ABSTRACT

Objectives: In this time of sweeping healthcare reform, traditional payment models, which include an individual charge per service received, are undergoing significant changes. New payment models increase systemic and organizational accountability, achieving improved outcomes by incentivizing providers and payers to cooperate. This literature review examines the possibility of implementing these new payment models in a pharmacy setting in order to move pharmacist efforts beyond dispensing prescriptions to providing patient care services.

Study Design: This article discusses implementing value-based incentives (VBI) programs in community pharmacy practice through an extensive and systematic review of the literature and an examination of key VBI programs currently in operation within community pharmacy and other healthcare settings.

Methods: An advisory group of experts synthesized a systematic review of the literature and investigated relevant existing VBI programs, and offered suggestions as to how VBI programs may be appropriately applied in community pharmacy.

Results: The advisory group identified 3 implementation strategies necessary for applying VBI programs in community pharmacy settings: 1) determining appropriate outcomes and incentives, 2) developing a business model based on successful VBI programs, and 3) enacting operational strategies that yield successful and sustainable VBI program implementation.

Conclusions: The community pharmacy is an underutilized and broadly available healthcare setting that could positively affect population health. It would be possible to apply VBI programs in a community pharmacy setting using various strategies developed and implemented in other healthcare areas, which would result in financial incentives being provided to pharmacies for the achievement of specific quality metrics dependent on patient-focused interventions.


METHODS

This consensus article was developed from a systematic literature review using search terms and resources derived from a collaborative advisory group consisting of 32 pharmacy...
services experts (see the Acknowledgments section in the eAppendix [available at www.ajpb.com]). These experts included pharmacy managers and senior leaders, academicians, policy makers, physicians, leaders within the pharmaceutical industry, Medicaid and Medicare officials, and health economists. Online searches were conducted through PubMed and Google Scholar databases using a hierarchy of approximately 50 terms provided by the advisory group members.

RESULTS AND DISCUSSION
The Changing Healthcare Landscape
Trends toward VBI programs and coordinated patient care approaches will continue to change service delivery throughout the healthcare system. Although still deeply rooted in the traditional fee-for-service (FFS) model, payment for community pharmacy services will undergo substantial changes. With the significant role that medications play in the management of acute and chronic conditions, pharmacists’ medication expertise is increasingly being sought on healthcare teams, making pharmacists accountable for patient care in a new way.

In a VBI system, payment amounts depend on outcomes (eg, enhanced medication adherence, reduction in inappropriate or unneeded medications) rather than the volume and variety of services provided by the pharmacy. Improvements in value that yield benefits for patients, providers, and payers also strengthen the healthcare economy. The transitions from pay-for-volume to pay-for-outcomes, and the movement from units of care to “systems of care,” have resulted in the need for an integrated and team-based approach to patient care. This approach relies on multidisciplinary coordination, but in order to coordinate care, healthcare professionals must be provided with the tools to do so.

New care models. New care delivery models, such as accountable care organizations (ACOs), attempt to achieve this goal of a coordinated, high-performing healthcare system. An ACO consists of providers who are jointly held accountable for achieving measured quality improvements and reductions in costs. The payer associated with the most ACOs is CMS, but other private payers, state Medicaid programs, and employers are also using this care model. The ACO typically must promote evidence-based medicine and patient engagement, as well as monitor and evaluate quality and cost measures, meet patient-centeredness criteria, and coordinate care across the care continuum. Community pharmacy involvement within ACOs that coordinate care between pharmacists and other healthcare professionals is increasing, and thus the time is ripe for collaborations between ACOs and pharmacists.

