

# Community Emergency Medical Technician Services

Purchasing and Service Delivery  
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**Table of Contents**

I. Executive summary.....4

    Post-Hospital Discharge Visit.....4

    Safety Evaluation Visit .....4

II. Legislation.....7

III. Introduction.....8

**CEMT Advisory Group Process**.....9

IV. Community programs .....11

    A. Park Nicollet Methodist Hospital, post-hospital discharge visit pilot .....11

    B. Tri-County Health Care Community Paramedics.....13

V. CEMT Proposed Covered Services .....15

    Post-Hospital Discharge Visit.....15

    Safety Evaluation Visit .....15

VI. CEMT Payment Rate .....17

VII. Report recommendations .....18

    C. CEMT Services.....18

    D. Community Emergency Medical Technician Payment Rate .....18

VIII. Appendices.....19

## **I. Executive summary**

This report provides a proposed list of Community Emergency Medical Technician (CEMT) services and payment rate to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and spending.

The CEMT Advisory Group created this proposed list of services. The group consisted of emergency medical service providers, healthcare providers, emergency response providers, and local public health personnel. The Department of Human Services (DHS) provided a proposed payment rate to the advisory group for their input.

The CEMT Advisory Group recommends the following CEMT services:

### **Post-Hospital Discharge Visit**

The patient's physician (hospitalist or primary care) orders the post-hospital discharge visit. The visit is included in the patient's care plan.

Included components:

- Provide verbal or visual reminders of discharge orders
- Recording and reporting of vital signs to the patient's primary care provider
- Medication access confirmation
- Food access confirmation
- Identification of home hazards

### **Safety Evaluation Visit**

Primary care would coordinate and be responsible for the treatment plan ordering the CEMT services.

Circumstances that may trigger a safety evaluation visit:

- Repeat ambulance calls due to falls
- Nursing home discharges
- Individuals identified by primary care as at risk for nursing home placement

## Community Emergency Medical Technician Services

Included components:

- Medication access confirmation
- Food access confirmation
- Identification of home hazards

The CEMT Advisory Group recommends a CEMT payment rate of \$9.75 per 15 minutes.

### **Community programs reviewed**

This report contains information on two community programs. The first is a EMT post-hospital discharge visit pilot program at Park Nicollet Methodist Hospital. The services provided during the pilot served as a foundation for the proposed CEMT services.

The second is a rural community paramedics (CP) program in Wadena, Minnesota. This program shed light on the question of CEMT services increasing access to quality care in rural communities. The addition of CP services may increase access to quality care if three programmatic characteristics are present: a strong information-sharing infrastructure, a community value of working together for the good of the patient, and strong financial strategies.

### **Readmission rates**

Both community programs collected readmission rate data to understand if the services affected hospital readmission or emergency room utilization. The CEMT post-hospital discharge visit pilot has shown a slight decrease of 0.6% in hospital readmissions. The rural CP program had a reduction of 33% in hospital readmissions.

Although these programs show promise, it may be too soon to understand the impact on hospital readmissions and emergency room utilization. Continued readmission data collection, including

## Community Emergency Medical Technician Services

randomized assignment and control groups, and CEMT program maturation may provide additional insight.

## II. Legislation

Minnesota Session Laws 2015, Chapter 71, Article 9, **Sec. 18. COMMUNITY MEDICAL RESPONSE EMERGENCY MEDICAL TECHNICIAN SERVICES COVERED UNDER THE MEDICAL ASSISTANCE PROGRAM.**

(a) The commissioner of human services, in consultation with representatives of emergency medical service providers, public health nurses, community health workers, the Minnesota State Fire Chiefs Association, the Minnesota Professional Firefighters Association, the Minnesota State Firefighters Department Association, Minnesota Academy of Family Physicians, Minnesota Licensed Practical Nurses Association, Minnesota Nurses Association, and local public health agencies, shall determine specified services and payment rates for these services to be performed by community medical response emergency medical technicians certified under Minnesota Statutes, section 144E.275, subdivision 7, and covered by medical assistance under Minnesota Statutes, section 256B.0625. Services must be in the CEMT skill set and may include interventions intended to prevent avoidable ambulance transportation or hospital emergency department use.

