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FOR THE PHARMACIST

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The intersection of technology and management

Long-term Care: The Trends to Watch

by Will Lockwood

Long-term care (LTC) pharmacy has an increasingly important role in patient care, as the population in the United States continues to age. Here we'll look at the current trends. **Story begins on page 13**

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Interoperability

THE OFFICE OF THE NATIONAL COORDINATOR FOR HEALTH INFORMATION TECHNOLOGY (ONC) has had interoperability as a top priority for healthcare data exchange for a number of years. However, with all the hype behind interoperability, it is still far from a widespread reality.

Evidence of this is an article in the Aug. 31 issue of *The Philadelphia Inquirer* titled "Vaccine records testing hospitals." Data being stored in different databases presents the problem of determining who has been vaccinated for COVID-19 and when. The city of Philadelphia has its own immunization reporting system, PhilaVax, but this does not capture vaccinations given in the surrounding counties or across the Delaware River in New Jersey. So accessing the city's data would show only those vaccinated in the city. Consequently, since more than one database has to be queried, this is a time-consuming process. In other words, there is no interoperability.

The CDC (Centers for Disease Control and Prevention) is now going to hire contractors to upgrade its vaccination records system to allow a single on-ramp for access to a person's vaccination history. If this were to materialize, what would be the role of the state and local immunization information systems to which pharmacies are now required to report immunizations? Or would these registries feed the CDC database?

State prescription drug monitoring programs found a solution to a similar problem. This was the impetus behind NABP PMP InterConnect. It allows states to share data. Now a single query can access a person's opioid prescription history from more than one state. There is no need for a national database. There is an article in this issue on InterConnect that is worth reading. This is a success story on interoperability. The CDC should follow the path that prescription drug monitoring programs took. **CT**

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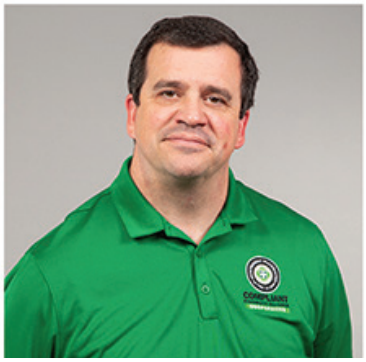

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National Community Pharmacists Association (NCPA) CEO Doug Hoey, R.Ph., M.B.A., has been elected to simultaneously serve as president of the World Pharmacy Council (WPC), an international group with a mission of building international recognition of community pharmacy and its role, policies, and value to citizens around the world.

In addition to the United States, the WPC includes community pharmacy organizations in the United Kingdom, Ireland, Spain, Portugal, Denmark, Australia, and New Zealand.

Omnicell has announced that it has entered into a definitive agreement with FDS Amplicare to acquire its business for total aggregate cash consideration of $177 million, subject to customary adjustments.

The acquisition will add a suite of financial management, analytics, and population health solutions to Omnicell's EnlivenHealth division.

McKesson Prescription Automation, RelayHealth, CoverMyMeds, and RxCrossroads by McKesson have been unified under the **CoverMyMeds** brand.

Capsa Healthcare, which provides **Kirby Lester** Rx filling technology, announced its expansion into central-filling and mail-order pharmacy. Capsa completed the acquisition of European **RoboPharma**. RoboPharma specializes in high-volume, high-speed medication picking and prescription processing for hospitals, retail pharmacies, digital/web pharmacies, and drug wholesalers.

DrFirst's Backline care collaboration platform earned high marks from customers in KLAS Research's First Look report.

KLAS surveyed customers at hospitals and health systems of all sizes, as well as clinics, long-term care facilities, and payers. The survey found that 82% would again purchase Backline.

Backline is a comprehensive care collaboration and telehealth platform that improves communication for transitions of care. It provides seamless and secure communications with internal and external clinical teams as well as patients and their family caregivers.

KLAS notes that customers appreciate Backline's electronic medical record integration and its easy implementation.

Case Study: Elevate Pharmacy Through Automation

In the last few years, Jana Bennett, Pharm.D., and her husband, Randy, owners of Medicine Shoppe Pharmacy in Sherman, Texas, have installed two **RxSafe** 1800 towers and RapidPakRx for adherence packaging. Both are proving their worth. Even better, the Bennetts have found RxSafe to be a strong partner beyond the install, joining a business transformation group of fellow pharmacists sponsored by the company to learn not only how to deploy the technology to achieve their ROI (return on investment) goals, but also how to elevate their pharmacy operations overall. It's a textbook example of a rising tide lifting all boats. Read all about it at wp.me/p9LtTd-4l7. **CT**

Micro Merchant Systems has announced a partnership with Florida-based Benasource LLC, a provider of group purchasing opportunities for independent pharmacies at significantly discounted rates.

Currently Benasource serves more than 135 pharmacies nationwide. In commenting on the partnership, Ketan Mehta, CEO of Micro Merchant Systems, says that Benasource has a proven record of helping independents by providing access to leading products and services.

Datarithm is providing an ongoing series titled "They Don't Teach This in Pharmacy School." This is a series of educational articles to help pharmacists, pharmacy technicians, and others understand the ins and outs of pharmacy inventory management. The series covers topics from basic definitions to the best inventory management practices.

The first topic covered defines the most important operational terms that will be used throughout the series.

The next installment discusses the best method to use for inventory management to avoid overstock or out-of-stock situations. The top three methods outlined include the visual method, periodic method, and perpetual method.

This information is provided at no cost, and there is no enrollment or obligation. Check the blog on the Datarithm website (datarithm.co/news/blog/) for the installments in the series. **CT**

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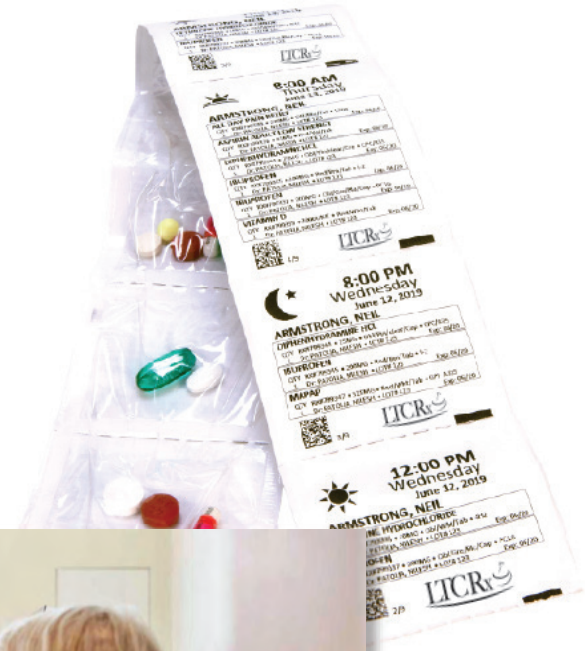

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Creating a Cult

by Bruce Kneeland

MY SON IS A PARTNER IN A MARKETING AGENCY called Cult. The name is meant to be provocative. The agency's goal is to help companies find ways to impress customers so much that they become fans. Cult claims this can be done without increasing advertising budgets. The most frequent changes the agency recommends focus on helping employees take better care of customers. The idea is that when employees take better care of customers, the customers will recommend the company's products to their friends.

The idea is so simple that most people think it won't work. Cult points to Harley Davidson and asks, "When was the last time you saw an ad suggesting you buy a "hog"? Now ask, "When was the last time you saw someone wearing a leather jacket or t-shirt emblazoned with the Harley Davidson logo?"

Here are a few principles that Cult says contribute to a cult-like following.