Another evolving care model is the patient-centered medical home (PCMH). PCMHs, medical neighborhoods, and advanced primary care practices provide patients with access to integrated healthcare through ongoing relationships with medical professionals. The PCMH model works under a philosophy of high-quality primary care that is patient-centered, comprehensive, team-based, coordinated, accessible, and safe. In PCMHs, pharmacists may be employed or contracted by a medical practice on a full- or part-time basis and can participate in the practice’s management of: 1) transition of care between a variety of settings; and 2) optimization of medication effectiveness and safety via the application of brief interventions, comprehensive medication reviews (CMRs), ongoing medication monitoring, and other medication therapy management (MTM) services. If pharmacists are integrated into the PCMH, adherence can be improved and unnecessary healthcare spending can be avoided.

Traditional Financial Incentives
Depending on where the pharmacy is located, purchasers or payers could consider using any of the following financial incentives: a) bonuses—generally annual payments by payers that range from 5% to 20% of the provider’s current total reimbursement based on the provider meeting minimum target requirements for a small number of measures. Usually, bonuses are easier to implement than other incentives because provider contracts will not require renegotiation. Participation in bonus programs can also be a voluntary offering; b) withholds—payers can withhold a percentage of the reimbursement and return all, or part, of the withhold if a provider meets a portion or all of a target requirement for a small number of measures. Withholds need to be negotiated into provider contracts and are not voluntary, unlike bonuses; c) adjustable

Value-Based Incentives in Community Pharmacy

PRACTICAL IMPLICATIONS
Healthcare is transforming through new payment models called value-based incentives (VBI), which provide incentives to providers and payers for improved outcomes. VBI programs could also be implemented in community pharmacy.

- Traditional fee-for-service models are changing to pay-for-performance (such as VBI) models.
- It would be possible to apply VBI programs in a community pharmacy by examining how these programs are implemented in other healthcare areas.
- Pharmacists could contribute to new care models by providing services, including brief interventions and medication therapy management. The community pharmacist is a broadly available, yet underutilized, resource that could positively affect population health.
reimbursement schedules—payers can provide for a tiered reimbursement schedule based on the services provided, and reimbursements can be retroactively adjusted based on the specific time frame; d) quality grants—payers can fund quality improvement and evaluation projects proposed by providers to assess targeted clinical/process improvements; and e) additional reimbursements for specific clinical activities and investment in point-of-care clinical information systems—providers can receive a small additional payment (on a per-member-per-month basis) for completing additional quality-improvement services or for purchasing point-of-care information systems.

**Traditional Nonfinancial Incentives**

There are traditional nonfinancial approaches that managers can use with community pharmacies. First, there are preferred pharmacy networks, where payers can channel patients into pharmacy networks whose performance meets pre-selected criteria. A preferred pharmacy network based on a FFS model using volume of services is not viewed as an incentive to community pharmacies. Instead, as payers increase their focus on improving patient outcomes and medication adherence, these preferred networks will be composed of community pharmacies that provide the highest quality services at reasonable cost levels. In 2016, 85% of stand-alone Part D drug plans use preferred pharmacy networks, up from just 7% in 2011. Network preference can be “hard” (ie, involving benefit and contractual segmentation of providers based on performance) or “soft” (ie, permitting patients to understand provider cost and cost-sharing benefits so patients may select certain providers over others).

Managers can also use public report cards, honor rolls, and community recognition. Health plans and employer coalitions can publicly report pharmacy performance to recognize high-performing providers via an “honor roll” that may be used in a public awareness campaign. Often, the higher-performing providers receive further incentives via participation in 1 or more VBI programs.

**Transitions in Payment Structures**

Slowly, traditional payments are giving way to new payment models that are tied to quality metrics. It is important for community pharmacy organizations to understand these newer payment models, such as shared savings payments, bundled/episode payments, and capitiated payments, as they are often used with collaborative practices. CMS is also currently exploring new healthcare delivery models for health systems and providers associated with various payment structures (see Table 1).

The payment structures contained in Table 1 are intended to stimulate thinking among community pharmacy executives about how to engage with relevant decision makers (eg, payers, care organization leads, employers) and negotiate different reimbursement models tied to the added value their pharmacy services would provide.

