Pharmacy, The Ohio State University College of Pharmacy
Clinical Pharmacist, PrimaryOne Health
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How is this service being used in your practice?
MTM services are one of the programs offered by our clinical pharmacists. We are using the OutcomesMTM portal for billing. In Ohio, some of our managed Medicaid plans contract with OutcomesMTM, which has been a great opportunity for our pharmacists to seek reimbursement for our services. We proactively identify patients from the clinic schedule that are eligible for comprehensive medication reviews (CMR) or targeted interventions so that we can offer these services to patients when they are already in the office.

Requirements unique to the use of the MTM billing portals in an FQHC
Billing requirements for these services do not differ in the FQHC setting compared to other settings. The billing is done through the OutcomesMTM portal, which allows the pharmacist to bill for services rather than utilizing the billing department. This is a great opportunity for an initial service because of this benefit.

Clinical Pearls
Consider what workflow is going to work best for your environment. Our patient population has a high no show rate, so we knew that investing the time to contact and schedule patients to come in for this service might not be the best method for recruiting patients. Offering the service at the same time of their provider appointment increased efficiency for implementing the service. We are often able to complete a CMR with a patient, identify medication-related problems, discuss them with the provider, and get them resolved all within the same amount of time that the patient would have spent in the clinic anyways. The providers appreciate that we take the time to review medications with the patients in detail as this allows them to focus on other issues during their time with the patient.

Roadblocks
Finalizing the contract was the most time-consuming process. I would recommend setting up a face-to-face meeting with decision makers to describe the service and its benefits to the practice and patients. Include the lawyers or other decision makers who will be reviewing the contract in this meeting so any concerns can be addressed up front.

Role of Resident and Students
We have a PGY2 Ambulatory Care resident at PrimaryOne Health, as well as IPPE and APPE students. All trainees are trained on our EHR system and the OutcomesMTM system. IPPE and APPE students are responsible for identifying eligible patients for that clinic day and reviewing patient information in the EHR and OutcomesMTM portal to prepare for the CMR. The resident and/or clinical pharmacist preceptor will review the student's work-up prior to seeing the patient. The visits are led by the

student or pharmacist depending on where students are within their rotation month. Utilizing the students to identify these billing opportunities frees up resident and pharmacist time to work on other clinical activities.

Recommended Resources
American Pharmacists Association MTM Resource Library: http://www.pharmacist.com/mtm_library

Heritage Health
Kellogg, ID
Jolie Jantz, PharmD, BCPS, CDCES
jjantz@myheritagehealth.org

How is this service being used in your practice?
MTM services are offered to all patients of Heritage Health. As part of our participation in our regional Accountable Care Organization (ACO), we are also required to perform a certain percent of Comprehensive Medication Reviews (CMR) for the total population of eligible patients signed up with certain Medicare insurance plans.

Requirements unique to the use of the MTM billing portals in an FQHC
MTM billing is submitted separately from any FQHC-specific services, so the reimbursement is contractual with the MTM program or 3rd-party payor rather than FQHC-related. We perform 3rd-party-specific MTM services using proprietary software called MTMPath.

Clinical Pearls
Since our clinic has integrated clinical pharmacists who see complex patients face-to-face along with providers, we focus on this as the primary and most beneficial avenue for affecting patient education and improving quality of care. Our MTM services are primarily used to close quality gaps related to our ACO contracts.

Roadblocks
It would be nice if all 3rd party payors used the same software platform for MTM documentation. This would allow for more Medicare patients to receive documented MTM interventions, which in turn would help clinics more easily meet payor-agnostic quality goals required by Centers for Medicare and Medicaid Services (CMS).

Role of Resident and Students
N/A

Resources
- https://www.aphafoundation.org/medication-therapy-management

340B Pharmacy

Background
Based on section 340B of the Public Health Service Act, manufacturers participating in Medicaid provide outpatient drugs to covered entities (safety net providers, including FQHCs) at significantly reduced prices. The reduced prices are passed to the uninsured/underinsured patients. Additionally, the 340B program enables covered entities to expand access and services offered to their underserved patients without relying on the scarce federal resources. The Health Resources and Services Administration (HRSA) and the Office of Pharmacy Affairs (OPA) are responsible for interpreting and implementing the 340B law.

Billing
Pharmacy bills for medication cost and dispensing fees under the normal adjudication process for community/retail pharmacies.

National vs. State
340B is a federal program. However, states might enforce certain restrictions on use, billing, and reimbursement.

Examples in Practice

AxessPointe Community Health Center
Akron, OH
Magdi Awad, MSA, PharmD
Associate Professor of Pharmacy Practice, Northeast Ohio Medical University;
Director of Pharmacy Services, AxessPointe Community Health Center
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How is this service being used in your practice?
We have 4 in-house pharmacies plus contract arrangement with local pharmacies. The 340B program ensures affordable access to medications for our patients. The 340B savings are used to expand and enhance services offered at the health center. Having the in-house pharmacies allow our medical providers to directly access the pharmacists' expertise.

Does this service support the sustainability of other pharmacy services?
Portion of the 340B savings is used to support the clinical pharmacy services.

Clinical Pearls
Knowing that the 340B savings are utilized to expand services offered at the health center, it is important to explain and show the value of the clinical pharmacy services in improving patient outcomes and satisfaction. Additionally, the clinical pharmacy services will help increase patient capture rate. For a successful 340B program, the in-house pharmacy needs to retain insured patients

who have the option to use any other pharmacy. Therefore, insured patients must see an added value to continue using the in-house pharmacy. Clinical pharmacy services can capitalize on our access to the clinic's electronic health records and the trusting relationship with the medical providers at the clinic to our advantage and allow us to better serve our patients.

Our pharmacy team utilizes academic detailing to help our providers prescribe more cost effective and evidence-based medications. Academic detailing is defined by AHRQ as peer-to-peer educational outreach that is used in improving care quality and to build priority for change in clinicians and leadership.[1]

Roadblocks
There are numerous tools available to assist in opening an in-house pharmacy. However, linking clinical and dispensing services and showing how they can support each other can be a challenge.

Role of Residents and Students
Our residents provide clinical pharmacy services and staff one day a week at the in-house pharmacy. The residents have helped expand the clinical pharmacy services offered at AxessPointe. Students are helping in both areas. During orientation, both students and residents are introduced to the 340B program's benefits and requirements.

Reference:

1. Agency for Healthcare Research and Quality. Practice Facilitation Handbook: Module 10. Academic Detailing as a Quality Improvement Tool (last reviewed May 2013). Available at: https://www.ahrq.gov/ncepcr/tools/pf-handbook/mod10.html (accessed 2021 Dec 16).

Recommended Resources
- HRSA - https://www.hrsa.gov/opa/educational-resources/index.html
- Apexus 340B University - https://www.apexus.com/

Health Partners of Western Ohio (HPWO)
Lima, OH
Diane Russell, PharmD
Director of Pharmacy
drussell@hpwohio.org

How is this service being used in your practice?
We currently operate four in-house pharmacies and manage five contract pharmacy arrangements.

Does this service support the sustainability of other pharmacy services?
We use the savings generated from the 340B pharmacy to help support our clinical pharmacy services.

Clinical Pearls
The 340B program is vital to the organization and the health of our patients. Patients must have access to affordable medications. Even though Ohio is a Medicaid expansion state, there are still a great number of patients that fall through the cracks of healthcare coverage. Our patients receive a tremendous discount on medications based on household size and income. Without this program, many of our services at HPWO would not be viable.

Roadblocks:
The biggest roadblock is getting the program started on a firm foundation of support for quality and integrity. There are specific regulations with the 340B program, and it is important that the entity is responsible for the integrity of their 340B program. The responsibility of a good program should not be outsourced.

Role of Residents and Students
Students come through on rotations, but we do not depend on them for sustainability.

Recommended Resources
- HRSA's Peer to Peer Program - http://www.hrsa.gov/opa/peertopeer/index.html
- Apexus - https://www.340bpvp.com/controller.html
- LinkedIn - The 340B Resource Network
- HRSA Office of Pharmacy Affairs - http://www.hrsa.gov/opa/index.html

Heritage Health
Kellogg, ID
Jolie Jantz, PharmD, BCPS, CDCES
jjantz@myheritagehealth.org

How is this service being used in your practice?
We have a Street Medicine Homeless Outreach program that now operates a Prescriber Drug Outlet, which allows us to order and dispense meds to homeless patients at no cost to the patient. Since our clinic system does not utilize a standard in-house dispensing pharmacy for all patients, we rely on contract 340B pharmacies in the community as well as several mail-order options to provide 340B savings directly to the patient. Without an in-house pharmacy, we must be creative in our ways to provide 340B discounts to patients, so we offer a special card for patients to fill prescriptions at contract pharmacies at 340B cost plus the pharmacy's dispensing fee. Any 340B program-generated revenue is used to further support the patient services provided to all FQHC patients.

Does this service support the sustainability of other pharmacy services?

Our clinic does not require the clinical pharmacy service team to justify its sustainability through hard revenue documentation. The executive and clinical staff realize the benefit of these services outside of revenue generation.

Clinical Pearls

Since the 340B program is highly complex, there is often misunderstanding about the appropriate use of 340B direct drug discounts to the patients, so it is important for both providers and patients to know how to access these discounts. In addition to 340B, we offer a multitude of medication assistance programs for our patients to obtain medications affordably.

Roadblocks

Though opening our own in-house 340B pharmacy would be ideal, it is an incredibly expensive up-front endeavor to finance.

