COMPLETED GRANT SYNOPSIS

Advancing Community Pharmacy Practice through Innovation

A Tool Kit

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Objectives

1. Identity innovative pharmacy practices that have disrupted/innovated by developing new practice/payment models.
2. Interview the founders/innovators of these innovative practice/payment models to identify key components of the models utilizing the implementation guide as a data collection tool.
3. Describe the innovative practice/payment models to support adoption using a structured process (Innovation Guide).
4. Disseminate results via CPF website and published paper
5. Develop practice tools to help pharmacists perform an environmental scan of their market and a guide to assist them in evaluating opportunities.

Methods

A multi-case approach was used to collect data on five innovative practice models. Data were collected using semi-structured key informant interviews with leading developers of each innovative model. The key informants are using these innovations in their own practices, so were informed about their own models/services.

An initial list of innovations was developed by the research team in discussions with their contacts throughout pharmacy. Then, a panel of pharmacy thought leaders was asked to identify their top 5 innovations and to add any others they thought should be considered. A Qualtrics survey was used to collect their ratings. Once the innovative models were selected, key informant developers of each model were identified by input from the thought leader panel and the research team. Each of the key developers were contacted about participating in the study be being interviewed virtually. As the developers agreed, a virtual interview was scheduled.

An interview guide was developed to collect information about each innovation. Interviews were conducted and recorded on Zoom. The recordings were transcribed verbatim. The transcriptions were coded using a template developed from the interview guide. The interview asked about: a description of each innovative practice model, how they got started, what was done to develop the model, what resources were added for it (e.g. personnel, equipment, software), how long it took to develop the model and payment model. The interview also asked about their marketing of the service or model.

Each interview was conducted and recorded on Zoom. Two members of the research team participated in each interview. The interviewees were provided with the interview guide beforehand so they could think about answers. The intent was to smooth the flow of the interviews. The researchers took notes during the interview.

The interview recordings were transcribed using a transcription service. The transcripts were coded using a rapid approach that utilized a coding template derived from the interview guide topics. This approach focused on extracting the information that was used to create an innovation guide for each innovative model. Topics included in the innovation guides included a description of the service or model of care, key stakeholders in establishing and operating the innovation, competitors for new service/care model, resources needed to provide the new service/care model, promotional plan and monitoring metrics.

Results

The five selected innovation models were: Cost Plus Pharmacy, Long-term Care at Home, Functional Medicine, Direct Contracting and Direct Patient Services under a Team Model. The innovation developers interviewed for each of the models were Kyle McCormick (Blueberry Pharmacy) for Cost Plus Pharmacy, Lindsay Dymowski (Centennial Pharmacy Services) for Long-term Care at Home, Aaron McDonough (Towncrest Pharmacy) and Lauren Castle (Functional Medicine Pharmacists Alliance) for Functional Medicine, Mike Deninger and Aaron McDonough (Towncrest Pharmacy) for Direct Contracting and Amina Abubakar (Avant Pharmacy and Wellness) for Direct Patient Services under a Team Model. This section briefly describes each of the innovations. A more detailed innovation guide is provided for each innovation in the Appendix of this article.

The Cost Plus Pharmacy model is a cash only pharmacy where insurance is not accepted. A patient pays the amount that is the sum of the cost of the medication being dispensed plus a dispensing fee that covers the pharmacy's costs of dispensing the medication (e.g. labor, overhead, computer, supplies). The cost plus pharmacy also sells memberships that provide enhanced service levels and selected discounts.

The Long-term Care at Home model is focused on the population of older patients who are ill enough to need care services, but well enough to remain at home. They transitioned from a strictly retail community pharmacy to a combo shop and then eventually went full closed door. A closed-door pharmacy gets lower costs for medications (e.g., part of a long-term care purchasing group) and better payments for services. Their long-term care at home patients tend to have insurance coverage from Medicare plans and/or Medicaid MCOs. A Long-term Care at Home pharmacy provides medication management services needed by the patients. These services can include adherence packaging, care coordination, medication reviews and communication with local doctors.

The Functional Medicine model provides an approach to systematically identify and address the underlying processes and dysfunctions that can be causing imbalance and disease in an individual. It works to understand a person's genetic, environmental and lifestyle influences to create personalized interventions that can restore health and well-being. Often supplements are used along with lifestyle changes to address the targeted health problems. Functional medicine can serve as a complement to traditional medication therapy, so can fit within a community pharmacy.

Direct Contracting is when a pharmacy contracts with an employer to provide pharmacy services to that business's employees. Under this model, a pharmacy can use a cost plus approach that adds a professional fee to the actual cost of the medications. Because PBMs often have high mark-ups, there can be a cost/price range where the employer lowers its costs for medications for its employees and the pharmacy gets paid a fair price for dispensing the medications. A pharmacy can partner with a low-cost third party administrator to run claims for these employees, apply copays and prepare monthly invoices for the prescriptions at a small cost per prescription.

In the Direct Patient Services under a Team Model, a pharmacy partners with a primary care provider (PCP) to deliver chronic care management, coaching and ongoing monitoring. The patient is seen by the PCP and progress notes, labs and other clinical data are shared with the pharmacy, which does not need to be co-located with the PCP. The pharmacist and PCP develop a care plan, which is facilitated by the pharmacist. This model can be attractive to PCPs with value-based payment contracts that have metrics pharmacists can help achieve (e.g., blood pressure control, medication adherence improvement).

Conclusion

The Appendix of this article can serve as a Tool Kit for pharmacists, technicians and pharmacy support staff to implement a new service within their practice. The Innovation Guides can be used after the staff at the

participating pharmacy has done an environmental scan and needs assessment of their market (see Needs Assessment Guide). Once an area of need is identified, pharmacy staff can use this Tool Kit to review key aspects that should be considered when starting a new service. Developing and implementing a new service requires investments of time, money and talents. There is no such thing as a "turnkey" approach to providing services. Each market, each practice, each situation is unique to the individual practice. It is important that the key staff that has responsibility for service creation and implementation fully understand the factors/variables within their marketplace and their own practice to ensure that a service will have long term viability and success. It is also important to understand that implementing a service requires dedication, commitment, and engagement. For a new service to reach its potential success, it takes time, patience, and persistence. The Innovation Guides are intended to inform users about key issues identified through interviews with developers if the five innovations included in this Tool Kit.

Step 1: Once the Needs Assessment has been conducted and a potential service identified, determine who are the key stakeholders within your marketplace to connect regarding the service. Questions to consider in completing the step include:

a. Will you be starting a new corporation/business? If so, legal representation will be important.

b. Does the service, to be successful, require the support of another provider? What kind of support (e.g., referrals, contracting, etc.)?

c. Do you need external funding (e.g., bank loan) to implement the service (banker)?

d. How will you determine if the service is successful (e.g., financials). Will you separate out this service from an accounting perspective to monitor its progress (accountant)?

e. Will you need to hire new employees (employment platform, recruiters, etc.)?

Step 2: From the Needs Assessment, not only will you identify potential needs of your market, but you will also uncover competitors or potential competitors. Recognizing what your competitors are doing (what their service entails) and what they are charging (their fees) will help you to create a service that, in some way, differs from the competition (e.g., better service, better service delivery, better cost).

Step 3: Developing the actual service. In this step, it is important to consider all the resources needed to create the service including where it will be delivered (space), a description of the actual service (including its policies, procedures, and processes), staff needed, equipment/technology needs, office supplies needed, inventory needs (if needed), and patient workflow considerations.

Step 4: Determine the costs associated with providing the service. This includes fixed, variable, and semi-variable costs (e.g., labor). It is important to think about the entire cost of providing the service including space (rent), overhead, personnel, operation expenses, inventory (if needed) equipment/technology, office supplies, and marketing costs. A sensitivity analysis may be performed to determine how your costs can vary as the variables change (e.g., utilizing a technician instead of a pharmacist for some components of a service).

Step 5: Determine the pricing structure of your service. How are you reimbursed? Is insurance being billed? If so, what is a reasonable reimbursement for your services, and will the amounts be realized from the payer? If cash-based, are you making enough to not only cover your costs, but a reasonable profit being generated while being aware of the competition's fees. Will you use a cost-plus model or a subscription fee. Are there supplemental products that you will be selling that are associated with the service? If so, what is your markup on those products.

Step 6: Developing a marketing plan complete with a promotional plan. This will include information from the Needs Assessment (e.g. market analysis). To maximize your success, you will need put time, effort, and dollars into a marketing strategy. This will include not only traditional marketing strategies, but the use of social media, and one-on-one meetings with key stakeholders. There is a cost to marketing which needs to be incorporated into the costs of providing the service.

Step 7: Developing a financial plan for the service. What are the projected expected revenues (and growth) and costs in the next year, three years, and five years. This will also help you to determine if you need to seek external funding.

Step 8: Implement the service and the marketing plan.

Step 9: Monitor to determine if you are meeting your projected goals (revenues and profits). Adjust the service variables as needed by the outcomes (e.g., fees, costs, marketing).

Step 10: If you have put together a solid plan along with a strong needs assessment, it is important to stay engaged and committed with the service. Growth may not be as you hoped or expected, but this is when persistence becomes important. Many times, a new service/business does not succeed because of inadequate funding which may lead to a premature decision to stop the service. On average, it takes a new business/service two to three years to breakeven so Don't Give Up too Soon!

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Appendix. Toolkit for Using an Innovative Practice Model

Needs Assessment for Community Pharmacy

As community pharmacists seek to disrupt and thrive in today's challenging healthcare environment, they often are interested in developing new and profitable revenue streams. To be successful in developing and delivering a new service or new model of care, pharmacists should identify opportunities that allow them to address a meaningful unmet need with resources they can feasibly gather, manage and sustain. A key starting point in such a process is conducting a needs assessment of the pharmacy's community. A needs assessment is a systematic process for creating a profile of the needs and resources of a given community or

pharmacy service area. A needs assessment can guide a community pharmacy in identifying opportunities for new services or care models that can fulfill an unmet need with a feasible approach.