(b) In order to be eligible for payment, services provided by a community medical response emergency medical technician must be:

(1) ordered by a medical response unit medical director;

(2) part of a patient care plan that has been developed in coordination with the patient's primary physician, advanced practice registered nurse, and relevant local health care providers; and

(3) billed by an eligible medical assistance enrolled provider that employs or contracts with the community medical response emergency medical technician.

In determining the community medical response emergency medical technician services to include under medical assistance coverage, the commissioner of human services shall consider the potential of hospital admittance and emergency room utilization reductions as well as increased access to quality care in rural communities.

(c) The commissioner of human services shall submit the list of services to be covered by medical assistance to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and spending by February 15, 2016. These services shall not be covered by medical assistance until legislation providing coverage for the services is enacted in law.

### **III. Introduction**

There are currently 10,309<sup>1</sup> licensed emergency medical technicians in Minnesota. To understand how Minnesota could better utilize these resources to manage patient care and costs, the Minnesota Legislature passed legislation during the 2015 session, pursuant to Minnesota Session Laws 2015, Chapter 71, Article 9, Section 18, Community Medical Response Emergency Medical Technician Services covered Under the Medical Assistance Program, that calls on the Department of Human Services to convene a stakeholder group of emergency response and medical professionals. This group was asked to identify community emergency medical technician (CEMT) services that, if covered by medical assistance and within the CEMT skillset, could potentially increase access to quality care in rural communities and reduce hospital admittance and emergency room utilization.

The Community Emergency Medical Technician (CEMT) Advisory Group developed the content of this report. The CEMT Advisory Group represented the perspectives of emergency medical service providers, healthcare providers, emergency response providers, and local public health personnel.

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<sup>1</sup> Emergency Medical Services Regulatory Board, "License Count Report, December 14, 2015." Accessed December 15, 2015



## **CEMT Advisory Group Process**

The following organizations staffed the CEMT Advisory Group:

- Minnesota State Fire Chiefs Association
- Minnesota Professional Firefighters Association
- Minnesota State Firefighters Department Association
- Minnesota Academy of Family Physicians
- Minnesota Licensed Practical Nurse Association
- Minnesota Nurses Association
- Carlton-Cook-Lake-St. Louis Community Health Board
- North Country Community Health Services
- Stearns County Human Services - Public Health
- Southwest Health & Human Services Public Health
- Le Sueur-Waseca Community Health Board
- St. Paul-Ramsey County Public Health
- Hennepin County Public Health

In addition to ensuring representation across service sectors, the Department of Human Services (DHS) also considered geographic representation. A list of participant names is in Appendix A.

The group met twice in November 2015 and created a draft list of proposed medical assistance covered services. As follow up to the meetings, the members provided additional input on the proposed list of services as well as a DHS proposed CEMT payment rate.

The advisory group met via web-supported technology for two hours on November 6 and November 13, 2015. The agendas are in Appendix B. During the first meeting, the group discussed their charge, the community paramedic scope of services and the possible benefits of CEMT services in local communities.

During the second meeting, the group heard from Park Nicollet Methodist Hospital on their post-hospital discharge visit pilot and Tri-County Health Care's community paramedic program. Both

## Community Emergency Medical Technician Services

of these programs provided valuable insight. The first in understanding possible CEMT services and the second in how those services may provide increased access to quality care in rural communities and reduce hospital readmissions and emergency room utilization.

#### **IV. Community programs**

##### **A. Park Nicollet Methodist Hospital, post-hospital discharge visit pilot**

In January 2014, the St. Louis Park Fire Department met with Park Nicollet Methodist Hospital to discuss the high percentage of department emergency medical calls that were occurring after hospital discharges. Following that conversation, Park Nicollet initiated a continuous improvement effort to reduce the number of readmissions. The post-hospital discharge visit pilot program resulted from that effort. In the pilot program, Park Nicollet collaborated with the fire departments in St. Louis Park, Minneapolis, Minnetonka, Hopkins, and Eden Prairie to conduct post-hospital discharge visits.