Specialty Pharmacy

Background
Specialty pharmacy is an evolving concept. Originally, costly, and infused medications were classified as specialty medications. Currently, specialty medications include a wide range of medications that are utilized to manage complex disease states such as rheumatoid arthritis, HIV, cancer, and hepatitis. Ongoing disease and medication management is vital to the success of these medications. Pharmacists are expected to play a great role in care coordination, patient education, disease management, and effectiveness and safety drug monitoring. Pharmacies need to go through an accreditation process to verify that they have systems in place to meet the patient needs.

Billing
Most pharmacy benefit managers require specialty pharmacy contracts.

National vs. State
Depends on the insurance type.

Examples in Practice

Equitas Health
Columbus, OH
Aaron Clark, PharmD, AAHIVP
Chief Healthcare Operations Officer
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How is this service being used in your practice (integration, benefits, value)?
Specialty Pharmacy services are integrated into the operational and clinical service models at each of our in-house pharmacies. Upon presenting a prescription for a specialty medication to any of our pharmacy locations, patients are enrolled into a comprehensive Patient Management Program. The Patient Management Program includes an initial assessment, ongoing reassessments, individualized care plans, and additional customized services when needed.

Our specialty pharmacy model also includes a Quality Management Program that is utilized to ensure we offer high-quality service and patient care at each pharmacy location. This program includes extensive reviews of quality data and metrics, as well as ongoing Quality Improvement Projects.

Requirements unique to health centers
Not Applicable

Clinical Pearls (tips for success)
Preparation and Planning: Starting a specialty pharmacy program can be very time consuming and requires a significant amount of planning. Before starting a specialty program, first identify the specialty therapeutic classes that your pharmacy would like to dispense. You will need to determine if

there are any dispensing or purchasing requirements for the medications in the specific classes. Also, assess the insurance plan's and/or pharmacy benefit manager's requirements for dispensing a given medication or class of medications. This will help you plan for new processes to implement or accreditations the pharmacy may be required to obtain.

System: To meet the requirements of any specialty pharmacy accreditation, a pharmacy must maintain extensive documentation on each patient. It is imperative to select a pharmacy operating system or specialty patient management software that can maintain all the required components of patient documentation.

Training: Learning a new system and becoming an expert on specialty medications takes time and effort. Creating a mechanism for training on both process implementation and clinical information is key to running a successful specialty pharmacy program.

Roadblocks (and how to overcome)

Accreditation: In general, one or more specialty pharmacy accreditations will be required by insurers to dispense specialty medications at a pharmacy. Ensure that you select the appropriate accreditations and create a realistic timeline for submission.

Cost: Initiating specialty pharmacy services within a pharmacy can be costly. Costs include salaries for staff to develop and implement the program, purchase of patient management software, accreditation fees, and ongoing staff time. Before starting a specialty pharmacy program, consider creating a cost-analysis review, and ensure the figures placed in your budget are realistic.

Network Access: Receiving specialty pharmacy accreditation does not automatically give a pharmacy access to all insurance networks. Many networks have separate application costs and criteria, while some networks are closed entirely. Researching each insurance plan or pharmacy benefit manager's requirements is key to determining if a pharmacy will be eligible to access the network.

Role of Resident and Students

Residents can be trained on the specialty pharmacy program and assist in the Patient Management Program workflow. Residents are also able to assist in the creation, implementation, and analysis of Quality Improvement Projects.

Each of our pharmacy sites host pharmacy students nearly every month. However, students are not integrally involved in our specialty pharmacy model, as extensive clinical knowledge is required to manage specialty conditions. Students have an excellent opportunity to learn about specialty medications and observe patient management program services.

Recommended Resources

Accreditation Commission for Health Care (ACHC): https://www.achc.org/pharmacy.html
American Society of Health-System Pharmacists (ASHP): https://www.ashp.org/Pharmacy-Practice/Resource-Centers/Specialty-Pharmacy

Center for Pharmacy Practice Accreditation (CPPA): https://www.pharmacypracticeaccredit.org/
The Joint Commission: https://www.jointcommission.org/accreditation-and-certification/health-care-settings/pharmacy/
URAC: https://www.urac.org/programs/specialty-pharmacy-accreditation

Spirometry

Background

Spirometry is an office test used to assess and monitor lung function and aid in diagnosis of pulmonary diseases, including asthma and COPD. Those who perform spirometry should receive formal training that includes set-up and operation of the spirometer, knowledge and application of standard maneuvers, and the ability to identify whether results indicate obstructive or restrictive patterns of disease. Quality of spirometry feedback is also needed. Education of those interpreting the results should also be provided so that quality and clinical nature of results can be graded.[1] Additional information can be found in the resources listed below.

Billing

Procedure Code	Definition
94010	Spirometry, including graphic tracing, total and timed vital capacity, expiratory flow rate measurement(s), with or without maximal voluntary ventilation
94060	Pre- and Post-bronchodilator Spirometry: Bronchodilation responsiveness

National vs. State

Depends on the insurance type.

Resources

1. Ruppel GL, Carlin BW, Hart M, Doherty DE. Office spirometry in primary care for the diagnosis and management of copd: national lung health education program update. Respir Care. 2018;63(2):242-252.
2. Graham BL, Steenbruggen I, Miller MR, et al. Standardization of spirometry 2019 update. An official american thoracic society and european respiratory society technical statement. Am J Respir Crit Care Med. 2019;200(8):e70-e88.
3. Ferguson GT, Enright PL, Buist AS, Higgins MW. Office spirometry for lung health assessment in adults: A consensus statement from the National Lung Health Education Program. Chest. 2000;117(4):1146-1161.
4. Culver BH, Graham BL, Coates AL, et al. Recommendations for a standardized pulmonary function report. An official american thoracic society technical statement. Am J Respir Crit Care Med. 2017;196(11):1463-1472.

Examples in Practice

AxessPointe Community Health Centers
Barberton, OH
Tiffany Rentsch, PharmD, BCACP
Pharmacy Manager
trentsch@axesspointe.org

How is this service being used in your practice?
Patients are referred to pharmacy services in 1 of 3 ways: self-referral, provider referral or via standing order. The standing order at our practice allows for pharmacy-generated referrals for anyone with COPD or asthma listed in their chart who has not had pulmonary function testing for 2 years. The patient is then scheduled by a student or pharmacy staff member for a 1-hour, 1-on-1 visit with the clinical pharmacist, resident pharmacist, student pharmacist or some combination. In addition to the testing, the pharmacists evaluate the pulmonary regimen and provide recommendations/education to enhance regimen and compliance. Documentation and therapeutic recommendations are communicated via the patient's electronic health record.

Requirements unique to the use of these codes in an FQHC
Use 94010 if no bronchodilator was used during spirometry test; use 94060 if post-bronchodilator testing was performed. These codes are not to be combined.

Clinical Pearls
Creation of a standing order with criteria for spirometry being required every 1-2 years for anyone with asthma or COPD listed in their medical chart, or prescribed inhalers chronically, offers an opportunity to capture patients. Incorporation of ordering spirometry via standing order into dispensing pharmacy, including reminders in the dispensing software on inhaled medications, further increases use of the standing order.

Administering the COPD Assessment Test, modified Medical Research Council Dyspnea scale, Asthma Control Test or similar evaluation tool, in addition to collecting symptom history and performing spirometry, allows pharmacists to make comprehensive medication recommendations.

It should be noted that due to the potential for spreading SARS-CoV-2 virus due to possible coughing and/or aerosol generation during the procedure, the American Thoracic Society recommended that spirometry be limited to only those patients for whom it is essential for immediate treatment decisions, and that staff performing the tests as well as patients being tested take precautionary measures, including personal protective equipment (https://www.thoracic.org/professionals/clinical-resources/disease-related-resources/pulmonary-function-laboratories.php). Furthermore, as the prevalence of COVID-19 continues to increase and decrease over time, it is recommended that operating procedures be frequently reassessed and modified in accordance with current recommendations.[1]

Roadblocks

Patient engagement: Anecdotally, patients attend spirometry visits at a more reliable rate than other pharmacy services, such as comprehensive medication reviews, since they often are referred by their primary care provider. Along with that, the test is non-invasive and occurs in a familiar setting. Educating patients on the importance of the diagnostic test for evaluation and monitoring during scheduling often increases buy-in for scheduling.

Time: Performing spirometry, associated data collection and a comprehensive medication review can take an hour or longer depending on patient complexity. In cases where not all disease states or medications are able to be assessed, the spirometry visit can be used to establish rapport and the patient can be invited back for a follow-up visit where the remainder of the medications or medical history can be reviewed. Alternatively, a phone follow-up can be conducted to review changes made and education provided during the spirometry visit, in addition to completing the outstanding assessments. This can be billed as a telehealth visit.

Cost: The initial cost of the spirometry device and accessories may be cost prohibitive at $1000-2000, plus consumables. However, performing in-office spirometry adds a revenue stream with a quick return on investment.

Role of Residents and Students

Residents and students often see the patients and present them to the clinical pharmacist for review of the results of spirometry, as well as medication therapy management recommendations. Students also schedule the appointments and make the appointment reminder calls.

Recommended Resources

1. Wilson KC, Kaminsky DA, Michaud G, et al. Restoring pulmonary and sleep services as the covid-19 pandemic lessens. From an association of pulmonary, critical care, and sleep division directors and american thoracic society–coordinated task force. Annals ATS. 2020;17(11):1343-1351.
2. aarc.org – offers low-cost spirometry training with available certification and website offers free guidance on coding for respiratory services
3. http://jonesmedical.com – offers coding, testing and supply resources

Chronic Care Management (CCM)

Background

Chronic care management (CCM) services are focused on offering advanced primary care through a continuous relationship with a designated member of the care team that provides chronic disease support with 24/7 patient access to care and health information and preventive care, engages patients and caregivers, and shares timely health information. These are non-visit based payments for services to exchange health information, management of care transitions, and coordinate home and community based services. Patients eligible for CCM services are Medicare beneficiaries who reside in the community setting with two or more chronic conditions expected to last at least 12 months and place the individual at a significant risk of death, acute exacerbation, acute decompensation, or functional decline. Chronic care management may be furnished by clinical staff, including pharmacists, through the direction of the qualified FQHC practitioner (physicians, nurse practitioner, physician assistant, and certified nurse midwife) and under general supervision by a physician.