Needs Assessment Process

A needs assessment process can include the following steps: 1) define scope of assessment, 2) develop an assessment plan, 3) plan data collection, 4) collect and analyze data and 5) report findings. [Adapted from Community Action Partnership].

Needs Assessment Process
Step 1. Define scope
Step 2. Develop assessment plan
Step 3. Plan data collection
Step 4. Collect and analyze data
Step 5. Report findings

Step 1. Define scope: The scope of a needs assessment defines the geographic area of interest, potential patient groups, key stakeholders and resources to be evaluated. For example, public health data could be helpful in identifying areas for improving health in a pharmacy's service area. Identifying key stakeholders can help focus data collection and uncover likely support or opposition to addressing new opportunities.

Step 2. Develop assessment plan: An assessment plan lists the domains to be assessed and likely sources of such information. For example, state public health data could help define a community's cardiovascular health, or Census data could be used to quantify the size of a potential target market in the area. In addition to secondary data, a pharmacist could collect primary data from interviews or focus groups with key informants (e.g. providers, patient advocates).

Step 3. Plan data collection: A data collection plan determines what data will be collected and how it will be collected. Various public data sources often can be accessed directly via the Internet, while other data may need more steps to be obtained. Interviews or focus groups take more time and effort to collect the data, but typically allow better focus on questions of interest, compared to secondary data (e.g. Census).

Step 4. Collect and analyze data: Data collection and analysis is when the various data are collected, organized and analyzed. A data collection timeline can be helpful in coordinating multiple data collection activities. For most public data, descriptive statistics could be calculated (e.g. mean, median, range) to describe characteristics and/or groups of interest. Interviews or focus groups are best audio-recorded, transcribed and analyzed, though having someone take good notes could be sufficient if recording isn't viable. Once data are analyzed, then they should be interpreted to identify unmet needs and other promising opportunities.

Step 5 Report findings: Such unmet needs can be described in a report that identifies areas of patient need and organizational opportunities that the pharmacy could pursue. Once an opportunity is determined, a community pharmacy can address it.

Innovation Guide

Innovative Practice/Business Model: ***Cost Plus Pharmacy***

Innovator/Subject Matter Expert: ***Kyle McCormick of Blueberry Pharmacy, Owner***

Purpose

This innovation guide describes an innovative practice/business based on an interview with one of its early adopters. It is intended to provide essential information regarding key components to starting and implementing the new pharmacy practice model. Its objective is to provide guidance to interested pharmacists to develop a similar approach in their practices.

Description of the Service or Model of Care

Their cost plus practice opened in March 2020 with a transparent, insurance-free business model from the very beginning. They started the cost plus practice because of the decreasing reimbursements in traditional insurance-based payment models. There is a trend towards higher out-of-pocket costs for insured patients with the rise in high deductible plans. Lastly, there is a lack of transparency in the traditional AWP-based U&C insurance model. If patients are paying more and pharmacies are receiving less, why not change the model and make it transparent pricing for the patient, allowing better control of their reimbursement? The belief behind this model is that there is a need for a fair and transparent marketplace for generic drugs because generic medications are fundamentally non-insurable products, since insurance is normally purchased for unpredictable high-cost events. Visiting the pharmacy regularly to pick up prescriptions is predictable and out of pocket costs (especially for generic medications) generally are low. Additionally, since they dispense generic medications, inventory carrying costs are low. Patients who present with a name-brand or high-cost medication (this is an example of an insurable product) are referred to other pharmacies to obtain that medication.

The focus of cost plus is not on just the cost of the drug, but also the professional dispensing fee (the cost of a pharmacist and technician's time and profit margin). The cost plus model operates

from the base assumption that pharmacists are not filling a patient's full medication regimen. The responsibility then falls on the dispensing pharmacist to determine the patients' full medication profile to be able to properly assess the patient for medication safety and efficacy. These assumptions make the pharmacist more intentional in communicating with the patient, collecting a complete medication list and evaluating the patient's medications for appropriateness (safety and efficacy). Once you have a fair price on all generics, eventually a patient is only going somewhere else for their brand or high dollar items. If you look at the statistics, that's just one in ten prescriptions.

Cost plus is a cash-based direct pay model that is external to traditional insurance contracts. In other words, patients pay directly to the pharmacy (with no insurance contracts). The "cost" component takes into consideration the pharmacy's costs for the drug, handling costs (e.g. credit card fees), supplies (e.g. vial, label, and lid) and technology fee (e-script fee). So, this is the actual cost for the pharmacy (not NADAC, or National Average Drug Acquisition Cost). The "plus" component is the dispensing fee, which covers the costs for the professional services. The positive aspect of cost plus is that it emphasizes setting a floor price (without losing money) that a pharmacy can accept to make a profit on every prescription (but a fair and transparent price to the patient). You cannot separate the product from the services associated with dispensing.
Their cost plus model includes a membership option for patients. The idea of the membership is that if a patient pledges loyalty to the pharmacy for 90-days or a year, then there are dispensing efficiencies (since the first prescription fills are the most costly to a pharmacy) that get passed onto the patient. In other words, the "costs of dispensing" are lower for future fills than initial fills and that savings is passed on to the members.
Subject Matter Expert Note*: The membership model is truly aligned with patient incentives. It doesn't matter if patients are taking 1 to 2 medications or 20 medications—we just want to provide the best service so that patients continue to want our services. It aligns with patients, because the pharmacy is not driven by refills or day-supply, because the fee is constant and transparent. Our profits are generated from membership sales, not the number of scripts a patient takes (i.e. how sick/ill they are). Our subscription model is paid quarterly or annually. We made the decision to not offer monthly subscriptions because we fill 90 day supplies and patients can stop paying for the two of the months (since they received a 90 day supply). The patient received a 90-day supply of medications and their subscription, therefore, should be for at least 90 days.*

The membership model also gives patients free delivery every 90 days. With the free 90-day delivery, patients prefer that their medications are synchronized so that they receive all their medications at the same time, while the pharmacy improves its efficiencies (using only 4 days of Rx filling efforts versus 12 days a year). As part of the membership, their patients also receive 15% off on over-the-counter items and supplements as an added perk. The percentage of members (subscription) versus non-members has changed over time. Initially it was a 25:75 split (member:non-member). Over time, this percentage has increased to a 50:50 split. Members also get more prescriptions filled at the cost plus pharmacy so the percentage of prescriptions filled is probably closer to a 60:40 split.

Key Stakeholders
They have two cohorts of patient demographics. The first cohort is those patients who are 30 to 40 years old where they are probably filling 100% of their generic medications. These patients, they assume, have high deductible plans or no insurance. The second cohort is patients aged 65 and older.

The cost plus pharmacy is not usually filling all the medications for this second cohort, but they utilize the cost plus pharmacy for their insurance's tier 3 and/or tier 4 medications. Some of these 65-plus patients may have started out only filling their formulary exception medications, but because of the service provided, actually start filling some of their tier 1 generic medications as well. Over time, they do convince more and more of their patients to get all their medications filled at the cost plus pharmacy even if they were getting their previous medications for free through insurance.

Medications that have a large discrepancy between AWP/U&C and actual invoice price are key targets for cost plus.

Subject Matter Expert Note*: Our customer demographics actually align pretty closely with the demographics of GoodRx users—including some Medicaid patients (5%). We do have some Medicaid patients that just started with cost plus before they qualified for Medicaid—they were uninsured at the time and appreciated the service of our practice, and so they stayed with our practice after getting insurance.*

Competition for New Service/Care Model

Their largest competitor is the pharmacy that is charging $0.00 copay and accepting reimbursement rates below their costs—it is difficult to compete with that predatory pricing model.

Resources Needed to Provide the New Service/Care Model

1. Determining the structure of the business/practice (e.g. Partnership versus S-Corp) should include feedback/advice of your legal and accounting professionals.
2. Human resource needs (committed people who provide quality services).
3. Unlike traditional community pharmacies, cost plus requires few resources.
    a. A basic pharmacy management system that can check for drug interactions and print a label (but not all the bells and whistles that almost all current platforms provide so you can appropriately adjudicate a prescription.
4. Utilizing a primary supplier for medications, but the model is much more simplistic since there are no rebates, metrics to meet and leakage to monitor. Working with one or more trusted suppliers, who provide consistent and fair pricing, cuts down on the time spent on shopping for best prices.
    a. Everything is paid with a credit card that provides a 2% credit card reward
5. A front end of typical over-the-counter products (both generics and name brands), evidence-based supplements

Costs of the Service/Care Model

1. Start-up costs overall were under $100,000.00 including inventory purchase, supplies, furniture, shelving, counters, etc.
    a. Inventory (generics only—so low inventory carrying costs).
    b. Human resources (HR)—determined by practice growth, scheduling needs, and other practice needs. Initial HR needs may be low.
        i. Initially the practice did not have any technicians (first three years) and, only recently, did they add a technician to their staff. Although they did have summer interns and precepted rotation students from schools of pharmacies (up to 1 or 2 rotation students at a time)

2. Other practice stakeholders/team members—legal, accounting and business.
3. Operational costs: Time for services performed during the dispensing process and additional costs for consultations.

Pricing
This cost plus model includes services pharmacists perform during the dispensing process as mandated in the Omnibus Budget Reconciliation Act of 1990 (OBRA '90) since their core service is dispensing. To promote what they do as part of the dispensing services, they created a drug therapy problem board where they tally up every pharmacist's intervention. The whiteboard is patient-facing so patients can see the level of service provided. If the patient requests additional consultation with the pharmacist, they do have a fee per 10-minute consultation.

Membership reduces the dispensing fee compared to the fee for non-member patients. With the membership model, the pharmacy is not profiting from dispensing medications, but rather the profit comes from the membership fees. The fee is paid quarterly or annually.

Cost plus is a simple formula and the pharmacy sets the price versus accepting an underwater reimbursement or insufficient reimbursement from the current payer system.

Promotional Plan
Ninety to one hundred percent of the cost plus practice is referral driven. Word of mouth is their marketing engine. It's creating a positive patient experience including transparent pricing. The cost plus practice has created a marketplace for services because plans have no effect in directing the patient to preferred pharmacies who have accepted lower contract reimbursement terms. Customers of a cost plus pharmacy may be better able to differentiate a service-oriented, patient-centered pharmacy practice.

