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Pharmacy-Based Clinical Services:

From Pharmacogenetics to Chronic Care

Pharmacy is advancing clinical care through collaborative practice arrangements, genetic testing, and personal care, and system vendors are responding. story begins on page 15

Creating a Clinical Environment for Pharmacy Practice
An award-winning pharmacist uses technology to improve patient care.
8

Pharmacy Ownership Transition: A Primer
Thinking about buying or selling?
Here is some helpful advice.
11

2018 Expectations
What to keep an eye on as we move through the year.
31

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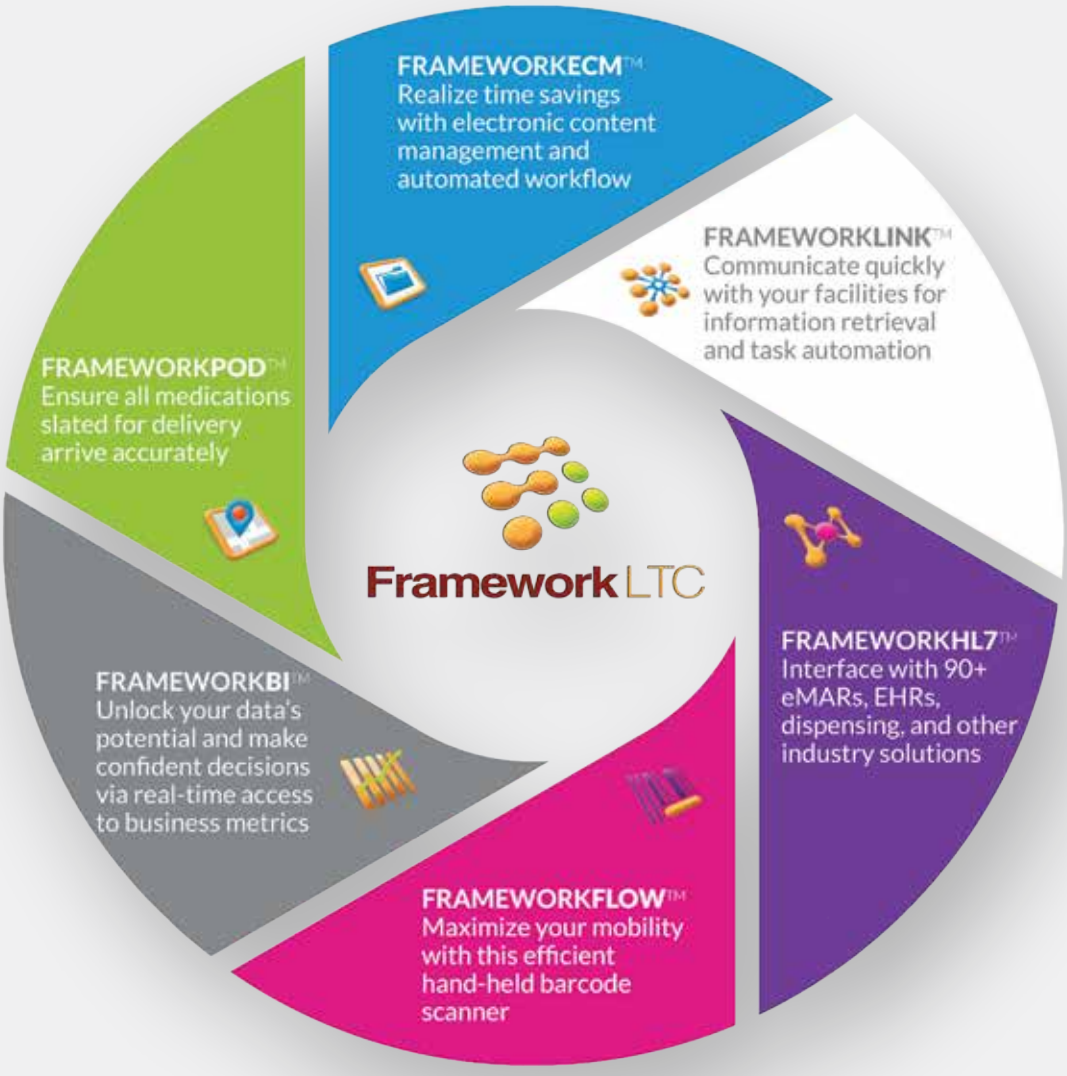

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FOR THE PHARMACIST

jan/feb 2018
The intersection of technology and management.

Pharmacy-Based Clinical Services:

From Pharmacogenetics to Chronic Care

by Will Lockwood

Pharmacy has been in a state of evolution for some time now, with consistent effort to integrate a clinical model into practices. Here we'll review different ways in which this movement has gained traction, and cases in which pharmacies are having success in providing cutting-edge clinical services to patients, pushing forward into a role as providers and collaborating effectively with prescribers and other providers. **Story begins on page 15**

Plus…

Elevating Pharmacogenetics through Pharmacy Connect, pg. 19 Pharmacies are rapidly including pharmacogenetics. Find out how forward-thinking pharmacies are using streamlined prescriber communication via secure messaging to ensure that their patients are receiving the full impact of these services.*

Why Pharmacogenetics Is Important, pg. 20 Find out how pharmacogenetics is expanding pharmacists' clinical role.

features

8 Creating a Clinical Environment for Pharmacy Practice
by Maggie Lockwood

Cheri Schmit, R.Ph., pharmacist and director of clinical pharmacy for GRX Holdings, LLC, was presented with the Medicine Shoppe International Clinical Innovation award for her work in implementing clinical programs at the pharmacy's 22 locations. With a vision of providing services such as vaccines and immunizations as a gateway to other clinical services, Schmit looks to technology partners to provide the tools in the pharmacy workflow to support the pharmacist's relationship with the patient.

11 Pharmacy Ownership Transition: A Primer
by Bruce Kneeland

Twenty-five percent of current pharmacy owners are 55 or older. Read how owners are working through the transition challenge and helping to ensure that their independent pharmacies continue as pillars of their communities for the next generation.

departments

4 Publisher's Window
Disruptive Technologies

6 Industry News

27 Technology Corner
May the Phorce Be with You

29 George's Corner
Marijuana (Oops: Cannabis)

31 Viewpoints
2018 Expectations

33 Catalyst Corner
2017: An Interesting Year

34 Index of Advertisers

35 Conference Circuit

industry insider

6 Focus as the First Step to Success

Integra LTC Solutions President and CTO of the J M Smith Corporation and the new Long Term Care Center of Excellence Kevin Welch talks about what it takes to keep technology on the cutting edge and streamline the process to bring new technology to the market that meets the needs of customers.

the back page

36 Health-System Pharmacy Evolution: An Expanded Role for Med Reconciliation

Carolinas HealthCare System Director of Outpatient Pharmacy Services Frank McCree talks about the accelerating shift toward allocating pharmacy resources where they can best impact health-system performance, with a special focus on medication reconciliation both when patients enter and when they leave the health-system setting.

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Disruptive Technologies

THERE WAS AN INTERESTING article in the Sunday, Jan. 14, business section of *The New York Times* about Jeff Bezos, the founder and CEO of Amazon. What started out as an online bookseller has morphed into a giant online seller of a vast variety of consumer products and technology. I say technology because Amazon's Web Services division is a moneymaker for the company and enjoys the largest share of the cloud-based computing market. And its Alexa digital assistant is used in a little over 70% of smart speakers, with Google's assistant a distant second in market share.

Amazon has rocked the foundation of brick-and-mortar retailers, forcing store closures and causing profits to plummet. With its recent acquisition of Whole Foods Market, this has the entire grocery industry on edge. I am not sure what the play here is with Whole Foods. We'll have to watch how this pans out.

Bezos is now the richest person in the world, with an estimated net worth of $105 billion. Princeton has to be proud of this alum.

The *Times* article pointed out that Amazon, with a market cap of $600 billion, has become one of the faces of "big tech," along with Apple, Google, and Facebook.

But according to the article, "these companies are facing a backlash." Amazon, for example, is apparently under the microscope for what critics say is "its corrosive effect on jobs and competition." However, Amazon employs more than 540,000 people and says that it will bring 50,000 new jobs to its second headquarters, wherever that may be. So the company is a big employer in its own right.

What I find interesting is Bezos's acquisition of *The Washington Post*. He paid $250 million for the paper. Bezos doesn't make foolish investments. This tells me that print still has legs, so to speak. The *Post* is an influential newspaper, up there with the *Times* and *The Wall Street Journal*. It will be interesting to see where he takes the paper.

Next up may be pharmacy. That's the buzz, but pharmacy is not groceries. It's not diapers. It's not books. It is highly regulated, and run-of-the-mill prescriptions these days are not moneymakers. Specialty drugs are, but this is a different breed of pharmacy, one that I do not see fitting into the Amazon business model. Nevertheless, it could be a problem for community pharmacy, both chain and independent, if Amazon enters the pharmacy market.

There is no question that Amazon has been a disruptive force. It took a while for the company to turn a profit while it went after market share. But let's face it — Amazon is now a success story on all counts. **CT**

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PrescribeWellness has introduced PrescribeCare Management Services Organization (MSO), with enhanced capabilities to provide billing and revenue cycle management. The PrescribeCare MSO negotiates reimbursements and contracts with health plans, payers, and accountable care organizations on behalf of community pharmacies. This allows these pharmacies to participate in risk-based, value-based, and shared-savings contracts.

The new MSO also includes an online platform for pharmacy providers to enroll in state Medicaid medication therapy management (MTM) initiatives. As a result, the MSO is now approved by Michigan's Medicaid program as a third-party administrator to provide revenue cycle management services to Medicaid-participating pharmacies enrolling in Michigan MTM reimbursement programs.

"The PrescribeCare MSO was created to help community pharmacies go 'beyond the fill' by collaborating with other healthcare providers to improve the quality of care for the patients they serve," says Al Babbington, CEO of PrescribeWellness. Babbington sees this as a vehicle to allow more community pharmacies to participate in MTM initiatives in Michigan and elsewhere.

Medicine-On-Time has acquired the blister card manufacturing assets from **Manrex, LTD**, based in Winnipeg, Manitoba, Canada. This purchase will add additional capability to Medicine-On-Time's new manufacturing facility outside Tampa, Fla., while expanding the company's business in Canada. Manrex will continue to distribute a full line of medication management products to its customers,

Industry Insider

Kevin Welch: Focus as the First Step to Success

Kevin Welch

Integra LTC Solutions President Kevin Welch talks with ComputerTalk's *Maggie Lockwood about his new role as CTO of J M Smith Corporation and the new Long Term Care Center of Excellence. We caught up with Kevin to hear what this meant for the PrimeCare LTC (long-term care) system and how, as CTO, he will head the move to keep the technological edge J M Smith is known for, and to streamline the process to bring new technology to the market and meet the needs of customers.*

ComputerTalk: This seems like a new path for QS/1 by breaking PrimeCare away from QS/1 and bringing it together with Integra LTC's assets. Can you tell us a little about how this came about?