Principal care management (PCM) is another form of chronic care management, which allows for a specialist to be reimbursed for care management services more targeted in a specialty (a single high risk disease). Please use the following link for more information: https://chroniccareiq.com/connected-care/what-is-principal-care-management/

Billing

CPT codes for CCM[a,b,c]

In FQHC setting, G code G0511 must be added, or used in place of, any of the below codes:

Non-complex		
99490	Comprehensive care plan established, implemented, revised, or monitored.	20 minutes of service
99491	Comprehensive care plan established, implemented, revised, or monitored.	30 minutes of service
Complex		
99487	Establishment or substantial revision of a comprehensive care plan with moderate or high complexity medical decision making.	60 minutes of service
99489	Add-on code to 99487 for each additional increment of clinical staff time.	30 minutes of service

[a] Only one code can be billed per calendar month

[b] Only one qualified health professional can be paid for CCM services per calendar month

[c] General care management code G0511 must be added to the billing claim for CCM services.

Documentation Requirements

An initial visit with the FQHC practitioner is required within one year of furnishing the CCM service. Identification of patients who meet criteria for and would likely benefit from CCM can only be completed by an FQHC practitioner. Patient consent (verbal or written) must be documented before the initial CCM encounter. Patient health information and a personalized care plan must be

documented using certified EHR technology with a copy provided to the patient or caregiver. Other required service elements can be found at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/FQHC-RHC-FAQs.pdf.

National vs. State

Medicare Fee-For-Service Part B recipients are offered this service nationally.
States can use chronic care management as a quality improvement effort, cost savings effort, and policy maker mandate effort. Please use the following link to see more information on how states may use chronic care management from the Agency for Healthcare Research and Quality:
https://www.ahrq.gov/patient-safety/settings/long-term-care/resource/hcbs/medicaidmgmt/mm1.html

Resources

- ASHP Resource Center document: https://www.ashp.org/-/media/assets/pharmacy-practice/resource-centers/ambulatory-care/chronic-care-management-faq.ashx?la=en&hash=EA004AD497E3CB118327EC61CE1B2B14762789D2
- https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/chroniccaremanagement.pdf

Examples in Practice

Salina Family Healthcare Center
Salina, KS
Cassandra Shields, PharmD, CDCES
cshields@salinahealth.org

How is this service being used in your practice (integration, benefits, value)?

Our EMR automatically integrates with the CCM program using a manually entered program that recognizes qualified patients. We often sign up patients that qualify after transitional care or those that want to avoid home health or leaving their home. We also do medication management, and have care coordinators that help to manage patients. We also do TIPS and CMRs for patients in the CCM program. Diabetes and hypertension management are done at the clinic as well. We enroll patients in CCM as long as they have primary and supplemental insurance or are willing to pay for the service. We also set up pill boxes. We have a 340B pharmacy and use medication synchronization to help with medication management. We also provide respiratory services, such as managing CPAP, trilogy, and set up spirometry appointments. We also set up transportation for patients to get to their appointments. We can also obtain food, medication, and travel vouchers.

Requirements unique to health centers?

FQHCs encompass all care in a single visit when possible, so payment is mostly from CPT codes that are submitted, through which CCM allows pharmacists to get paid.

Clinical Pearls/tips for success?
ACOs are also an avenue for more Medicaid reimbursement with CCM (they target those that are at highest risk). Chronic care management helps to prevent hospital visits. For example, a patient with heart failure with an EF of 25% who is not taking his or her medications and is being admitted to the hospital for 1-2 weeks at a time with fluid overload is a good candidate for the service. With our CCM service, this patient can obtain transportation to get to appointments and to obtain medications, begin filling all medications at their pharmacy and enroll in medication synchronization. Pill burden can also be reduced as much as possible. Having the option to waive some fees is also helpful.

Roadblocks and how to overcome them?
Ensuring a patient actually does want the service and getting the paperwork done is a challenge. Often the patient is hard to get a hold of and there are several departments involved. It is helpful to get all the paperwork done when the patient is at the clinic and have good communication between departments. Finding a central location for documenting can be hard. Building a template into the chart helps. Also making sure documentation happens properly by ensuring staff knows what to document and when.

Role of residents and students?
They don't currently have pharmacy residents but do work with medical residents. Pharmacy students document surveys and adherence questions.

Recommended resources?
CMS is the big one. If you are part of an ACO it is an excellent resource and can provide a high-risk panel of patients, and then you can work off of that. The billing department is a good resource as they will likely know what you can bill for and make things easier to set up. Also, your EMR system to help set things up is a good resource.

What are the billing codes used? Is the billing specific to your state or based on a federal program?
Refer to the table above for billing codes. FQHCs must include G0511.

You need a few people to make CCM work but if you have the staff that are motivated to help change. CCM does a wonderful job of helping patients. The patients really feel like you care.

Heritage Health
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How is this service being used in your practice?
Our clinical pharmacists have offered CCM services to patients since 2016. Without in-house nurse care managers, the program was slow to grow until 2020, when we outsourced our care management services to assist in providing CCM to a larger portion of our 10,000+ Medicare patients. We now have almost 2,000 patients receiving CCM services. These services encompass almost anything involved in

care coordination such as medication refills, addressing transportation barriers, and providing patient education.

Requirements unique to the use of these codes in an FQHC

Our FQHC general care management codes set our reimbursement rate at an average of the rates for standard (20-min) and complex (60+-min) interventions, so we can only bill one code (G0511) for any amount of time 20 minutes or greater cumulatively spent in a calendar month for one patient.

Clinical Pearls

If your practice is large like ours (30,000+ patients), it is advisable to at least partially outsource care management services while building your internal team structure. The caveat to this would be to make sure the abilities of those off-site care managers is highly integrated into clinic workflows so that both patients and provider staff benefit from the direct communication and documentation by care managers into the Electronic Health Record (EHR). We use Athena as our EHR, which is a cloud-based program easily accessed by off-site staff.

Diabetes Self-Management Training (DSMT)

Background

Diabetes self-management education and support (DSMES), referred to as diabetes self-management training (DSMT) by CMS, is an essential component of diabetes medical care that aims to provide people with diabetes the knowledge, skills, decision-making, and confidence necessary for diabetes self-care. Improved diabetes outcomes associated with DSMES include a reduction in hemoglobin A1C, lower self-reported body weight, quality of life improvements, reduced all-cause mortality, improved coping abilities, and reduced health care costs.[1] The four critical times to provide DSMES are at diagnosis, annually and/or when not achieving treatment targets, when complicating medical, physical, or psychosocial factors develop, and when transitions in life or care occur.[2]

Billing

Accredited/recognized DSMES programs through the American Diabetes Association or the Association of Diabetes Care and Education Specialists are eligible to bill insurance payers. Only individual (1-on-1) DSMES visits can be billed by FQHCs, group DSMES visits are not a billable service. Pharmacists who are certified DSMES or medical nutrition therapy practitioners can bill for a visit under the program's or pharmacy's NPI.

Code	Definition
G0108	Diabetes outpatient self-management training services, individual, per 30 minutes

National vs. State

Medicare covers 10 hours of DSMES in the first year and 2 hours in subsequent calendar years. Some state Medicaid and other insurance plan sponsors may cover DSMES.

Resources

1. Powers MA, Bardsley JK, Cypress M, et al. Diabetes self-management education and support in adults with type 2 diabetes: a consensus report of the american diabetes association, the association of diabetes care & education specialists, the academy of nutrition and dietetics, the american academy of family physicians, the american academy of pas, the american association of nurse practitioners, and the american pharmacists association. Dia Care. 2020;43(7):1636-1649.
2. Beck J, Greenwood DA, Blanton L, et al. 2017 national standards for diabetes self-management education and support. Dia Care. 2017;40(10):1409-1419.
3. Centers for Disease Control and Prevention. Medicare Reimbursement Guidelines for DSMT (last reviewed 2021 Feb 4). https://www.cdc.gov/diabetes/dsmes-toolkit/reimbursement/medicare.html (accessed 2021 Dec 16).

Examples in Practice

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Joel Isais, PharmD, BCACP
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How is this service being used in your practice?
Advanced practice pharmacists conduct 30-60 minute appointments for diabetes management in a one-on-one setting. After seeing the patient, the pharmacist will submit the code.

Requirements unique to the use of these codes in an FQHC
To bill for these codes, you must have Medicare accreditation to administer Diabetes Self-Management Training (DSMT). Accreditation can be obtained through either the American Diabetes Association (ADA) or American Association of Diabetes Educators (AADE). The pharmacists billing for these encounters must receive 15.0 units of diabetes-specific continuing education annually.

Clinical Pearls
Our organization has both AADE and ADA accreditation, but only one is needed to receive reimbursement from Medicare. We recommend having a template built within your electronic health record for documentation purposes. This can house your referrals into the program, patient self-assessment, patient readiness to learn, your assessment, goals, barriers to care (social, financial, etc.), and your annual quality improvement project. We also recommend having a designated program coordinator to keep the program in compliance and utilizing a data analyst who can pull and build reports for annual review.

Role of Residents and Students
Residents and students complete the DSMT assessments needed for compliance. Residents can also be used in development and implementation of your annual quality improvement project.