Other promotional activities include social media posts, connecting with insurance brokers, participating in community events/activities such as support group presentations, detailing prescribers and use of a practice website that shows the pricing of their medications.

There is a question regarding the challenges of an existing pharmacy conversion to cost plus versus a new start-up cost plus pharmacy. There may be some challenging marketing messages that have to be addressed such as no longer accepting insurance, no longer carrying name brand, and paying fully out-of-pocket for medications that were part of a pharmacy benefit. On the other hand, the existing pharmacies have the relationship and experience with their patients so that trust is already established. So, either scenario has both pros and cons to establishing a cost plus pharmacy.

Financial Overview
The Profit and Loss statement (P&L) is a key financial statement that is monitored. Prescription counts are not as important, but the number of members is an important metric to watch. The bottom line is whether the practice is profitable and, if yes, can you grow that profitability.

Monitoring Metrics

1. Number of patients (currently they service 3,600 unique patients)

2. Number of Memberships
3. Profitability (P&L)
4. Patient comments/satisfaction
5. Student feedback

Authors' Notes

- This subject matter expert used for this guide in starting his cost-plus pharmacy from the very beginning of its existence. We realized that many owners, with existing practices are looking for guidance on how to transition into this model. This is complicated by the fact that most pharmacies who still fill prescriptions through insurance, have to protect their Usual & Customary pricing to be compliant with their contracts with pharmacy benefit managers (PBMs) and not further reduce their reimbursement on dispensing. There are options, however. One existing pharmacy created a second pharmacy (cost plus) within their existing pharmacy with a different NPI and license, therefore a new practice entity. Another pharmacy created a cash-based practice, initially within their existing pharmacy that was focused on non-sterile compounding. Due to growth, they eventually moved this practice into its own building, adding functional medicine (cash-based) which naturally fit well implementing cost-plus. It's a matter of keeping your lines of businesses separate (traditional insurance-based dispensing from cost-plus with a separate pharmacy license, NPI, and NCPDP.)

- To be successful, pharmacists who are interested in pursuing this model should do their own research, strategic & business planning. Part of this preparation is determining their estimated revenues and costs to determine the appropriate "plus" fee to charge and also determine an acceptable membership/subscription price that is competitive and provides value to the patient through price reductions in products (e.g. reducing the "plus" fee) and/or addition of value-added services. Much like any new business line, planning is very important and this guide is only that—a guide—and does not replace good business planning.

- Sales messaging strategies to patients should focus on transparency and information so essentially, patients are making informed decisions. Cost plus focuses on generics, so pricing is transparent and supports good service levels. The pharmacy is not losing money to the insurance companies so can staff properly and spend the time each patient needs. Some of their patients don't have insurance and others are at a high tier for cost sharing – both groups are not benefitting from drug insurance.

- A sale strategy may be to do an analysis of what they currently pay and what they will pay with cost-plus. The subscription model adds in services so discussing the benefits to the patients will be important. Much like any new service being implemented, pharmacists and their staff need to believe in their service, educate themselves on the benefits to patients, develop marketing materials including in-store advertising, bag stuffers, and fliers. Pharmacists utilizing personal selling strategies will help to "sell" cost-plus to patients and other stakeholders. https://doi.org/10.1331/154434503321831076

- Determining cost of dispensing—guide

- Cost of Dispensing Report
  https://www.nacds.org/pdfs/government/2018_COD_QA.pdf
    - Commissioned by:
        - National Association of Chain Drug Stores (NACDS)
        - National Association of Specialty Pharmacy (NASP)
        - National Community Pharmacists Association (NCPA)
    - Mean overall cost of dispensing (COD) per prescription was $12.40.
        - Payroll
        - Prescription containers
        - Professional liability insurance
        - Prescription department license, permits, accreditation, and fees.
        - Delivery expense
        - Computer and Technology expenses
        - Equipment needs.
        - Other
            - Carrying costs (20 to 30% of actual cost of inventory)
                - Storage costs—ensuring appropriateness of proper storage.
                - Managing inventory
                    - Employee time and labor
                    - Technology platform costs
                    - Performing quarterly inventory costs (Vendor and employee time)
                - Accounting costs
                - Insurance costs
                - Obsolescence (outdates)
            - Out of stock costs
            - Opportunity costs
                - Cash flow
                - Interest costs (lines of credit)

- The cost-plus model does not preclude pharmacies from adding on other services that can bring in non-dispensing revenue whether that be cash-based services (e.g. point of care testing, vaccinations – not billing insurance through a cost-plus pharmacy though, quality supplements, medication management services). If this is added, business planning along with pricing becomes important.

- Although a cost-plus pharmacy may not fill all the patients' medications, good pharmacists will keep a complete updated profile of medications in the patient record so that they can perform the needed safety checks during the prospective drug utilization review processes.

How to Use this Guide

The innovation guide was developed to help provide the foundational information needed to start this innovative practice model. Use of this guide, along with the needs assessment can guide pharmacists who are interested implementing a cost plus practice within their respective markets. We also have included the contact information of the subject matter expert (SME) for those practitioners interested in taking a deeper dive into this practice model.

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Innovation Guide

Innovative Practice/Business Model: **Long-term Care at Home**

Innovator/Subject Matter Expert: **Lindsay Dymowski, Centennial Pharmacy Services, Co-Owner**

Purpose
This innovation guide describes an innovative practice/business based on an interview with one of its early adopters. It is intended to provide essential information regarding key components to starting and implementing the new pharmacy practice model. Its objective is to provide guidance to interested pharmacists to develop a similar approach in their practices.

Description of the Service or Model of Care
There is a population of older patients who are ill enough to need care services, but well enough to remain at home. This model of long-term care at home is focused on this group of patients. Initially, this pharmacy referred to their practice as a medication management pharmacy because that was the focus of their activities. They were not providing medications to a long-term care facility but were helping patients manage their medications at home. They began with an "all meds" program that asked patients to get all their medications dispensed from their pharmacy – to be able to provide comprehensive medication management. This program led them to interact more with clinic practices since they were requesting medication lists, asking questions about therapy and recommending adjustments as needed.

Over time the clinics started referring patients to the pharmacy because they realized the pharmacy was better at caring for patients with chronic conditions and who were in more risky living situations, living on their home or had a caregiver who was overwhelmed with their pharmacy care. So, they provided consultations to the patients and began dispensing in adherence packaging once a month to these patients. Then, the pharmacy would make follow-up calls to the patient to make sure they were taking their medications correctly and no issues had arisen. Over this time, they realized they had begun to deliver long-term care at home. During this time period, they transitioned from a strictly retail community pharmacy, then migrated to a combo shop and then eventually went full closed door. A closed-door pharmacy gets lower costs for medications (part of a long-term care purchase group) and better payments for services (depending on PBM, but also eliminating or reducing DIR fees). They started in the back of one of their retail locations and opened a new business when they decided to go fully closed door.

When a patient begins with long-term care at home, a virtual or face-to-face visit is performed to make sure the patient and any caregivers understand the service and have contact information. On average, the pharmacy cares for these patients about four years before they must move into a long-term care facility or pass away. However, they do have some younger patients who are dual eligibles (i.e., for Medicaid and Medicare) and severely chronically ill.

Subject Matter Expert Note: *So, there was acknowledgement of this type of population by CMS back in 2012, and it was just brief mention, and then there was another memo released back in the 2015 timeframe. And*

then in December of 2021, CMS really went into feet first and acknowledged that there was not only a population of medical at home, but that they support PBMs paying for medical at home. So that really was the biggest acknowledgment that we were able to have. And then there have been conversations as of late to phrase this as long-term care at home over medical at home, because one, there's so many hospital and home programs and things that get very confusing with where does pharmacy play in with medical at home? So if we phrase it to long-term care at home, which there's wide support in the industry to make that happen, including at different alliances and lobbying groups that are working with CMS, if we call this long-term care at home, it best reflects how it's actually being paid for in the market currently and how we want it to continue to be paid for in the future.

Key Stakeholders

Their long-term care at home patients tend to have insurance coverage from Medicare plans and/or Medicaid MCOs. In addition, the City of Philadelphia provides coverage for some others in need and can't afford LTCF care.

Subject Matter Expert Note: *It was around the 2015 timeframe that we started transitioning to a combo shop, and then we went full long-term care in, I believe it was 2020 or 2021. And I want to be clear to do this model, you don't necessarily have to be full long-term care. You can be a combo shop, and you're still going to get the same types of contracts and similar benefits from it. The reason why we decided to go closed door, and specifically why we went closed doors so early was because we were doing different types of beta testing and data sharing with payers and plans and PSAOs. And to prove the point that this is a long-term care model of pharmacy and not a retail pharmacy, it was much easier for us to just say we're a closed door long-term care pharmacy and have that conversation than it was to have to explain out combo shop too, the plans and the payers and people who were doing different beta tests with us.*

Competition for New Service/Care Model

A competitor for this pharmacy is large mail order pharmacies that package medications to support adherence. However, these organizations often just focus on medication distribution and do not provide the medication management services needed by the patients. Key differences between long-term care at home and the packaging mail order pharmacies start with the coordination of care. Second would be the connection and the empathy long-term care at home pharmacies have with their patients. Third, is the clinical work that can be done on the long-term care at home side. There's more communication with local doctors, more medication reviews, more annual CMRs that are being done by the actual individuals who are seeing a patient's medications every single month. In addition, a long-term care at home pharmacy can have an impact on community events. For example, they could see these patients and give them their vaccinations or do a brown bag at their independent living community. There are opportunities where the local long-term care at home pharmacy can actually interact with their patients, while the mail order pharmacies cannot.