Kevin Welch: Historically, QS/1 has been providing pharmacy management systems and related products to multiple markets. When Integra became part of the J M Smith family of companies, we brought an increased depth of offerings to the long-term care market. As we all listened to our customers, we heard their desire for greater focus on their specific needs, and it made sense to create a center of excellence for long-term care. The install base of PrimeCare and the install base of Integra Solutions gives us a footprint of about two-thirds of the long-term care market. Integra will focus solely on the needs of that market. We think focus is the first step to success. This way we can respond in a timely manner to customer needs. And that's what we're going to try and do. Integra has a great reputation for service and support in the industry. And we aim to continue that reputation as we support PrimeCare, building on the excellent work that QS/1 has done.

CT: What are you excited to address right off the bat?

Welch: Integra has historically provided products such as DocuTrack and DeliveryTrack that complement the core pharmacy system. As a result these products interface with many different pharmacy systems. With the addition of our own pharmacy system, PrimeCare, we will be able to complete the suite and provide a one-stop shop for all our customers. Now that being said, we are very committed to open platforms. One of the moves that we see in the market today are tightly integrated suites that do not interface with disparate external systems. This creates problems for many of our customers who need enterprise-class systems that simultaneously support multiple different systems. Furthermore, in many instances the solutions provided are not as robust as the stand-alone solutions that we provide. In other words, if they've got many pharmacies, we can handle them. And if they've use different pharmacy management systems, accounting systems, and CRM systems, our products, being open, can simultaneously work with all of those. I think that's going to prove to be a big competitive advantage, in addition to us being the one-stop shop for those customers who choose that route.

CT: Will focus mean a new level of responsiveness to products that are closed-door specific?

Welch: We've announced this transition, but there are a lot of moving parts and so we have set up an employee-led process to transition PrimeCare from QS/1 to Integra. All the current staff (including product managers, developers, and support people) will remain but report into Integra. From a product responsibility point of view, Integra will be taking the lead. We'll be communicating with our customers what they need to do to adapt to the transition. Plus, we are already going out and visiting customers in large numbers, talking to them about this transition, and also soliciting their feedback of where they would like the product to go. For me, personally, I have been spending at least a week a month on the road visiting customers, and our staff members have been doing the same. So we have a lot of input, and we're in the process right now of putting that into detailed product plans both for PrimeCare and our suite. **CT**

Read more and learn details about the conference at www.computertalk.com/center-of-excellence.

including Medicine-On-Time's products, which will include Medicine-On-Time's multidose color-coded blister card system. Guy Bryant, co-chairman and CEO of Medicine-On-Time, views the transaction as a positive step in extending its geographic reach and expanding its product line.

Liberty Software has announced a partnership with **Script Management Partners** to provide automated electronic connections to state and local immunization information system registries. The service will connect the Liberty systems to the IIS registries in order for pharmacists to have access to the patient's immunization history at their fingertips. The reporting connection will also allow pharmacists to electronically report the immunizations they administer to their IIS registry. This new option will assist in building immunization programs and maintaining compliance with the IIS registries.

Liberty also announced that **Adam Engel** has joined the company as director of client services. Engel comes to the company with over 10 years of experience in pharmacy. Prior to joining Liberty, he was a pharmacy manager at CVS Health and before that worked as a pharmacist at an independent pharmacy in Kansas. He holds a doctor of pharmacy from the University of Kansas and an M.B.A. in finance and strategy from Southern Methodist University.

PerceptiMed has signed a partnership agreement with **OmniSYS** through its OmniCONNECT Partner Program. The OmniCONNECT Partner Program is composed of pharmacy IT companies with solutions that have been certified on OmniSYS technology. Certified partners are featured in the OmniCONNECT Marketplace, an online community where OmniSYS customers can search for new pharmacy technology solutions that are compatible with their existing OmniSYS solutions.

PerceptiMed provides pharmacy automation solutions for prescription verification and will-call retrieval. OmniSYS's focus is on solutions that improve clinical, operational, and financial outcomes.

Creative Pharmacist has announced a partnership with **iMedicare** to give pharmacists access to an end-to-end solution that simplifies the number of dashboards they're using on a daily basis. Creative Pharmacist is the creator of the STRAND clinical platform that helps community pharmacists launch clinical services and identify bill payers for completed encounters. The service offered by iMedicare helps reduce the consumer's out-of-pocket expense for prescriptions.

Micro Merchant Systems has released it latest software update, PrimeRx v2.9.4.x, with a number of new automated refill management features, enhancements to a customized pharmacy workflow, and the new My PrimeRx Owners App for real-time business performance analytics. Pharmacy owners now have the freedom to define their workflow through a completely automated refill management system to improve patient adherence. To help here as well, the new version includes a convenient way to synchronize refills and create custom care plans.

The company also included in the new release two-way outbound calling, SMS/TXT, and email to stay in touch with patients. This feature reduces the time and cost in sending patient reminders.

Ketan Mehta, CEO of the company, sums it up this way: "With a client-centered approach, our customizable suite of products accommodates the needs of individual pharmacies for optimal operational success." **CT**

Creating a Clinical Environment for Pharmacy Practice

by Maggie Lockwood
VP, Director of Production

CHERI SCHMIT, PHARMACIST AND DIRECTOR OF CLINICAL PHARMACY *for GRX Holdings, LLC, in West Des Moines, Iowa, has a passion for clinical care, and coordinates and supports the clinical efforts of all pharmacists working in 22 Medicap pharmacies in central Iowa. A practicing pharmacist in a community setting since she graduated from pharmacy school, Schmit's passion has been clinical services and helping improve patient care outcomes. She received the Medicine Shoppe International Clinical Innovation award at Cardinal Health's annual Retail Business Conference for her support of the clinical work of GRX Holdings' 50-plus pharmacists.*

ComputerTalk: Congratulations on the award. Tell us a little about your role at GRX.

Cheri Schmit: Thank you! My job is to help develop, implement, and assure quality clinical services at the 22 different pharmacy locations in and around the central Iowa area. The goal is to compete in the value-based healthcare world. Based on reports that show patient adherence and other clinical metrics, I offer the pharmacists guidance on how to be more efficient with their time and recommend clinical tools to use when they meet with patients.

CT: What is the technology landscape like?

Schmit: All the pharmacies use Computer-Rx. It's helpful for me to pull reports for the stores, and helpful for the pharmacists because they don't have different systems when they move between pharmacies. We also use PrescribeWellness for pharmacy communications and campaigns. We've gradually increased our use for sync fill campaigns and medication therapy management (MTM) through OutcomesMTM, a Cardinal Health company, and we plan to start using the eCare plan more efficiently. With the technology tools, I can go in and proactively identify patients who might be good candidates for sync fills. The pharmacists can also schedule time in person with the patient for an MTM meeting to see what is happening with other areas of the patient's healthcare. I'll review the cases that are in Mirixa and OutcomesMTM, and let the pharmacists know what cases are outstanding.

Cheri Schmit

"I think we're at a point in time when we need documentation tools that are integrated into the workflow process. Pharmacy is not just about dispensing a medication; it's about documenting the care the pharmacist provided during the dispensing."

CT: Adherence and clinical programs are clearly a priority.

Schmit: I think we're at a point in time when we need documentation tools that are integrated into the workflow process. Pharmacy is not just about dispensing a medication; it's about documenting the care the pharmacist provided during the dispensing. We're hoping to start using the PrescribeCare module for some of our documentation purposes, in addition to the MTM feature in Computer-Rx, which we've been using for information that's important in value-based care.

CT: What are some examples?

Schmit: There is value in documenting a patient's A1C, blood pressures, lab values, or problems to follow up on. It was pretty much a paper process prior to electronically documenting what we had done and what follow-up was needed. We're excited to have a new way to document within our existing workflow. The next step is to share that record with other healthcare providers. Ultimately, this could help

continued on page 10

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continued from page 8

pharmacists earn provider status to be paid for work they're doing, especially around chronic care management, medication recommendations and transition-of-care opportunities.

CT: How does the pharmacy management system help with the clinical services?

Schmit: One goal is for our pharmacies to be an immunization center for patients. It is a priority for our pharmacists to screen patients at every opportunity that's available to see what vaccines may be needed. We screen for ACIP (Advisory Committee on Immunization Practices)-recommended vaccines and educate patients about them. We can put a queue in our system to follow up with patients if they don't want a vaccine that day. I think vaccines and immunizations are a big part of clinical services and are a gateway to offering other clinical services. I can run an immunization report out of Computer-Rx to see the patients who meet certain criteria and haven't had an immunization, and are therefore good candidates for our pharmacists to contact.

We record clinical measures we've selected, like A1C and blood pressure in the Computer-Rx MTM module section of the patient's profile. We also want to make it easier for the patients to share their lab and other health data. We are looking to roll out an app from OneTouch where patients can download a smartphone app, and the OneTouch Verio machine works with Bluetooth to communicate with the app. In the app, patients can put in a clinical code for our pharmacy and share their lab data and glucose values with our system via the cloud. This will load metrics into our system that we now update manually. I can run a report that shows patients who are struggling with their levels and flag those as good candidates for more education, and the pharmacist can follow up.

CT: You spoke about pharmacy moving away from dispensing to providing clinical care. How are you supporting that effort at GRX?

Schmit: I serve as a luminary for the CPESN-Iowa [Community Pharmacy Enhanced Services Network]. We evaluate how the pharmacies are doing around core services, so when a payer comes who will cover those services, we have the metrics. We've worked with TELLIGEN, Iowa's CMS QIN/QIO (Centers for Medicare & Medicaid Services Quality Innovation Network-Quality Improvement Organization), as well as both colleges of pharmacy to get reports and data to show metrics and performance. There is also a commercial payer in Iowa doing a project with select pharmacies on how pharmacists' clinical care can affect the total cost of care and improve patient outcomes. They focus primarily on four disease states: diabetes, depression, hyperlipidemia, and asthma. They also consider how to reduce preventable emergency room visits and hospital readmissions, looking at total cost of care for all patients. I monitor the stores' performance in these categories to provide actionable reports and performance measures. We look for the services that have an impact to evaluate and prioritize the services we provide. Much of this is also focused on communication and collaboration with other healthcare providers to close the gaps and improve continuity of care.

We're always looking to develop new services. In the past few years we've started administering long-acting antipsychotic injections as a service in our pharmacies. We're starting to see more patients being referred for that service. To be successful, we assess what we're doing and ensure we're doing it consistently well and meeting our goals. However, we're also looking to see what else may be a need in the community that we could help with.

CT: What other ways are the GRX pharmacies involved with new practice models?

Schmit: Two of our locations are involved in a new model that is a waiver of Iowa Board of Pharmacy rules to allow for the practice of technician product verification. The pharmacist still checks the hard-copy prescription, conducts drug utilization review, looks at adherence and performs all the clinical tasks of dispensing a prescription. Certified and specially trained technicians are checking product using barcode technology. A study following the results of the program found that the pharmacist time on patient care nearly doubled, and their time in dispensing activities decreased — and patient safety has not changed. So the error rate has not increased and, in some cases, the error rate has gone down. This proves technicians can verify product just as safely with barcode technology and, as a result, give the pharmacist more time to provide clinical services to patients.