How Billing Differs from Other Practices
There must be a reason for one-on-one visits in an FQHC, which may relate to a language barrier, need in an underserved population, physical disability, etc.

Recommended Resources
The following link takes you to a document designed by the Indian Health Service to assist programs in setting up DSMT services:

- https://www.ihs.gov/MedicalPrograms/Diabetes/HomeDocs/Resources/InstantDownloads/DSMT_Guidebook_508c.pdf
- https://www.ihs.gov/sites/sdpi/themes/responsive2017/display_objects/documents/DSME.pdf
- https://www.medicare.gov/coverage/diabetes-self-management-training
- https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/DSMT-Accreditation-Program
- https://www.cdc.gov/diabetes/dsmes-toolkit/reimbursement/medicare.html
- https://www.diabeteseducator.org/docs/default-source/practice/deap/standards/2017-interpretive-guidance-nov-rev_final.pdf?sfvrsn=4

Jordan Valley Community Health Center
DSMES Program
Lisa Cillessen, PharmD, BCACP
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University of Missouri-Kansas City
Clinical Pharmacist, Jordan Valley Community Health Center
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How is this service being used in your practice (integration, benefits, value)?
Our organization has one clinical pharmacist and one dietitian who work together to provide ADA accredited DSMES services to patients across eight clinics. We hold a 2.5-hour group session twice a month for patients to learn the basics of diabetes and nutrition management followed by one-on-one appointments as needed. The classes are held at our main clinic; however, patients can join from a satellite clinic or home through our telehealth program. Follow up appointments are conducted in-person or through our telehealth program from a satellite clinic or the patient's home if they have a telehealth unit. The pharmacist works under a collaborative practice agreement to manage diabetes medications and/or manage potential complications from diabetes (ACEi/ARB for albuminuria, statins as indicated, smoking cessation, etc.). Providers place a referral to the diabetes education team and a clinical community health worker (CHW) assesses the patient's needs/ability to attend a class prior to scheduling the patient. If a group setting is not appropriate for the patient, the clinical CHW will schedule the patient for individual appointments instead.

Requirements unique to health centers
Requirements for DSMES do not differ among health centers; however, there are differences between ADA and ADCES accreditation. We recommend working with administration to determine the best route for your facility. Additionally, each health center may have different disciplines working within the DSMES program. Based on expertise, availability, feasibility, we recommend to develop a Diabetes Education Team (ours consists of dietitian, pharmacist, PGY2 pharmacy resident, nurse practitioner, registered nurse, licensed practical nurse, behavioral health consult, clinical CHW, medical director, and director of quality).

Clinical pearls (tips for success)

1. If possible, create a policy that allows members of the health care team to refer patients to the DSMES program. We initiated a policy that allows our nursing staff, in addition to our providers, to refer patients to the DSMES program if they met certain criteria (A1c >9%, new diagnosis, patient requesting education, or patients the provider deems necessary). This has allowed other members of the health care team to refer patients to the program in a timely manner. We have Nurse Care Managers who work with our Medicaid population who refer patients from their assigned panel.
2. DSMES accreditation requires continuous quality improvement projects annually. We recommend selecting one area to work on each year and set a reasonable goal with a clear plan on how to achieve this goal. In our early years, we set goals, but jumped into providing the care without continuing to assess our goals throughout the year. This then provided for quite a bit of data mining before our annual report was due only to find out we set unrealistic goals.

Roadblocks (and how to overcome)

Billing DSMES in a community health center is one of the biggest roadblocks (see below for discussion). The data collection for annual reports can be time consuming. We have utilized a clinical CHW to assist with the data entry aspect to allow the pharmacist and dietitian to continue to see patients opposed to devoting time to data entry.

Role of residents and students

We have a PGY2 ambulatory care resident as well as APPE and IPPE students spend time in our clinic. Students are allowed to participate in the one-on-one patient visits under the supervision of their clinical pharmacist preceptor. The PGY2 resident is able to participate in group classes after being added as a faculty member with ADA (our renewal is October, so gives the resident time to obtain the necessary CE requirements) as well as work more independently as they demonstrate appropriate knowledge and skills providing one-on-one sessions. The PGY2 resident also serves on our Diabetes Education Team to help with continuous quality improvement projects as a part of accreditation and develop new initiatives to improve our diabetes services (Diabetes Day).

Recommended resources

- ADA's (American Diabetes Association) Education Recognition Program: https://professional.diabetes.org/diabetes-education
- ADCES's (Association of Diabetes Care and Education Specialists) DEAP (Diabetes Education Accreditation Program): https://www.diabeteseducator.org/practice/diabetes-education-accreditation-program-(deap)
- CDC's DSMES Toolkit: https://www.cdc.gov/diabetes/dsmes-toolkit/index.html
- Comparison of ADCES and ADA: https://www.cdc.gov/diabetes/dsmes-toolkit/pdfs/AADE-and-ADA-Requirements-for-Each-Standard_508tagged.pdf
- Free Continuing Education credits: https://professional.diabetes.org/continuing-education
- Additional credentialing (BC-ADM or CDCES): https://www.diabeteseducator.org/practice/bc-adm-cdces-information

What are the billing codes used? Is the billing specific to your state or based on a federal program?
We currently do not bill for any DSMES services. Our clinic chose not to set up billing codes due to the large number of uninsured patients (over 20%) that would potentially be excluded from the DSMES services if they were unable to pay out-of-pocket. Therefore, to help improve quality metrics, our clinic provides DSMES services at no charge to all patients of the health center.

In select states, you may be able to bill Medicaid for DSMES services; however, this is an add-on benefit and is not available in every state. You may also contract with private insurances to bill for DSMES services.

Value-Based Care

Background
Value-based care is a model of healthcare delivery in which providers are paid based on patient outcomes. The "value" is from measuring health outcomes against the cost of achieving these outcomes. Shared savings or risk reduction contracting are two types of arrangements that exist under the umbrella of Value-based reimbursement. Under shared savings arrangements, providers are paid a portion of any savings that are generated when their actual experience is lower than the financial target. Under shared risk arrangements, providers must also pay back a portion of any loss that is generated when their actual experience is higher than the financial target. Please use the link for more details: https://axenehp.com/need-know-shared-savings-financial-targets/

Billing
N/A

National vs. State
Certain regions are included in Comprehensive Primary Care (CPC) initiative. For more information please visit: https://innovation.cms.gov/initiatives/comprehensive-primary-care-initiative/

Examples in Practice

PrimaryOne Health
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How is this service being used in your practice (integration, revenue allocation, benefits, value)?
PrimaryOne Health has been a part of Ohio Medicaid's Comprehensive Primary Care (CPC) program since its inception in 2017. The quality care metrics incorporated into Ohio's CPC program overlap with the clinical pharmacy services provided by pharmacists at PrimaryOne Health. Examples of Ohio's CPC metrics include controlling high blood pressure, statin therapy for patients with cardiovascular disease, A1c poor control (A1c >9%), medication management for asthma, and tobacco cessation interventions.[1] Pharmacists at PrimaryOne Health currently have collaborative practice agreements for diabetes management, hypertension management, and for smoking cessation. Pharmacists also participate in quarterly care team meetings. The meetings are led by PrimaryOne Health's nurse care coordinators and are scheduled individually based on site availability. The meetings are made up of pharmacists, nurse care coordinators, dieticians, and behavioral health. Each member brings a list of patients, who do not need to be on Ohio Medicaid, to present to the group with recommended referrals and follow up. Patients presented often have multiple comorbid conditions and are in need of

a variety of internal and external services. Currently revenue is attributed based on sites and not to individual departments, and this is because Ohio Medicaid aggregates CPC payments based on a "per member per month" (PMPM) prospective risk-adjusted payment. This PMPM is stratified into three tiers depending on patient risk, paying more if a patient falls into a higher risk tier. However, pharmacists can bill visits either as incident-to (99211) or under the smoking cessation codes (99407 or 99406). Billed visits are directly attributed to the pharmacy department. CPC has opened up additional revenue streams to PrimaryOne Health, which have allowed for PrimaryOne Health to build additional programs that have helped to improve interprofessional collaboration and patient care at PrimaryOne Health.

Requirements unique to health centers

For FQHCs to participate in the CPC program, they need to have the patient-centered medical home (PCMH) designation. Particularly in Ohio, information on PCMH eligible providers can be found at OAC 5160-1-71. Also, FQHCs have to meet the same activity metrics, efficiency metrics, quality metrics, and attributed patient targets as all other providers who participate in the program. [2]

Clinical pearls (tips for success)

The clinical pharmacy team makes efforts to market our services to the providers as often as possible. Pharmacy services are also marketed/education to support staff and allied health providers (behavioral health, dieticians, nursing, etc.), often time's pharmacists and other allied health providers complete shared patient visits with the goal to increase collaboration. Also, when deciding to develop new services we take into account how pharmacists can continue to impact additional quality metrics. Also, each member of the pharmacy team is able to run site-specific reports that include patients' A1c, blood pressure, and smoking status. These daily reports assist the pharmacists by allowing them to proactively identify and reach out to providers and patients.

Roadblocks (and how to overcome)

In-person care team meetings can be difficult to coordinate once a quarter, especially since we do not have a pharmacist embedded in all of our medical sites. We have our pharmacists call in by phone to participate in care team meetings at health center sites where we do not have any pharmacy presence. This also allows us to better share our services and expertise with staff at pharmacist-naïve sites. Another consideration is when you discover your clinical pharmacy services are already impacting those quality metrics, but you are unsure if any of the outcomes are attributed in part to clinical pharmacy. To start, we recommend working with your health center's quality and/or finance team to clarify how CPC revenue/outcomes is attributed (by site, by department, etc.). There are many hands in the pot and even if there is not "direct" attribution to clinical pharmacy, starting these discussions will put clinical pharmacy on the radar of those contributing to the CPC revenue coming in.