These models can include the following features, offered individually or in combination:

- **Per-beneficiary-per-month (PBPM) for care coordination.** The provider receives a total payment for providing care coordination to all patients within a network, calculated as a price per network member multiplied by the total number of members.

- **Quality incentive payments.** The provider receives additional financial incentives for exceeding or meeting predetermined quality metrics. These incentives are often considered as “bonus payments.”

- **Shared savings payments (for meeting cost and quality thresholds).** Providers within a defined care organization (ie, an ACO) ideally share in its savings. However, before providers engage in a risk model via an ACO, they should determine the ACO’s policy for how savings will be shared with providers. In some cases, savings are retained by the ACO for infrastructure support and are not necessarily shared with providers. There are 2 types of shared savings payments: 1) the 1-sided risk model, where the participating organization (eg, pharmacy) receives payment if the care entity’s savings exceed spending thresholds, but the organization is not at risk for sharing losses when costs exceed the spending threshold; and 2) the 2-sided risk model, where the participating organization (eg, pharmacy) receives payment if the care entity’s savings exceed spending thresholds and the provider is also at risk for sharing in losses when costs exceed the spending threshold.

These payment structures will provide community pharmacy executives flexibility when considering their unique pharmacy services, patient population, and business model. Shared savings programs are not the same as withhold programs, which involve payers withholding additional payments depending on provider performance. In shared savings programs, the specified savings shared by providers are derived from how well the ACO reduced healthcare costs while still providing targeted quality care.

**Developing VBI Programs in Community Pharmacy**

To successfully participate in VBI programs, community pharmacies should consider the following:

- **Determine what outcomes should be highlighted with a payer.** Examine the organization’s current patient health and care quality–associated outcomes and how...
these outcomes are linked to quality evaluations used by payers like Medicare Star Ratings.\textsuperscript{11} The Star Ratings are divided into 4 domains: 1) Drug Plan Customer Service; 2) Member Complaints, Problems Getting Services, and Choosing to Leave the Plan; 3) Member Experience With Drug Plan; and 4) Drug Pricing and Patient Safety. There are 18 individual measures in total, but medication safety and adherence measures are within the Drug Pricing and Patient Safety domain. These methods in particular should be considered when implementing a VBI program.\textsuperscript{56} It is best to begin with a small number of targeted metrics and increase this number over time.

**Patient engagement.** Currently, there are no standard patient-engagement measures used in pharmacy services. However, patient engagement is important to payers, and pharmacies should develop methods and tools for measuring patient experience. Pharmacies should collect engagement data valuable to both pharmacy services and to the payers.

**Verify the outcomes.** Develop a process for verifying outcome measurement accuracy and communicate this with the payer. If a verification process has not been developed, work with the payer to determine how outcomes will be verified and communicated.

**Know the data.** Before a VBI program/pilot is initiated, it is important to understand which data will be needed, where the data source(s) reside, and the processes by which current data will be shared between involved entities. Further, pharmacies and pharmacists must understand how the modifications to their pharmacy services will likely affect targeted pharmacy measures, patient clinical outcomes, and care-coordination measures.