Be remarkable. One idea for a pharmacy would be to have an organized and carefully choreographed new customer program. This could include making sure the new patient gets a warm greeting and a carefully rehearsed explanation of things the pharmacy does that people appreciate, such as delivery or compliance packaging. They should also be introduced to the pharmacist, who comes out front to say hello. Then perhaps a handwritten thank-you note that includes a gift certificate for something that will get the new customer to come back to the pharmacy as soon as possible.

Have a noble purpose. Everyone on your staff should understand that your pharmacy is a place where people get the products and information they need to live a healthier life. The power of a noble purpose is enormous. While working for a paycheck is central to their job, the more your staff members believe people get better care in your pharmacy than in any other, the better.

To illustrate, consider that during World War II, Uncle Sam's recruitment efforts relied heavily on the idea that we were fighting to protect our freedom and the American way. Sure, we paid our soldiers, but they were willing to eat crummy food, sleep in foxholes, and charge machine gun nests because they believed in the cause, not just for the money.

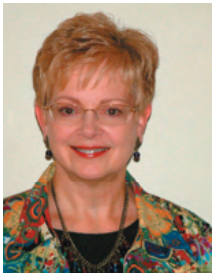
Congregate. To help build a team, reinforce your noble purpose and find more ways to be remarkable. You need to spend time together and with other positive people. Get team members involved in community events, invite a key staff member to join the downtown retailer's association, hold weekly staff meetings, and get together to celebrate major accomplishments. If at all possible, take a staff member to a wholesaler or buying group dinner meeting. The point is to build positive attitudes by creating ways your team members can share positive experiences with each other, and with others.

Treat team members with respect. Asking staff members for ideas, listening to these ideas, and actually implementing some of them is a great way to build respect. Make sure everyone on your team knows you are looking for practical ideas, ones that can be done within current budget constraints. Most people will understand they work in the real world and that work schedules must be met, customers taken care of in a timely manner, and the cash register balanced. Remember, people like to be liked, and they need to be needed.

These ideas are tried, tested, and proven. But they must be done artfully and sincerely, or they could backfire. Still, finding ways to build a cult-like following for your pharmacy will pay off in happier employees and a better bottom line. Here's hoping something you read here will help you do more and be better. **CT**

Bruce Kneeland is an independent pharmacy veteran, author, and podcaster. He can be reached at BFKneeland@gmail.com and listened to at www.pharmacycrossroads.com.

A Decade Strong:
PMP InterConnect Serves as a Vital Tool to Protect Public Health



by Danna E. Droz, J.D., R.Ph.

These developments will continue to make it easier for users to monitor the system, get reports and other vital information when they need it, and enable stronger, secure connections between PMPs.

AT THE HEIGHT OF THE PRESCRIPTION DRUG ABUSE EPIDEMIC, NABP (National Association of Boards of Pharmacy) was approached by several states to develop a solution that would make it possible to share vital information from prescription monitoring programs (PMPs) across state lines.

As a culmination of this request and months of shared effort, NABP PMP InterConnect was launched in 2011, allowing participating state PMPs throughout the United States to share PMP information. This service enhances existing PMPs and allows physicians, pharmacists, and other authorized users to better identify patients whose prescription history may indicate issues with prescription drug misuse and diversion, particularly in cases where patients are crossing state lines. Despite the COVID-19 pandemic, PMP InterConnect is now stepping into its second decade of serving the states (at no cost to them) in a position of strength. Now a comprehensive, fully integrated option for reviewing patient prescription history, PMP InterConnect is expected to soon reach the significant milestone of more than 1 million users.

COMBATING A HISTORIC EPIDEMIC

In 2011, the healthcare community was starting to recognize the full scope of the opioid epidemic and the role that prescription drug abuse and diversion were playing. The Centers for Disease Control and Prevention (CDC) data showed that more than seven Americans per 100,000 were dying of opioid overdoses, and more than half of those overdoses (4.9 per 100,000) involved commonly prescribed opioids. An estimated 21,088 people died of opioid overdoses in 2010 alone.

Eager to find ways to fight the rapidly increasing number of overdose deaths, many states developed PMPs and passed laws that required prescribers and pharmacists to use PMPs to watch for patients who might be in danger of developing an opioid use disorder or diverting opioids. As PMP technology was developed, expectations increased. However, a significant blind spot was identified when it became clear that some of these activities were happening across state lines.

"We weren't able to share information," explains Mark J. Hardy, Pharm.D., R.Ph., executive director of the North Dakota State Board of Pharmacy. "That was the problem we were looking to solve. It was the height of the prescription drug abuse epidemic, and a lot of individuals we identified were moving between states. Data wasn't flowing between practitioners in those states, and it became clear that something like PMP InterConnect was needed."

NABP and its technology provider, Appriss, developed and deployed the necessary technology and infrastructure for PMP InterConnect in just seven months. At launch, PMPs in Ohio and Indiana had started to share data, and Connecticut, Kansas, North Dakota, South Carolina, Virginia, and West Virginia were in the process of implementing the technology. In total, 15 states had already agreed to take the steps necessary to participate in the program.

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To help govern the system and ensure responsible use and rollout of the technology, a PMP InterConnect steering committee was created, composed exclusively of representatives of the PMPs that were participating in the system. During the early meetings of the committee, the group engaged in many discussions about security, methods for auditing access to PMP data, and ways to integrate PMP InterConnect into clinical workflows of healthcare providers. As a result of these discussions, a software solution known as PMP Gateway was developed to allow PMP InterConnect integration into electronic health records (EHRs), making it possible to view PMP data without having to manually access a separate website.

"PMP InterConnect and Gateway facilitate integration — integrating the PMP into the clinical workflows through [EHR] systems and pharmacy management systems," says Steven W. Schierholt, executive director of the State of Ohio Board of Pharmacy. "That has been huge — honestly, a game changer. Ohio was the first state in the country to provide that feature to its hospitals, doctors, and pharmacies free of charge. It has driven our use exponentially, and it was probably the biggest step in turning our PMP into an indispensable healthcare tool here in Ohio."

"In 2016, Indiana started integrating PMP data directly into [electronic medical records]," says Kara Slusser, director of the Indiana Scheduled Prescription Electronic Collection and Tracking Program, Indiana's PMP. "In 2017, we launched a statewide integration project with the added benefit of allowing practitioners to access multistate data using PMP InterConnect. This was all made possible because of NABP's work and the PMP InterConnect system. Over the last decade, NABP has worked diligently to develop connections with nearly all 50 states. Without that ability to view patient data from multiple states, our integration efforts would not have been as successful as they are today."

PANDEMIC SURGE SHOWS VIGILANCE IS STILL NEEDED

In the decade since PMP InterConnect was introduced, PMPs have become a vital tool in helping to reduce prescription drug misuse. Although the opioid crisis continues to be an important priority for NABP and its member boards of pharmacy, overdoses related to prescription opioids have declined significantly. Similarly, dangerous pain clinics run by unscrupulous prescribers and problematic patient behaviors such as "doctor shopping" (visiting multiple prescribers to seek the same or similar controlled substances) have also declined. "I don't think it's a coincidence that a decrease in these metrics occurred after PMP InterConnect started to see widespread use," Hardy comments when discussing the impact PMPs have had on the pandemic in North Dakota. "It fostered sharing between jurisdictions, addressed major problems we had 10 years ago, and made PMPs into a high-level tool. It's been built on a lot of successes."

"Once sharing through PMP InterConnect began we saw significant decreases in the number of people crossing state lines to obtain controlled substances as part of illegal activity," adds Joe Fontenot, R.Ph., assistant executive director of the Louisiana Board of Pharmacy. "To my knowledge, there was no mechanism in place to share information across state lines before PMP InterConnect."

"Our instances of doctor shopping have fallen 93% since 2011," says Schierholt. "That is directly attributable to our PMP, PMP InterConnect, PMP Gateway, and the prescriber community. Today, healthcare providers are all working diligently to be a part of the solution, and interconnectivity is a huge part of that."