Role of residents and students

The PGY2 Ambulatory Care resident at PrimaryOne Health attends the quarterly care meeting at the site they are responsible for. Students will attend meetings with preceptor and can assist in identification of the patient. Both residents and students help to extend pharmacy services and allow for the pharmacist to see more patients.

Recommended resources

Each state would have its own unique program. The Ohio Medicaid website has a list of resources and is updated frequently.

Citations

1. Ohio CPC Program updates for 2020. https://medicaid.ohio.gov/Portals/0/Providers/PaymentInnovation/CPC/CPC-Program-Updates.pdf?ver=2019-06-20-131208-510. Published June 2019. Accessed January 24, 2020.
2. Ohio Comprehensive Primary Care (CPC) Program Frequently Asked Questions. https://medicaid.ohio.gov/Portals/0/Providers/PaymentInnovation/CPC/FAQ.pdf. Updated December 2018. Accessed January 24, 2020.
3. https://catalyst.nejm.org/doi/full/10.1056/CAT.17.0558 (value based care)

Quality Measures (UDS)

Background
Quality measures are tools that help measure or quantify healthcare processes, outcomes, patient perceptions, and organizational structure or systems. These tools examine the ability to provide high-quality health care and/or relate to one or more quality goals for health care. These goals include: effective, safe, efficient, patient-centered, equitable, and timely care.

The Uniform Data System (UDS) is a core system of information appropriate for reviewing the operation and performance of health centers. UDS is a reporting requirement for Health Resources and Service Administration (HRSA) grantees, including community health centers, migrant health centers, health care for the homeless grantees, and public housing primary care grantees. The data are used to improve health center performance and operation and to identify trends over time. UDS data are compared with national data to review differences between the U.S population at large and those individuals and families who rely on the health care safety net for primary care. Data collected include patient demographics, services provided, staffing, clinical indicators, utilization rates, costs, and revenues of grantee health centers.

Billing
Quality measures are used in Medicare Pay-For-Performance or Value Based Programs, please use the following link for more information on how these measures are used:
https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Value-Based-Programs

National vs. State
Please use the following link for more information (updated 2021):
- CMS guidance to states on value based programs: https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/smd20004.pdf
- CMS factsheet on value based programs: https://www.cms.gov/newsroom/fact-sheets/value-based-care-state-medicaid-directors-letter

Resources
- https://www.healthypeople.gov/2020/data-source/uniform-data-system
- https://bphc.hrsa.gov/datareporting/reporting/index.html

Examples in Practice

Family HealthCare
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How are pharmacists at your site involved with quality measures?
Our pharmacists are involved regularly with our clinic quality improvement team to evaluate clinical measures, such as clinical UDS measures, that could benefit from clinical pharmacist involvement. Several clinical programs have been developed in order to address the needs of improving upon clinical measures, such as tobacco cessation, diabetes and hypertension programs. We now have referral-based programs for scheduling patients to be seen for these three disease states (among others). Specifically, two more recent programs were developed to address the diabetes and hypertension measures:

- Diabetes: Reports are run quarterly to identify patients whose Hgb A1C is >9%. APPE pharmacy students then do outreach phone calls to these patients to identify drug-related problems (e.g. adherence, cost, dosing, etc.), and if any are present work to get the patients scheduled to see a clinical pharmacist. The medical provider team has a standing referral order that any patient identified through this program can be managed automatically by the clinical pharmacist in between regularly scheduled primary provider visits. Pharmacists then seek to be involved with these patients' care long term through continued follow up and team-based diabetes management.
- Hypertension: Patients are referred by medical providers for hypertension management, with a focus on home blood pressure monitoring. Patients are then scheduled with the clinical pharmacist for hypertension assessment and home blood pressure monitor education. A recent grant program has allowed for home blood pressure monitors to be provided to patients, that will allow home readings to be transferrable to the electronic health record. Pharmacists then regularly assess home blood pressure readings, either in-person or telephonically, and make lifestyle recommendations as well as medication adjustments as necessary to meet blood pressure goals.

How does the impact of pharmacist services on these measures relate to shared savings or financial benefit (How does this help demonstrate pharmacy service value; e.g., cost avoidance)?
Our clinic has considered our service as part of the team approach to healthcare, so it is difficult to attribute changes to any one measure to just clinical pharmacy involvement. Additionally, we do not generate direct revenue through these services. Due to the likelihood that UDS measures are improved upon, there is a cost avoidance factor that supports the service, noting the financial importance of the clinic meeting UDS clinical measures.

Requirements for quality measure tracking
UDS diabetes measure – Percentage of patients 18-75 years of age with diabetes who had most recent hemoglobin A1c > 9% or no A1c in the last 12 months.

UDS hypertension measure—Percentage of patients 18-85 years of age who had a diagnosis of essential hypertension and whose blood pressure was adequately controlled (<140/90 mmHg) during the measurement period.

UDS Tobacco measure—Percentage of patients aged 18 and older who were screened for tobacco use one or more times within 12 months and who received tobacco cessation intervention if identified as a tobacco user.

Clinical Pearls

- Leveraging APPE students in helping implement these programs has been a tremendous benefit. It also provides the students with opportunity to interact with patients outside of regular clinic visits, and gain experience with quality measures and improvement.
- Developing a relationship with the clinic quality improvement team involved the pharmacist reaching out to offer support. Initially, the QI team did not realize everything that pharmacists have to offer, but over time have become dependent on us to help them achieve outcomes. We now get quarterly reports of all clinical measures, and can identify areas that we can help develop our practice to achieve clinic outcomes.

Role of Residents and Students

APPE students are directly involved in all aspects of patient care, including the telephonic diabetes outreach outlined above. Students assist with working up patients prior to visits, performing face-to-face and telephonic visits, documenting progress notes and evaluating lab results. We also have a hired pharmacy intern who helps to support the practice through patient reminder calls for overdue labwork, scheduling and re-scheduling (for no-shows/cancellations), referral education and scheduling, grant management duties and various duties related to clinical program development and implementation.

The Dimock Center
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How are pharmacists at your site involved with quality measures?

The clinical pharmacy team is part of an interdisciplinary diabetes program within the adult medicine clinic. Patients are seen in the diabetes clinic one half-day session per week. Pharmacist, nutritionist, and endocrinologist may all see patients, depending on need.

How does the impact of pharmacist services on these measures relate to shared savings or financial benefit (How does this help demonstrate pharmacy service value; e.g., cost avoidance)?

The clinical pharmacy team utilizes insurance formularies to pick lower–tier medication options and improve patient access to their medications. The pharmacy team may also consider manufacturer drug

coupon cards for high co-pays. The pharmacy team also provides extensive counseling on proper use of these medications (particularly injectable agents) to promote correct use and subsequently achieve intended therapeutic outcomes and reduce the risk of complications of uncontrolled diabetes. The pharmacy team also ensures that patients are receiving appropriate eye and foot care and are screened for social resource needs.

Requirements for quality measure tracking
UDS measure – Percentage of patients 18-75 years of age with diabetes who had most recent hemoglobin A1c > 9% or no A1c in the last 12 months
HEDIS measures - # patients with dilated eye exam in last 12 months, # patients with completed resource screen in last 12 months, # patients who completed 4 of 8 diabetes classes

Clinical Pearls
Administrative buy-in/support was critical to the success of our program and enabled us to get support from QI, IT, practice manager, etc. In addition to these support staff members, our team consists of a resource specialist, patient access coordinator, medical assistant, nurse, pharmacist, nutritionist and endocrinologist, who all contribute to the care of our patients. Developing new workflows was instrumental in defining roles.

Role of Residents and Students
Pharmacy students work up patients in advance of the scheduled appointment and report on labs and screenings that patient is due for. Students conduct medication reviews with the patient (under pharmacist supervision) and report any issues to the endocrinologist. They also help with formulary questions and prior authorization requests. The resident and students provide device teaching and diabetes education. Resident leads several diabetes group classes and incorporates pharmacy students into planning activities for classes.

Resources

- Schottenfeld L, Petersen D, Peikes D, Ricciardi R, Burak H, McNellis R, Genevro J. Creating Patient-Centered Team-Based Primary Care. AHRQ Pub. No. 16-0002-EF. Rockville, MD: Agency for Healthcare Research and Quality. March 2016.
- https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures

RiverStone Health
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How are pharmacists at your site involved with quality measures?
Our pharmacists are not routinely involved in the review and strategic planning around improving UDS measures. Occasionally, we are involved when leadership reaches out to us for our assistance. The most recent example of this is with the Asthma UDS measure (percentage of persistent asthma

patients on a maintenance controller medication). The clinical pharmacy team was asked to isolate patients not in compliance with the measure, double check that their diagnosis appears accurate, and call patients to schedule for pharmacist consult. We do have an existing collaborative practice agreement that covers asthma for adults, which would allow us to prescribe, when appropriate, a controller medication. Due to staffing shortages and the recent pandemic focus, we have not begun this project formally.

How does the impact of pharmacist services on these measures relate to shared savings or financial benefit (How does this help demonstrate pharmacy service value; e.g., cost avoidance)?
We are a fully integrated service, participating in 3 different carve out clinics and working side-by-side with providers seeing patients for CMM. Our clinic has considered our service as part of the team approach to healthcare, so it is difficult to attribute changes to any one measure to just clinical pharmacy involvement.

In Montana, we have recently been able to bill Medicaid and private insurers for clinical pharmacy services, which has allowed us to improve the sustainability of our services and expand services as well.