CT: Who nominated you for the award?

Schmit: Bob Kloeppel, senior business consultant at Cardinal Health, nominated me for the award. I had no idea. I was completely surprised and very grateful. I really feel like I'm not deserving, because it's the pharmacists in our stores who do all the hard work. I just try to be a resource for the services they need to do the work. I really think it's their award, and it speaks to what they've been able to accomplish with clinical services for our patients in their locations. **CT**

Read more from Cheri Schmit at www.computertalk.com/features-schmit.

Maggie Lockwood is VP, director of production at ComputerTalk. *She can be reached at maggie@computertalk.com.*

Pharmacy Ownership Transition: A Primer

by Bruce Kneeland
Community Pharmacy Specialist

ONE OF THE KEY ISSUES facing independent community pharmacy is ownership transition. And with more than 35% of current pharmacy owners age 55 or older, it seems likely that many independent pharmacies will be sold in the next few years.

Experts estimate that between 500 and 600 independently owned pharmacies were sold to another independent last year, and experience indicates that many others will continue to be sold to chains, hospitals, or other entities.

Charlie Le Bon, director of pharmacy ownership services for AmerisourceBergen, says, "Good Neighbor Pharmacy and Amerisource-

Charlie Le Bon

Bergen got involved in pharmacy ownership transition to make sure buyers and sellers could be brought together to ensure that independent pharmacies are sold to other like-minded pharmacists who will keep the pharmacy open as a pillar of the community."

Jean Ly, Pharm. D., is a partner in a small chain in southern California. His company recently worked with Le Bon to buy its eighth location, Carson Pharmacy, in Torrance, Calif. Ly says that he has been through the process of finding and buying existing pharmacies before, but found working with Le Bon to be advantageous.

"First off," he says, "buying a pharmacy takes a lot of time." Having the Good Neighbor Pharmacy team manage the process allowed him to focus on running his pharmacies. Ly says the list of tasks associated with selling a pharmacy includes many things everyone would expect, like finding a buyer, preparing financial documents, helping establish a realistic selling price, and arranging financing.

But, as Charlie Le Bon says, closing a sale also requires a lot of coordination that a first-time seller might not consider. He lists details such as tax issues, the transfer of leases, and utility hookups. He notes that a successful sale must also involve the transfer of title for capital equipment and making sure that pharmacy, DEA, and other licenses are obtained and third-party vendors are in place.

Jim Morisoli, R.Ph., worked with Le Bon to purchase a pharmacy in Carlsbad, Calif., and sell one in San Bernardino, Calif., in 2015. He says that among the most impressive things he encountered during the process was the detailed plan the Good Neighbor Pharmacy team used to help navigate the transaction.

Jim Morisoli

One factor that emerged in talking with brokers, buyers, sellers, bankers, and industry observers is the variety of ways in which buyers and sellers can be introduced. Le Bon adds that he does not see his team as competing with brokers, as they often find themselves working side by side to conclude a successful sale.

Kurt Proctor, Ph. D., R.Ph., senior VP for strategic initiatives for NCPA (National Community Pharmacists Association) says, "For more than a decade NCPA has helped our members understand the benefits of having a plan for the sale of their pharmacy. By approaching the transfer in an orderly and informed manner, they are more likely to realize an attractive price and ensure the best possible outcome for their employees and patients."

Among the programs NCPA supports are the Good Neighbor Pharmacy NCPA Pruitt-Schutte Student Business Plan Competition. Invited pharmacy school students form teams and create plans for opening an independent pharmacy.

It was through the business competition program that Amanda Miller, Pharm. D., while a student at Ohio Northern University, first contemplated becoming a pharmacy owner. She says that while not a presenter, she was involved in helping her school prepare its ownership plan for competition in 2008.

Upon graduation, Miller took a position with a nuclear pharmacy in Ohio but couldn't suppress the urge to own her own pharmacy. So a little over a year ago she contacted

continued on next page

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Amanda Miller

John Pross, the Good Neighbor Pharmacy transition advisor in her region, and started looking for a store that met her professional and personal characteristics. In December 2017, she closed on Antwerp Pharmacy, a 5,000-square-foot pharmacy in Antwerp, Ohio.

In addition to all the technical support she received, Miller says, she was impressed with the personal attention and support she and the seller received through the process. Miller and the previous owner arranged an orderly transition by allowing her to continue her work at her previous pharmacy while working part-time at the new pharmacy, to begin familiarizing herself with customers and the new business.

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Miller says she was pleased with how Pross was able to "go beyond the numbers" when helping evaluate the value of the pharmacy, looking at factors such as location, community demographics, and the types of doctors in the community. They also did an extensive evaluation of the mix of prescriptions and third-party contracts. "All of this," she says, "helped my husband and I get comfortable with the decision to buy."

Jean Ly says that one other benefit he found in working with Good Neighbor Pharmacy's ownership transition service is its continued interest in the success of the pharmacy. To help with the transition, Ly brought in his Good Neighbor Pharmacy business coach to help train employees and implement innovative marketing plans.

Immediately upon taking over the pharmacy, Ly replaced the previous owner's pharmacy management system with the same PioneerRx system he uses to run his other stores. With a common platform for all eight locations, Ly says, he can leverage the benefits of owning multiple stores to reduce operational costs such as bookkeeping and human resources.

Unlike Ly, Miller plans to take a slower approach to change. She says, "Since I have worked for months with the staff, I am confident in their ability." Miller says the one major change she does plan to make will be to start letting customers know that flu shots and other immunization services will be offered, with the hope that, by flu season next year, this will be a profitable new addition to her pharmacy.

Charlie Le Bon says the biggest piece of advice he can provide anyone contemplating buying or selling a pharmacy is to start planning now. He says the process is usually measured in years, not months. This is not because of all the paperwork or legal details, but because of all the personal issues and business complications that happen. Jim Morisoli says, "The most important thing that Good Neighbor Pharmacy did for me was talking with the buyer when problems came up."

Because of the continued challenges facing independent community pharmacies, it is anticipated that even more pharmacies will change hands in the coming years. We hope the suggestions mentioned here will help many more of you take a serious look to see if the time is right for you to buy or sell a pharmacy. **CT**

Bruce Kneeland is a semi-retired pharmacy industry consultant living in Prescott, Ariz. He visits dozens of community pharmacies each year and delivers CE programs intended to help pharmacy owners be more successful. He can be reached at bfkneeland@gmail.com.

Key Things to Consider When Buying or Selling a Pharmacy

Start Early. A successful sale can take years.

Have an NDA (non-disclosure agreement). And have everyone you work with on the sale sign one. Confidentiality is critical.

Have a plan. If buying, know what your personal, professional, and financial goals are. If selling, carefully consider if you want to leave a legacy, simply get out, or perhaps even help finance the sale and stay involved.

Look at the numbers. Make sure all financial documents have been adjusted to reflect "real world" profitability. Have an accurate valuation of your business.

Get help. Certified public accountants, lawyers, brokers, and coaches who have done this before can prevent a lot of problems.

Make it better. If buying, have some ideas on technology, marketing, or clinical offerings and other changes you can make. If selling, clean up, fix up, and throw out. In real estate, they call it staging, and it makes a huge difference in finding a buyer.

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Whether you're thinking of buying a pharmacy or getting ready to exit the business, it's important to remember that this is not only one of the biggest financial decisions of your life, but it's also a move that impacts your entire community. Maintaining patient and staff continuity is crucial, which is why we're dedicated to preserving the legacy of independent pharmacy.

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Pharmacy-Based Clinical Services:

From Pharmacogenetics to Chronic Care

By Will Lockwood
Vice President | Senior Editor

Will can be reached at
will@computertalk.com

Pharmacy has been in a state of evolution for some time now, with consistent effort from many sides within the profession to integrate a clinical model into practices. Here we'll review different ways in which this movement has gained traction, and cases across the practice spectrum in which pharmacies are having success in providing cutting-edge clinical services to patients, pushing forward into a role as providers, and collaborating effectively with prescribers and other providers.

You need to have an open mind, but building a practice based on patient care is entirely possible right now, as we'll see.

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PHARMACY AS HEALTHCARE HUB

AMINA ABUBAKAR, PHARM.D., has spent the last several years building a clinically oriented practice at Rx Clinic Pharmacy, starting with clearly defined workflow tasks for staff members within her PioneerRx pharmacy system that put the patient at the center of her model. This was just a beginning, though, and Abubakar has been building the practice further through collaboration with local medical providers, creating what she describes as a population health management hub, in which clinical pharmacists provide chronic-care management services and annual wellness checkups for patients.

Rx Clinic Pharmacy puts together a care plan in collaboration with prescribers that is patient- and disease-state specific. But the real work, and the real benefit, notes Abubaker, come from following up on that care plan month after month. "We are able to focus on helping manage not just adherence," says Abubakar, "but behavior as well. Let's say we develop a care plan for a diabetes patient and we want that patient to stop drinking soda. We are checking in with them and asking them, how many did you drink last month? Or we realize that our delivery driver is bringing a patient's prescriptions back at the end of the day. That's an adherence problem, and we follow up." These interactions are driven by the workflows within PioneerRx and documented within a care-plan platform.

El Rio Community Health Center deploys a similar model in the health-system setting, according to Josh Carzoli, Pharm.D., director of operations, using two distinct arms of pharmacy services. "We have

Amina Abubakar, Pharm.D., AAHIVP
Owner
Rx Clinic Pharmacy
Charlotte, N.C.

the traditional brick-and-mortar retail pharmacy setting," he says, "where there's an emphasis on preparing and dispensing medications. And then there's what we call our advanced practice pharmacy team. These pharmacists have one-on-one visits with patients as part of their appointments with other providers in our system. Our pharmacy team members are typically spending half an hour to an hour with these patients, doing chronic disease state management." At El Rio Community Health Center, the pharmacist can access a patient's complete record directly in the electronic medical record (EMR), while also accessing all the dispensing history and notes in the pharmacy management system, in this case from Liberty Software.

This is a crucial time, notes Carzoli, for effectively helping to manage a condition such as diabetes and its associated comorbidities, such as hypertension or high cholesterol, or to address behavioral health. The El Rio Community Health Center pharmacy staff also manages annual wellness visits, which focus on preventative care.

Clearly, this is a model with real traction now. And this is being driven, as Abubakar notes, in large part by the outcomes measurements that have come to be front and center for providers. "Doctors have 15- or 30-minute visits with patients," says Abubakar, "and then they may not see that patient for another three months. This limits the extent to which they can truly impact outcomes." But these prescribers' limited resources have proven to be, as we've seen, an opportunity for Rx Clinic Pharmacy to deploy a collaborative approach that leverages the pharmacy's structured workflow within PioneerRx and high rate of interaction with patients. The documentation of these interactions by Abubakar's clinical pharmacists is now a regular source of information for prescribers, with insight into a range of issues that they can identify during regular talks with patients. "For example, we see a prescription coming from urgent care," says Abubakar. "So we talk with the patient and find out that she fell. We add this to our history and make sure that the patient's doctors know."