Although efforts to combat the opioid crisis have seen great strides since 2011, the COVID-19 pandemic and emergency measures taken to slow the spread of the disease may have complicated the situation. The CDC and other authorities report that the opioid crisis in recent years has been driven by the proliferation of illegally manufactured fentanyl being sold through various methods. In addition, the CDC has reported significant increases in overdose deaths over the last two years, and evidence suggests that this resurgence can be attributed, at least in part, to the pandemic. In summary, increased isolation and greater economic stresses may have led to a resurgence of opioid overdoses. As the pandemic-related isolation has eased over the last year, vigilance regarding prescription opioids continues to be important.

HEALTHCARE PROVIDERS BENEFIT

As of fall 2021, 52 states and jurisdictions are participating in PMP InterConnect. Of the nearly 1 million users of PMP InterConnect, approximately 900,000 are physicians and prescribers,

and 100,000 are pharmacists. In fact, in the last five years, the volume of information requests sent through the system has increased more than 7,000%. According to Appriss, PMP InterConnect regularly delivers information to one out of every three prescribers in the United States, and over 132,000 facilities have integrated PMP Gateway into their workflows.

Another important metric for PMP InterConnect is the amount of time it saves providers, particularly when fully integrated into EHR systems and healthcare system workflows. Appriss estimates that PMP InterConnect saves providers between two and five minutes per patient encounter. Because the system now processes over 1 billion annual patient encounters per year, PMP InterConnect is saving PMP users a minimum of 33 million hours each year.

Schierholt believes that PMP Gateway integration has been an important part of improving participation in his state's PMP. "Seven years ago, I heard that our PMP was slow and cumbersome," Schierholt says "Now, it is seamless. With a click of a button, providers can get a prescription history from Ohio or any other participating state. Integration is a game changer, and we would encourage any state to work toward it. It is also helping prescribers get time back — time once used to log into a system, enter data, and make queries can be used to have more meaningful conversations with patients."

Enhancements to PMP InterConnect continue to be developed and implemented, with several new technical improvements underway.

Enhancements to PMP InterConnect continue to be developed and implemented, with several new technical improvements underway. These developments will continue to make it easier for users to monitor the system, get reports and other vital information when they need it, and enable stronger, secure connections between PMPs. **CT**

Danna E. Droz, J.D., R.Ph., is the prescription monitoring program liaison at the National Association of Boards of Pharmacy. She can be reached at ddroz@nabp.pharmacy.

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1. kff.org/medicare/issue-brief/more-than-half-of-all-people-on-medicare-do-not-compare-their-coverage-options-annually

Long-term Care: The Trends to Watch

By Will Lockwood
VP | Senior Editor
Will can be reached at will@computertalk.com

Long-term care (LTC) pharmacy has an increasingly important role in patient care, as the population in the United States continues to age.

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HERE WE'LL TAKE A LOOK AT THE CURRENT TRENDS IN THE SECTOR AS the COVID-19 pandemic wears on, which may bring with them significant changes to pharmacy workflows, a need to emphasize and document LTC pharmacy services, and a movement to base LTC billing on the level of care rather than the patient's status as a resident of an LTC facility. We reached out to three experts in the area: The Senior Director of Program Development and lead for the National Community Pharmacists Association (NCPA) Long-Term Care Division Bri Morris, Pharm.D.; Paul Shelton, president of PharmaComplete Consulting Services; and the American Society of Consultant Pharmacists (ASCP) Vice President of Pharmacy Practice and Government Affairs Arnie Clayman.

CARE SETTINGS ARE CHANGING

The LTC facility census has traditionally been a major driver of a variety of pharmacy metrics, starting with overall prescription volume and carrying through to staffing, technology needs, and financial performance.

Those census numbers saw steep declines in 2020 and early 2021 as a result of the COVID-19 pandemic. According to Paul Shelton, at the lowest census levels skilled nursing facilities saw a 13% decline. "It went from 80% pre-pandemic, which has historically been a rate that's marginally profitable for a skilled nursing facility," says Shelton, "down to 67% in January 2021. Census numbers have crept back up to a little over 70% as of June 2021." And while Shelton judges that we've seen the bottom, and the trend is to higher occupancy rates, what's interesting in his view is that the overall population of Americans who need LTC services is never going to be completely addressed by facility-based care, even at 100% occupancy.

"As of 2020, about 14 million Americans need some sort of long-term care," Shelton notes. "There are only about 3 million beds in facilities. Where do the other 11 million people receive care?" The most likely answer is at home, although there are some real problems to solve here, not least of which are a fragmented and understaffed market for providing home health nursing and the fact that payment models are based on patient location and not service level.

Shelton's take is backed up by an analysis of Medicare data performed by the Senior Care Pharmacy Coalition (SCPC) and ATI Advisory, which shows that a need for LTC services exists independent of a patient's location. In fact, SCPC's summary of the study states that medical and pharmacy expenses and complexity are similar whether people are aging at home or are resident in LTC facilities. SCPC goes on to state that:

Bri Morris, Pharm.D.
Senior Director, Program Development and Lead, National Community Pharmacists Association (NCPA) Long-Term Care Division

"Despite this close resemblance, current policy limits LTC pharmacy services to individuals living in facility settings (e.g., skilled nursing facilities and assisted living communities), leaving older people who choose to live at home with potentially unmet needs. SCPC/ATI research shows that nearly 75 percent of today's Medicare beneficiaries with LTC needs live at home or in other community settings (e.g., independent living and retirement community), suggesting a gap in access to important services for these individuals and pointing to the need to clarify and expand current policy."

SUPPORT FOR AGING IN PLACE

"There's been quite a bit of industry effort around the movement for the medical home," says NCPA's Bri Morris. "We've seen aging in place really accelerate during this pandemic. And so this shift has been something that's top of mind. We've heard from a lot of our members about the need for payment to align with the service level that they're providing for patients who are aging in place."

Morris notes that NCPA's LTC division has been taking a leading role and working with other national LTC associations and with LTC GPOs (group purchasing organizations) in efforts at the federal and state levels to ensure that pharmacy reimbursements for LTC patients will move to being defined by service level.

This is critical work. As ASCP's Arnie Clayman points out, the problem for people aging at home is that they end up having to

pay for LTC pharmacy services out of pocket. Add to this the fact that individual patients and their caregivers may also not really understand the value of the medication management services that LTC pharmacists can provide. When they are asked to pay for these services themselves, you can see how significant this financial barrier can be.

Pharmacy has gained attention for this matter in Congress, fortunately. Arnie Clayman notes that the last two sessions of Congress have seen the bipartisan Long-Term Care Pharmacy Definition Act introduced into the Senate, with 12 cosponsors for the current version S.1574.

"The goal of the Long-Term Care Pharmacy Definition Act is to create a statutory definition of LTC pharmacy based on the ability to, as the act summary says, 'provide enhanced pharmacy and clinical services to individuals who have certain comorbid and medically complex chronic conditions and who reside in skilled nursing facilities, nursing facilities, or any other applicable setting (as determined by the CMS)'," explains Clayman. The summary goes on to note:

"The term *enhanced pharmacy and clinical services* includes medication dispensed in special packaging, drug utilization review, and 24-7 availability of medication delivery and on-call pharmacists."

"It's of the utmost importance that we have a uniform definition of LTC pharmacy that can be applied across a range of federal programs and agencies," says Clayman.

THE LTC SERVICE LEVEL

It's useful to take a closer look at the areas proposed to define LTC pharmacy in the act and consider the technology implications for providing these services not just to residents of traditional facilities, but to those aging at home as well.