Role of Residents and Students
We do not currently have a PGY1 pharmacy residency program here. We do accept pharmacy students from U of Montana COP routinely, who are not involved in UDS measure tracking. Students have multiple roles and responsibilities unrelated to UDS measures.

Collaborative Drug Therapy Protocols, Contract Agreements, Consult Agreements

Background
Collaborative drug therapy protocols, contract agreements, and consult agreements all create a formal relationship between a pharmacist and a prescriber–usually a physician but can be a nurse practitioner or another prescriber–allows prescriber to delegate some patient care functions to pharmacist under negotiated conditions in agreement.

Billing
As of 2010 Medicare Part B does not cover collaborative practice agreement. Billing practices vary from state to state.

National vs. State
Practice and billing is state dependent.

Examples in Practice

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How is this service being used in your practice (integration, benefits, value)?
I would preface this by saying with collaborative drug therapy protocols, they will differ state by state. Fortunately, in Washington state, we have had pretty broad practice agreements for years. We have collaborative drug therapy practice agreements with our chief medical officer that are filed with the state of Washington. This allows our clinic pharmacist to see patients and initiate, discontinue, or change the dose of medications. The pharmacist also orders any necessary labs under this practice agreement. We initially started out wanting to see all disease states but found in our clinic the larger need was for diabetic patients. This is where we saw the largest gap in patients who were being actively managed, especially with insulin dosing. These patients weren't being followed or well managed after initial visits. We also see patients for high blood pressure, cholesterol, and asthma. We are trying to increase transition of care visits as well.

Requirements unique to health centers
In Washington we are able to bill non-federal (non-Medicare) patient insurances, so this does include Medicaid. With this we are credentialing our pharmacists to bill for state insurances as well as a few other third party insurances. In order for our pharmacists to bill, we need to be credentialed with the insurance plans.

Clinical pearls (tips for success)
Sometimes it is difficult for patients to see the benefit in a pharmacist visit, which leads to higher no-show rates. Our clinic pharmacist is very good at working with patients on not only their medications, but also finding what motivates them and what is important to them. Each patient is different, and this

is helpful in making self-management goals and getting the patient to buy into the plan and come back for follow-up visits.

Roadblocks (and how to overcome)
Justifying our position and role is important, especially to the executive team. They are very supportive of pharmacy, but it can be hard from their perspective. When we are not able to bill for the visits, it is easy to say we should just have a PA or NP see the patients. It is important to really demonstrate our value to the executive team. We have had students create a presentation about a year into the process to show the clinical value. We used case vignettes to demonstrate great improvements in the patient's lives. When faced with budget cuts, it is always a program that gets looked at. We remind them that we have our 340B access dollars that help support the cost of care that isn't covered. We do other things such as encourage patients to use our pharmacy. They get to know the clinical pharmacists, so they are more apt to use our pharmacy when they didn't in the past. We try and show our administration that it is a valuable service, even if not all of the visits are covered.

Role of residents and students
We have about 3 students a year that rotate. They spend quite a bit of time with our clinical pharmacist. The students go from an observational and shadowing role at the beginning of the rotation, to leading the visits by the end of the rotation. Students are able to use their clinical skills to assess the patient and see what the patient may need.

Recommended resources
Each state is very specific on their requirements. We used the templates recommended by our pharmacy quality commission to make our collaborative drug therapy protocols. It is important to make sure you are making your protocols based on your state's specific requirements.
Our clinical pharmacist also took time to complete a lot of continuing education on diabetes care and continues to do so. She focuses mainly on diabetes care so she can stay up to date with the guidelines.

What are the billing codes used? Is the billing specific to your state or based on a federal program?
We are unable to bill for federal programs (Medicare). As far as Medicaid, we have three managed care Medicaid plans that our clinic accepts in our state. With credentialing, we are able to bill as a normal mid-level provider visit.

Resources
- https://www.pharmacytoday.org/action/showPdf?pii=S1042-0991%2818%2930260-3
- https://www.cdc.gov/dhdsp/pubs/docs/translational_tools_pharmacists.pdf

Clinica Family Health
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How is this service being used in your practice (integration, benefits, value)?

Our organization currently has two clinical pharmacists who provide patient care services across five clinics. We have collaborative drug therapy management (CDTM) protocols for type 2 diabetes mellitus, hypertension, dyslipidemia, smoking cessation, and anticoagulation. Providers place a referral to the clinical pharmacist for management, and the clinical pharmacist may then start, stop, and adjust medications for these disease states as outlined within the protocol on behalf of the referring provider. Patients are managed with face-to-face consultations or with telehealth appointments.

Requirements unique to health centers

Requirements for CDTM do not differ for health centers compared to other practice settings. However, rules and regulations for CDTM do vary from state to state. It is important to review your state's rules and regulations to determine appropriate professional qualifications and scope of practice, protocol requirements, etc.

Clinical pearls (tips for success)

1) Spend time building relationships with your providers. Our service depends on referrals from providers rather than an automatic referral process. For example, patients with an A1C greater than 9% are sent to our clinical pharmacist for management. While the latter option has benefits, we do not have the bandwidth within our team to handle the patient load that would come with this process. Developing good relationships strengthens trust, promotes collaboration and teamwork, and can ultimately lead to better patient care and outcomes.

2) It is important to do your research. When initiating a new collaborative drug therapy management protocol, it is important to review organization data/metrics and consult with stakeholders to find areas of need. While these may often be some of the more common chronic diseases, there can also be roles for management of less common disease states and/or diseases that may be less commonly managed in a primary care setting. For example, we have a U-500 insulin management section built into our type 2 diabetes mellitus CDTM. This has been very useful for our patients who exhibit large degrees of insulin resistance but may not be able to access specialist care due to lack of insurance coverage. While our primary care providers often lack comfort in managing this medication, they trust our expertise with selecting appropriate candidates and then initiating and managing its ongoing use. Being strategic with your CDTMs like this can expand and improve access, which we know is an important social determinant of health.

Roadblocks (and how to overcome)
The annual review process as required by our state rules tends to be the most challenging process for us. Setting timelines for completion of individual protocols and coordinating with organization leadership to ensure a smooth and timely flow through the appropriate approval chain has been helpful in streamlining this process for us.

Role of residents and students
We have had PGY2 ambulatory care and PGY1 community pharmacy residents as well as APPE and IPPE students spend time in our clinic. Students and PGY1 residents are allowed to participate in patient visits under the supervision of their clinical pharmacist preceptor, but they cannot independently practice CDTM. PGY2 residents are able to work more independently as they demonstrate appropriate knowledge and skills. They have also been valuable in the annual review and revision process of the CDTM protocols.

What are the billing codes used? Is the billing specific to your state or based on a federal program?
We currently do not bill for any services.

Resources
- Your individual state board of pharmacy rules
- Hammond RW, Schwartz AH, Campbell MJ, et al. Collaborative drug therapy management by pharmacists—2003. 2003;23:1210–1225.
- https://www.accp.com/docs/positions/whitePapers/CDTM%20CMM%202015%20Final.pdf
- https://www.cdc.gov/dhdsp/pubs/docs/Best_Practice_Guide_CDTM_508.pdf

Family Care Health Centers (FCHC)

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How is this service being used in your practice (integration, benefits, value)?
The mission of FCHC is to provide affordable and accessible comprehensive primary care services to anyone, with an emphasis on the medically underserved. Following the patient-centered medical home model, patients are offered a significant portion of their care within FCHC, including pediatrics, OB/GYN, family planning, internal medicine, behavioral health, dental and vision care, nutrition, HIV counseling, laboratory, and an access to an internal pharmacy. All patients at FCHC undergo an initial intake with a primary care provider (physician or advanced practice nurse trained in primary care, family medicine, or internal medicine). Embedded within primary care services is a behavioral health team of providers (recovery specialists, psychiatrist, psychiatric pharmacist, psychologists, and LCSWs). A primary care provider (PCP) may request a same-day brief intervention from one of the FCHC Behavioral Health Consultants (BHCs), consisting of mental health professionals with psychology and

social work backgrounds. PCPs may also request a "curb-side" consult from the psychiatrist or the psychiatric pharmacist. The primary goal of the embedded behavioral health team is to educate and empower PCPs to effectively integrate behavioral health interventions into the standard of care that they provide. At any time in the patient care process, the PCP can request a behavioral health consult referral from either the psychiatrist or psychiatric pharmacist. The purpose of the referral is to allow for more in-depth assessment and management of challenging psychiatric cases (common referrals include severe, refractory depression, bipolar disorder, schizophrenia, and post-traumatic stress disorder). The range of services provided by the psychiatric pharmacist during a patient care visit include mental health symptom assessment, psychiatric medication management, motivational interviewing, trauma-informed care, and crisis intervention/de-escalation. Initiation and discontinuation of a medication or the monitoring of treatment through laboratory assessment, is all under the authority of a collaborative practice agreement. FQHC's provide health services in established provider shortage areas. Psychiatric pharmacists fill an expanding and critical gap in access to mental health care, specifically within healthcare provider shortage areas across the country.

Requirements unique to health centers

Requirements for behavioral health / psychiatric pharmacy integration into health centers does not differ for health centers compared to other practice settings. However, rules and regulations for the scope of pharmacy practice do vary from state to state. It is important to review your state's rules and regulations to determine appropriate professional qualifications and scope of practice, protocol requirements, etc.