Patients who are discharged from Park Nicollet Methodist Hospital are selected for the program based on discharge address. Patients that are discharged to a nursing home, assisted living facility, or a family member's home are not selected. Hospice and obstetric patients are also excluded from the program. Initially, Health Unit Coordinators (HUCs) assisted with asking patients to participate, but eventually Park Nicollet hired a Care Integration Officer to handle the program's operations in coordination with the hospital's physicians. Prior to discharge, patients selected for the visit give their consent by signing an Advanced Visit Services (AVS) document that gives permission for their health records to be shared with the participating fire departments and CEMTs.

The focus of the visit is to enhance patient safety in the home. During the post-hospital discharge visits, emergency medical technicians (EMT) engage the patient around five areas of safety and wellbeing:

1. Medications – Does the patient understand what medications to take?

## Community Emergency Medical Technician Services

2. Follow up visit – Does the patient have a follow up visit scheduled with their doctor?
3. Symptoms – Does the patient know what symptoms to be aware of and who to call if they experience them?
4. Food – Does the patient have enough food in the house to get through the next few days?
5. Home safety – Are there hazards in the house? Is the smoke/carbon monoxide alarm working?

If necessary, the EMT will put the patient in contact with resources such as the local food shelf to have food delivered to the home. They will also ensure there is an operational smoke/carbon monoxide detector within the home.

Park Nicollet has established a hotline for the EMT to connect with the care team to address any issues that come up during the visit. The hotline is also a direct link to the patient's primary physician if needed.

### **Readmission rates**

The pilot began on May 12, 2014. Four hundred forty-eight post-hospital discharge visits occurred between May 12, 2014 and July 31, 2015. Of the 448 patients visited, 41% were male and 59% were female. Park Nicollet has seen a 2.9% decrease in male hospital readmission rates and a 1.9% increase in female readmission rates. Of the five cities participating in the pilot, three reduced readmission rates.

### **EMT information access**

EMTs did not have access to electronic patient information during the pilot.

Park Nicollet will be providing EMTs with read access to their information management system called EPIC Care Link. EMTs will be able to read the patient discharge after visit summary (AVS) information. The patient's primary care provider writes the AVS prior to discharge.

## B. Tri-County Health Care Community Paramedics

Tri-County Health Care is a twenty-five bed critical access hospital in rural Minnesota that owns and operates the ambulance service. As a part of their workforce, they employ community paramedics (CPs) to coordinate patient care and preventative services as well as provide emergency medical response. Tri-County's CP program has been in existence for two years. Tri-County is a certified medical home health care organization and automatically enrolls patients into its CP program. Although the CEMT proposed services are different from the CP services, this model is helpful in understanding the systemic considerations for making services accessible in rural communities.

### **Do these services increase access to quality care in rural communities?**

Allen Smith, Tri-County Ambulance Services Manager, suggested that the answer to this question lies within the community itself by looking at the level of collaboration within the community, availability and sharing of information, and funding sources. In the case of Tri-County, they are a hospital and an ambulance service located in Wadena Minnesota.

Tri-County CPs have the ability to update the patient's record and write patient referrals through an information management system called EPIC. The patient's primary physician receives the referral and takes the appropriate action. In addition to sharing information through EPIC, Tri-County reviews their patient needs on a weekly basis by meeting with care coordinators and social services. They also meet weekly with the medical director to review patient care and receive feedback.

## Community Emergency Medical Technician Services

An effort was made early in the program to bring all the disciplines and agencies that provide patient services together. Through their conversations, they created a shared understanding of how they could work together for the good of the patient.

Tri-County emphasized the importance of financing strategies in the CP program. Many fire departments will need to identify how to fund a CEMT program. Tri-County received a grant from their local managed care organization to start the CP program. They are developing a more sustainable reimbursement model based on the cost savings from the reduction of hospital readmissions. Using the data from their CP program, Tri-County estimated the annual readmission cost savings before entering into contract negotiations with their local managed care organization. Together they have agreed that Tri-County will receive an agreed upon percentage of the cost savings.

The strengths of the Tri-County CP program that makes this program effective and accessible are a strong information-sharing infrastructure, a community value of working together for the good of the patient, and strong financial strategies.