The act lists the following as defining LTC pharmacy services:

- Medications dispensed in specialized packaging.
- Drug utilization review.
- Medication reconciliation services at the transition of care and other necessary clinical management and medication services.
- Medication delivery 24 hours a day, 7 days a week.
- Pharmacist on-call availability to provider dispensing and clinical services 24 hours a day, 7 days a week.
- Emergency supplies of medication.

All of these items are addressable by current LTC pharmacy

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technology and workflows when patients are residents of facilities. For example, adherence packaging is standard in LTC pharmacy and is even becoming more and more common for retail-focused pharmacies. This is a very good thing because, according to Paul Shelton, almost 60% of patients served by LTC pharmacies have a cognitive impairment, Alzheimer's disease, or dementia. Drug utilization reviews — even multidrug interaction reviews — and medication reconciliation are both well within the scope of practice for pharmacies with the right technology platforms. But several items stand out as potentially requiring a significant rethink of processes by pharmacies serving patients at home.

DELIVERY MODELS CHANGING

For example, delivery is an area in which Paul Shelton sees a need for pharmacies to upgrade their processes. He sees a need to create what he terms an active delivery model. "It's not just FedEx, UPS, USPS, or even your driver dropping meds off at the door," he says. "It could even extend to the delivery person crossing the threshold into the patient's home and confirming the positive receipt of the medication. Short of that, you will want a way for the driver to observe and record that a person has received the delivery, with perhaps a geofenced photo or signature for proof. What we're talking about here is a true, engaged delivery process."

LTC pharmacies have also recently been moving from using one delivery method, for example either in-house delivery drivers or an outsourced courier service, to using multiple methods in what you can call a hybrid model. Which method is used can be a factor of distance from the pharmacy or be determined by time, with one service used during the week and others used after hours or on weekends or for stat deliveries. When it comes to on-demand delivery, for example for emergency orders, one interesting wrinkle is that pharmacies can now adopt the social style of delivery dispatch familiar to anyone who has used a ride hail service. In this case, the pharmacy has a group of drivers who are available on demand. When there's a delivery ready, the pharmacy can offer this up to the drivers through an app, and the first driver to reply gets the delivery.

What's important for pharmacies to realize is that while delivery is a core service for them, planning and managing routing is not. And the delivery-planning aspect is only becoming more complex as pharmacies need not just to manage a hybrid model of delivery methods, but also to plan routes for deliveries to both facilities and to patients in the home. This is where a strong technology base for delivery comes in, one that goes beyond a device carried by drivers or an integration with courier system platforms.

LTC pharmacies now need services that can pull in data on deliveries and produce optimized routing, taking into account factors such as historical traffic patterns and potentially even an optimized allocation of deliveries among the different methods. A pharmacy also has to consider the need for defined delivery windows that can be communicated to facilities and patients at home. In the latter case, it's particularly important to be sure there will be someone available at a residence to sign for a delivery. "Delivery coming sometime today" does not cut it.

Paul Shelton
President, PharmaComplete Consulting Services

THE CARE TEAM CONNECTED

Another area that requires attention is ensuring that pharmacy, prescribers, caregivers or facility staff, and patients are all connected as efficiently as possible. Again, there are tools for this, and LTC pharmacies and their technology vendors have been building out connectivity with facilities over the years — for example, eMARs (electronic medication administration records) and digital paperless care team communications channels.

However, there are still problems to solve here, notes Arnie Clayman. "We continue to see challenges in LTC pharmacy around interoperability and bidirectional exchange of information," he says. "Reducing the number of siloed IT [information technology] systems and creating standards-based data exchange remain two of the greatest needs we have." Clayman notes that a consultant pharmacist may have to interact with three or more different EHR systems and have consulting software that connects to only some of them. "And then you may have an e-prescribing connection between the prescriber and the pharmacy," Clayman continues, "but you don't necessarily have a three-way connection that includes the facility." If the pharmacy ends up having to recommend any

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changes to an order, Clayman says that it remains a challenge to ensure that the facility is updated efficiently so that staff there can match up deliveries with the order records in their systems and that nursing has a valid order to administer the medication.

None of this specifically addresses patients aging at home, though, and of course standards-based data exchange will be crucial here as well. For patients at home, pharmacies are going to have to be able to implement more one-to-one communications processes that allow them to manage this decentralized patient population and work with caregivers who may not be healthcare professionals.

THE LATEST IN-HOME APPS

One impact of the pandemic has been that people have grown increasingly familiar and proficient at interacting remotely, including for healthcare. This is as true of older populations as of anyone else, notes Paul Shelton. "The 75-year-old of today is not the 75-year-old of a few years ago," says Shelton. "Parents and grandparents may be on social media and making video calls more than their children are. This is a demographic central to LTC pharmacy, and they're constantly online." This means that pharmacies should be looking for ways to create secure telepharmacy connections with patients, even to the extent of supporting ad hoc consultations if a question or concern arises.

Shelton has also been keeping his eye on various remote patient monitoring products that sit inside a patient's home and bring data back into the pharmacy. "This could be something like a smart scale," says Shelton, "and it's going to alert the pharmacy that a patient on Lasix has now gained four pounds in 48 hours."

Shelton has also seen a variety of small countertop home dispensing devices that come with an app that contains the medication list and schedule, among other details. This kind of setup can provide patients and caregivers with structured access to medications and create a record of adherence that's available to the pharmacy. This is essentially the home version of the eMARs and dispensing cabinets at an LTC facility. There's one such solution out there with a $30 monthly subscription cost, which is an interesting price point, in Shelton's view. That's because, while payers typically have been reluctant to fund these devices, $30 a month is a cost level that can be within reach for many people. There are more expensive options out there as well.

This is just one example of the technology, whether apps or hardware-app combinations, being developed to support care for patients aging at home. "This technology is very intriguing," says Shelton. "Some of these companies are seeing real uptake, and the companies developing them are growing exponentially." And while the biggest barrier to getting such technology into the patient's home is consistently who pays for it, COVID-19 has led some payers to understand better the value of remote monitoring and a pharmacy's role in managing the information coming from these technologies. Of course, we circle back here to the need for standards-based data feeds so that pharmacy technology systems can interact with as many apps and devices as possible. "It is going to be really critical over the next 12 to 24 months to see where this in-home monitoring market goes," says Shelton. "Pharmacy needs to keep a close watch on these technologies, continue working to extend pharmacy services into the patient's home, and demonstrate the value of these services."

Arnie Clayman
Vice President of Pharmacy Practice and Government Affairs, American Society of Consultant Pharmacists (ASCP)

MANAGING CHANGES IN CARE LEVEL

Another area to watch is transition of care. "We're seeing short-term rehab facilities start to fill back up as people have the elective procedures that have been postponed during the pandemic," says Paul Shelton. "And there is a need for pharmacies to manage and reconcile a patient's medication regimen to ensure that it's appropriate, safe, and that there aren't unnecessary or redundant drug therapies." Interestingly, however, Shelton also predicts that we are entering a time when we will see the care level shift without requiring a change in provider or care setting. Even without a change in setting, every time there's a change in care level, there's a risk of medication mismanagement. The flip side of this risk, notes Shelton, is the opportunity for a pharmacy to provide the

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services that reconcile the patients medications and manage the transition of care.

COMBO SHOP OUTLOOK

There is a great deal of opportunity in these LTC trends for pharmacies that operate as a retail-LTC combo shop, notes NCPA's Bri Morris. "You don't have to be a closed-door pharmacy serving a large number of patients and facilities," she says. "Especially when it comes to providing LTC services for patients at home, this is a whole new market share that combo shops haven't touched yet. There's going to be new technology that you want to invest in, certainly, but it's also as much about looking at what you are doing now and seeing how that applies as opportunities for care expand."