Subject Matter Expert Note: *Traditionally community pharmacy has stayed in the community and long-term care pharmacy has stayed in facilities. So, there is this space now where the two meet and there is definitely going to be opportunities for these long-term care pharmacies to continue to support the patient once they leave that facility where traditionally that patient would be handed off to that community pharmacy, but that doesn't have to happen anymore. So, there's kind of this new competition between community pharmacies and long-term cares that you haven't seen previously. Some long-term care consultants will just use software to identify some patients for further evaluation, which can differ from a community pharmacist evaluating all patients comprehensively.*

Resources Needed to Provide the New Service/Care Model

1. Space: They began in the back of a pharmacy, and then went to a combo shop that served about 1,200 patients from about 2,000 square feet. When they became a closed shop focused solely on the long-term care at home market, they moved into a space nearly 6,000 square feet and are serving about 3,000 patients. They rent their space, using contracts that typically are for about 5 years.
2. Professional services: Accounting, legal and consultants all increased as they grew. To be able to get the accounting details they wanted for projects and growth, they chose a nationwide accounting firm. They utilized legal advice and consultants as new types of contracts were developed to serve the long-term care at home patients and payers.
3. Human resource needs changed as their long-term care at home business grew. They were able to service about 300 patients before having to expand their workforce. They use several different teams within their operations to build efficiencies and expertise.
    a. One team (e.g., one pharmacist, one technician) should be dedicated to clinical work.
    b. Another pharmacist-technician team focuses on onboarding patients to make sure the logistics are properly established (e.g., reviewing patient's profile, educating patient/caregiver on the procedures, getting the patient into your pharmacy system).
    c. A billing and filling team is important too. At least a pharmacist and a technician who are focused solely on billing and then a pharmacist and technician who's focused solely on the filling and the dispensing of the medication into the adherence packaging.
    d. A delivery team keeps things going smoothly. While some pharmacies use in-house personnel and software, others utilize a courier service for deliveries. With either option, having an in-house delivery coordinator helps keep medication deliveries properly tracked.
    e. Leader of long-term care at home program to serve as manager and also faces externally to build relationships needed for referrals and contracts.
4. Funding for growth can be helpful, though they mostly expanded by bootstrapping their own resources. When they bought new automation for their growing operations, the need for capital was greater.
5. A variety of software is needed.
    a. A robust pharmacy management system is needed – one that supports clinical notes and lets you customize different types of reports. Not only reports that you're going to use internally, but reports that you're going to be providing to patients, to doctors, like medication lists, MARs and adherence reports. They use PioneerRx, which meets their needs (for about 3,000 patients) and is less expensive than typical long-term care software.
    b. Adherence packaging software is necessary, since this is the standard in this market. Automation likely would be needed for the adherence packaging above a volume of patients (e.g., 500).
    c. A delivery software is advised if a courier service is not utilized. This could be part of a pharmacy management program, but also could be a separate platform.

Subject Matter Expert Note: *Currently, we are in a space that's a little over 6,000 square feet. We have, the way that we have it laid out is in a big circle. So, we have our offices, we have our clinical, our billing, our fulfillment, and then our delivery. And it all goes in order and nobody has to cross paths. So, our workflow is laid out in order as it should be. And to be honest with you, I think that we probably need some bigger space, again, due to growth. If we were planning on being 2,500, 3000 patients, we would be totally fine where we are. But we have plans to grow this to four or 5,000 potentially more patients. And so, I think if we want to get to that level, we're going to need probably around 10,000 square feet.*

Costs of the Service/Care Model

1. Space, equipment for adherence packaging and additional software would be costs to begin long-term care at home. Some pharmacies could be able to utilize some of their current resources.

2. Human resources likely would need to be expanded as long-term care at home patient volume grew. See the Resources section for suggested types of personnel.
3. Professional service expenses increased in order to establish and grow the long-term care at home business. See the Resources section for a description of use of professional services.
4. The use a primary vendor wholesaler for over 99% of their medication and supply purchases.

Pricing

The pharmacy's payments are about 50% Medicare and dual eligibles, 40% solely Medicaid and 10% commercial or cash. They conducted some pilot programs with MCOs that showed savings on total health spend. These findings allowed them to negotiate better payments with the participating MCOs for the Medicaid beneficiaries. They noted that some PSAOs are obtaining contracts that include long-term care at home, as more PBMs engage that market.

Promotional Plan

Their goal is to target the chronically ill and individuals who are aging in place. They work with key stakeholders who affect a person's decisions around long-term care and home care. These parties include home care agencies, primary care providers, senior care specialists and geriatric practitioners. Also, within integrated health systems, they develop relations with cardiac practices, endocrinologists and renal practitioners. These three groups care for many of the patients who can benefit from long-term care at home.

They work to establish trusted relations with key referral sources, using business-to-business advertising, word of mouth, lunch-and-learn sessions about their services and promotion of their quality metrics. They learn what concerns each stakeholder has and then engages in discussion about how they could help improve their situation. For example, one provider might want help improving their own metrics, while another wants delivery services for their patients with transportation challenges. Meeting those needs improves their relations and raises the likelihood of getting referrals. They produce brochures about their services that they are able to place in the practices and offices of their referral stakeholders, including clinics and home care agencies.

Subject Matter Expert Note: *So, when you're messaging to the providers about your services, what are some messages, what are the talking points that you emphasize? Value-based supporting metric outcomes. I always advocate that you need to talk to the providers in the language that they want to hear it in. So if you go to your provider and say, we're going to fill patient's medicine and pouch packaging and deliver it to them, that is not nearly as impactful as we're going to support the adherence metrics of patients by giving them the tools and resources they need to meet the metric results that you want them to have.*

Financial Overview

Compared to typical community pharmacy financials, long-term care at home can be more profitable. The profits can come from lower product carrying costs, better dispensing payment terms and revenue from medication management services.

This pharmacy has about 3,000 active patients. About 10% pf these patients may be on "leave of absence," meaning they are in a facility for temporary care (e.g., rehab) or have insurance issues. At that patient volume they purchase about $1 million of inventory every month. Though the inventory costs are high, they are able to fully use just-in-time purchasing and stock at lean level. They reported having an annual inventory turnover rate over 40 because the medications don't sit on their shelves very long. This improves their cashflow as well.

Subject Matter Expert Note: *I think that you really start to see the difference in this model when you have about a thousand patients. It's that thousand patient mark where you really start to see not only am I making a different impact on the providers that I'm working with, but I'm making a very large impact on my metrics and my quality ratings. And then you really start to reach a point at a thousand patients where you've hit that plateau where you should have hired enough staff already to where you don't feel like you're constantly hiring or growing and you kind of get to cruise for a little bit and go, wow, there's a lot of impact here.*

Monitoring Metrics

1. Medication adherence rates (e.g. PDCs) and other ones used by CMS.
2. Patient retention rates, which can be decreased by patients changing pharmacies, going to a long-term care facility and passing away. The focus here is to provide high quality services so the patients and care givers get what they need related to medications. They aim to achieve at least 93% retention rate.
3. Referral rates are the percent of patients referred become their patients. They aim to keep this above 90%. Related to this is the number of referrals they receive and the sources of the referrals.
4. They send annual satisfaction surveys to their patients and referral sources. This feedback can help identify areas that may need improvement.

How to Use this Guide

This innovation guide was developed to help provide the foundational information needed to start this innovative practice model. Use of this guide, along with the needs assessment can guide pharmacists who are interested in implementing a cost-plus practice within their respective markets. We also have included the contact information of the subject matter expert (SME) for those practitioners interested in taking a deeper dive into this practice model.

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Innovation Guide

Innovative Practice/Business Model: **Functional Medicine**

Innovator/Subject Matter Expert: **Aaron McDonough, Towncrest Pharmacy, Co-Owner**
Innovator/Subject Matter Expert: **Lauren Castle, Functional Medicine Pharmacists Alliance, Founder**

Purpose

This innovation guide describes an innovative practice/business based on an interview with one of its early adopters. It is intended to provide essential information regarding key components to starting and implementing the new pharmacy practice model. Its objective is to provide guidance to interested pharmacists to develop a similar approach in their practices.

Description of the Service or Model of Care

Towncrest Pharmacy

Functional medicine (FM) is an approach to patient care that can be described as the clinical application of systems biology. Chronic disease often emerges after a period of declining function of one or more of the

body's systems. Functional medicine provides tools and a reproducible method to allow clinicians to identify dysfunctions and promote restoration of the physiology to improve patient health. With appropriate training, a variety of clinicians can perform functional medicine activities, including pharmacists. Community pharmacies can deliver a functional medicine practice that consults with patients to evaluate their needs, develops a comprehensive plan for improving their health, supplies specific products when needed and follows up to monitor performance.

A useful focus of functional medicine for pharmacists is drug-induced nutrient depletion. Many medications can result in depletion of nutrient levels over time, which can affect functioning and health. In this approach, a detailed patient history is taken to learn about their health and treatment experiences. The history is used as part of a comprehensive medication review that also assesses for drug-induced nutrient depletion. This process allows the pharmacist to identify the nutrients (e.g., vitamins, minerals, amino acids) that are likely being affected by the patient's medications and could be contributing to the underlying cause of their condition, illness or symptom. Another important piece is to learn the patient's goals with the functional medicine. For example, do they want to get off some of their medications or perhaps minimize the number of medications they are taking.

In addition to the comprehensive medication review, the pharmacist also talks to patients about their eating habits. For this, they may ask patients to fill out a nutritional log for 5-7 days to determine what they are consuming daily, what nutrients they're getting from food and what they're missing from their food as well. Additionally, these food logs provide answers to the following dietary questions. Does the patient eat calories in excess? Do they eat pro-inflammatory fatty and fried foods? Are they consuming too many sugary beverages? Do they drink enough water? Then, that information can be put into software that identifies and quantifies the nutrients the patient is getting from each food, where nutrient depletion is occurring and which nutrients they are getting in substantial amounts. Next, diet recommendations can be made using various healthy diet plans including those from the Institute for Functional Medicine (IFM), such as the Mediterranean, ketogenic, mitochondria, and elimination diets.

Also, the FM pharmacist evaluates his patients' physical activities. Some patients are in pain and want to work back into physical activity that is not too strenuous. This typically requires working with the patients and their providers, therapists and/or chiropractor to create a plan for gradual and monitored changes in activities. If needed, the pharmacy has arranged with a partner to be able to order labs to help with evaluating and monitoring the plans being carried out. For example, a micronutrient test could be helpful in determining the severity of a particular nutrient depletion.