**Data measuring and reporting.** All VBI programs involve a method of measuring and reporting a targeted

---

Table 1. Evolving VBI Payment Models

<table>
<thead>
<tr>
<th>Program</th>
<th>Payment Structure</th>
<th>Potential Pharmacy Reimbursement Model</th>
</tr>
</thead>
</table>
| Medicare Shared Savings Program              | An ACO is eligible to “share savings” with Medicare depending on its scores on 33 quality measures.  
• 1-sided risk ACOs: up to 50% shared savings  
• 2-sided risk ACOs: up to 60% shared savings\textsuperscript{22} | Pharmacies/pharmacists are contracted to assist in meeting quality measures related to medication use, such as medication adherence.  
Arrangement is negotiated for pharmacists/pharmacies to share savings with other ACO providers if quality measures related to medication use are improved. |
| Comprehensive Primary Care Initiative        | CMS will pay providers for improved and comprehensive care management, and after 2 years offer them the chance to share in any savings they generate.\textsuperscript{29} | PBPM payments based on quality scores related to appropriate and safe medication use are shared with pharmacists/pharmacies. |
| Physician Value-Based Payment Modifier      | Groups of 100 or more eligible physicians receive payment increases of up to 2% (with an additional 1% available to the highest performers) or losses of up to 1% based on a quality tiering approach which establishes domains of high, average, or low quality versus high, average, or low cost.\textsuperscript{33} | Pharmacy providers are contracted and paid a consultant fee pro-rated on tiered improvements in medication use quality scores. |
| Episode of Care/ Bundled Payments            | These payment structures establish financial accountability for episodes of care rather than single services. In the “bundled” payment model, providers, hospitals, and postacute care providers provide a set of services over a specified period of time for a single target price.\textsuperscript{34} | Pharmacies are contracted to assist in meeting quality measures related to medication use, such as medication adherence, and thus provide a continuum of patient care.  
Arrangement is negotiated for pharmacies to share savings with other care organizations/program providers if quality measures related to medication use are improved. |
| Global Payment Models (BCBS of Massachusetts)| The provider share of surplus increases as quality improves—from 20% in level 1 to 80% in level 5—based on quality payments paid PBPM.\textsuperscript{35} | Pharmacies/pharmacists are contracted to assist the care organization/program in meeting quality measures related to medication use, such as medication adherence.  
Arrangement is negotiated for pharmacies to share savings with other care organizations/program providers if quality measures related to medication use are improved. |
| Medicare Star Ratings                        | If annual plan bids are below the benchmark established in the plan’s county, the plan receives a rebate:  
• 4.5 or 5 stars: 70% rebate  
• 3.5 or 4 stars: 65% rebate  
• Less than 3.5 stars: 50% rebate  
Plans receive bonus payments based upon their calculated Star Rating for a given quality metric.\textsuperscript{36} | Pharmacies/pharmacists receive additional revenue as determined by medication use quality scores associated with the Medicare Star Ratings program. This would be separate from current MTM opportunities through the Medicare Part D program and could be 1-sided or 2-sided risk models. |

ACO indicates accountable care organization; BCBS, Blue Cross, Blue Shield; MTM, medication therapy management; PBPM, per-beneficiary-per-month; VBI, value-based incentives.
quality construct. Often the payers will prescribe how the metrics related to these targeted quality constructs should be collected and reported. The providers then must develop valid processes for collecting and reporting the data the payers prescribed.

**Determine how incentives will be applied.** Evidence suggests that how incentives are applied can impact whether pharmacists engage with additional patient care quality programs. For example, when organizations are transparent regarding how they have applied financial incentives and when they apply a critical level of their incentives as a reward to staff who have successfully implemented care quality measures, the incentives will more effectively support continuous staff engagement with care quality programs.

**Consider case mix.** If a community pharmacy can demonstrate that its patients are sicker or have more complex psychosocial issues than patients at other pharmacies, it can make the argument that it is more difficult for its patients to achieve targeted improvements in patient health. Thus, the community pharmacy can negotiate different incentive structures than other providers within the payer pharmacy network.

**Understand the organization’s general ability to change.** It is important for both payers and pharmacy providers to assess an organization’s ability to change and be successful within a VBI program. Some organizations will require the initial application of more realistically achievable quality care outcomes.

**Facilitate change within the organization.** A lean and efficient pharmacy is necessary to carry out successful VBI programs. Reexamine the work flow and establish a regular schedule of evaluations on both a pharmacy and pharmacist level so that “course corrections” can be implemented quickly.

**Provide training to pharmacy staff on VBI goals and objectives.** It is imperative that all pharmacy staff receive effective training regarding the VBI program goals and objectives so they understand the rationale behind new work practices.