Clinical pearls (tips for success)

1. Identify a physician champion and partner for the development of a collaborative practice agreement. If your focus and interest is the treatment of psychiatric disorders, your collaboration should be with a board certified psychiatrist. Be sure to review your specific state guidelines with regard to collaborative practice agreement development, as this will dictate the level of autonomy you will be offered in your partnership.
2. If teaching is of importance to you as you develop a successful career, look for practice sites that have partnerships with medical schools, residency programs, or other experiential learning programs. If you hope to integrate advanced practice pharmacy students into your practice site, ensure that there is room for student involvement. It is wise to request an identified space for you at the practice site and also an established and separate space for your students.
3. A good working relationship and partnership with administrative personnel can dramatically enhance your job satisfaction and personal investment in your clinical service. Clearly determine and define who will fund your position (e.g.- University/college, federal or local grant funding, provider-service reimbursement system).
4. Take the time to determine the most effective and user-friendly method of documentation. Learn what credentialing process is necessary to allow for a clinical pharmacist to document within their system. As you learn the electronic database, determine if the system will allow for a more global evaluation of the treatment interventions you provide. An ongoing review of your interventions will provide you the opportunity to assess your clinical impact at your practice site.

5. Ensure that there is opportunity for routine peer and performance assessment. For some practice settings, this process may be led by a pharmacy director or clinical program director. For practice sites without a significant pharmacy presence, clinical review may be conducted by your collaborating physician or medical director.
6. Remember, you bring a unique and wonderful clinical perspective to your non-pharmacy colleagues, that is of great value to overall patient care. In an inviting and engaging manner, take the time to educate others on your extensive training and expertise.

Roadblocks (and how to overcome)
Finishing patient care notes after hours and on the weekends is a quick way to burn-out. Complete your patient care documentation during the patient encounter; allowing you to stay current and on top of required EHR documentation.

Advocating for use of established billing codes has been our biggest roadblock. In our state, we have established billing codes for psychiatric pharmacists, but we cannot use these codes within a federally qualified health center.

Role of residents and students
We have ~10 APPE students who spend time in our clinic throughout the year. We also have PGY1 and 2 pharmacy residents who complete their behavioral health rotation experiences at our clinic. Family medicine medical residents complete their training program within our clinic as well.

Recommended resources
- Your individual state board of pharmacy rules
- https://cpnp.org/
- https://www.bpsweb.org/bps-specialties/psychiatric-pharmacy/
- https://cpnp.org/_docs/about/position/medical-home-model.pdf

What are the billing codes used? Is the billing specific to your state or based on a federal program?
99241 HE - Consultation Services (Psychiatric Pharmacist) - Services consisting of a review of a consumer's current medical situation either through consultation with one (1) staff person or in a team discussion related to a specific consumer.

Evaluation/Management, Established patient (Psychiatric Pharmacist)
99212 HE
99213 HE
99214 HE
99215 HE

9107H - Mental Health Consultation to FQHC Physicians (APN/Psychiatric Pharmacist) - Assisting a FQHC physician in providing services to an individual not having an episode of care with the CMHC.

Population Health

Background
Population health is the health status and health outcomes within a group of people rather than considering the health of one person as a time. The priority goal in this area is disease prevention through pharmacy services and medication therapy management.

Billing
Please view the following link for a billing toolkit offered by the National Association of County & City Health Officials: https://www.naccho.org/programs/community-health/other/billing-for-clinical-services#billingtask

National vs. State
CMS developed the Medicare Shared Savings program that offers providers and suppliers (physicians, hospitals, and others involved in patient care) an opportunity to create an Accountable Care Organization (ACO). The ACO agrees to be accountable for the quality, cost, and experience of an assigned Medicare fee-for-service beneficiary population. Please see the link for more information: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/about

Please use the link provided to see an example of a value based payment reform at the state level, Ohio's Health Transformation Plan: https://www.healthpolicyohio.org/wp-content/uploads/2018/04/Moody.pdf

Examples in Practice

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How is this service being used in your practice (integration, benefits, value)?
There are 8 clinical pharmacy specialists embedded in the primary care medical home, who provide visits in-person or telephonically for a range of things. These include diabetes, HTN, anticoagulation, and numerous population health issues (MTM (CMRs and TIPs), HTN QI, medication adherence). We have been doing MTM for about 2-3 years now and have integrated it into our daily/weekly work and complete it via telephone or in-person visits depending on the patient's needs and schedule. Because we have great relationships with our medical providers, we have great collaboration and a care team approach. Our providers very often agree and accept our recommendations and are able to implement

changes often immediately. MTM is currently our only service for which we receive financial reimbursement. We currently are on track to have a strong ROI for this year with our MTM work. I think providers definitely value the services we provide, but we do not bill for our services and thus only have soft dollar savings with all of our services but MTM.

Requirements unique to health centers

We do not bill for any of our visits within our FQHC setting. When I first started in my position, I was grant funded by a large grant from CMS, so we were really unable to bill for anything as it would have been considered double dipping. Since the grant funding ended, we were funded by our organization, but have not done any billing at all. The only service we are reimbursed for is MTM, which we complete through a third party vendor with whom we contract. Our organization recognizes us as providers and the State of Colorado is moving in that direction, but organization is not yet reimbursed for any of our services through insurance companies. Our FQHC recognizes Clinical Pharmacists, Physicians, Behavioral Health Consultants (Clinical Psychologists), PAs, and NPs as Health Care Providers.

Clinical pearls (tips for success)

We started out focusing on cultivating on our relationships with providers to establish trust and with diabetes, hypertension and medication reviews. As providers saw we improved A1c and BP control, they referred more and more patients, and patients were appreciative and engaged. After some time, we added anticoagulation, and more recently have added population health management. We measure our impact on metrics to help demonstrate our successes. I think building relationships is one of the most important things you can do so providers feel comfortable and trust our recommendations and management of various disease states.

Roadblocks (and how to overcome)

The biggest challenges are patient population along with patient and provider acceptance of clinical pharmacy recommendations. We have worked hard on our relationships with providers throughout the organization, including patients, RNs, medical assistants, clerks, specialty and others to earn the trust of our colleagues. They now seek our assistance and input regularly.

The biggest challenge working in an FQHC is the patient population, health literacy, and ability for patients to afford their medications, visits with providers, rent, etc. This in turn greatly affects their adherence compared to traditional health centers. However, I would say the patients we serve are also what make working in an FQHC the most rewarding. They are very appreciative for our help and care. When I first started here 10 years ago, pharmacy was not at the table for many important conversations, but that has changed immensely over the years I have been here. We are being asked to be involved in workgroups when they are created, or by word of mouth through the projects we are working on.

We are doing more population health work each year, and some of our challenges thus far have been acceptance of our recommendations by providers and patients, especially if the recommendation doesn't come from one of us pharmacy specialists within the primary care medical home. Our

Ambulatory Care provider primary care teams know our Ambulatory Care pharmacy team pretty well and trust our recommendations. We added a population health pharmacist last year, and it has taken a little bit longer for providers to get to know that person and be fully accepting of their recommendations. We put in detailed notes on population health outreach to patients, try to include evidence-based recommendations, and ask for provider buy-in and co-signature. This person is also getting more involved in various workgroups within the organization for diabetes, HTN, osteoporosis, and other disease states to help establish and improve rapport.

Role of residents and students
We are an academic medical center and take learners of many levels. We take IPPE and APPE pharmacy students at all times of the year along with PGY1 and PGY2 pharmacy residents. We have a PGY2 Ambulatory Care Pharmacy Resident program, as well as work closely with medical interns and residents, and many of us provide education to the medical residents as well.

What are the billing codes used? Is the billing specific to your state or based on a federal program?
We are an FQHC and initially our positions were grant funded, so we were unable to do any type of billing as it was considered double-dipping. Our grant funding ended, and our positions were then funded by the organization, and we have not really looked into the issue of billing for our visits since then to my knowledge.

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How is this service being used in your practice (integration, benefits, value, etc)?
We have both seen an increased focus on population health over the last 3 years. There are a few programs that have been started, and Joel manages the hypertension program. Patients are identified as having uncontrolled hypertension based on their blood pressure from their last 3 doctors' visits. A list is generated, and they are referred to the hypertension clinic. Sarah manages a diabetes initiative that looks at patients with diabetes that are not on a statin and reaches out to providers to get them on the statin. The list of these patients is generated similarly to the one for hypertension. There is also a program that looks at statin use in cardiovascular disease that works similarly to the statins in diabetes program. They also do medication adherence outreach focusing on hyperlipidemia, hypertension, and diabetes. This list is generated when there is a late fill at the pharmacy.

Requirements unique to health centers
The patients they see are empaneled for them based on them having established care within their health system (PCP visit at least once in the last 18 months is how the system defines established care). Also, about 2/3 of our patients fill with us and we have a pharmacy in or connected to most of our clinics. This helps with adherence as well as tracking and documentation in EPIC. They also track lists on a secure server which you need to request access to.

Clinical pearls (tips for success)
Having an FTE pharmacist embedded within the health system is a bonus for this kind of work. You are there when issues come up and for follow up. There is also more trust with both providers and patients when outreach occurs because you have the established relationship with them already and they are more likely to listen to you and do what you recommend because of that. Also, having a design that allows for both telephone and in clinic follow up is great. Having sets of documents that allow for standardization of the documentation and follow up makes it so that the information is the same regardless of the clinic or pharmacist doing them. Tracking the time spent on these programs is a good thing to do as it allows you to figure out where they best fit in the practice's workflow (monthly, daily, etc.). Ideally there should be a way to cross reference the lists generated from each of the programs so that if a patient meets the criteria for more than one program, we can reach out to them for each situation all at the same time. This streamlines the work to help as many people as possible.

Roadblocks and how to overcome them
In our system specifically there are a lot of different clinics that vary in size, some are larger, and some are smaller. Balancing the workload across those clinics can be challenging. We find that grouping some of the smaller clinics together helps with that. Consistent documentation in order to be able to demonstrate impact can be difficult. We overcome that by working in smart phrases to our EHR and building standard excel files into the EHR for documentation which allows similar documenting and allows us to see consistent work across the clinic.