The pharmacy documents their patients' functional medicine products in their dispensing software system. That is, they treat every supplement like a prescription medication in the patient's medication profile. Most dispensing software should be able to accommodate documentation of the FM products.

Functional Medicine Pharmacists Alliance

There are a lot of lifestyle related diseases that pharmacists encounter. Things like dementia or even autoimmune diseases that can be really complex but have their roots in the lifestyle, the environment, and all of these modifiable factors. So, a functional medicine pharmacist blends the best of what allopathic medicine has to offer with this sort of integrative and functional medicine approach. But the main thing as pharmacists is meeting patients where they are.

Anyone that works in a pharmacy is probably familiar with that unfortunate feeling of seeing a patient on so many medications that they're stressed out, they don't feel well, they're getting side effects from different combinations and unfortunately their numbers perhaps still aren't trending in the directions they want. That's

when pharmacists can pause and ask themselves what they can do differently and how they can start to look at underlying causes of all of these seemingly disparate or myriad disease states that oftentimes have very simple fundamental causes. For example, inflammation is a big one, that can relate to diet and lifestyle.

Some of the common conditions, things like cardiovascular disease and cardiometabolic disease go hand in hand. Interestingly enough, for some patients who have high cholesterol, one of the actual root causes of their high cholesterol can be undiagnosed thyroid dysfunction. And oftentimes that connection is not made. Rather a typical approach is your cholesterol is high, cut down on your dietary cholesterol and take this statin and that's it. We'll see you back in a few months to retest. But in fact, many people have cholesterol issues driven through their sugar intake. Sugar oftentimes is much more inflammatory and causes greater increases in the cholesterol levels than dietary cholesterol. So, it goes back to pulling in that nutrition component and really starting to ask the patients about the types of foods they're eating and if they're consuming a whole food plant-based diet or if it's mostly processed foods, which really is unfortunately what a lot of patients are having to deal with.

The chain rolled out a program that trained select pharmacists in functional medicine in what they call these specialty pharmacies of the community. And so now there's certain hubs of pharmacists in different local pharmacies that have gotten this extra training and the ability to do these more involved high touch experiences for patients who are getting their specialty medications at those retail locations.

Also, the pharmacists would do wellness days at a local market every three months. They would all be trained on how to do point of care testing, so things like blood glucose, cholesterol, even A1cs. And those were opportunities to have hands-on experience with the patient and talk about changes over time. For example, if blood glucose has been trending up over time, it's likely to keep trending up over time unless you do something about it now. So, the pharmacists can look to optimize their patients' levels when it comes to things like laboratory testing by getting them involved in a proactive approach and looking at how they can prevent the diabetes from emerging. So really, preventive care is important, from a functional medicine standpoint, and is something to consider.

There are some pharmacists who are moving into cash-based health coaching programs. This is an area that could incorporate pharmacy technicians, who could go through a health coach certification. Then they could serve as a contact point for patients and work collaboratively with the pharmacist. And then it could be expanded even further with collaborative practice agreements with physicians, maybe involving compounding and hormone management or a GLP-1 diabetes program and bringing in this functional medicine approach. There are so many different ways that pharmacists can imagine and create for delivering a functional medicine approach.

Supplements can be an entry point into exploring functional medicine concepts if pharmacists are thinking about ways to potentially decrease medications that might be having side effects and potentially utilize some supplements as either alternative or complimentary approaches to treating a patient's conditions. Many patients are not eating a whole food plant-based diet that has plenty of protein in it and healthy fats and produce, then yeah, a lot of times nutrient deficiencies can be a major issue. So, supplements can be important to think about as a pharmacist and for patients that are on medication.

Subject Matter Expert Note: *Someone comes in off the street and says, hey, that looks cool. I'm going to start a Magnesium product. Our staff is notified or is trained to at the register to say, "What's your name and what's your phone number? Because we want to document this in a profile for you and follow up with you to make sure things are going well for you." [Aaron McDonough]*

Subject Matter Expert Note: *So again, it's blending in that allopathic and functional medicine approach and meeting patients where they are with what they need, so many different ways to potentially create these innovative new products, services, programs, groups. And then, yeah, I think just being really strategic and clear about what is the goal, what is the outcome that we're looking for? [Lauren Castle]*

Target Markets

Promotion of the functional medicine program includes targeting groups of patients, as well as for providers. Patients can be categorized by the goals they seek from functional medicine. For patients who want to get off their medications, the FM pharmacist works to find natural substances that mimic what a prescription drug had been doing mechanistically. A second group is patients wanting to minimize the medications they're taking. With this group the FM pharmacist evaluates which medications are best replaced with natural substances. A third patient group is those who just want to feel better. Here the FM focus is on replenishment of depleted nutrients due to their medication and diet. Given the use of social media and the internet, promotion to patients outside the pharmacy's usual market is possible and can be supported by holding virtual consultations and shipping product. Thus, the FM program can expand a pharmacy's geographical reach.

Providers in internal medicine, family medicine, pediatrics and orthopedics have been responsive to the efforts and have made patient referrals. In addition, the FM pharmacist has discussed the functional medicine program with other types of providers, such as physical therapists and chiropractors.

In addition, employer health benefits could be a target for a functional medicine program. For example, FM could be aligned with or a part of a corporate wellness program. An advantage here is being able to layer the functional medicine onto ongoing wellness services being provided by an employer.

Subject Matter Expert Note: *And I think the important thing to note is that when I started this, I thought our patient demographic was going to be a hundred percent people who are anti-pharmacy or anti-medications. And when you look at it, I would say, our demographic looks like the traditional pharmacy right across the street. We just have different conversations. And so, we can't make a judgment that it's just people who are anti-prescriptions or only interested in natural things. [Aaron McDonough]*

Key Stakeholders

A pharmacy adding a functional medicine program into their operations likely would not need to engage new professional advisors (e.g., legal, HR, accounting, marketing). However, one important stakeholder would be a functional medicine champion or expert. This person should be knowledgeable about the approach to, key topics and the nutritional substances used in functional medicine. This person also should have effective communication skills to interact with providers, work closely with patients and create videos put on social media. Pharmacists have a background that is helpful for learning the FM material. Someone seeking to build up their FM knowledge by doing it on their own, working with FM product vendors who provide education or by becoming certified by the Institute for Functional Medicine (IFM). Though IFM certification adds a credential, it isn't required and can cost thousands of dollars.

While the FM champion is the central figure in a functional medicine program, he/she also should lead the training of staff who likely will engage some patients initially in a conversation about their needs and benefits of functional medicine for their health. This training could address basic knowledge of FM, as well as personal selling techniques that can help focus the interactions or developing a standard set of questions to ask patients. Similarly, the FM champion would coordinate efforts to produce or obtain patient materials (e.g., forms, educational pieces) used in the functional medicine program.

The FM champion needs to educate and encourage all staff members to "buy in" on FM. For example, you can't say we recommend this product (i.e., magnesium) for our patients who can afford it. Alternatively, that product (i.e., magnesium) needs to be recommended to every single person who would be a good candidate for it, regardless of unique circumstances/factors. Everyone deserves to have the opportunity to be educated with the same information as the last person. Staff should be trained by the FM champion to provide FM education to every single patient, not just hand-selected patients.

Subject Matter Expert Note: *But when we talk about it being evidence-based and we can always back up our recommendations with literature, I feel like that develops a sense of comfort with the providers that we work with. And then on top of that, we set it up so that we are in constant communication with them as well so that we can send them progress notes and they can understand what's going on with the patient. And then subjectively, the patients are coming back and oftentimes saying, I'm feeling better. And that's kind of what wins over a provider who is hearing from their patients that they are feeling better. And then it's just a second layer of comfort to hear that one, we're a pharmacist, we have a Pharm D, but two, we are making those recommendations based off the literature. [Aaron McDonough]*

Competition for New Service/Care Model

Competitors for this pharmacy's functional medicine program are other healthcare professionals engaged in functional medicine. This pharmacy has about 5 FM practitioners in its community that it competes with in the functional medicine market. None of them are in a pharmacy, which does allow this pharmacy to readily emphasize the drug-induced nutrient depletion.

Subject Matter Expert Note: *Well, I think what you could do is say you're in small town Missouri, and you do a demographic analysis of who in the surrounding communities are offering that service. I think we don't want to think so much of the only way it's going to be successful is based off who's in the community. Because if you do a demographic analysis 60 miles in each direction and find out that no one's offering that service, you just got access to many more people. [Aaron McDonough]*

Resources Needed to Provide the New Service/Care Model

1. Space: A functional medicine program would benefit from a small space for consultations with patients. Such a space could be the same space used for delivering other services such as vaccinations and comprehensive medication reviews. Since functional medicine can be delivered virtually, having a defined consultation space may not always be necessary.

2. Human resources: The primary HR need for a functional medicine program is a staff member (e.g., pharmacist) who has, or can get, the expertise needed for performing FM activities. Such expertise could be developed with a formal certificate or less formally through self-study and education provided through FM product vendors. Further, ongoing participation in FM conferences can support an FM champion staying current with emerging trends. In addition to technical knowledge, ideally, this person has communication skills needed to discuss functional medicine with providers and patients.

3. Marketing: It is important for the marketing of a functional medicine program to reach providers and patients. Providers can be important partners for an FM program by referring patients to it. Face-to-face interactions, as well as mailings and emails can be key for working with providers. Directly reaching patients can be done via the internet, social media and in the pharmacy via staff interactions.

4. Capital: At most pharmacies having a consultation area, it is likely limited funding would be needed to start a functional medicine program. If space was needed, then that cost would need to be funded. Also, it is likely some initial pharmacist time would be needed to develop expertise, establish the FM procedures and to create awareness of the program with providers and patients. Initial inventory costs likely would be modest.