**Seek education and support.** In other healthcare areas, payers are providing education and ongoing technical assistance to providers (eg, emergency departments, inpatient hospital programs, primary care programs) to implement new evidence-based practices. Pharmacies and pharmacists should be included for consideration in these payer-supported models.

**Prove that the organization is likely to succeed.** Health plans may wish to initially provide resources to the members of their network most likely to succeed. If the community pharmacy organization has successful pharmacy service performance data that may be of interest to the payer, use this information to convince the payer the organization should be among the first to receive incentives.

**Seek “seed money” to test new care models and conduct pilot studies.** Grants provided by the pharmaceutical industry, private foundations, pharmacy quality groups, or academic institutions can provide “seed money,” which can be used to test and evaluate new models or conduct a pilot study.

**Operational Strategies for VBI Programs**

When planning, implementing, or participating in a VBI program, it is important to keep in mind that the organizational culture predicts success. Organizations with strong, knowledgeable, and stable leadership and staff, and a culture that empowers all members to achieve optimal performance, are more likely to provide higher quality services recognized by a VBI program. Being sensitive to ceiling effects is also key, as certain patient populations may have a limited capacity for change. Successful clinical interventions involve a continuum of approaches that are effectively applied both within and across patient populations over time. Tactically, no single strategy will work for all patients; an approach to improving clinical outcomes across a large patient population may be ineffective at the individual level. Interventions aimed at improving a population’s clinical outcomes should be modified when necessary to meet the needs of individual patients. Furthermore, no single strategy will work for all organizations. The organization may want to periodically change internal incentive programs to adapt to the community’s changing healthcare needs. Lastly, where measures are concerned, it is important to keep report cards simple. Keep in mind that complex report cards are difficult to understand and ineffective in correcting and educating the staff members.

**Table 2** provides a framework for community pharmacy executives who are considering implementing VBI programs within their organizations. **Table 3** provides principles for improving VBI impact.

**Tracking the Success of VBI Programs**

Community pharmacies working with payers and providers can use a number of strategies to evaluate the impact of a VBI program: a) conducting scientific studies—partnering with the payer and/or experienced researchers to conduct controlled studies can provide compelling evidence of the program’s effectiveness; b) conducting program evaluations—using qualitative methods (ie, key informant interviews or focus groups) or quantitative methods (ie, surveys) to determine the effect of incentives on staff work ethic, determine ways to improve the
Value-Based Incentives in Community Pharmacy

Table 2. Implementation Framework for Developing VBI Programs in Community Pharmacies