### **Tri-County Health Care readmission rates**

Tri-County Health Care has seen a 33% decrease in overall readmission rates. This percent equates to one less patient readmission.

## **V. CEMT Proposed Covered Services**

The CEMT Advisory Group created a draft list of proposed CEMT services during their second meeting. The list included post-hospital discharge visits and safety evaluation visits. Many of the members discussed the services with their organization and suggested modifications or provided additional input.

### **Post-Hospital Discharge Visit**

The patient's physician (hospitalist or primary care) orders the post-hospital discharge visit. The visit is included in the patient's care plan.

Included components:

- Provide verbal or visual reminders of discharge orders
- Recording and reporting of vital signs to the patient's primary care provider
- Medication access confirmation
- Food access confirmation
- Identification of home hazards

### **Safety Evaluation Visit**

Primary care would coordinate and be responsible for the treatment plan ordering the CEMT services.

Circumstances that may trigger a safety evaluation visit:

- Repeat ambulance calls due to falls
- Nursing home discharges
- Individuals identified by primary care as at risk for nursing home placement

Included components:

- Medication access confirmation
- Food access confirmation
- Identification of home hazards

**CEMT Advisory Group member proposed services comments**

Some of the CEMT Advisory Group members provided input on the proposed list of services. Most of the comments focused on who would deliver the services and the documentation and sharing of that information.

**Coordination of services**

A few members commented on the need for coordinated services among all service providers, especially primary care providers, starting with a clearly understood referral process.

**Patient visit documentation**

A few members commented on the need for tools to serve as checklists and documentation for the various components to ensure consistency across service providers.

**Effective information sharing**

A few members questioned how information collection and sharing would occur. They believe this would be important for the service community to avoid duplication of services.



## VI. CEMT Payment Rate

The Department of Human Services compiled various service rates for advisory members to provide input on the proposed Community Emergency Medical Technician (EMT) rate.

Provider	Current Rate per 15 minutes	Percent of Community Paramedic
Homemaker (Waivered service only, not covered by medical assistance)	\$4.61	30.7%
Community EMT (proposed)	\$9.75	65%
Community Health Worker (1:1)	\$9.97	66.5%
Community Paramedic	\$15.00	100%
Nursing care in the home <sup>2</sup>	\$15.43	103%
Medication Therapy Management Pharmacist (repeat visit)	\$34.00	227%

The members of the CEMT Advisory Group provided comments regarding the reasonableness of the proposed Community EMT payment rate. All those responding thought the proposed rate was reasonable when compared to similar healthcare provider services. A list of professions and covered services is in Appendix C.

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<sup>2</sup> PHNC nursing care in the home: this would be **both the public health and home health**

## **VII. Report recommendations**

The CEMT Advisory Group recommends the following list of services and payment rate for legislation to provide medical assistance coverage.

### **C. CEMT Services**

#### **Post-Hospital Discharge Visit**

The patient's physician (hospitalist or primary care) orders the post-hospital discharge visit. The visit is included in the patient's care plan.

Included components:

- Provide verbal or visual reminders of discharge orders
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#### **Safety Evaluation Visit**

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Included components:

- Medication access confirmation
- Food access confirmation
- Identification of home hazards

### **D. Community Emergency Medical Technician Payment Rate**

The CEMT Advisory Group recommends a rate of \$9.75 per 15 minutes.

## VIII. Appendices

### E. Appendix A

#### Community Emergency Medical Technician Covered Services Advisory Group Members

<b>Organization</b>	<b>Name</b>
Minnesota State Fire Chiefs Association	Wayne Kewitsch
Minnesota Professional Firefighters Association	Chris Parsons
Minnesota State Firefighters Department Association	Bob Van Lith
Minnesota Academy of Family Physicians	Dr. Jeremy Springer
Minnesota Licensed Practical Nurse Association	Deb Tauer, Tara Erickson
Minnesota Nurses Association	Jon Tollefson, Mathew Keller, Carrie Mortrud
Carlton-Cook-Lake-St. Louis Community Health Board	Kelly Chandler
North Country Community Health Services	Bonnie Engen
Stearns County Human Services - Public Health	Marion Larson
Southwest Health & Human Services Public Health	Ann M. Orren
Le Sueur-Waseca Community Health Board	Sarah Berry
St. Paul - Ramsey County Public Health	Diane Holmgren
Hennepin County Public Health	Kristin Mellstrom, Jim Mara
Park Nicollet's community paramedics experience	Nicole Barnes
Tri-County Medical Director	Allen Smith