5. Software/Educational Resources: Functional medicine should be supported by specialized data resources, such as the Lifestyle Matrix Resource Center, the Institute for Functional Medicine and the Personalized Lifestyle Medicine Institute to a name a few. Ideally, a pharmacy has a clinical patient record system that can be used to support documenting functional medicine services and products.

   There are plenty of educational resources available, practitioners will just need to find two or three that resonate best with them. These resources can provide guidance on delivering functional medicine, as well as resources used in the FM program. Also, binders of hard copies of information about supplements or handouts of topics of interest to patients can be useful in educating patients about functional medicine. Having key materials in one place and accessible to patients can support efficient processes for a FM program. Similarly, creating a small library of books about functional medicine could support patient learning about FM topics. Hosting educational webinars/seminars regarding FM topics can also facilitate patient engagement and understanding of FM practices.

6. Suppliers: There are a range of FM product suppliers that vary in their pricing, educational support and product quality. Since building a pharmacist's FM knowledge can be vital, having suppliers provide educational experiences is helpful. Some well-known suppliers include Ortho Molecular, Pure Encapsulations, Metagenics and Thorne. In working with Ortho Molecular, the pharmacy was able to establish their own brand of FM products.

   There are different companies within the supplement and lab space that have free resources for putting together clinical programs that are very outcomes based. For example, it could take six months, meeting every month, to go through a protocol or program that the pharmacist can really put together with the supplier's support. So, there are ways to get involved in FM that allow a pharmacist to get involved pretty readily.

Subject Matter Expert Note: *The way I kind of describe it when I do CEs, because people, that's always their number one question is what brand do you recommend or what company do you work with? And I say, I look for a couple things. One is where they're sourcing the raw materials. So, you got to make sure you have good high quality raw materials. And the way that you'll know you have good high quality raw materials is that vendors should be able to provide a certificate of analysis and probably tell you exactly where those materials are coming from. Two, I say they need to be evidence-based formulas, meaning we don't just throw a bunch of random ingredients into a capsule or a formula just because they're hot topics on the market right now. We need to have evidence or literature that backs why we're choosing a particular proprietary blend or a particular dosing of a supplement. As I say, if they're [supplier] willing to back up that their products are the highest quality and they're ready to take the product back and reimburse the pharmacy or give the pharmacy a new product so that their patients have the opportunity to try their products at no risk, then I think that's a pretty strong candidate for a supplier. [Aaron McDonough]*

Costs of the Service/Care Model

Costs for a functional medicine program would include pharmacist time to promote and deliver the FM activities. This staff time likely could start out part-time and build to full time as the functional medicine

program grew. In addition, costs would be incurred for developing program materials and accessing FM informational resources. Also, an initial inventory of functional medicine products would be needed with costs beginning at a few thousand dollars.

Pricing

Depending on the supplier, the gross margin of functional medicine products can exceed 50 percent. In addition, purchase volume can reduce product costs. Pricing for consultations can range from $2.00-$4.00 per minute. The functional medicine business is cash only. There currently is no insurance involvement.

Subject Matter Expert Note*: Cash-based options can be good because you don't have to worry about the extra steps in paperwork and contracts. More and more patients are getting comfortable with the idea that patients have direct providers who are out of network and they're willing to pay $100 or more for a visit because they know that they're going to get so much out of it. And then once you get into a model like that, you can actually start to scale it through group visits. So, group visits are a really effective way to create a program, whether that's around something like diabetes or thyroid. [Lauren Castle]*

Promotional Plan

Patient promotions are done through a variety of communication modes, including online videos, social media, presentations by the FM pharmacist, pharmacy staff interactions and in-pharmacy displays. The pharmacy staff has been trained to discuss drug-induced nutrient depletion with patients and refer to the FM pharmacist as needed. For example, they might talk with patients who are taking a statin medication about how coenzyme Q10 can be depleted by statins. Some patients will be interested, and others will not. Interested patients may even want to proceed to a functional medicine consultation to find out more.

The pharmacy targets providers for the functional medicine program to establish collaborative relationships that generate patient referrals. The FM pharmacist conducts face-to-face and/or virtual interactions with primary care providers, as well as specialists. Providers in internal medicine, family medicine, pediatrics and orthopedics have been responsive to the efforts and have made patient referrals. In addition, the FM pharmacist has discussed the functional medicine program with other types of providers, such as physical therapists and chiropractors.

One key message the pharmacy makes to providers about their functional medicine program is the benefits of helping patients address drug-induced nutrient depletion. The providers often are aware it occurs but may be limited on the details of how to treat it. So, they see the functional medicine program as something that could benefit their patients without taking away something they could do themselves. A second message that resonates with providers is that a functional medicine pharmacist can bring both traditional pharmacist expertise around medications and functional medicine to help bring balance to a patient's health with a holistic approach.

Subject Matter Expert Note: *If someone's getting involved in this space, then are there certain products you would say, I mean, how do they make a determination of what they carry for imaging? They'll start you on, or what Ortho will do if you were to utilize Ortho, and what I would assume most of these companies would offer or recommend is a replenish or replete program is what Ortho calls it, which is targeting drug induced nutrient depletion. [Aaron McDonough]*

Financial Overview

Because the pharmacy had limited start-up costs, it was able to break even with its functional medicine program in less than a year. They have continued to focus on growing the FM business. They have been able to make profits from both consultations and FM product sales. Cash flow is not a concern because no insurers are involved with their functional medicine program. All patients pay cash for their FM products and services.

Monitoring Metrics
Revenue from functional medicine products and services is monitored. The most important metric is supplement sales. In addition, the number of referrals from various providers could be tracked to guide marketing efforts. That is, relationship building efforts could be done to enhance ongoing referrals and to develop new referral sources. Another metric could be to track patient retention. Some patients could naturally stop taking a supplement, while others could continue to offset nutrient depletion from their prescription medications.

Subject Matter Expert Note: *The next thing I would want to stimulate is Google reviews and product reviews too. We already have Google reviews and product reviews, but we haven't really pushed those. Plenty of our products have great reviews from people, and they actually get a discount if they were to do that. If you have a Google review that you'd like to leave or a product review that you'd like to leave, you'll get a discount on your next purchase. So that's kind of been our way of assessing satisfaction from patients. But other than that, anecdotally, I get patient emails all the time. [Aaron McDonough]*

How to Use this Guide
This innovation guide was developed to help provide the foundational information needed to start this innovative practice model. Use of this guide, along with the needs assessment can guide pharmacists who are interested in implementing a cost-plus practice within their respective markets. We also have included the contact information of the subject matter expert (SME) for those practitioners interested in taking a deeper dive into this practice model.

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Innovation Guide

Innovative Practice/Business Model: **Direct Contracting**

Innovator/Subject Matter Experts: **Mike Deninger and Aaron McDonough, Towncrest Pharmacy, Co-Owners**

Purpose
This implementation guide describes an innovative practice/business based on an interview with two of its early adopters. It is intended to provide essential information regarding key components to starting and implementing the new pharmacy practice model. Its objective is to provide guidance to interested pharmacists to develop a similar approach in their practices.

Description of the Service or Model of Care
Direct contracting is when a pharmacy signs a contract with a self-insured employer to provide dispensing and perhaps other services for its employees. The intent is to find pricing for the services that costs less than a

PBM charges the employer, while paying the pharmacy more than what the PBM reimburses the pharmacy. Such agreements can bundle in services such as delivery and adherence packaging, in addition to discounts on over-the-count products.

In this case, the pharmacy worked with an employer that had unbundled its healthcare insurance from its prescription coverage. This unbundling allowed the employer to seek lower cost approaches than those provided by traditional PBMs. A direct contract with a pharmacy was the approach that they pursued. First, the employer shared some claims for their employees from several months, which allowed the pharmacy to compare the costs of a potential direct pay contract with what the employer was paying to their PBM. The employer and pharmacy agreed on a cost plus model using medication invoice costs plus a single professional fee. The services that were bundled into the direct contract included annual medication reviews, adherence packaging, drug utilization review and delivery service.

In addition, the agreement had lower patient co-pays ($4 generic/$25 brand) than did the use of another pharmacy ($8 generic/$35 brand). Employees of the contracted employer were encouraged to utilize the directly contracted pharmacy but were not required to do so. After an initial period of managing the payment processing for the contract, the pharmacy later contracted with a third party administrator to process prescription payments for these employees. The prescriptions for these employees proceed through the pharmacy's dispensing software system using the agreed upon terms and are processed into a monthly report by the third party administrator. This report then is used to create an invoice to the employer to pay.

In the case of a direct contract for prescription medications, an employer likely will wish to purchase stop loss insurance. Under this type of coverage, the employer will pay for medications up to the stop loss limit. Then, any prescription medication expenses above that amount will be paid by the insurer. This approach reduces the risk that the employer would need to pay unexpectedly high amounts for prescription medications for their employees.

Another opportunity that can arise from direct contracting for prescription medications is to upsell or offer to provide corporate health and wellness services to the employer. The initial prescription medication contract can open a dialogue between trusting partners about having healthy employees, which can include health and wellness services. For example, on-site immunizations, health screenings or a health fair could become the focus of such discussions. This guide will not address those opportunities other than raising their viability.

In performing its DUR role, the pharmacy will look for opportunities to save the patient and employer money, rather than optimize its own rebate amount like a PBM. This DUR involves a clinical assessment of the patients and medication. Is this the right drug and dose for this patient? Are they likely to have the desired effects from it? Is it cost-effective? There is not a formulary that needs to be followed. Rather, a trigger amount could be set for when the employer needs to approve paying for the medication (e.g. $500). At that point the pharmacy would talk with the patient and employer about the best way to proceed (e.g. dispense what is written vs. substitute another medication). Also, the provider would need to be consulted as well. A benefit here is that a large organization (e.g. PBM) that is located in another state is not making the decision, but rather the local parties involved do so.

Subject Matter Expert Note:
Nowadays I think in this new market where the employees are really focused on health and wellness, it's now pitching to the employer groups. Hey, we controlled your cost as it relates to medication spend, but now let's try to control your health and wellness and potentially preventable costs that might be associated with the hospitalization or emergency department visit.