<table>
<thead>
<tr>
<th>Understanding the Current Environment</th>
<th>How to Approach Payers and Providers About Pharmacy Services in New Models</th>
<th>Developing the Infrastructure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Understand the business model</td>
<td>Inquire about the possibility of an incentive arrangement with a payer</td>
<td>Prepare and implement an effective workforce training program</td>
</tr>
<tr>
<td>Understand how organizations change and improve**</td>
<td></td>
<td>Assign someone to lead the effort</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Provide ongoing assistance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ensure required data are accurate, complete, and reliable</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Disperse incentives effectively</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Take control of the evaluation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Highly specify and document the process</td>
</tr>
<tr>
<td>Make sure the organization has determined how much it costs to provide its services, as well as when and how the resources provided by a VBI program will demonstrate an efficient return on investment. Make sure the organization is aware of infrastructure costs for administering a VBI program that will need to be considered during the contracting process.</td>
<td>Once pharmacy organizations understand fully the implications of healthcare reform (and specifically, the Medicare Star Ratings program) for patients, payers, and themselves, they can propose strategies to payers that can be beneficial to all.</td>
<td></td>
</tr>
<tr>
<td>A key assumption is that organizational change results from decisions by the pharmacy staff that are spurred by management’s policy decisions and directives. Fear is the typical reaction of frontline staff when they are faced with change. However, when they understand that performance measurement can help them accomplish their job and do it more efficiently, they often become more interested in its potential. Educating and involving staff is important in spearheading change.</td>
<td>Pharmacists’ thorough understanding of the VBI program will increase the likelihood that they will support the program. Pharmacy organizations should ensure that their pharmacists understand the VBI program in terms of: a) how it will result in improved patient outcomes; b) which quality targets are used in the program; c) how the program is consonant with the organization’s vision; d) how the quality measures will be accurately collected; e) how the incentives will be distributed within the organization; f) what support the pharmacists will receive, including timely access to clinical data beyond just pharmacy claims, to ensure they have the resources necessary to achieve the intended targets; and g) how the results of the program will be communicated to the workforce.</td>
<td></td>
</tr>
<tr>
<td>Pharmacy organization leaders should assign someone within their organization to lead their participation with the VBI program. The point person would help pharmacists understand the importance of the work associated with the program, how this work fits into the organization’s greater purpose, and how to break down their work into the intended processes that will lead to improved patient outcomes. If practice guidelines are too complex, then the providers will not be able to implement them.**</td>
<td>Pharmacy organizations require ongoing assistance in implementing any new strategies required by the VBI program. Pharmacy organizations can designate pharmacists as internal teachers who can provide assistance to their peers. These internal teachers may require additional training and ongoing management access and support.</td>
<td></td>
</tr>
<tr>
<td>Pharmacists will be less supportive of an organization’s participation in a VBI program if they feel the data provided to the payer are inaccurate.</td>
<td>Apply quality-improvement efforts to ascertain and correct data errors before the payer realizes them. Pharmacists will be less supportive of an organization’s participation in a VBI program if they feel the data provided to the payer are inaccurate.</td>
<td></td>
</tr>
<tr>
<td>Take care not to apply incentives that sabotage cohesiveness within the organization. It is important to be transparent and to ensure that those who were responsible for providing the quality care share in the incentive in some way.</td>
<td>Take care not to apply incentives that sabotage cohesiveness within the organization. It is important to be transparent and to ensure that those who were responsible for providing the quality care share in the incentive in some way.</td>
<td></td>
</tr>
<tr>
<td>Conduct a thorough evaluation of the VBI program’s success and share these results with the workforce and the payer.</td>
<td>Conduct a thorough evaluation of the VBI program’s success and share these results with the workforce and the payer.</td>
<td></td>
</tr>
<tr>
<td>Document care processes and changes in the processes over time to support replication throughout the organization. Share this documentation with the payer as evidence of the organization’s commitment to quality.</td>
<td>Document care processes and changes in the processes over time to support replication throughout the organization. Share this documentation with the payer as evidence of the organization’s commitment to quality.</td>
<td></td>
</tr>
</tbody>
</table>

VBI indicates value-based incentives.

VBI program, and provide additional evidence on the effectiveness; c) tracking internal quality metrics—tracking changes in quality metrics with pharmacy organizations involved in VBI programs over time; d) measuring penetration and fidelity—it is necessary to document the care management strategy’s penetration and fidelity as well as changes in the targeted patient outcomes. The process will show the relationship between the care management strategy and the clinical outcomes. Pending an examination of the organization’s business model, the degree to which the incentives permitted the application of the care management strategy provides evidence that the VBI program was necessary to support the care management strategy; e) using performance measures derived from health information exchanges (HIEs)—HIEs are emerging throughout the healthcare community as a way of ensuring coordinated care. Pharmacy services may be recorded and evaluated through information contained in HIEs; f) learning from negative outcomes from early VBI demonstrations—examine your outcomes iteratively. Negative outcomes early on can give insight on how to improve your VBI program, overcome barriers, and improve outcomes**; and g) refining application of a VBI program—when scaling a VBI program from small to large, you may need to simplify quality targets, refine patient algorithms, and adjust health- and risk-level assessments for patients.**
Table 3. General Principles for Improving VBI Impact