F. Appendix B: Meeting agendas

## Community Emergency Medical Technician Covered Services Advisory Group Meeting

**Date:** Friday November 6, 2015

**Time:** 9:30am – 11:30am

<b>Agenda</b>	<b>Activities</b>	<b>Lead</b>
9:30	Welcome and Introductions	Sara Drake, DHS
9:40	Agenda and ground rules	Kris Van Amber, MAD
9:55	The story behind the legislation	Buck McAlpin, North Memorial Hospital
10:15	Community paramedic covered services report <ul style="list-style-type: none"> <li>• What services are covered?</li> <li>• Paramedic pay rate</li> </ul>	Shawnet Healy, DHS
10:30	Community paramedic scope of training <ul style="list-style-type: none"> <li>• What is the community paramedic scope of training? How is it determined?</li> <li>• Scope of services in relation to other providers</li> </ul>	Mike Wilcox, MD Medical Director
10:45	Workgroup members' insight <ul style="list-style-type: none"> <li>• What role do you see for CEMTs in your community?</li> <li>• What services may they provide?</li> </ul>	Kris Van Amber, MAD
11:00	Initial CEMT covered services list <ul style="list-style-type: none"> <li>• Identify potential covered services</li> </ul>	Kris Van Amber, MAD
11:20	Next Steps <ul style="list-style-type: none"> <li>• Next meeting – Friday November 13, 9:30-11:30</li> <li>• CEMT pay rate</li> <li>• Finalization of CEMT covered services list</li> </ul>	
11:30	Adjourn	

# Community Emergency Medical Technician Covered Services Advisory Group Meeting

**Date:** Friday November 13, 2015

**Time:** 9:30am – 11:30am

<b>Agenda</b>	<b>Activities</b>	<b>Lead</b>
9:30	Welcome and Introductions	Sara Drake, DHS
9:40	Agenda and ground rules	Kris Van Amber, MAD
9:45	DHS Community paramedic managed care data	Shawnet Healy, DHS
9:55	Park Nicollet's community paramedics experience	Nicole Barnes
10:15	Tri-County Medical Director <ul style="list-style-type: none"><li>• Rural MN issues</li></ul>	Allen Smith
10:30	CEMT Covered Services and payment rate Group conversation <ul style="list-style-type: none"><li>• Post-hospital discharge assessments</li><li>• Home safety evaluations</li></ul>	Kris Van Amber, MAD
11:20	Next Steps <ul style="list-style-type: none"><li>• Legislative report timeframe</li></ul>	
11:30	Adjourn	

## G. Appendix C: Services by profession comparison

Profession	Covered Services	Non-covered Services
Homemaker (Waivered service only, not covered by medical assistance)	<p>Homemaker home management activities may include assistance with the following:</p> <ul style="list-style-type: none"> <li>• Meal preparation</li> <li>• Shopping for food, clothing and supplies</li> <li>• Simple household repairs</li> <li>• Arranging for transportation.</li> </ul> <p>Homemaker home management providers deliver home cleaning services, and while onsite, provide assistance with home management activities as needed.</p>	<p>Services cannot duplicate other Minnesota State plan or waiver services.</p> <p>Homemaker services are not covered when the person resides in:</p> <ul style="list-style-type: none"> <li>• Licensed foster care</li> <li>• Supervised living facility</li> <li>• Residential care services.</li> </ul>
Community Health Worker (CHW) (1:1)	<p>Diagnosis-related patient education services, including diabetes prevention and pediatric obesity treatment provided by a CHW with the following criteria:</p> <ul style="list-style-type: none"> <li>• MHCP requires general supervision by an MHCP-enrolled physician or APRN, certified public health nurse, dentist or mental health professional.</li> <li>• A physician, APRN, dentist, certified public health nurse or mental health professional must order the patient education service(s) and must order that they be provided by a CHW.</li> <li>• The service involves teaching the patient how to self-manage their health or oral health effectively in conjunction with the health care team.</li> <li>• The service is provided face-to-face with the recipient (individually or in a group) in an outpatient, home or clinic, or other community setting.</li> <li>• The content of the educational and training program is a standardized curriculum consistent with established or recognized health or dental health care standards. Curriculum may be modified as necessary for the clinical needs, cultural norms and health or dental literacy of the individual patients.</li> </ul>	<p>Social services such as enrollment assistance, case management, or advocacy delivered by a CHW</p>