For example, Morris sees a strong med sync program helping pharmacies tailor their delivery programs to serving LTC patients aging at home. "Pharmacies that have truly adopted med sync will find it much easier to create a sophisticated delivery program for patients at home," she says. "And when I say truly adopted med sync, I mean pharmacies that have 80% to 90% of their prescription volume in the program. Think about how this will allow your pharmacy to create a rationalized delivery schedule that works through the delivery area, for example by dividing your delivery area into quadrants and delivering to each quadrant one day a week."

And then Morris sees pharmacies that are part of a CPESN (Community Pharmacy Enhanced Services Networks) network being well placed for care at home. Many of the enhanced pharmacy services that are part of the CPESN model can address the needs of patients aging at home. Pharmacies that have developed these programs already have experienced staff and the right workflows and technology for providing services, in addition to dispensing prescriptions. "I think it's really about making sure you're meeting the patient where they are," says Morris. Pharmacies should keep a close eye on how CPESN can evolve into a way specifically to address LTC care needs too.

GETTING READY FOR WHAT'S AHEAD

No pharmacy, no matter what its level of experience in LTC, should be resting on its laurels right now, however. "The trends in the number of people who need LTC pharmacy are going to mean a significant increase in workload, frankly," says Paul Shelton. "This will be particularly true as we find ways to allow patients to age at home. Instead of interacting with several facilities, pharmacies will be helping manage care for many more patients individually. There will be myriad challenges that come from having different levels of health, education, or medical understanding and different types of caregivers."

Arnie Clayman sees the medical at-home model undergoing a real evolution in the near term. "We're talking more and more about how critical long-term care pharmacy services are," he says. "Dispensing medications will continue to be a central part of the pharmacy offering, but to set yourself apart it can't just be about the product. Patients do best when there's a high service level as well." So the question that Clayman wants pharmacies to ask is, how will they provide the same service level to patients at home as they do to residents in skilled nursing and assisted living facilities?

Pharmacies that want to stay ahead of these trends and provide what the market is demanding can do a few things. Bri Morris emphasizes being plugged into what your associations are doing to support you. "I think that there are quite a few independent pharmacies that don't even realize that NCPA has a separate LTC division that's working to build new models for members," she says.

Arnie Clayman notes that ASCP is working broadly to support LTC pharmacies in this evolving environment — from participation in the Pharmacy HIT Collaborative on standards to drive systems interoperability, to working with the DEA (Drug Enforcement Administration) on the issues surrounding electronic prescriptions for controlled substances in LTC pharmacy, and keeping a finger on the pulse of efforts to shift the payment model to focus on service level rather than location.

Closed-door and combo-shop LTC pharmacies also need to stay up to date with the latest technology marketed to patients and facilities, as well as the capabilities of their own pharmacy technology platforms. Those pharmacies that develop a clear understanding of both the tools and processes they already have that can address trends, while also identifying any gaps that they need to address, will be the ones best equipped to lead in the market and provide the highest service levels no matter where LTC patients reside. **CT**

Automation Drives Innovation, Scalable Home Delivery Programs

Case Study Provided by Parata Systems

WITH ADULTS AGED 65 AND OLDER TAKING AN AVERAGE of four medications per day, the pharmacy is a frequent and required stop for this population. After the onset of the pandemic, pharmacies were handed a difficult blow — being asked to continue their daily fulfillment of already overwhelming dispensing volumes while acting as frontline workers. Innovation became critical, and creating a workflow that was both cost- and time-effective while meeting the needs of increasingly vulnerable populations was imperative to protecting these patients, pharmacy staff, and the viability of the business.

Innovative Pharmacies Ahead of the Curve

Grane Rx, a high-output, long-term care pharmacy in Pittsburgh, Pa., was positioned for success. The pharmacy had already been operating under a model that aimed to keep seniors at home, aging in place and out of not only the hospital, but also the pharmacy. Come COVID-19, the pharmacy's biggest objective was to continue business as usual.

Grane's key to success was its decision to lean on pharmacy automation. With the ability to rapidly fill thousands of prescriptions each day, keeping up with volume was a passive act. Much of Grane Rx's customer base relies on its adherence packaging, which can be delivered straight to a patient's home or facility. At a time when contactless services are an absolute must, especially for at-risk individuals and their caregivers, Grane Rx makes safely aging in place a reality.

> "Grane Rx has worked with our nursing home to help us get better than benchmark status on quality measures. I want to say in 23 out of 26 months — 5 star quality rating."
>
> **Mary Anne Foley, R.N., M.S.N.**
> Chief Operating Officer
> Jewish Association on Aging

A Measurable Value-Add for Facilities

Grane Rx's Meds2Home program is a shining example of how pharmacies, especially those using central-fill models, can produce positive patient outcomes simply by making compliance easy and accessible. Pharmacies that offer adherence packaging for multimed patients are immediately more attractive to health systems and care facilities than those offering only vial filling. Compliance packaging has been proven to prevent medication dosing errors not just for patients taking their own meds, but for caregivers and nurses as well. Those quality improvements in turn result in meaningful payer relationships.

The Meds2Home program uses pouch packaging options suited for patients taking multiple medications, and goes beyond day-of-the-week labeling by offering custom layouts unique to a patient's regimen. Additionally, Grane Rx's packaging uses easy-to-read instructions, incorporating pictures, symbols, and colors to make dosing clear — and is likely the only pharmacy in the United States to produce such packaging in 22 different languages.

Taking These Innovations Forward

With programs like home delivery already in place, Grane Rx was well positioned to handle the pandemic. While you may be inclined to attribute these successes to the pharmacy's scale, Grane Rx sets the standard for adherence and home delivery programs that can set your pharmacy up for success. This model, which is replicable by facilities of any size, can be scaled down or up using a myriad of assisting and supportive levels of automation.

With refills and deliveries for the highest-need patients happening reliably behind the scenes, pharmacists are able to perform at the top of their license, and technicians are freed up for meaningful and effective in-person consultation. As the role of the pharmacist continues to evolve and expand, automating as many tasks as possible will be the baseline standard for success, and the critical foundation upon which all of pharmacy can step into the future. **CT**

Learn more about Parata Systems at wp.me/s9LtTd-parata.

Lessons Learned from the COVID-19 Vaccine Rollout

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

AT THE TIME OF THIS WRITING, the Department of Health and Human Services (HHS) just announced that booster shots would be necessary to "maximize vaccine-induced protection" against COVID-19 infection (https://www.cdc.gov/media/releases/2021/s0818-covid-19-booster-shots.html). While rates of administration of first and second doses remain lower than desired, it is clear that those who have received these doses will need a third dose, especially in the context of the surging Delta variant.

This news comes in the context of continued disparity in vaccine access, especially among poorer countries. From a global perspective, experts suggest that policy must support development, dissemination, and deployment of vaccines to countries with limited access. Specifically, regulatory and government policies must encourage research and development to provide the quantity of vaccines necessary on a global scale, as well as development of vaccines to address the emerging virus variants. Recent history has demonstrated inequities in delivery of promised doses of vaccine to poorer countries. Policy must address this disparity. Lastly, deploying the vaccine focuses on getting the vaccine "the last mile" to the providers who will administer it, as well as addressing vaccine hesitancy among the general public.

For those who may have been skeptical or simply unaware, the pandemic has served as an explicitly clear example of the connectedness of today's global society and economy. While I recognize the critical nature of the global society, I am going to focus on community pharmacies in the United States. Specifically, I am going to explore several insights that have risen to the forefront of my mind as I consider community pharmacy's role in rolling out the vaccine.

> The lesson from COVID-19 testing is that pharmacy has an opportunity to tap into the yet largely unexplored opportunity of test/treat.