Role of residents and students
We fully integrate residents and students into the process. We train them into the importance of the programs and how to do them. They do a lot of the outreach and chart reviews. Usually, they will consult the PharmD before making any changes, but we do often have PGY2 residents who are comfortable changing things on their own.

Recommended resources
ASHP, in particular this project, is a great resource to look at. Also, the FQHC pharmacist listserve is a great resource and which allows us to ask questions of other pharmacists in similar practices. APhA also has a group for underserved populations, not specifically FQHCs, but a lot of the pharmacists on there are FQHC pharmacists. Also, knowing your state laws and what they say about things like collaborative practice and billing opportunities is important, but there isn't a lot of literature on these initiatives. Many of them have been done before, but not as population health.

What are the billing codes used? Is the billing specific to your state or based on a federal program?
Due to state laws and the fact that we are tied to a health system, we do not bill for our services. They are bundled in with other services at the facility. We often wave copays for our services because our work is very important to patient health and we want to remove barriers that the patient may have in getting our services. Labs are really the only thing that is billed for and we try to be sensitive to the patient's ability to afford those by balancing the necessity of the labs and safety concerns with the patient's ability to afford them.

Resources

- https://www.pharmacytimes.com/view/population-health-management
- https://www.amcp.org/about/managed-care-pharmacy-101/concepts-managed-care-pharmacy/population-health-management
- https://www.cdc.gov/pcd/issues/2020/20_0350.htm
- https://www.health.ny.gov/events/population_health_summit/docs/what_is_population_health.pdf
- https://www.ashp.org/Pharmacy-Practice/Resource-Centers/Quality-Improvement/Support-the-National-Quality-Strategy/Population-Health?ct=c5c28fbea3f35300f672127db7e446f92f2e6dbb5c04076fba25ccea51fd4f4536242f7cfd1b0d284242380b50d73c88d1ff0df6913b11dc787041a77de15a96

Jordan Valley Community Health Center
Hepatitis C Clinic
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How is this service being used in your practice (integration, benefits, value)?
Our organization has two physicians treating Hepatitis C. Two pharmacists (one from the dispensing pharmacy and one clinical pharmacist) assist in the Hepatitis C clinic. Patients are referred to the Hepatitis C clinic after diagnosis from their primary care provider and necessary screening labs have been complete (viral load, Hepatitis A and B, HIV, etc.). A clinical community health worker (CHW) reviews the patient's chart to ensure all necessary lab work has been completed prior to scheduling the patient with the Hepatitis C clinic. They also discuss the cost of treatment with necessary appointments, lab work, scans, vaccines, etc.

During the Hepatitis C clinic day, the team selects a Hepatitis C treatment plan based on patient-specific factors, including assessment for drug interactions. After a treatment plan is created, a pharmacist counsels the patient on the medication selected. If the patient has insurance, a pharmacist

from the onsite dispensing pharmacy will meet with the patient to start the prior authorization process. If the patient does not have insurance, a pharmacist from the clinic will meet with the patient to start the patient assistance program paperwork.

The clinic pharmacist meets with the patient when their medication comes in through the patient assistance program (typically takes 4-6 weeks) to re-educate on the medication and provide education on the disease state and treatment process. After starting the medication, the patient returns to see the pharmacist to obtain 4-week labs to assess for safety and efficacy of treatment. After completion of therapy (typically 8-12 weeks), the patient completes one additional appointment with the physician to test for cure.

Requirements unique to health centers

With a large percent of uninsured patients, health centers should look for ways to reduce barriers for patients to seek treatment. We created a nurse position to assist with the paperwork required for patient assistance programs (they cover all medications, not just Hepatitis C) and they have been a vital aspect to launching our Hepatitis C program for our uninsured patients.

Clinical pearls (tips for success)

1. With joint appointments, developing a workflow that worked for all members of the team was vital. The pharmacy team spent time shadowing the physicians as well as each other to ensure the same level of care is provided to all patients. This also allowed the team to build relationships in order to gain trust in care for each other's patients.
2. While as a pharmacist, we like to handle all things medication; however, there are times we can utilize a nurse or technician to make our team more efficient. Our dispensing pharmacist utilizes a technician to help with the prior authorization process. For those without insurance, we utilize a nurse to help with the patient assistance paperwork. If the task does not require clinical judgment and you have access to someone who can manage paperwork, pass it off to spare your time!

Roadblocks (and how to overcome)

The cost of Hepatitis C treatment has been a barrier for many patients. Fortunately, many insurance companies are covering the medication. For patients without insurance, developing a process to access the medication as well as vaccines through patient assistance programs has been vital to our success. Prior to purchasing a FibroScan, many of our patients struggled to afford the necessary scans, labs, or biopsies to assess their liver damage.

Role of residents and students

We have a PGY2 ambulatory care pharmacy resident as well as APPE and IPPE students spend time in our clinic. The PGY2 resident often covers the joint Hepatitis C clinic appointments with the physician. Both the resident and students provide medication education, complete drug interaction checkers, and provide disease state education for the follow up appointments. The residents have been a valuable part of designing and honing the work flow over the last several years.

Recommended resources

- Your individual state board of pharmacy rules to ensure the pharmacist can order labs or if the physician will need to place orders for you
- Your individual state may have an ECHO project devoted to Hepatitis C management
- AASLD/IDSA Guideline: https://www.hcvguidelines.org/
- https://liverfoundation.org/for-patients/about-the-liver/diseases-of-the-liver/hepatitis-c/
- UCSF Clinician Consultation (for challenging patient cases, hotline or email): https://nccc.ucsf.edu/clinician-consultation/hepatitis-c-management/

What are the billing codes used? Is the billing specific to your state or based on a federal program?
The physician will bill for their visit (typically 99214), as well as the FibroScan. The pharmacy team does not currently bill for any services. We utilize pharmacy team visits that are supplemental to the physician visits to reduce the cost of the patient's overall treatment. We do collect payment for lab tests performed by the onsite lab prior to obtaining bloodwork.

Medicare Annual Wellness Visits (AWV)

Background
Medicare annual wellness visits are yearly health assessments done to develop or update a disease prevention plan. Prevention plan is done to prevent disease and disability based on current health and risk factors. The plan includes: review of medical and family history, developing or updating list of current providers and prescriptions, vitals, detection of any cognitive impairment, personalized health advice, list of risk factors and treatment options, screening schedule, and advance care planning.

Billing
Initial AWV G0438, Subsequent AWV G0439

National vs. State
Please see the following link for CMS guidance: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/preventive-services/medicare-wellness-visits.html

Examples in Practice

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How is this service being used in your practice?
Annual Wellness Visits (AWVs), initial and subsequent, are one of the services offered by our MTM primary care pharmacists. Currently, we offer AWVs for patients who are already enrolled in our MTM services for either chronic disease management or anticoagulation management. Some of our sites are now offering AWVs for non-MTM referred patients to help with the workload of the nurse case managers that also complete these visits. The ability for the pharmacists to complete these AWVs during the patient's already scheduled appointment allows for the patient to only present to the clinic for one visit for either chronic disease management or anticoagulation management with completion of their annual wellness visit. In order to identify these patients, we utilize AMP reports in our EHR that identifies gaps in patient care, including AWV.

Requirements unique to the use of these codes in an FQHC
There is extensive documentation criteria that needs to be met for AWVs to be recognized as billable. As long as those criteria are met, billing for AWVs is completed under direct supervision in our clinic utilizing the same G codes as other non-FQHC sites would use; G0438 for initial visit and G0439 for subsequent visit.

Clinical Pearls
As I noted above, AWVs have extensive criteria that must be completed during a visit for it to be billable and not face issues with an audit. These criteria also ensure that the AWV is personalized to the patient in order to address any crucial gaps in the patient's health care. Therefore, documentation of this specified criteria is very important. Any issues that are identified are then discussed with the primary care physician or nurse case manager so the issue(s) can be resolved. One important thing to note in the time of COVID-19 is that AWVs can be performed via telehealth as well.

Roadblocks
As I mentioned, my clinic is completing these visits along with anticoagulation or chronic disease management visits. Although most of the time these visits are identified in advance, time/schedule conflicts can arise if the chronic disease appointment or AWV appointment takes longer than expected. Therefore, if completing these visits along with other scheduled appointments, it is crucial to verify enough time is scheduled.

Role of Residents and Students
Residents and students are both great resources in completing AWVs. Residents can complete AWVs independently. Students will be present as the AWV is conducted by a pharmacist and can have an active role in checking vitals, medication reconciliation, review of allergies, etc.

Resources
- https://www.pharmacytimes.com/publications/issue/2018/March2018/pharmacists-and-annual-wellness-visits
- https://www.medicare.gov/coverage/yearly-wellness-visits

Electronic code of Federal Regulations
Annual wellness visits providing Personalized Prevention Plan Services: Conditions for and limitations on coverage
https://www.ecfr.gov/cgi-bin/text-idx?SID=b88181e2130f26ae6c4741f95a518bbf&mc=true&node=se42.2.410_115&rgn=div8

Other Potential Opportunities for Pharmacists and Billing

1. Transitional Care Management (TCM)
    a. Moderate medical decision complexity – visit within 14 days of discharge CPT 99495
    b. High medical decision complexity – visit within 7 days of discharge CPT 99496
2. Pharmacists and FQHC can negotiate payment with any commercial plan directly for pharmacy services
3. FQHC contracting pharmacist services with self-insured groups or Indian tribes that are not participating with Indian Health Service (IHS)

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If you are participating in any of the identified opportunities identified within the document and would like to share a practice example, please contact:

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