Key Stakeholders

A direct pharmacy contract likely would work best with smaller companies (i.e. <500 employees) that are self-insured. Employers of this type could be willing to carve out the pharmacy benefit from their larger health insurance coverage. Depending on the organization, the key person could be the owner or the head of human resources.

Subject Matter Expert Note:

When the prescriptions are filled, they go through the normal process as before. The only difference then is at the end of the month we run a report for that carrier which lists all the prescriptions that were filled. It lists all of the copays that were collected and it lists the total cost for the drugs that is based upon the contract that we set up with the employer. And so that difference column is what is entered then as a receivable in their charge account and they get that report as their documentation of what was dispensed.

Competition for New Service/Care Model

The PBMs are established in providing prescription medication coverage through a network of pharmacies. In this way, they compete with a pharmacy offering direct contracting for prescription services. The PBM can be used as a comparator for the pharmacy based on what it is charging the employer. In addition, the various restrictions and opacity of a PBM provide a contrast to what can be offered by a pharmacy through direct contracting. For example, a pharmacy can be flexible with days supply being dispensed and eliminate prior authorization to contrast with a PBM's rules.

Resources Needed to Provide the New Service/Care Model

1. Space: No additional space typically would be needed

2. Professional services:
   A third party administrator is helpful to process prescriptions as claims. This process allows proper calculation of the patient co-pays. Also, the processor can provide a list of the prescriptions that can be used to invoice the employer each billing period (e.g., month).

   A pharmacy likely will need legal services to develop and sign the agreement with the employer. These documents can be straightforward about the services to be covered and language about billing and payments.

3. Human resources:
   Whether or not a pharmacy doing a direct contract needs additional staff depends on how close they are to maximum capacity with their current staff. If the direct contract raises the number of prescriptions dispensed enough, it is possible additional staff would be needed. Or, perhaps a part-time staff member could work more hours. Depending what services are bundled into a direct contract, a pharmacy may not need to hire anyone with specific expertise.

4. Software/Technology:
   Technologies (e.g. dispensing automation) could be used to distribute added prescription load or central fill might be used to optimize a pharmacy's workflow. Also, added use of bundled services could affect a need for more technology, such as greater capacity for compliance packaging.

Subject Matter Expert Note:

We've made a lot of changes in our processes to optimize efficiencies over time. None of them were directly associated with direct contracting, but just in a general effort to free up the pharmacists to do what pharmacists can do best. W*e've got robotics, clinical documentation software, and things that can let our*

pharmacists work with a patient in need. We haven't actually added anything explicit to direct contracting. It's all dovetailed together into the whole package. We are a clinically oriented community pharmacy.

Costs of the Service/Care Model
For a direct contract for prescriptions, a likely cost added beyond usual dispensing costs would be for the third party administrator to process the "claims." This could cost as low as $1.00 per prescription, depending how simple it is and the administrator's fees.

Pricing
A starting point for pricing was to analyze a set of claims the employer paid through its PBM. This analysis showed there was a sizable gap between what the employer was paying and what the pharmacy could get paid to cover its costs and some profit. After negotiation about pricing and bundled services, a pricing formula was set. The formula was invoice cost plus a $12.00 professional fee. The services that were bundled into the direct contract included annual medication reviews, adherence packaging, drug utilization review and delivery service. Additional detail on the initial analyses of claims is available in the following article. Witry M, et al. Examining the case for direct contracting: A multistakeholder case study. *J Am Pharm Assoc*. 2023;63:1592-1599.

Promotional Plan
The targets of promotion of direct contracting for prescription services are smaller employers (<500 employees) who have self-insured. These organizations should be presented with the benefits and costs of leaving their PBM and going direct contract with a pharmacy. A local pharmacy can customize its services for the employer's employees, meeting their medication and pharmacy needs. Also, many smaller businesses are open to working with a local business over a large national organization. Further, PBMs are not providing proper transparency on costs and payments, which offers an opportunity for a pharmacy to discuss that with a prospective direct contract client.

Also, once a pharmacy has a direct contract with an employer, they can approach them to discuss providing additional services. Depending on they employer's needs, such services could include testing, monitoring and even test and treat in some states.

Subject Matter Expert Note:
I think asking the business owner what they're paying for, and actually not just know what the bill is, but what are they paying for? Striking up the conversation that way. And if they don't know exactly what they're paying for, you can start by getting an itemized receipt of what their prescription drug usage is, which they should be able to get from their insurance carrier, and then telling them what you could charge them.

Financial Overview
While the gross margin from direct contracting should be better than for contracts with PBMs, the time to get paid could be longer. That is, PBMs have been compelled to pay quicker (e.g. every 15 days), while the direct pay contract may be monthly. However, it is possible that the billing and payment for the direct contract could be set at 15 days rather than monthly.

Monitoring Metrics
While the financial aspects (e.g. profitability, cash flow) are important to monitor, another thing to monitor is whether the employees are satisfied with the pharmacy services they are receiving. Employee satisfaction could be monitored with an annual customer satisfaction survey. The employer wants its employees to be healthier and to retain good employees, to which a direct contract for prescriptions could contribute.

How to Use this Guide
This innovation guide was developed to help provide the foundational information needed to start this innovative practice model. Use of this guide, along with the needs assessment can guide pharmacists who are interested in implementing a cost-plus practice within their respective markets. We also have included the contact information of the subject matter expert (SME) for those practitioners interested in taking a deeper dive into this practice model.

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Innovation Guide

Innovative Practice/Business Model: ***Direct Patient Services under a Team Model***

Innovator/Subject Matter Expert: **Amina Abubakar, PharmD, AAHIVP, CEO**
Avant Pharmacy and Wellness

Purpose

This implementation guide describes an innovative practice/business based on an interview with one of its early adopters. It is intended to provide essential information regarding key components to starting and implementing the new pharmacy practice model. Its objective is to provide guidance to interested pharmacists to develop a similar approach in their practices.

Description of the Service or Model of Care

Direct primary care (DPC) is under the primary care umbrella. There is the ***traditional model*** where patients are coming to see their primary care provider (PCP) and have insurance. But there also are those patients who have high-deductible plans or have no insurance, so creating a ***membership model*** where the patient pays the clinic directly (cash) for the clinic providers to be available for them as primary care.

Community-based pharmacies have an existing brick and mortar building that patients are already accessing for part of their care. Bringing in a PCP (nurse practitioner, physician assistant or medical doctor) allows for collaboration to happen at the pharmacy level. The pharmacy can be involved in creating a formulary that allows patients to afford their prescriptions within their membership. Basically, the community-based pharmacy serves as the convening point (co-location) for patient care. The patient sees the PCP, then they can receive their prescription medications from the pharmacy. It's two separate practices (businesses) co-existing. In this model, the owner of the medical part of the clinic depends on the state (some states allow for non-physician owners, others do not). But from the public perspective, even though they are under the same roof, there are two separate practices—the medical provider practice and the pharmacy practice.

Beyond this model (DPC) and co-location, though, is the model of ***Direct Patient Services under a Team Model.*** In this model community-based pharmacy providers are part of the patient care experience. There are many PCPs that are associated with value-based contracts in which they (PCPs) need to meet certain outcomes, certain metrics which are challenging to attain with short patient visits (<15 minutes). *These providers are potentially interested in contracting with*

community-based pharmacies to provide chronic care management (CCM), coaching and ongoing monitoring. The patient is seen by the PCP, progress notes, labs, and other clinical data are shared with community-based pharmacy team (in this model, the PCP and Pharmacy are not co-located). The patients are categorized by their health needs (e.g. BP control, adherence improvement, cholesterol control, blood sugar control). The community-based pharmacist now facilitates the care plan with the actions to actually achieve the outcomes desired.

This Direct Patient Services under a Team Model can fit with the concierge (membership) model as well as the insured (Medicare and commercial) model. It's about the community-based pharmacy team being part of the integrated care of patients (medical and pharmacy providers working together to achieve the therapeutic goals for patients). Pharmacy is contracted to provide CCM with the difference being the payer (e.g. Medicare, commercial insurance, patient). Also, CCM can also be part of the membership fee in the concierge/co-located models.

Amina got into this space in 2012 as she was trying to figure out how to get paid to do clinical work. She came upon a journal article explaining how pharmacists can get paid through annual wellness visits. In the article it was about vertical integration within a health system. Amina started exploring how she can do this outside of the vertically integrated model with each provider (physicians and pharmacists) owning their own practices (horizontal integration). So, she learned about the Medicare rules about supervision needed and created agreements with medical practices to provide these expanded clinical services. Amina has seen this integrated practice expand over the past twelve years, where she started with Annual Wellness Visits (AWV), moved into Chronic Care Management (CCM), and then to behavior health integration, remote patient monitoring (RPM) and remote therapeutic monitoring (RTM). Information between provider is shared through an electronic health record (EHR)

This approach is recognized by Medicare and gives you a framework on the different codes you can use to bill, the time limits, and the amount for billing. This same approach can also be used for the cash-based or concierge practice because that is what the market is bearing.

Subject Matter Expert Note: *Initially, Amina did not create new business entity. She approached a physician colleague about annual wellness visits and wanted to see if they were interested in partnering to provide Annual Wellness Visits (AWV) based on an article she had read. She worked collaboratively with the physician and received a successful billed claim. Eventually it became more of their business than the actual pharmacy itself. That is when she separated her consulting (Avant consulting arm) revenue from her pharmacy revenue. Eventually, through her discussions with physician practice, she realized that many of those practices do not have good understanding of the "business-side" of their practice and this led to her developing her management service organization (MSO) in which she helps to manage the practice. Her MSO is a separate corporation. As an MSO, she worked with billers, learning appropriate billing codes, and how to look at the practice metrics (consumables, revenue, and growth opportunities). This led to co-location opportunities in which a primary care provider (PCP) is co-located in a community pharmacy.*

Key Stakeholders

Key stakeholders changed over time for Amina. Currently, she recommends that you look for medical providers who are under a value-based contract who are incentivized by achieving clinical metric goals. She finds this information through communication with providers. By researching a provider's NPI, it will tell you if they are part of an Accountable Care Organization (ACO) which informs you that they have metrics. If they are not part of an ACO then they have a Merit-Based Incentive Payment System (MIPS) which is a program that will determine Medicare payment adjustments using a composite performance score. So, it's understanding the value-base system and how prescribers are receiving reimbursement based on metrics. Then, the next conversation becomes how are you doing on what you're being measured? Another thing is for pharmacy not to go in thinking they need a lot of lives. The idea is you can start small by asking for a subset of patients that are affecting their bottom line because of this value-based contract.