Pharmacists at El Rio Community Health Center can provide extensive services around certain disease states, explains Carzoli. "We've worked with our chief medical officer and our pharmacy safety therapeutics committee to develop collaborative practice agreements and implement certain therapeutic interchanges and changes to records that are initiated by the pharmacist, including initiating certain prescriptions on the primary care provider's behalf," says Carzoli. For example, if a prescriber writes for a medication that's non-formulary for a patient's insurance, the pharmacist can be authorized to change it to a formulary or preferred

continued on page 18

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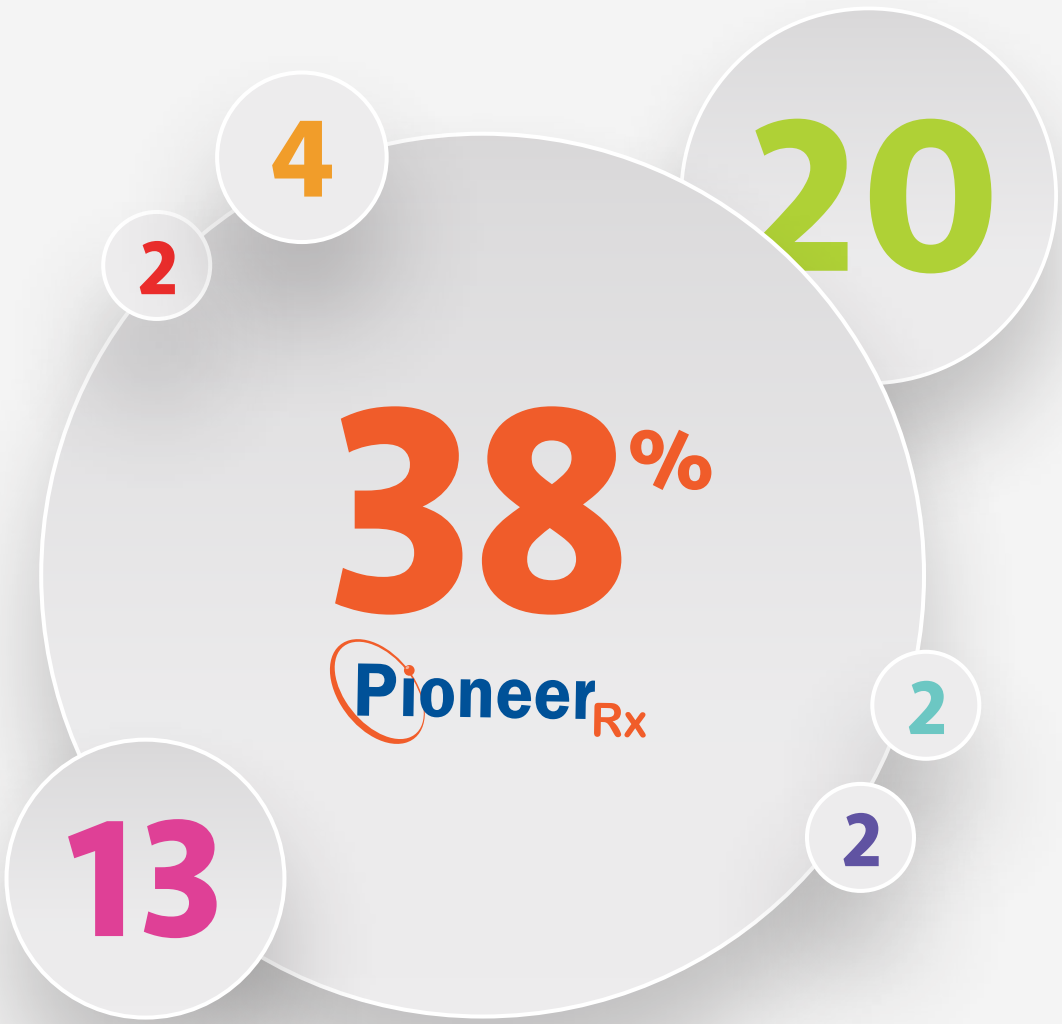
*Based on 2017 National Survey



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drug right at that point, without having to go back and request the change from the prescriber. The change gets made, the patient's cost is lower (and lower costs are one factor leading to better adherence), and because the pharmacist has access to both systems the change is noted in both. That's real efficiency in clinical care.

"We have a variety of literature that's been published on the amazing success that we have with this model," says Carzoli. "We are truly able to demonstrate that the intervention of a pharmacist in the day-to-day life of a patient makes a significant difference."

PHARMACISTS AT THE CENTER OF COMMUNITY

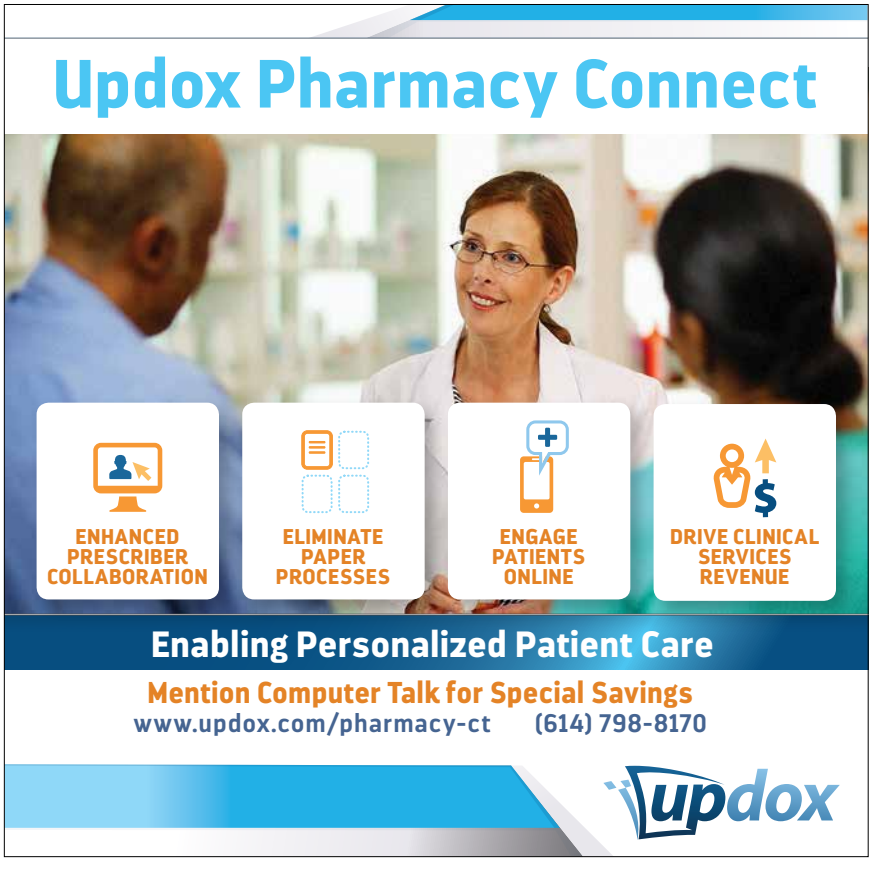
NCPA PHARMACIST OF THE YEAR

Lynn Connelly has made Medicine Mart Pharmacy a mainstay in West Columbia, S.C., over the years, with a long history of providing health screenings and services such as blood glucose and blood pressure monitoring. Connelly also started a pharmacy residency program about five years ago, in conjunction with the University of South Carolina. "With that we've really broadened our clinical services," says Connelly. "We're offering medication synchronization, medication therapy management, and comprehensive medication reviews, as well as one-on-one health coaching and a hypertension coaching program. We've got a pharmacogenetic testing program, and we offer a wide array of immunizations."

Lynn Connelly, R.Ph.
Owner
Medicine Mart Pharmacy
West Columbia, S.C.

While that's an impressive list of clinical services offered by Medicine Mart Pharmacy, Connelly reports that med sync tops his list for impact for improving outcomes and pharmacy performance, with immunization programs coming in a very close second.

The pharmacy residents are the driving force here, according to Connelly, tasked with running this broad array of programs down to the level of making those all-important monthly calls to med sync patients to check for any changes. But Connelly also points to a recent transition to QS/1's SharpRx pharmacy management system as an important step. "There are more ways to document what we're doing now in SharpRx," says Connelly, "and this is critical when we're providing so many services as a pharmacy that go beyond dispensing." Connelly is a Community Pharmacy Enhanced Services Network (CPESN) luminary, leading the effort in South Carolina to bring together performance-focused pharmacies around a set of clinical services and, perhaps most importantly, the Pharmacist eCare Plan. This, says Connelly, is a standards-based pharmacy services documentation transaction, which a range of pharmacy technology vendors, including QS/1, are working to build into their platforms. "With the eCare Plan, we collaborate with prescribers and show payers what we're doing to help patients,"



says Connelly. "It's all new right now, but CPESN pharmacies are successfully billing for clinical services. For example, when you sit down and do a 30-minute medication review with a patient, you can get reimbursed for that." But it's critical to have up-to-date systems in place to participate. "That was among the top reasons that I did choose to move from QS/1's NRx to its SharpRx," explains Connelly. "I felt that this was what we needed to do in order to be able to keep up with the changes in pharmacy."

BUILDING SERVICES ON TECHNOLOGY

RUTLAND PHARMACY IS ANOTHER example of a pharmacy that's built a central role in the community over the years by offering everything from retail prescriptions to adherence packaging, wellness programs, immunizations, DME, nonsterile compounding, and URAC-accredited specialty services. Just ask around for Smilin' Steve, and people will point you to pharmacist Steve Hochberg and his sons Jason and Jeff at their four pharmacies in the area.

"Obviously, in today's world you have to have the technology," says Jason Hochberg. "We've had ScriptPro robotics for well over a decade, which has helped us with inventory and dispensing speed. It helps our technicians to focus more on answering calls and doing data entry, and our pharmacists to actually be pharmacists, talking with prescribers and counseling patients." Hochberg reports that the pharmacy's technology path toward greater efficiency and a stronger customer focus has led to integrating all four pharmacies on ScriptPro's SP Central pharmacy management software as well.

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Elevating Pharmacogenetics through Pharmacy Connect

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Independent pharmacies are rapidly expanding clinical services, and one that is gaining popularity in the industry is pharmacogenetics — the study of the effect genetic factors have on drug interactions and metabolism in individuals.

As pharmacogenetics grows, pharmacies will have to rely on technology to take full advantage of this clinical service. Updox supports independent pharmacies interested in pharmacogenetics with collaborative patient and pharmacy tools in several ways:

Enhanced Care Coordination Services

Pharmacogenetics tests are new to the market, but early adopters have shown that the offering is most effective when there is a strong pharmacist-prescriber collaboration. A Direct referral network allows independent pharmacists to leverage these relationships in order to:

- Coordinate patient care and test results.
- Communicate medical and prescription records.
- Become a prescriber's preferred referral source.

Elimination of Inefficient Paper Processes

There is a steady shift toward automated processes that decrease inefficient manual processes in a pharmacy. Technology that allows for electronic fax, digital document editing, and streamlined prescriber communication via secure messaging will become more popular in the coming years, and advanced clinical services like pharmacogenetics require efficient processes in order to communicate patient test results and arrange effective drug therapies with prescribers and patients.