While the vaccines were under development, the initial focus in community pharmacies and other settings was testing. In April 2020, HHS authorized pharmacists to order and administer COVID-19 tests. Known as POC (point of care) testing, the COVID tests received CLIA waiver status, which authorized the tests to be performed outside of a clinical laboratory setting. There are more than 100 tests with CLIA (Clinical Laboratory Improvement Amendments) waiver status, including for influenza and strep. From a patient's perspective, there is significant value — in the form of convenience — in going to a single location for testing and treatment. Similar to the management of prescription drug monitoring programs (PDMPs), "test/treat" authority for pharmacists is regulated at the state level. As an example, collaborative practice agreements with physicians are a common method under which pharmacists are able to perform test/treat patient care services. The lesson from COVID-19 testing is that pharmacy has an opportunity to tap into the yet largely unexplored opportunity of test/treat.

Scheduling was a challenge that spanned POC testing procedures and the subsequent administration of the vaccine. *ComputerTalk* readers are surely familiar with the stories — and many have their own scars — of trying to schedule patients to come for POC testing, vaccine doses, or both. Some pharmacies hired pharmacy students. Some pharmacies propped up web-based scheduling, only to have it crash under the demand. Other pharmacies experienced overloaded phone systems that were unable to handle the call volume. In clinic settings, reports describe successful methods of HL7

FHIR-enabled (Fast Healthcare Interoperability Resources) application programming interfaces (APIs) that automated scheduling with minimal information from patients. It is worth acknowledging that pharmacies, health systems, IT vendors, and virtually all groups involved had inadequate time to prepare for the demand that was placed on the healthcare system in 2020. But as we face a particularly contagious variant and an impending demand for booster doses, are systems going to be in place to schedule patients? I believe pharmacy has learned what to expect and will meet the challenge head-on.

While all of this was happening, community pharmacists still needed to meet patients' routine needs for chronic meds, short courses of antibiotics, oral contraceptives, and the full range of medication dispensed in customary operations. Similar to scheduling, additional staff were sometimes hired. Above all, this was an opportunity for automation to shine. Pharmacies that were able to shift routine, manual processes were better positioned to meet the nonroutine demands that arose from the pandemic. Med sync also proved to be of considerable value, as it allowed pharmacists to reduce patients' trips to the pharmacy. Besides the obvious convenience it provided, med sync allowed pharmacies to address patients' concerns of potential exposure to the virus in public settings. For similar reasons, medication delivery services grew in popularity.

Previous columns in this series have touched on the importance of immunization information systems (IIS) or registries. Vaccine administration data (including that from pharmacies) is critical to public health tracking purposes. Those pharmacies that reported to an IIS via manual methods faced an uphill battle to submit data in a timely manner. Simply stated, the pandemic provided the ideal use case for bidirectional standards-based data exchange. Again, the looming round of booster shots will underscore this need in community pharmacies.

Learn more:

CDC report on the pandemic's impact on routine vaccinations: https://www.cdc.gov/mmwr/volumes/70/wr/mm7023a2.htm?s_cid=mm7023a2_w

Simply stated, the pandemic provided the ideal use case for bidirectional standards-based data exchange. Again, the looming round of booster shots will underscore this need in community pharmacies.

The need goes beyond booster shots, however. Data from the CDC highlights the pandemic's impact on routine vaccination procedures for vaccines such as HPV, DTaP, and MMR (see link above). Specifically, there were fewer childhood and adolescent vaccines administered in 2020 compared to both 2018 and 2019. This decrease was most striking during the period from March to May 2020 and among those 13 to 17 years of age. Of note, vaccination rates in June–September of 2020 increased compared to March–May, but they remained lower than rates from 2018 and 2019. As demand for routine vaccinations increases among these age groups, pharmacies will be called upon again to meet patients' needs. It is critical that this information is readily accessible from and shared with state registries.

As the country faces a second wave of COVID-19 infections, we must leverage the lessons learned during 2020. Pharmacies and pharmacy staff were resilient in their efforts to meet an unprecedented and unexpected public health demand. Here, I've explored a few of the lessons that may help U.S. community pharmacies better respond to the current wave. I have tremendous respect and appreciation for my colleagues who have served and continue to serve their patients and their communities. **CT**

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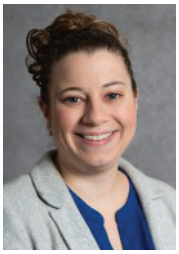
Changes for 340B Coming?



Ann Johnson, Pharm.D.

IN 1992, CONGRESS ENACTED SECTION 340B of the Public Health Service Act, which requires manufacturers to enter into an OBRA '90 Medicaid National Drug Rebate Agreement with the Department of Health and Human Services (HHS) in order to have their drugs covered by Medicaid. Manufacturers agree to provide discounts on covered outpatient drugs purchased by covered entities, with the rebates for brand drugs being partially based on the manufacturers' "best price." Covered entities may include federally qualified health centers, disproportionate share hospitals, critical access hospitals, and several other organizational types. The original purpose of the 340B program was to enable covered entities to provide comprehensive services to the nation's most vulnerable patients. Covered entities choose how to use the 340B discounts. These 340B discounts or savings do not have to be pharmaceutically focused, and may, for example, be used to add additional service offerings (e.g., dental) or expand primary care access.

Within the last year, eight pharmaceutical manufacturers have announced that they will no longer provide 340B discounted product to contract pharmacies or will do so only if covered entities meet certain data submission requirements. These manufacturer announcements have set off a chain of events in the industry that have led to legal actions, and ultimately may force legislation that provides more definitive 340B guidelines.

CONTRACT PHARMACY HISTORY

In 1996, the HRSA (Health Resources and Services Administration) issued guidance stating that a covered entity can purchase and dispense 340B drugs through an internal or a single external pharmacy, meaning that a covered entity could have a single contract pharmacy. In 2010, the HRSA issued new guidance stating that eligible covered entities, including those with an in-house pharmacy, could access 340B pricing through an unlimited number of contract pharmacy arrangements. From 2010 to today, there has been a 4,000% increase in the number of contract pharmacies in the 340B program, with almost 110,000 current contract pharmacy arrangements. The unlimited number of covered-entity contract pharmacy relationships has pushed the program beyond its original intention and is one catalyst for the current 340B controversy between pharmaceutical manufacturers, covered entities, and the HRSA.

340B IMPACT ON MANUFACTURERS

Per PhRMA (Pharmaceutical Research and Manufacturers of America), the 340B program is the second-largest federal drug program behind Medicare Part D. Discounted purchases under the 340B program reached $38 billion in 2020, a 27% increase over 2019. Despite these robust 340B discounts, approximately two-thirds of covered-entity hospitals have charity care rates that are below the national average for all hospitals.

TIMELINE OF CURRENT EVENTS

Based on our review of the currently available information in the marketplace, we understand the current timeline events to be as follows. Note that this is a rapidly changing area, and the events are constantly evolving.

July 2020: Eli Lilly and Company announced it would no longer allow certain strengths of Cialis (if purchased by a 340B provider at the 340B price) to be delivered to contract pharmacies. The HRSA announced it lacks the authority to stop Lilly from taking this action.

July 2020: Merck announced that contract pharmacies would be required to submit data on every Merck drug dispensed beginning August 14.

July 2020: Sanofi and Novartis announced that contract pharmacies would be required to submit data on every one of their respective drugs dispensed beginning October 1.

September 2020: Lilly announced it would stop providing discounts to 340B contract pharmacies on Sept. 1, 2020. 340B discounts would only be given to covered entities and their child sites. Insulins would be exempt.

September 2020: AstraZeneca announced it would stop providing discounts to 340B contract pharmacies on Oct. 1, 2020.

September 2020: Sanofi announced that contract pharmacies not providing the requested data would no longer be able to obtain 340B pricing as of Oct. 1, 2020.