Community Emergency Medical Technician Services

Profession	Covered Services	Non-covered Services
Community Paramedic	<ul style="list-style-type: none"> <li>• Health assessments</li> <li>• Chronic disease monitoring and education</li> <li>• Medication compliance</li> <li>• Immunization and vaccinations</li> <li>• Laboratory specimen collection</li> <li>• Hospital discharge follow-up care</li> <li>• Minor medical procedures approved by the ambulance medical director</li> </ul>	<ul style="list-style-type: none"> <li>• Travel time</li> <li>• Mileage</li> <li>• Facility fee</li> <li>• Services related to hospital-acquired conditions or treatments</li> </ul>
Skilled Nursing Visit	<p>Skilled nursing visits include any of the following:</p> <ul style="list-style-type: none"> <li>• Completion of a procedure requiring substantial and specialized nursing skill such as administration of intravenous therapy, intra-muscular injections and sterile procedures</li> <li>• Consumer teaching and education/training requiring the skills of a professional nurse</li> <li>• Observation, assessment and evaluation of the physical and/or mental status of the person</li> </ul> <p>All skilled nursing visits must be:</p> <ul style="list-style-type: none"> <li>• Made in accordance with the accepted standard of medical and nursing practice in accordance with the Minnesota Nurse Practice Act</li> <li>• Made in accordance with the plan of care or service plan</li> <li>• Ordered by a physician</li> </ul>	<p>Skilled nursing visits to the place of residence of a person are not covered when made for the sole purpose to:</p> <ul style="list-style-type: none"> <li>• Directly observe medication administration for communicable tuberculosis (may be billed under procedure code X5699 TB Direct Observation Therapy)</li> <li>• Monitor medication compliance with an established medication program</li> <li>• Public health nursing (PHN) clinic visit</li> <li>• Set up or administer oral medications, pre-fill a medication or for any other activity that can be delegated to a family member</li> <li>• Supervise a home health aide (supervision may be done during a SNV where the visit qualifies for payment)</li> <li>• Train other home health agency workers</li> </ul> <p>Nursing visits that are required by Medicare but do not qualify as SNVs are an administrative expense for agencies and cannot be billed to MA. Examples include Medicare evaluation or administrative nursing visits required by Medicare.</p>

Community Emergency Medical Technician Services

Profession	Covered Services	Non-covered Services
<p>Medication Therapy Management Pharmacist (repeat visit)</p>	<ul style="list-style-type: none"> <li>• Performing or obtaining necessary assessments of the patient’s health status</li> <li>• Face-to-face or interactive video encounters done in any of the following:                             <ul style="list-style-type: none"> <li>○ Ambulatory care outpatient setting</li> <li>○ Clinics</li> <li>○ Pharmacies</li> <li>○ Recipient’s home if the patient does not reside in a skilled nursing facility</li> </ul> </li> <li>• Formulating a medication treatment plan</li> <li>• Monitoring and evaluating the patient’s response to therapy, including safety and effectiveness</li> <li>• Performing a comprehensive medication review to identify, resolve, and prevent medication-related problems, including adverse drug events</li> <li>• Documenting the care delivered and communicating essential information to the patient’s other primary care providers</li> <li>• Providing verbal education and training designed to enhance patient understanding and appropriate use of the patient’s medications</li> <li>• Providing information, support services, and resources designed to enhance patient adherence with the patient’s therapeutic regimens</li> <li>• Coordinating and integrating medication therapy management services within the broader health care management services being provided to the patient</li> </ul>	<ul style="list-style-type: none"> <li>• Encounters by telephone or by email</li> <li>• Encounters in skilled nursing facilities</li> </ul>