Stronger Patient Loyalty

Offering patient-centric technologies will continue to drive patients to community pharmacies. Community pharmacies have retained a loyal customer base within healthcare because of the personalized, individual care provided to their customers. Today's rapidly changing healthcare landscape has proved that patient-centric health is the focus, and that won't change any time soon. Advanced technology supporting pharmacogenetics testing will allow pharmacies to use tools like a patient portal, online payments, and self-scheduling in order to engage with patients in a user-friendly, collaborative online platform. **CT**

Read the rest of the resource guide on technology in independent pharmacies at https://www.updox.com/5-ways-ct.

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Rutland Pharmacy has now also rolled out ScriptPro's Third Party Management System (TPMS) to manage reconciliation, reimbursements, and contract adherence for payers — especially important across four locations.

Even more critical, though, is the recent addition of ScriptPro's Advanced Pharmacy Clinical Services (APCS). "This is going to allow us to have a tool integrated into SP Central for managing and documenting our clinical work and key clinical data, like lab results," says Hochberg. The Rutland Pharmacy staff can communicate with a physician's office about patient progress and any changes to his or her medications that may help in reaching goals. "It's going to allow our pharmacists and doctors to communicate much more easily and seamlessly, all via the web," explains Hochberg. "There's no lag time in the communications with this platform, and it makes it very easy for us to have the same goals for patients." On top of this, Hochberg reports, Rutland Pharmacy also gains documentation that shows its proactive work in keeping patients healthy by staying on top of their chronic disease states.

Returning to El Rio Community Health Center, Josh Carzoli points to the transition to Liberty Software's RXQ pharmacy management system about 18 months ago as a big step in moving pharmacy services forward. "We made this move as part of a push to really give our pharmacists more time," says Carzoli. "We had the goal of supporting them to provide more comprehensive services and provide more support for patients. You don't realize how important the efficiency of your pharmacy software is at first."

"We're tasking our pharmacists with looking at and updating the patient record not just in the pharmacy system, but in

continued on page 22

Why Pharmacogenetics Is Important

Robert Alesiani, Pharm.D., BCGP
Chief Pharmacotherapy Officer
Tabula Rasa HealthCare, Moorestown, N.J.

MOST DRUGS TAKEN ON A DAILY BASIS REQUIRE SOME ENZYMATIC response for metabolism. Whether making the molecule more water soluble for elimination by the kidneys or changing the molecule in a way to activate it after swallowing — what we call prodrugs — enzymes play a critical role in how one's body deals with a medication. Add to that the transporters that are necessary to carry the drug to a remote site of action and the receptors that accept the drug, all of which may be genetically defined.

Until very recently, everyone was typically treated as "normal," that is, as part of that 80% to 90% of the population with whom the drug was tested in clinical trials. However, if you are part of the 10% that might have picked up a bad gene from one of your parents, it could mean a poor response, a disproportionately slower elimination of the drug from your body, or some other unexpected outcome.

For example, the drug codeine is used for pain control. Codeine is a prodrug and it needs an enzyme, CYP2D6, to convert approximately 8% of the dose into morphine. If you have "normal" 2D6 genes from both parents, you should get an appropriate response from the drug. If you got a bad gene from one parent and a good gene from the other, you will have a partial response. Bad genes from both would be no response, but you are still stuck with the side effects. It is also possible to have an exaggerated response to the drug — rapid or ultrarapid metabolism — by converting too much codeine into morphine.

If that's not complicated enough, Codeine also requires a different enzyme, CYP3A4, to water solubilize the molecule for elimination by the kidneys. Not enough enzyme, and the drug builds up in the system, risking accidental overdose. Too much enzyme, and the drug does not work long enough to be effective. Pharmacogenetic testing takes so much of the trial and error out of prescribing.

When we review a complex medication profile, it's necessary to not only look at the individual effects of the patient's genetics on the drugs, but to also account for time where multiple drugs are competing for enzymes in the same pathway. For instance, consider a cardiac patient on both a calcium channel blocker for blood pressure and a statin for cholesterol, a combination we use quite often. Both drugs utilize CYP3A4 for elimination, but if both drugs are taken together, we expect the blood pressure medication will slow the elimination metabolism of the statin to a point where the patient may develop muscle aches and weakness. Unchecked, this may lead into rhabdomyolysis and organ failure. It's a serious problem with a simple solution: Separate the drugs by a few hours, letting each have its turn at the enzyme. Other cases may not be as easy and may require alternative treatment.

My entire team of board-certified geriatric pharmacists have trained in genomic application as well as enzyme competition and "phenoconversion," a phenomenon where certain drugs can change the patient's response to other drugs, making someone with a genetically normal metabolic panel appear "abnormal." Our science and education department also holds an accredited postgraduate (PGY1) residency program in pharmacogenomics. **CT**

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continued from page 20

the EMR as well, so it's critical to be able to navigate quickly and efficiently," explains Carzoli.

The new pharmacy system is also supporting El Rio Community Health Center's current project of taking a larger look at adherence. Carzoli reports that this project makes use of the medication possession ratio metric in the Liberty pharmacy system as a flag to identify significant sets of data for the project. "This is giving us the data we need to put a stronger focus on 90-day prescriptions," says Carzoli. The goal, however, is not to use 90-day fills to reduce touches with patients, but instead to convert what would have been filling events into times for pharmacists to actually speak with patients between scheduled visits with other providers in the system.

PHARMACOGENETICS: PERSONAL CARE FOR POPULATIONS

AND WHEN YOU TALK ABOUT building pharmacy services on cutting-edge technology, it's important to note that there are now a number of pharmacies deploying what may have sounded like science fiction just a few years ago as a key component of patient-centered clinical management: pharmacogenetic testing, which assesses how a patient's genome impacts drug efficacy.

Theresa Tolle, Pharm.D., has been working at bringing pharmacogenetic testing to her patients at Bay Street Pharmacy for over six years, after hearing from a vendor that physicians were struggling to make it work in their practices. That's not a commentary on the value of the testing, according to Tolle. Rather, physicians would order the tests, but then often had a hard time reviewing and interpreting them.

Marcus Wilson, R.Ph.
CEO and Co-owner
Integrity Pharmacy
Springfield, Mo.

Bringing new information like this into the pharmacy workflow can be a challenge, too, which is why Tolle is so enthusiastic about the myRightMeds partnership between Rx30, her pharmacy system vendor, and pharmacogenetics testing lab Alpha Genomix. "Getting the process and the results integrated into the pharmacy system has really been the missing piece," says Tolle.

For Marcus Wilson, the power of pharmacogenetic review was brought home personally through an event he and his wife experienced with their special-needs daughter, Lydia. "Our daughter had a severe cold," explains Wilson, "and my wife and I, who are both pharmacists, agreed to give her a time-release cough syrup. Unfortunately, what happened was our daughter reacted to this medication by pulling an all-nighter. None of us got any sleep, and our daughter certainly didn't get the relief from her cold symptoms and the rest that she desperately needed." Wilson and his wife were determined to figure out what happened, during which process they did a pharmacogenetic test. "What we got back was a report that showed the graded medications for our daughter in green, red, or yellow. And now that list is part of every conversation we have with Lydia's doctors."

With this personal proof of how important pharmacogenetics was, Wilson began to look for a way to make this a standard part of his pharmacy practice. He began using testing and drug-gene review software from MedTek21 in January 2017, with a focus on panels that review for interactions with pain management, cardiovascular, and psychiatric drugs, as well as for medications used for diabetes, urology, infectious disease, and cancer. "We're using this at Integrity Pharmacy not only because we believe in it from experience. We're utilizing the MedTek21 app to cross-check in real time any new medications prescribed for our daughter so that we know while we're still in her doctor's office if she is going to react in a positive or a negative manner. But we are also using it because we know professionally that there's clear evidence that the more meds any patient is taking, the greater the chances are that there's a drug-gene interaction occurring," says Wilson. "Integrity Pharmacy's population is high acuity and is prescribed on average 10 drugs. So pharmacogenetic review has become a central part of what we offer."

Integrity Pharmacy is now able to leverage this application in conjunction with its FrameworkLTC pharmacy management software from SoftWriters to monitor these drug-gene interactions, much in the same way, Wilson notes, as pharmacies have normally done drug-drug interaction checks. "The applications can look at a patient's current medications and allow us to suggest alternatives to their physician

continued on page 24

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Jesse Murphy, PharmD
Manager, Polk's Drugs

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"With some pharmacy software, you feel like the system's fighting you. Not SharpRx. It's so intuitive to pharmacy, everything just makes sense. Training is easier, so is adjudication, inventory management and workflow."

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continued from page 22

for better outcomes," he says.

Tabula Rasa HealthCare is one more example of a company seeing the impact of pharmacogenetic testing on high-acuity patients — in this case, as part of the call-center-based population health management programs the company provides for special-needs Medicare Advantage plan patients who are residing in the community, but are nursing home eligible. According to Robert Alesiani, Pharm.D., "We've developed proprietary tools and expertise in pharmacogenetics that give us the ability to know, based on genetics, how the patient is going to manage particular medications. Our job is to make sure people stay independent by reducing the medication-related risk of hospitalizations or nursing home admissions."

Tabula Rasa focuses the pharmacogenetic review of patients using high-risk medications in cardiology, behavioral health — including antipsychotic and antidepressant therapies — and diabetes management, as well drugs for both chronic and acute pain. Frequent hospitalization is another indicator for this testing, particularly since adverse drug events are often the cause.

Focusing on the right patients has been important for Theresa Tolle as well. The myRightMeds module in Rx30 provides screens for identifying not just patients who are candidates for pharmacogenetic testing based on their medication profiles, but also prescribers whose specialties and prescribing histories make their patients candidates. "This allows us to have targeted conversations with patients and physicians," says Tolle. "I've found it's particularly important to reach out to doctors and let them know we have the capabilities to do drug-gene interaction reviews for their patients. I want to make sure they are comfortable with this, and it helps for them to understand that this is something special that we offer."

Theresa Tolle, Pharm.D.
Owner
Bay Street Pharmacy
Sebastian, Fla.

The genetic profile is derived from a one-time test, but the value of the review is ongoing, notes Wilson. "Once we have the test results, we'll get any potential drug-gene interactions flagged in MedTek21's application," he explains. "Then we utilize this clinical data and communicate with the patient's physician on medication alternatives and dose changes based on the patient's genetic analysis. The next time the doctor adds or changes a drug in the patient's regimen might be the time when an adverse drug event puts them in the hospital," says Wilson. "Now we are at the point where we are assessing these risks before the prescription is dispensed, and using our patient-specific insight to make recommendations to prescribers that can eliminate adverse events and keep our patients in their homes longer."

Theresa Tolle has this information integrated directly into her Rx30 software, where it's presented as a interaction for review just as a traditional drug-drug interaction would be. "With this integration we don't have to disrupt our workflow," she says. "The results are right there, and we're able to quickly review the interaction for its severity and significance, and then take the appropriate action." For example, says Tolle, after double-checking the pharmacogenetic alert, she might talk with the patient and let him or her know that she needs to have a conversation with his or her doctor before dispensing. "I can let the patient know that I think there could be alternative medications that we should use that are more appropriate," says Tolle.