September 2020: Apexus, the 340B Prime Vendor Program, published a sample form for covered entities to report instances where covered outpatient drugs are not available at a 340B ceiling price and/or are charged at the incorrect 340B ceiling price.

October 2020: Novartis announced it will continue to provide 340B pricing to contract pharmacies, as long as they are within 40 miles of their covered-entity parent facility.

November 2020: United Therapeutics notified covered entities that contract pharmacy orders placed on or after May 13, 2021, will be denied unless the covered entity provides associated claims data for its products.

December 2020: Novo Nordisk announced that beginning Jan. 1, 2021, it will no longer give 340B discounts to contract pharmacies.

December 30, 2020: HHS issued an advisory opinion on contract pharmacies under the 340B drug program. The Office of the General Counsel reiterated that contract pharmacies are acting as agents of the covered entity. HHS notes that "manufacturers' rationale for precluding the use of contract pharmacies is not supported by the language of the statue and leads to absurd results." HHS concludes that manufacturers are required to deliver covered outpatient drugs to contract pharmacies and charge covered entities no more than the 340B ceiling price for those drugs.

January 2021: The American Hospital Association (AHA) and similar groups sued HHS to get the agency to clamp down on these manufacturers.

January 2021: Three manufacturers (Eli Lilly, AstraZeneca, and Sanofi) sued HHS over this advisory opinion, with each company filing a separate lawsuit. The manufacturers claim that the advisory opinion contradicts the 340B program statues and does not require manufacturers to recognize contract pharmacies.

February 2021: HHS is granted a motion to dismiss a lawsuit accusing the department of failing to force manufacturers to pay 340B discounts for drugs dispensed from contract pharmacies. The judge noted that the issue cannot be challenged in court because HHS has not issued a final agency action on 340B discounts for covered entities that use contract pharmacies.

March 2021: Federal courts side with Eli Lilly and grant a preliminary injunction barring the HRSA from implementing the final administrative dispute resolution rule that was to allow a panel to resolve disputes between participating 340B covered entities and pharmaceutical manufacturers participating in the 340B program.

May 2021: The HRSA notes that six drug manufacturers are in violation of the 340B statute and must begin offering their drugs at discounted prices to covered entities participating in the program. The HRSA states that these manufacturers must credit or refund all hospitals for overcharges that resulted from the limiting policies or face civil monetary penalties for each instance of overcharging. The HRSA gave the manufacturers until June 1 to release a plan on how to resume giving the discounts.

May 20, 2021: Eli Lilly filed a motion to halt 340B-related monetary penalties until a court case between Lilly and HHS is resolved.

June 2021: HHS withdrew its advisory opinion on the use of contract pharmacies. Federal courts sided with Lilly in March, noting that the HHS December rule did not follow the Administrative Procedure Act. HHS cited the "need to avoid confusion and unnecessary litigation."

June 2021: Boehringer Ingelheim notified 340B covered entities that it would stop providing discount pricing for covered drugs dispensed in contract pharmacies.

August 2021: Merck announced that it will stop providing 340B discounts on drugs dispensed from community-based pharmacies if those covered entities and contract pharmacies do not submit claims data by September 1.

GOING FORWARD

The 340B program is a complex program that has seen rapid expansion over the last five years. Adding another layer of complexity, the recently passed American Rescue Plan Act of 2021 removes the maximum cap on Medicaid rebates starting Jan. 1, 2024. The OBRA Medicaid rebate calculation will change, and all CPI (consumer price index) inflation adjustments will be included without a cap. This means that a manufacturer of a brand drug with cumulative price increases that are greater than 76.9% of the CPI will be required to pay Medicaid programs for dispensing its drug. Previously, these products were known as penny products, where the 340B price was equal to $0.01 per unit. If manufacturers are expected to pay to have their drug used, some manufacturers will simply discontinue these drugs, rather than take losses on them.

The historic lack of regulatory guidance on 340B may soon be coming to an end. The change in rebate calculations, coupled with the rapid growth of contract pharmacy arrangements, has prompted eight manufacturers to take steps challenging the current 340B program structure. These manufacturers are refusing to provide 340B discounts to contract pharmacies or are only doing so when the covered entities provide the claims data associated with all 340B contract pharmacy claims for the manufacturer's covered outpatient drugs. This ongoing dispute has resulted in legal battles that will likely continue until Congress clarifies the intent of the 340B program through definitive regulations. **CT**

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The Pandemic Drives Price Consciousness, But Are Discount Cards the Answer?

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

MY LAST TWO COLUMNS HAVE BEEN about digital health trends and interoperability, with a focus on patient opinions. So it was with great interest that I read about Surescripts' recent survey of patients, pharmacists, and prescribers about their interactions and how the COVID-19 pandemic has changed this dynamic. The survey was conducted in mid-July by phone among 300 patients, 200 prescribers, and over 500 pharmacists. Key takeaways are that the pandemic is driving the need for greater interoperability, especially because of increased technology use during the past 18 months and increasing desire for price transparency to serve patients who were more anxious and price conscious than ever.

Both prescribers and pharmacists reported an increase in questions from patients about medications (58% and 30%, respectively) and general health (68% and 45%, respectively) during the last 18 months. Pharmacists said they often did not have all the patient information they needed to address these questions or provide medication therapy. They often turn to prescribers and report that they contact the prescriber regarding 22% of all prescriptions they process. Top reasons for contacting prescribers are not surprising and include:

- Seeking refill renewals (27%).
- Asking for prior authorization to be done (25%).
- Clarifying prescription orders (24%).
- Asking for lower-cost alternatives to be prescribed (10%).
- Resolving drug interaction issues (10%).
- Seeking more-effective alternative medications (3%).

Unfortunately, the majority of these interactions still occur via phone (36% for prescribers, 38% for pharmacists) and fax (14% for prescribers, 20% for pharmacists) rather than using the electronic health record system (42% of prescribers) or the pharmacy management system (35% of pharmacists). This survey data is reflective of my experience working at various pharmacy locations across the Minneapolis and St. Paul area during the pandemic. The advent of using electronic prior authorization has been helpful in addressing some of the workload. And integrated electronic prior authorization is the top tool pharmacists surveyed say would make prescription processing easier, and it is among the top three tools mentioned by prescribers. Pharmacists also would like to see drug alternatives in the pharmacy system, and prescribers would like to see medication adherence support tools. Both groups, however, ranked medication pricing information as their second top-desired tool.

Both prescribers and pharmacists said they believe prescription costs are among the top issues in healthcare today. Among the patients surveyed, 19% report it has become more difficult to afford medications during the pandemic. Not surprisingly, a quarter of the prescribers said patients asked them to prescribe a less-expensive medication, and pharmacists reported 10% of patients not filling a prescription because of cost. Prescribers and pharmacists alike say they have difficulty accessing a patient's out-of-pocket prescriptions costs. Part of this difficulty may be the growth in non-plan payment for prescriptions. Several years ago, Walmart started offering $4 generic drugs, and other pharmacies soon matched the offer. These payments were not applied to patients' insurance deductibles, and because they were not processed through a patient's insurance, some drug utilization review functions could not be done.

Today, it is common for more than half the patients I see to ask me about a discount plan of some kind. Many have been spurred to ask after viewing television commercials, often starring celebrities, for specific products or discount cards. Others bring in cards they received in the mail or from their healthcare clinic. RxSaver and GoodRx are two of the plans that patients most frequently ask

me about. At some pharmacies, the pharmacy system can easily make comparisons between GoodRx prices and company-specific discount plans in order to provide patients with the best price, including better pricing than their insurance at times. Other pharmacies that do not have agreements with GoodRx or RxSaver may provide their own discount plan to help patients. Many independent pharmacies do not have agreements with prescription discount programs at all, and in fact are voicing concerns about these programs.