***Subject Matter Expert Note**: It's about patient clinical outcomes and NOT about being measured on adherence rates based on a 90-day fill. The 90-day rate may be an easier metric to tackle, but it may not be realistic for many patients and it is not a true metric of non-adherence. Having that conversation with prescribers and emphasizing how pharmacy and medicine can work collaboratively to impact clinical metrics (e.g. A1c, Cholesterol levels, blood pressures) which improved value-based reimbursement by achieving clinical metrics with which the medical practice is being measured and paid. And they realized they would make more money focusing on those measures than what they thought was the easy (90-day fill). Medical providers wanted the easy measure 90-day pharmacy fill because they don't want to tackle the A1C, they don't want to tackle the blood pressure. Part of the issue is that community pharmacy has not socialized/normalized the value of community pharmacists impacting patient clinical outcomes. There are many non-professionals offering this service and cutting corners which is not what we want to put in a guide model, but it happens.*

Resources Needed to Provide the New Service/Care Model

6. Labor (started with existing employees)
7. Computers/Laptops
8. Cybersecurity (since everything is virtual)
9. Training for pharmacists
10. Consultation room(s) that can fit desk/table and 2 chairs
    a. With growth, more consultation rooms may be needed

***Subject Matter Expert Note**:*

A question that comes up is if you need to be under the same roof as the physician/prescriber and that is the case for Annual Wellness Visits, but not chronic care management (CCM). Since COVID, CCM is under general supervision so it can be done via phone. We are not sure when this might end or it may stay that way—we are just not sure at this time. This is also true for remote patient monitoring (RPM), remote therapeutic monitoring (RTM) and behavior health integration (general supervision)

Costs of the Service/Care Model

1. Pharmacist time
2. Computers/laptops

3. Creating patient care areas
4. Office supplies/furniture

Pricing

The fee for the service is based on the codes. So, if Medicare, for example, already pays for (using this as an example to show the numbers/financials) chronic care management 20 minutes is $60, we can estimate the percent of work we do for that code. So, then we turn around and give the clinic a fee for service hours, meaning they still are responsible for billing it, they're responsible for supervision, they're responsible for review. And so that's kind of how you gauge your time involvement. And then you create your fee schedule to give them.

Pharmacist payment should not be based on a percentage of claim billed, but rather a rational amount based on time performed for services keeping in mind that a pharmacist costs $2.00 per minute. If CCM takes 20 minutes, that is how you come up with a $40.00 fee charged to the prescriber practice. And remember, the prescriber practice is receiving large quarterly bonuses for achieving their clinical metrics.

***Subject Matter Expert Note**:*

I think the tricky part is what Medicare doesn't want is you only get paid when Medicare pays. That means you are only doing this because Medicare will pay not because the clinic is willing to hire someone to do a service. Our legal team said you have to provide the service even if they don't get paid. The truth of the matter is when you have the denials, they (the provider's clinic) still have to pay you, but what we realized is that when you do a great eligibility check of your patient you minimize what they're not going to get paid. So, your eligible patient, if you hear, oh, Blue Cross Blue Shield does not cover remote patient monitoring, then we're not going to manage remote patient monitoring for Blue Cross Blue Shield patients, things like that.

The billing codes are the currency that affords you to bring in a high level clinician to drive where your big bucks are. So, Medicare gave prescribers these codes to be able to do this work in between office visits. So, for example, you're a doctor, you have your office visit, 15 minutes, you get $70, but then Medicare is telling you, or commercial is telling you, I need X percent of your patients to have these goals. That's never going to happen in that office visit. So, then they give you a list of codes that say, no, use this. Call them every month for chronic care management, give them a blood pressure device and coach them. So, Medicare has given you a pathway, whether you do it as a doctor yourself or team or you contract it out, you have a pathway to afford someone to do it. So that shouldn't be where you make your money. That should be where it affords you these extra activities that would drive results.

Promotional Plan

Many patients don't understand this type of practice you have if they do not fill prescriptions at your pharmacy. So, the best way we have promoted to patients is that their providers are offering it and letting them know that it's okay. It's kind of like if you want success, but we go in and we put a note in the EHR, for the provider, those patients who are eligible. Every time they see them, they say, "Hey, Amina is going to call you. She's part of our team and I do want her to follow up with you guys."

Now, if you had to cold call because the clinic isn't helping you, the best approach is never to call the patient to tell them they're being enrolled in any program. It is really to check in and see where the patient is with their overall health, how they feel, and let them become part of the conversation. It happens all the time. You are like, "Hey, William, just calling in from practice A, B, C. Dr. Wynn

wanted me to check in how are things going since the last visit, I see that you got your prescriptions, did the pharmacy fill it on time?" And so that's when you invite them because patients aren't going to sign up if they don't feel like you can bring any more value to their lives. So that's when we say, yes, you are eligible to be part of our chronic care management program where we will be making these phone calls, checking in with you in between visit. Physician referrals definitely help, but most do not want to do the work to recruit patients so it is up to the pharmacy team to recruit.

And so, we are now more going deeper into other clinical services including HIV PrEP and PEP starts. We have extended outside of Medicare service to other clinical services. We also expanded into substance use disorder (SUD). Our pharmacists are seeing patients and getting them off opiates and starting them on MAT.

Subject Matter Expert Note:

The question was asked to Amina about why we are seeing more of this being done by pharmacists. She answered, "I think one of the barriers is pharmacists went in way early before the docs really got penalized and it was like, "Hey, this is coming." And they didn't see it coming. So, some of them got the early no and they stopped. And then two, the physicians that people are approaching are not wanting to let you into their EHR. And because it is a trust factor, it's like me coming to a pharmacy and knocking on your door and saying, Randy, you have all these Medicare patients, I could go in and manage their diabetes. There's a comfort zone of letting people into your patient management system and it hasn't been normalized from the physicians. So, writing these things and getting more people to write where a physician sees it as normal, I think it is the work we have to do. I was lucky because I started with those that they already trusted me. I think trust is the factor that because once they get you into their EHR, you basically can see it so much more. And when they hear you're a pharmacy, they think you want to get prescriptions to your pharmacy."

Financial Overview

This financial model is based on labor, but because her costs are relatively constant, her margins are better compared to her pharmacy. The point to remember is that the money is in value-based contracts with incentives. For example, one clinic that Amina worked with signed up because they received the bonus upfront, but now they are responsible for the outcomes and they realize they cannot do it alone. Even though they may hire nurses, Amina predicts that approximately 90% of all interventions are medication-based.

Monitoring Metrics

1. Productivity Tracker: At the end of the day, how do we pay you? So, we have a productivity tracker, we set a benchmark, they see what they have, X number of encounters that they have to reach, and then when they reach a certain level, we now make them part of a team. So, we bring in assistance that helps them with calling patients follow up enrollment, and now they're in charge of that whole cohort success. And it also helps them understand what provider status means and that you've got to do services that produce enough to pay their time. It's a hard concept. We had people leave, pharmacists want provider status, but they're not prepared to do the work required to be paid as a provider.

2. The value of this model is the ability of community pharmacists to improve clinical metrics. It's about the quality of the service, working collaboratively with prescribers in a true integrated model. It was emphasized throughout this interview that the emphasis needs to be about the quality of care that community pharmacists can provide. Though this is a new model of care in which pharmacists can drive new revenue, it is the pharmacist's ability to improve patient care and patient outcomes that drives this model.

3. It was mentioned by Amina that 90% of the issues her team helps to resolve for the patients does center around medications.

4. Patient satisfaction: In the very beginning Amina's team did a lot because they needed to prove how they could do better than previously tried strategies that a provider clinic may have tried. This service has to be meaningful to the patients, otherwise they become disengaged which leads to push back from clinic provider. Amina keeps patient engaged by have a planned focus for each call by using a health topic calendar as a guide.

Subject Matter Expert Note

So, this is a growth area for community pharmacy. It's a much needed service for our population with chronic disease that is bankrupting our health care system. It's a crisis! But for Amina's business, what she actually ended up doing is instead of expanding further and getting the next provider that works with her team, they really don't expand anymore because the clinics they have worked with, it is growing within—even to the point of pharmacists who in the past worked for Amina as a chronic care pharmacist, have been leased by physician clinics to help manage their patients. Some pharmacists have even been hired by the clinics. Now, Amina's focus is on training other pharmacists to do this.

It was asked of Amina if board certification is needed for pharmacists to provide this service and this was her response: "Hustle is required. You've got to be able to think about, am I efficient, am I giving value? I feel like every pharmacist has what it takes to engage patients way better than any medical clinic is engaging right now. So, on the get go, lots of patient counseling opportunities. Then you start to kind of like if you're managing a practice, one of our practices is the largest HIV clinic. If you're not up to date with the HIV meds and the side effects and what patients should look out for, then you got to increase your knowledge to do those things. If pain management is a key, then your calculations of morphine milli equivalent identifying patients at risk that you let the providers know. So, I feel like that clinical aspect is underutilized in the marketing of this program."

How to Use this Guide

The innovation guide was developed to help provide the foundational information needed to start this innovative practice model. Use of this guide, along with the needs assessment can guide pharmacists who are interested implementing a cost plus practice within their respective markets. We also have included the contact information of the subject matter expert (SME) for those practitioners interested in taking a deeper dive into this practice model.

Reference

Amina referenced this education offering that she and her team assisted the American Pharmacists Association in developing to help pharmacists interested in the practice. This educational offering also has information about billing and coding.

https://www.pharmacist.com/Education/Certificate-Training-Programs/Pharmacists-Getting-Paid-Through-Collaborative-Clinical-Services

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