THIS DOESN'T HAPPEN OVERNIGHT

AMINA ABUBAKAR HAS BEEN building the care management model methodically at Rx Clinic Pharmacy, and that diligence is paying off. She participated in the CPESN pilot program in North Carolina and saw that physicians really engaged and appreciated the collaborative care relationship.

"We're using all the touches we have to provide the ongoing care management," says Abubakar. "It's the phone calls and the time we can spend with chronically ill patients face to face to prevent another doctor's office visit or to prevent hospitalization. Medical practices don't have the staffing to manage a couple of hundred patients, much less a couple of thousand, month after month. We have been able to demonstrate that we can help with managing large patient populations."

For those prescribers' offices that are using cloud-based patient management systems, Abubakar's clinical pharmacists can receive log-in credentials that permit access for documenting care. For those prescribers without that capability, Abubakar uses a chronic-care management platform that interfaces with physician's office servers. At the end of the month, Rx Clinic Pharmacy captures all the care management work pharmacists have done

continued on page 26

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Linsey McMinn, RPh – Pharmacist, Patterson Family Pharmacy, Patterson, CA

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continued from page 24

and sends it to the physician's office billing staff to submit for payment using the chronic-care management code available to providers. That's revenue that Rx Clinic Pharmacy then shares in. "In less than two years, we grew from just me and one clinical pharmacist doing this to where we now employ 10 clinical pharmacists to manage chronic care," says Abubakar. The pilot program provided proof of concept that pharmacy-based chronic-care management does indeed work. And it led to Rx Clinic Pharmacy having a solid business and care plan case to make as it is marketing its services to new prescribers.

DEMONSTRATING RESULTS

ADDRESSING DRUG-GENE ISSUES, adherence, and behavioral issues greatly reduces the potential for ADEs (adverse drug events), which makes for improved outcomes and reduced ADE-related hospitalizations.

The value for Marcus Wilson is in having the real-time monitoring alerts and reports for drug-gene interactions. "This is a tool that is desperately needed," says Wilson. "It's allowing us as clinical pharmacists to do work that directly impacts adverse events, changes outcomes, and increases performance. When you change somebody's pain medication from not working to maximum efficiency and they become a new person within two days, they feel as if they've been healed. It's powerful."

Theresa Tolle has seen the power of pharmacogenetics firsthand as well, and relates a story about how it impacted one of her patients at Bay Street Pharmacy. "I have an elderly patient on Percocet, and his doctor was doing regular urine testing as part of his pain management protocols — to ensure the patient was actually taking the medication and that there wasn't a risk of diversion," explains Tolle. "But this gentleman was testing negative, and his physician was about to fire him as a patient because the test was saying he wasn't using the Percocet. The doctor was worried he was selling it. Now, I know this patient and I didn't believe for a second that he was selling. I suggested pharmacogenetic testing, and it turned out that the patient was a slow metabolizer for Percocet. He was indeed taking the medication and actually benefiting from it, since it was controlling his pain, but he wasn't converting all of the medication into the active drug form, which is what is being tested for in urine." The test Tolle recommended saved that relationship between the patient and the doctor because the doctor was able to justify still prescribing pain medication. "This was about two years ago," says Tolle, "and the gentleman is still my patient and he's still with the same doctor. This is clearly the best outcome for that patient, and it's also an example that has led me to have some very good conversations with other doctors."

Steve Hochberg, R.Ph., VP and Jason Hochberg Director of Operations, Supervising Manager Rutland Pharmacy Rutland, VT.

INTEGRATING CARE NOW

THE WORK HAPPENING NOW ACROSS a range of pharmacy settings is a great demonstration of the power of better integrating pharmacy services into care. And Amina Abubakar sees more to come here. "Team-based care doesn't require that all providers are part of a vertically owned entity," she says. "Instead, it can rely on integration for effective sharing of information about the care plan. Building a clinical practice really means connecting to other providers to manage that patient. As a community pharmacist, I'm a very valuable part of the team-based care because I know the patients so well. As pharmacists, we are able to leverage our interactions with patients to make better plans of care for patients, and this is a benefit to the whole care team's performance."

The tools available range from highly efficient, modern pharmacy management systems that provide adherence management and med sync functionality to pharmacogenetic testing and review platforms and documentation and care plan management platforms. Pharmacists, too, are in the right place, taking on the clinical roles an integrated care system requires and stepping up as providers. "We're reaching a tipping point," says Theresa Tolle. Tolle see expertise in pharmacogenetics as a leading exemplar of where pharmacy is with enhanced clinical services. "I especially think that, with the pressure on physicians now to prove outcomes, pharmacogenetics is a really good fit and a great role for pharmacists. I have long said that this is a space that pharmacy and pharmacists should own, because we are the experts in pharmacology." Tolle's point is indisputable, and from the examples here, it's possible to extend it to say that pharmacy should trumpet its expertise in clinical care more broadly. **CT**

Read more online! Lynn Connelly and Jason Hochberg on expanding the pharmacist's clinical role through both advocacy and residency precepting. Josh Carzoli on how technology-driven efficiency supports clinical care.

May the Phorce Be with You

Brent I. Fox
Pharm.D., Ph.D.

Joshua C. Hollingsworth
Pharm.D., Ph.D.

IN OUR LAST COLUMN from 2017, "The Quantified Baby," we indirectly highlighted how the consumer electronics market can become a go-to source for health-related technology. This wasn't always the case. Two decades ago, even the most advanced mobile phone was simply that: a phone. However, with the introduction of the first personal digital assistants, innovators with a predilection for all things health related began exploring the use of these devices as tools for health and wellness. We have enjoyed benefiting from the nearly two decades of advancements that have brought us the modern smartphone — whichever flavor you prefer — as well as the myriad of health and wellness uses for these valuable tools.

In a not necessarily similar timeline, we have enjoyed the Star Wars film trilogies, dating back to *A New Hope* in May 1977. Like us, you may have been less than blown away with some of the movies in the prequel trilogy. However, the sequel trilogy has been widely acclaimed as living up to, and in many cases, exceeding expectations set by the original trilogy. In a matter of pure happenstance, Brent's family found themselves at Disney's Hollywood Studios amusement park in Florida this past December 15. In any normal year, this would have been a slow day at the park, as most children are still in school. However, this was not an ordinary day. This was the release day for *Star Wars: The Last Jedi*, as was very apparent by the crowd in the park.

Dressed in our best *Star Wars* gear — including matching Princess Leia hair buns for Brent's wife Georgia and daughter Grace — they joined the crowd and reveled in the energy and excitement of the release of *The Last Jedi.* As the title suggests, the eighth installment in this series focuses on the Jedi. For those who are not Star Wars fans, think of Jedi as members of an elite group of warriors who fight for justice and peace, often through nonviolent means whenever possible. Jedi have supernatural powers that allow them to control physical objects, and in some cases, read others' minds.

Remarkably, Star Wars continues to remain an extremely popular component of pop culture, even though it has been 40 years since the first movie was released. In today's culture, the label "Jedi" is given to individuals by their friends as an indicator of extreme, almost otherworldly abilities in virtually any activity. Childcare professionals, caregivers, and parents can demonstrate Jedi skills by their ability to quiet upset children or to get them to go to sleep. Information technology professionals exhibit Jedi skills when they solve a complex computer problem. One could confidently argue that pharmacists and pharmacy technicians exhibit Jedi skills in their daily efforts to solve PBM (pharmacy benefit manager) and insurance coverage issues. Maybe you have a Jedi shirt that you wear like a superhero under your clothes?

The challenge *ComputerTalk* readers face every day is the scope of challenges present in the pharmacy. Readers can rattle off the challenges: patient care issues, information technology, insurance, contracts — and the list goes on. Adding to the difficulties is the reality that some challenges often conflict with each other. Patients stand in front of you across the counter with questions pertaining to their medications, while the phone rings with calls from a prescriber and you are on hold (or is it, "ignore") with a payer. Prioritization in addressing the challenges becomes a critical skill that pharmacists must master to become a Jedi.

Pharmacists can play an important role in supporting patients' health behaviors, including medication adherence. Adherence is even more critical to patients, as the individuals receiving treatment. Pharmacists can impact adherence through simplification of dosing regimens, medication synchronization, patient education that leads to heightened appreciation of the need for medications, and numerous other approaches. However, patients (sometimes with the help of caregivers) are ultimately responsible for medication-taking behaviors. They must master these behaviors to become a Jedi.

DIGITAL MEDICINE

Of note, the FDA recently approved the first-of-its-kind digital medicine device that we believe has the potential to bring Jedi-like capabilities

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to tracking medication adherence. Proteus produces the technology, which is a sensor embedded in individual oral medication doses. The tracking technology has been approved for several years, but the recent approval marks the first time a medicine (aripiprazole, in this case) has been approved that also includes this type of digital technology.

When the sensor comes into contact with stomach fluid, a signal is sent to a patch that the patient wears. The patch then sends a date and time stamp to an app on the patient's smartphone, which can share the information with the patient's providers and authorized family members (or caregivers). This is anticipated to create a near-real-time record of medication administration. The app can also be a source of information for the patient in terms of medication-taking history, which can be especially important for patients who have trouble remembering if they took their medication (versus those who can't remember to take their medication).

As often is the case with technological advancements, we believe the primary challenge may not be the technical capabilities of the digital medicine. The primary challenge may be skepticism among potential patients. Recall that aripiprazole is used to treat schizophrenia, and that patients with schizophrenia experience paranoia, even as it relates to the caregivers monitoring their activity. So imagine the thoughts that may cross a potential patient's mind about having a device in the body that communicates a record of their behavior to others.

We are excited about the potential adherence-monitoring capabilities of this digital medicine technology. We also anticipate that *ComputerTalk* readers will hear more news about it and similar technologies in the coming months. As a potential source of information previously almost impossible to gather accurately, this digital medicine technology does offer Jedi-like monitoring capabilities. Pharmacists and other caregivers may need to use their Jedi skills to help patients understand and trust this new technology. We welcome your thoughts. **CT**

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Marijuana (Oops: Cannabis)

George Pennebaker, Pharm.D.

SOME MUSINGS ON perhaps the most popular Schedule I, legal in some states, illegal in the United States, drug.

Full disclosure: I am a Californian. I live in a rural farming area. I also chair a committee that advises the county regarding land use issues in our area.

As this is written, California is finalizing its implementation of a referendum that declared that the sale and use of recreational marijuana will be legal Jan. 1, 2018. It appears that the finalizing is rather tangled and there are a variety of versions of how it will work, confused by the fact that individual counties can declare their own rules in many matters.

It has become clear that polite society calls it cannabis.

In the early 1960s I was running a hospital pharmacy in Berkeley. A UC Berkeley student who worked there part-time asked me what I thought about marijuana. I said I saw it as a social drug not unlike alcohol. However, marijuana was new to society and alcohol has been around for a long time. So I asked her: How do you think society would react to alcohol if it were just now being discovered?