A good example is the concern expressed to a recently announced initiative between GoodRx and Surescripts (see https://www.mobihealthnews.com/news/independent-pharmacists-sound-alarm-surescripts-goodrx-partnership). The partnership between the companies would integrate GoodRx's discount pricing information into Surescripts' platform (see https://www.globenewswire.com/news-release/2021/08/05/2275675/0/en/GoodRx-Announces-Agreement-with-Surescripts-to-Provide-Real-Time-Drug-Discount-Pricing-in-Electronic-Health-Records.html). Prescribers would then have access to this information at the time of prescribing. The GoodRx pricing would only show for uninsured patients or those whose price information is not available from their PBM (pharmacy benefit manager) or insurer. The initiative is supposed to address price transparency and certainly addresses the top tools mentioned in the Surescripts' survey. However, a group of pharmacists wrote to Surescripts' board with their concerns that this would hurt independent pharmacies and further obscure pricing. In my experience, I have already seen numerous messaging in e-prescriptions from the prescriber stating the patient would be using a discount card and providing the card's BIN, PCN, group, and ID number. Sometimes this is for common off-formulary "lifestyle" medications (e.g., drugs for erectile dysfunction or weight loss), and at other times it is for ongoing therapy for chronic disease.

I often wonder, as do colleagues I query, whether GoodRx presents a conflict of interest. After all, it is partnered with Express Scripts (ESI), one of the major PBMs that along with United Healthcare and CVS Caremark control the vast majority of the prescription benefit management marketplace. This dominance is what has driven major PBM reform legislation across the country in the past several years, which has only become more feverish as federal DIR (direct and indirect remuneration) fee reform remains elusive. Isn't ESI — through its partnership with GoodRx — directly competing with any employer or insurer for whom the company creates and manages a prescription benefit? In this case, rebates and discounts go to ESI/GoodRx instead of returning any portion to ESI's clients or employers. Patients who use these discount card programs don't have their prescription costs counting toward their deductibles, which may mean they are paying out-of-pocket far longer than they may have without the discount cards, in spite of paying less for each prescription than they would running it through their insurance. In some cases, use of the cards is illegal — for example, in government-sponsored health plans. But in my experience their use is growing, and I am getting more-frequent emails directly from such programs touting their savings.

Writer Emily Olsen notes in her MobiHealth article that after becoming publicly traded, GoodRx announced its first earnings, bringing in $550.7 million in revenue in 2020, a 42% increase from the year before. For 2021, GoodRx reported first-quarter revenue growth of 20% year-over-year to $160.4 million. Industry expert Adam Fein noted in his Aug. 11, 2020, Drug Channels blog, that this means "…GoodRx earned about 15% of the $2.5 billion that consumers spent at pharmacies with its programs." In that blog, Fein goes on to say, "Pharmacies lose in two ways. One, they lose the potential revenue from a cash-paying customer, who would have paid more than what the pharmacy received from a PBM. Two, the pharmacies must pay a fee for the privilege of dispensing to a patient who may have used their pharmacy anyway. However, pharmacies are effectively prevented from offering low cash prices, because they risk undercutting their third-party margins."

This observation has led Fein to say in a recent blog that GoodRx, not Amazon, might be the true PBM pharmacy disrupter (see https://www.drugchannels.net/2021/08/why-goodrxnot-amazon-may-be-true-pbm.html; subscription may be required). He notes GoodRx and its discount card competitors profit by incentivizing people to bypass their own insurance plans. He writes, "…our crazy pharmacy pricing system deters pharmacies from pursuing consumer-driven pricing and PBMs from undercutting their own clients." He then posits, "…discount cards could become the force that upends PBMs' pharmacy benefit economics, plan sponsors' decisions, and the entire generic market. Should PBMs continue to profit from discount cards' rapid growth…while ignoring the risk that this growth could undermine the value of their benefit management services?"

That's a good question. I have written in *ComputerTalk* and spoken at ASAP meetings about Amazon's potential channel disruption. The company has since exited its healthcare initiative with JPMorgan and Berkshire Hathaway. Is Adam Fein right that GoodRx and the proliferation of discount cards may finally be the disrupter to our complex, and often untransparent, pharmacy pricing system, not Amazon? Stay tuned. **CT**

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Care Collaboration and Messaging Offers Next-Level Service

by Maggie Lockwood

COMMUNICATION IS THE KEY TO EFFICIENCY according to Chris Antypas, Pharm.D., owner, president, and COO of Asti's South Hills Pharmacy, which has three locations south of Pittsburgh, Pa. — one a community pharmacy, one a closed-door long-term care pharmacy, and one a specialty pharmacy. "It's about being able to access people without having to waste time playing phone tag, " says Antypas. Here is where DrFirst's Backline care collaboration app gives Antypas' staff a HIPAA-secure messaging platform to communicate, including sharing documents.

Secure messaging is quickly becoming the preferred method of communicating for Antypas, not only among pharmacy staff, but between the busy pharmacy locations, providers' offices, and the nurses at long-term care facilities. At Asti's, Antypas has watched the need to pick up the phone to solve a problem quickly disappear, and he and his staff are fine with that.

"Problems happen every day in the healthcare world," says Antypas. "It's astounding how many issues there are out there and it's equally astounding how a simple conversation, a two-minute conversation, or in this case a few texts, can resolve an issue."

DrFirst's Backline communication and collaboration tool helps providers achieve care coordination and improve transitions of care. The system supports attachments up to 20mbs, including photos, videos, audio files, and documents. Secure text messaging encryption protects privacy, prevents unintended disclosure, and meets HIPAA requirements. A telehealth option is available as well.

"It's a huge asset. I don't really see our pharmacy operating without it," says Antypas.

Chris Antypas, Pharm.D.,
Owner, President, COO
Asti's South Hills Pharmacy

"Backline is a huge asset. I don't really see our pharmacy operating without it."

Asti's started with the service among a handful of its pharmacists to communicate at night or on the weekends. Staff are pinged whenever there's activity on one of their chat threads. The advantages of messaging over phone calls quickly became apparent, and Antypas looked to extend the communication beyond the pharmacy to provider offices and the nurses at long-term care facilities.

His staff have dual screens, running the pharmacy through the Rx30 pharmacy management system and accessing the Backline chat threads through a web portal. Antypas can review any conversation if necessary. The staff can check their chats at any station, or through a secure app on a smartphone or tablet. When communicating with providers or nursing home staff, Asti's staff can send a secure text, and the recipient needs only to click on a link to access it, without being required to enroll or download the app.

From transferring a prescription from one pharmacy location to another and following up on a message from a doctor's office, the staff uses Backline continuously during the day and it is especially helpful at night and on the weekends. Timestamps allow the staff to see when coworkers reviewed and responded to a message. It provides complete accountability to every action taken around a prescription and patient.

"If you had an issue to resolve for a patient, or you could contribute to a situation, you can chime in from any location through the secure app," explains Antypas. "We can send an urgent message to a provider and know that everyone has seen it. It's helpful to have direct access to key people at a prescriber's office."

Prescribers love it because they know they aren't getting unnecessary phone calls. At any time, the office can look over the chat to see the discussion history. And it's particularly effective with providers who have a lot of patients with the pharmacy. "When you let the doctor know there is a secure messaging system that is easy to access and will reduce phone calls," says Antypas, "they are quick to sign up." Within five minutes, Asti's staff can have a new group thread established for a practice.

"We have found that Backline is a wonderful platform for us to connect with providers and get answers to questions and solve patients' problems quickly and efficiently," says Antypas. **CT**

Maggie Lockwood is VP at ComputerTalk. *She can be reached at maggie@computertalk.com. See a video about Asti's Pharmacy at https://drfir.st/asti-backline.*

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