1. VBI programs tend to have a larger effect when the organizations in which they are being applied are in good financial shape.31
2. When organizations have difficulty holding individual practitioners accountable, the VBI program should at least, in part, be applied to the individual practitioners rather than to the organization. However, care should be taken when applying incentives to individual practitioners as this can make them risk-adverse. Organizations are also better able to pool risk across larger groups of patients.32
3. Use caution when applying multiple VBI models with the same provider, as the impact of each incentive on performance can be difficult to sort out—especially if the impacts of the incentive programs on provider performance interfere with each other.16
4. Rewarding quality is always better than rewarding utilization.42
5. VBI programs may need to be temporary as they can cause providers to believe that they are ultimately involved, not in optimizing patient health, but in optimizing revenue, or that they are not professionally capable of doing their jobs well unless they are prompted via an incentive.43
6. Quality targets associated with incentive programs must be aligned with clinical goals so that providers do not forget the clinical goals in their efforts to focus on the quality targets.18
7. Reporting and measuring of outcomes should be based on a time period that is realistic so the organization can respond appropriately to impact the results (ie, reporting based on last month’s data, as opposed to last year’s data).

CONCLUSIONS

Community pharmacy organizations have a growing track record of improving patient health and care at reduced costs.8,45 Moreover, community pharmacists are some of the most easily accessible, prevalent, and trusted healthcare providers. Community pharmacy involvement in payers’ VBI programs can become an integral part of designing strategies to improve patient outcomes. This paper provides a number of strategies that pharmacy organizations can consider when evaluating and implementing new VBI programs. Pharmacy organizations can contribute to advancements in healthcare by pilot ing and researching VBI programs (eg, what types of incentives work best with pharmacy programs, how to best prepare the pharmacy industry to succeed with VBI programs, and what quality measures best reflect patient outcomes that are associated with reductions in downstream healthcare costs) with payers, and then sharing their experiences and results so that community pharmacies can continue to make a unique contribution to our healthcare system’s transformation from volume to value.

Acknowledgments

Please see the eAppendix (available at www.ajpb.com) for acknowledgments.

REFERENCES

Value-Based Incentives in Community Pharmacy


eAppendix. Acknowledgements

The authors wish to thank the following individuals for their contributions to the development and revision of this paper as part of the advisory group:

Shaharyar Ahmed  
CVS Caremark

Christina Duczakowski  
CVS Caremark

Chronis Manolis, RPh  
University of Pittsburgh Medical Center

Arnie Aldridge, PhD  
RTI International

Woody Eisenberg, MD  
Pharmacy Quality Alliance

Jesse W. McCullough, PharmD  
Rite Aid Corporation

Jan Berger, MD, MJ  
Health Intelligence Partners

Mark Gregory, RPh  
Kerr Drug, Inc.

Newell McElwee, PharmD, MSPH  
Merck & Co.

Mitch Betses, RPh  
CVS Caremark

Shannon Kearney, MPH, CPH  
University of Pittsburgh

Thomas E. Menighan, ScD, MBA, FAPhA  
American Pharmacists Association

Baeteena M. Black, DPh  
Tennessee Pharmacists Association

Rachel Thomas, MA  
University of Pittsburgh

David Nau, PhD  
Pharmacy Quality Solutions

Virginia Calega, MD, MBA  
Highmark, Inc.

Jaime Allen Fawcett  
University of Pittsburgh

Len Nichols, PhD  
George Mason University

Steve Courtman, MBA  
HealthMart, McKesson Company

David Kelley, MD, MPA  
Pennsylvania Department of Public Welfare

Jeff Rochon, PharmD  
Washington State Pharmacists Association

Laura Cranston, RPh  
Pharmacy Quality Alliance

Richard “Tripp” Logan, PharmD  
L&S Pharmacy

Peter Simmons, RPh  
CVS Caremark

William Doucette, PhD, MS  
University of Iowa