YEARS LATER

Over 50 years later we are still trying to sort out the role(s) of this drug.

At a federal level we are in a prohibition state of mind. Product is being burned, people are going to jail. Bootleggers are all over the place. The historical comparisons are awesome.

As an aside, I have peripheral neuropathy. It hurts a lot of the time. My niece applied some of her marijuana ointment to the bottoms of my feet. They were less bothersome for the whole day. I've used it several times since.

At the state levels there are several attitudes. It's illegal and that's that. It's okay for "medical" purposes. Or, anybody older than XX can buy it, sell it, and use it — provided all of the taxes get collected. Of course, to collect taxes states and/or counties and cities need to have licensing systems and tax collection systems.

THE MONEY ISSUE

Of course the prices of drugs that are desired and have limited availability are high. There is a lot of money changing hands. That creates some interesting issues. In order to run a bank in the United States you have to have federal deposit insurance. But to get that, a bank needs to not process money that is, according to the federal government, from an illegal source. So banks won't process marijuana money. The result is big bags of money in the trunks of cars looking for a money laundromat. And any time there are big bags of money, there are people who will be trying to get those big bags in nasty ways.

The science is bad. Bad, in that there isn't much that the medical sciences understand about cannabis sativa. The primary reason is that the academic centers that develop this knowledge can't do their thing. There are no National Institutes of Health (NIH) grants. And anyone who does study cannabis and who may later want an NIH grant is toast. To top it off, you might be able to do a study if you do go through all of the bureaucratic hassles to study it legally. However, there is only one federally approved source of cannabis, and the product is an old strain that is nothing like the potent stuff that is on the market today. So forget it. California, the sixth-largest economy in the world, a center of academic medicine, with a huge need to understand this drug, cannot begin to study it.

OTHER CHALLENGES

Law enforcement also has a problem. They can measure alcohol concentrations. And they have clear definitions about how much is too much. We don't even know what to measure in cannabis, much less how to measure it, and how much is too much to say that someone is stoned on marijuana.

Growing it is a challenge, even though it is a common weed. (Hence, one of its names, "weed.") Finding a place to grow it is problematic. Illegal grows have to be in remote areas so they won't be easily found. Rural legal grows do not need to be remote, but they do have to deal with neighbor issues and crop thieves. Neighbors say the plants smell bad, fences look

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bad, private security methods can be dangerous, greenhouse lighting is too bright at night, and "I don't like the stuff."

Dosing has always bothered me. The strength of street drugs is always an issue. Cannabis is problematic because it has more than one pharmacologically active chemical. And each of them has a different profile. Work is being done on sorting this out, but not in the places where it should be done. (See an above paragraph about the science issues.)

Do you remember all of the talk about track and trace in the drug industry? There is talk about doing that with cannabis. Trim off some of the plant, put it in a little bag, and tag the bag. It gets assayed, and the assay stays with that handful until a final product is sold to the user. Good luck with that one.

UNANSWERED QUESTIONS

The thing that fascinates me is trying to guess what the industry will look like in five years. What will its farming, distribution, testing, marketing, labeling, and retail selling system be? And what will be its retail prices? Will it be a huge industry dominated by a few companies, as with the tobacco industry? Will it be a cottage industry like it is now? Will it be like beer, with several big brewers and many small boutique brewers? And, of course, what will be the solution for the banking problem?

Those of us in the pharmacy world think our economics, laws, and regulations are a mixed salad. The cannabis economics, laws, and regulations are a salad still being tossed.

As for me, I am going to restrict my use to my feet. My preference is a social drug that I grew up with, that I understand, and that I can and do control: Jack Daniels. **CT**

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2018 Expectations

Tim Kosty
R.Ph., M.B.A.

Don Dietz
R.Ph., M.S.

WE SEE TWO MAJOR trends affecting the pharmacy market- place in 2018: generic cost deflation and vertical integration through mergers and acquisitions. Generic cost deflation is a 2017 trend that we expect will continue and perhaps accelerate in 2018. While a few select multisource products have increased in cost to pharmacies, generic drug prices overall have declined and will continue to do so in 2018.

GENERIC DEFLATION

Several reasons that are leading to declining costs for generics include:

- FDA approval for generic drugs, increasing the number of suppliers and encouraging manufacturers to submit additional products for approval.
- The FDA has published a list of drug products that are off patent and off exclusivity, and for which the FDA has not approved an ANDA (abbreviated new drug application) referencing the innovator product. This list can be found at https://www.fda.gov/downloads/Drugs/ResourcesForYou/Consumers/BuyingUsingMedicineSafely/UnderstandingGenericDrugs/UCM564441.pdf.
- Increased competition from international generic suppliers entering the market.
- Several blockbuster brand drugs losing patent protection, creating opportunities for generic suppliers to compete.
- Consolidation in buying power, where three large buying consortiums involving the three major wholesalers are now purchasing approximately 85% of retail generic drug volume.
- Greater transparency in the price pharmacies pay for generic drugs via public availability of NADAC (National Drug Acquisition Cost) and CMS FUL (federal upper limit) prices. The CMS FUL is a transaction price based on the submission of AMP (average manufacturer price) from the manufacturers.

Declining generic drug costs drive the following actions by pharmacists:

- Limit forward purchases of generics and only purchase what will be needed in the short term to avoid holding inventory that has gone down in value.
- Review NADAC pricing, a lagging indicator, to monitor the market for price reductions.
- Evaluate third-party generic reimbursement rates. Perhaps the PBM (pharmacy benefit manager) is aware of the change in market price and has adjusted the MAC (maximum allowable cost) accordingly.
- Regularly monitor wholesaler and GPO (group purchasing organization) pricing to ensure prices are being adjusted downward.
- Compare prices to a secondary wholesaler or distributor — another excellent way to lower costs for generic drugs and monitor market changes.

PBMs are acutely aware of the overall reduction in generic drug costs. Most third-party contracts enable PBMs to adjust their MAC prices for multisource drug reimbursement without prior notification to the pharmacy. Through our ongoing industry monitoring, generic effective rates (GERs) have declined approximately two percentage points in 2017. Based upon the above factors driving generic competition and lower costs in 2018, we expect the PBMs GERs to become more aggressive in 2018.

RETAIL PHARMACY OPTIONS

In the face of competitive market pressure, we have seen little retail pharmacy success in negotiating higher reimbursement rates. There are limited options for retail pharmacies to maintain profitability, but include the following:

- Reduce hours of operation, thereby lowering the labor costs per prescription.
- Acquire other pharmacies, buying their prescription files to leverage the fixed costs of their existing pharmacies at a higher prescription volume.
- Focus on nondispensing activities that generate revenue that exceeds the profit from dispensing prescriptions. Immunizations are the best example of this type of activity.

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We expect pharmacies to explore and test new nondispensing activities as a strategy to improve profitability in 2018.

VERTICAL INTEGRATION IN THE MARKET

In early December, CVS Health announced that it had agreed to buy Aetna in a $69 billion deal that would combine one of the largest drugstore chains and the number-three health insurer. Aetna has been a client of CVS Health since 2011 through its PBM that manages Aetna's retail pharmacy network and dispenses mail-service and specialty drug prescriptions. Aetna's business represents an estimated 22% of CVS Caremark's PBM revenue.

A cynical view is that the acquisition is locking up an estimated 20 million Aetna members, minimizing business risk when the existing PBM agreement expires in 2020. However, CVS Heath and Aetna management indicate they are intent on creating a new, more cost-effective healthcare model by leveraging CVS's 9,700 pharmacies and 1,100 MinuteClinics to provide unparalleled access for patients. This new model will create an integrated healthcare company that is not built around doctors, but has a more patient-centric focus.

COMMUNITY-BASED HEALTH HUBS

CVS Health and Aetna management project using the CVS pharmacies and MinuteClinics as healthcare hubs for members to access clinical services, resulting in a lower cost than traditional settings. This proposed acquisition will provide vertically integrated care for Aetna's members, while driving additional patient visits into CVS locations. The challenge will be educating members and providing them with financial incentives to use these settings for basic healthcare services. Not discussed has been the impact these new services would have on the existing Aetna provider network and whether this would be an adjunct to or a replacement of that network.

INTEGRATED HEALTHCARE BENEFITS

Highmark Blue Cross Blue Shield recently published a white paper comparing costs for companies that provide integrated pharmacy and medical benefits (carve-in) versus companies that have separate medical and pharmacy benefits (carve out). Companies with carve-in benefits saved an average of $172 per member per year. The Highmark study compared one million members in each group over a three-year period and found reductions in cost for the medical benefit for chronic and complex conditions. Savings were attributed primarily by identifying and responding to gaps in care that were apparent with integrated data. Additional savings were realized for specialty medications by coordinating the patient's benefit between the medical and pharmacy channels.

Bending the cost curve has been the holy grail of healthcare insurers. Treating sick patients has not proven successful, but rather preventing illness appears to be the long-term solution to the cost issue. Theoretically, coordinating care and directing patients to the most cost-effective setting should be the focus of healthcare insurers. However, engaging patients in this process has been challenging. We expect technology solutions to help patients manage these interactions in the future by using home monitoring of vital statistics to assist in determining when to seek professional care.

MERGER MANIA OR NOT

The proposed CVS Health-Aetna merger requires FTC (Federal Trade Commission) approval to move forward. This vertically integrated merger is different from the proposed Anthem-Cigna and Aetna-Humana horizontal mergers the FTC denied in 2017 due to competitive concerns. Furthermore, the impact of the proposed merger on the CVS Health-Anthem PBM deal remains to be seen. It's difficult to see Anthem (the number-two health insurer in the country) leaving its pharmacy business with a direct competitor, even with the proposed corporate firewalls. Time will tell whether the CVS-Aetna transaction is the beginning of a wave of mergers to streamline healthcare delivery.

A Walmart-Humana merger would provide similar strategic benefits, albeit through a smaller store base. Amazon may enter the healthcare market by acquiring a PBM, a retail pharmacy chain, and/or a health insurer. The potential combinations are endless, but all must eventually answer the question: Will the healthcare system be better off or more expensive? 2018 should provide some answers, and likely more questions.

Tim Kosty, R.Ph., M.B.A., is president, and Don Dietz, R.Ph., M.S., is VP of Pharmacy Healthcare Solutions (PHSI), which consults with pharmaceutical manufacturers, PBMs, retail pharmacy chains, and software companies on strategic business and marketing issues. The authors can be reached at tkosty@phsirx.com and ddietz@phsirx.com.

2017: An Interesting Year

Marsha K. Millonig, B.Pharm., M.B.A.

TODAY, AS THE NEW YEAR

begins, I found it interesting to scan some of the top healthcare- and pharmacy-related stories for 2017. *Modern Healthcare* and *Forbes* focused heavily on the year's attempts to "reform" the Affordable Care Act (ACA), as well as on the many mega mergers that were attempted and those currently underway. There were a few IT-related items of interest, as well as double the number of novel new drugs approved by the Food and Drug Administration (FDA).

Let's start with where things are with the ACA. It seemed every month in 2017 Congress and the administration were working on various ways to dismantle the ACA. In January, days after his taking office, President Trump signed an executive order that had government agencies back off implementation of the ACA. He continued with reducing funding for the Department of Health and Human Services (HHS) by nearly 18% with his budget request in February. That request also hit many programs designed to reduce poverty. Insurance companies were reacting, and much was being reported about the potential of these moves to destabilize the insurance market. As a result, a rule that would address this was issued by HHS in April. In a press release about the rule, Centers for Medicare and Medicaid Services (CMS) Administrator Seema Verma was quoted as saying, "CMS is committed to ensuring access to high quality affordable healthcare for all Americans and these actions are necessary to increase patient choices and to lower premiums. While these steps will help stabilize the individual and small group markets, they are not a long-term cure for the problems that the Affordable Care Act has created in our healthcare system."

Those problems continued to be addressed by the Republican administration and Congress, with the House passing the American Health Care Act, approved mostly along partisan lines, 217-213, in early May. The bill would cut ACA, phase out Medicaid expansion, cut tax credits, and allow states to opt out of many of Obamacare's protections and coverage requirements. In July, the Senate failed to pass a bill to repeal and replace the ACA, with most assuming that would be the end of attempts for the year. However, cost-sharing reduction payments to insurers were stopped in October. Then, with the passage of the GOP tax plan in December, the individual mandate for individuals to buy an ACA insurance plan or pay a penalty was repealed. With this repeal, the Congressional Budget Office estimates that 13 million Americans will not have health coverage, which translates into the federal government saving nearly $340 billion. Yet insurance enrollment through the ACA marketplaces reached nearly 9 million in spite of the enrollment period being cut in half, and more than a million of the enrollments were by new customers. While that is slightly less than the last enrollment period, observers were surprised it was not much lower, given that the outreach budget was cut by 90%. It will be interesting to track how the market responds in 2018. As one of those 9 million individuals, I can say that only efforts by my home state government allowed our insurance premiums to be reduced by comparison to last year. Stay tuned.

INDUSTRY CONSOLIDATION

The megamerger trends also received a lot of coverage in 2017. UnitedHealth Group's acquisitions of Surgical Care Affiliates in March and DaVita Medical Group's urgent and primary care business in December. Anthem and Cigna stopping their merger discussions in the spring. Amazon's purchase of Whole Foods and continued statements they may be interested in purchasing a PBM and moving in the pharmacy space. Walgreens' and Rite Aid's failed merger. Aetna's failed merger with Humana, and CVS's announcement of a deal to buy Aetna in December. Now, rumors that Walmart may be in discussions with Humana are surfacing on the internet. The Amazon and CVS/Aetna deals have been creating buzz throughout the blog world. Pharmacy has been responding with concerns being voiced at the Federal Trade Commission (FTC), especially in light of the continued problems that pharmacy is having with many preferred PBM networks, DIR (direct and indirect remuneration) fees, lack of transparency, "gag" clauses, and delivery prohibitions, among others. I expect to see this pressure by pharmacy to continue. CMS

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has at least tried to address some of these practices in its 2019 call letter, and the pharmacy community is currently in grassroots mode, encouraging CMS to make recommendations final in comments through the mid-January deadline.

HEALTH IT PROGRESS

On the information technology side, Texas enabled telemedicine visits without "in person" meetings between providers and patients — the last state to do so. The Pharmacy Health Information Technology Collaborative provided updates in August to the SNOMED CT value sets for pharmacy documentation that were published initially in 2016. In her press release, Executive Director Shelly Spiro noted, "The value sets are designed to support standardized documentation of pharmacy services across all practice settings, regardless of which software is used to capture the data. All data derived from the value sets could be used to exchange clinical information between providers or report quality measures for public and private quality payment programs." These value sets are being used in the CMS Enhanced Medication Therapy Management program pilots, and ClearStone Solution's Joshua Johnson said during Minnesota Pharmacists Association presentations that he feels this is one of the big benefits of the program. The year also brought more cyberattacks, especially of healthcare networks, with the Office of the National Coordinator for Health Information Technology (ONC) ratcheting up its communication efforts on how to prevent them and providing cybersecurity updates and tips. In a move welcomed by the pharmacy community, the DEA (Drug Enforcement Administration) clarified that DEA-registered pharmacies could transfer unfilled electronic controlled substance prescriptions to another pharmacy if they could not fill it for any reason. Finally, in December, the FDA issued draft guidance on digital medical devices and mobile apps, in keeping with requirements of the 21st Century Cures Act. I'll be writing more on that in a future column.

THE FDA MOVES THE NEEDLE

Finally, 2017 was a bumper crop year for new drug approvals by the FDA. The availability of new drugs and biological products often means new treatment options for patients and advances in healthcare for the American public. According to the FDA, "Certain drugs are classified as new molecular entities (NMEs) for purposes of FDA review. Many of these products contain active moieties that have not been approved by FDA previously, either as a single ingredient drug or as part of a combination product." FDA approved 46 NMEs in 2017, compared to 22 NMEs in 2016 and 45 NMEs in 2015. You can read about the details for this past year's NMEs at https://www.fda.gov/Drugs/DevelopmentApprovalProcess/DrugInnovation/ucm537040.htm. Several approvals were for drugs to treat rare diseases. Many were for drugs to treat various cancers. Other approvals were for drugs to treat a variety of chronic conditions, including diabetes and heart disease. These new treatments may represent important new therapies for patients moving forward. There are a number of NMEs that are up for review in 2018, and I look forward to sharing those with you later this year. In the meantime, I hope your 2018 is off to a great start! **CT**

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Index of Advertisers

AmerisourceBergen 13
American Society for Automation in Pharmacy ..... Inside Back Cover
Computer-Rx 9
HBS 28
Integra 7
Liberty Software ..... Back Cover
MedTek21 30
Micro Merchant Systems 5
PioneerRx 17
QS/1 23
RxMedic 3, 25
ScriptPro 14
SoftWriters 1
Tabula Rasa HealthCare 21
Transaction Data – Rx30 ..... Inside Front Cover
Updox 18

2018 ASAP Annual Conference

ADDITIONAL CONFERENCE COVERAGE: www.asapnet.org/2018-annual.html

The American Society for Automation in Pharmacy held its 2018 Annual Conference in January at the Ritz-Carlton, Naples, Fla., bringing together a dynamic group of pharmacy technology vendors, pharmacy association representatives, and pharmacists for a fast-paced speaker program and networking. Find the presentations at www.asapnet.org/2018-annual.html.

From left, QS/1's Sonny Anderson, J M Smith Corporation's Alan Turfe, and QS/1's Ed Vess.

Ben Leigh, left, and Craig Barton from CareKinesis, a division of Tabula Rasa HealthCare.

From left, David Cippel and Rob Maher from Klingensmith's Drug Stores, and Dave Lang from Avery Weigh-Tronix.

Speakers Ben Bluml from the American Pharmacists Association (APhA) Foundation, left, and Kevin Masci from FDS.

Michael Ziegler, left, from FDS and Richard Brook from eRx Network.

From left, Omnicell's John Ridyard, Sarah Sweeny, and Mike Cantrell, with Rite Aid's Mike Podgurski.

From left, SoftWriters' Lisa Miller, Robert Norton and Ben Crenshaw from Elsevier/Gold Standard, and Leah Carden and Wuhong Li from VUCA Health.

From left, BestRx's Hemal Desai with Sean Ramsey and Scot Fannin from Updox.

From left, Dawn White from AmerisourceBergen with Rick Bergin and Orion Newman from Retail Insights.

From left, Robert Terrell and Val Gurovich from Digital Pharmacist, Mike Zabonik from Cardinal Health, and Alan Stickler from Digital Pharmacist.

Carolinas HealthCare System's Frank McCree, left, with speakers, Marsha Millonig from Catalyst Enterprises and Doug Long from IQVIA.

Marshal Sanders from Hy-Vee and Laura Hull from Surescripts.

PrescribeWellness' Al Babbington, left, with Tim Garofalo from OmniSYS.

Lari Harding from Inmar, left, and Lisa Schwartz from the National Community Pharmacists Association.

Health-System Pharmacy Evolution: An Expanded Role for Med Reconciliation

Practice settings across healthcare are finding value in expanding the pharmacy's role, and health systems are no exception. In this interview with Carolinas HealthCare System Director of Outpatient Pharmacy Services Frank McCree, we hear an accelerating shift toward allocating pharmacy resources where they can best impact health-system performance.

ComputerTalk: Frank, how have you been seeing health-system pharmacy services evolve?

Frank McCree: A lot of health systems are realizing that they have an opportunity to move to where the pharmacy is playing a much more prominent role in providing care. The environment has changed to where there are payers, both private and of course government payers, that want to pay health systems to keep patients healthy, and to keep them out of the hospital. The shift is away from how many beds you have filled and, instead, toward performance in keeping people well. Pharmacy is definitely right in the middle of making this happen, because the number-one intervention that's used in order to treat most medical conditions is pharmaceuticals.

CT: What's been the practical impact of all this on how health systems are allocating resources?

McCree: Here at Carolinas HealthCare, as I imagine in all hospitals, we have put a lot of money into our infrastructure for supporting services for managing the patient population. This shift is really accelerating, and we in pharmacy are being given responsibility for a population. It's what we've been hearing so much about with the pharmacy home and neighborhood model.

Carolinas HealthCare System Director of Outpatient Pharmacy Services Frank McCree: "I see our hospital now ensuring that we have the proper pharmacist and pharmacy technician resources at the exit door, so to speak, just like we have them at the front door."

One of the most significant changes, I think, is actually taking place when patients are coming into the health system. We're placing a greater emphasis on the work being done to reconcile medications and to make sure that everyone involved with the care of that patient knows what the medication profile is. This is where we can make the best start for ensuring that we're not layering drugs on top of one another inappropriately. Everyone needs to be on the same page at the very start of each interaction we have with a patient, and this is particularly true of a patient's medication profile.

CT: What's pharmacy's ongoing role in patient care, then?

McCree: We're supporting the medication decision-making throughout the patient's time in the health system, of course. But the pharmacy resources we're allocating really pay off when the patient is discharged or leaves the clinic setting, and we're there to make sure that the med profile is complete and up to date, taking into account whatever medications the patient was on to begin with, whatever may have changed while they were in our care, and whatever may be new. It's our goal to make sure that we're doing a great job of sending the patient back out into the community with a rational and appropriate medication regimen and an accurate list of what they're taking so that everyone from the patient to their caregiver to their pharmacy to their doctor is on the same page, just as everyone within the health system was when we did the med reconciliation at intake.

CT: We've been talking about allocating pharmacy resources. What's this mean in practice?

McCree: I see our hospital now ensuring that we have the proper pharmacist and pharmacy technician resources at the exit door, so to speak, just like we have them at the front door. We are positioning the pharmacist as the resource to help both prescribers and patients with understanding the medications they are taking and also to be a resource that the patient can follow back up with if they got home and find they're confused. This is central to preventing negative medication-related outcomes. **CT**

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