The trend toward clinical care and an emphasis on measured performance are leading pharmacists to work harder than ever to elevate the level of engagement not just with patients, but with other members of the care team as well. Story begins on page 19.

Plus...

• Learning from Appointment-Based Medication Synchronization

• Differences Between the Australian and American e-Prescribing Models

• How a Web-Based Program Is Supporting Clinical Services
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Patient Engagement: Driving PHARMACY PERFORMANCE

by Will Lockwood

Community pharmacy has long excelled at making connections with patients. Now, the trend toward a greater focus on clinical care and an emphasis on measured performance are leading these pharmacies to work harder than ever to elevate the level of engagement not just with patients, but with other members of the care team as well. Find out how pharmacists are using a wide array of both cutting-edge and long-standing technology to help them in their efforts. Story begins on page 19.

Features:

10 Filling a Void with a New Clinical Service

An Interview with Rick McCoy

Rick and Marge McCoy, innovative pharmacy practitioners over the years, have developed a collaborative drug therapy agreement (CDTA) at their Lopez Island Pharmacy to fill a void in clinical care due to limited staffing at the island’s only clinic. Here, Rick McCoy explains to ComputerTalk’s Maggie Lockwood the process and the Web-based program that allows the pharmacy to support the CDTA.

15 The Effect of Appointment-Based Medication Synchronization on Clinical Services in a Community Pharmacy


The appointment-based model (ABM) for synchronization programs is gaining traction as a way for pharmacies to better organize and improve patient care. The ABM has been associated with improved adherence, as well as improved prescription workflow and an increase in time available for clinical services. This recent study sought to assess the model’s impact on revenue from prescription and clinical services and how well it allows for the reallocation of time from prescription filling to clinical services such as MTM and immunizations.
Increase patient adherence and your star ratings

How can QR codes, printed on receipts, enhance patient safety and pharmacy efficiency?

The majority of patients will discard patient information leaflets after leaving the pharmacy, creating the potential for confusion and misuse. When they do, there’s the possibility to negatively impact their health, their family, and even the pharmacy’s operations.

MedsOnCue enables pharmacies to automatically print medication specific QR codes on the receipt tape printed from RMS’ POS system. Patients can scan this code with their smart phones and access real-time, pharmacy-branded prescription medication counseling videos. Videos that deliver enhanced levels of medication safety and patient education.

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Paperless Labeling

The FDA recently published a proposed rule that would convert the manufacturer’s paper labeling, either on or in a product from which the drug is being dispensed, to electronic media. This would provide for far more timely information on warnings, adverse reactions, and contraindications that, in paper form, may take several months to work its way through the supply chain. Manufacturers are now required to update their labeling every six months with changes that have taken place. Moving to electronic labeling would give pharmacists access to changes within a few days — close to real time — by going to labels.fda.gov. I went to this site, and it is easy to select the drug in question and go right to the section of the labeling that would be of interest to you.

For pharmacies without Internet access (and these are in the minority), manufacturers would be required to have a toll-free number to request that the labeling be emailed or faxed, or a paper copy be mailed to the pharmacy. This toll-free number would be operational 24/7 and printed on the container label. So would a note that the prescribing information is available at the FDA’s website.

Moving from paper to electronic media will save the pharma companies a bundle. But the FDA anticipates that pharmacies would incur setup costs associated with this changeover and with the expense of printer and paper use when someone asked for a printed copy. On the other hand, pharmacists could refer the patient to the FDA’s website.

In a survey with pharmacists the FDA found overwhelming support for electronic access because it would increase patient safety. While they can go to the manufacturer’s website to access the labeling, having it all in one place simplifies the process. Moreover, pharmacists would no longer have to contend with the small print on paper that makes the information difficult to read. The FDA also found that pharmacists have access to other electronic drug compendia, so the labeling accompanying the product into the pharmacy is rarely referenced and often ends up in the trash. And the FDA is aware that patients are receiving drug monographs with their prescriptions and, where required, medication guides, so a copy of the manufacturer’s labeling isn’t really essential.

I doubt that when the final rule is published it is going to deviate very much from the proposed rule, since all the issues with the conversion to electronic media are addressed in the proposed rule.

I was involved with a PhRMA task force on this subject a few years ago that started us down this road. It seemed to me that this was a natural Web application. There was a lot of discussion at the time as to where the information would be stored. This has now been answered with labels.fda.gov.

Bill Lockwood, chairman/publisher, can be reached at wal@computertalk.com.
You’re an independent pharmacist with your own methods and way of working, so why are you conforming to a pre-defined workflow? QS/1® offers customizable solutions that work the way you want. Our Pharmacy at a Glance dashboard is user-defined, allowing you to flag bottlenecks and designate tasks from workstation to workstation. With QS/1, you can display exactly what you want, where you want.

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RxNet has announced a new pricing service called ProfitMax that allows pharmacies to lower prices on popular drugs without pricing too closely to the pharmacy’s acquisition cost or being paid at usual and customary pricing. According to Chuck Cannata, president of RxNet, ProfitMax automatically analyzes price overrides and compares these to recent third-party reimbursements, the pharmacy’s acquisition cost, and area market pricing. The pharmacy’s pricing will be adjusted based on its custom preferences, local market pricing, and third-party payment patterns. “Pharmacies will be more competitive and more profitable without risking being paid at usual and customary pricing or pricing too close to the product cost,” he says.

Cannata sees ProfitMax as set apart from other pricing services by its ability to analyze multiple data points simultaneously. “While some pricing services require their staff to act on data, RxNet’s services automatically make adjustments and a summary of what’s been done is provided to the pharmacy,” he says. Cannata says that he has found that a pharmacy’s profit margin can be increased one to three percentage points.

ScriptPro received the number-one ranking in the recently published KLAS report 2014 Best in KLAS Awards: Software & Services for the company’s SP Central Pharmacy Management System. Reports compiled by KLAS, the leading healthcare IT research and rating firm, represent the opinions of people actually using the technology being evaluated. According to Mike Coughlin, president and CEO of ScriptPro, “As our installed base increases, the KLAS reports are another important way that we receive objective, independent evaluation from the industry.”

QS/1 has added a feature to its mobileRx app that will remind patients on their smartphones when to take a prescription or over-the-counter (OTC) medications. Patients can access the list of prescriptions they are taking from their patient profile. They enter the times when they take the medications. The smartphone will then send an audible alert or vibrate as a reminder for the times set. For OTC items such as aspirin and vitamins, the person can manually schedule the reminder times. Charles Garner, QS/1 market analyst, explains that the goal is to help pharmacies provide better service that will result in a higher level of adherence, taking advantage of the trend in greater reliance on smartphones by consumers.

QS/1 has also announced a partnership with Community Care of North Carolina (CCNC) in order to coordinate healthcare providers. The QS/1 pharmacy management system has been enhanced to exchange information with CCNC’s software application used to conduct medication reconciliation for Medicaid patients in North Carolina.

Integra has added functionality to its flagship workflow management product DocuTrack to comply with a new policy of the Colorado State Board of Pharmacy. The policy requires that a computer system be capable of displaying for review at least 600 orders per hour, according to Amylynn Johnston, pharmacy manager for Good Day Pharmacy in Johnstown, Colo. “If a pharmacy’s computer system is unable to comply with this regulation it must cease maintaining records electronically. It was going to be impossible to have an inspector key in 600 prescription numbers and view not only what we had in DocuTrack, but QS/1 as well, in one hour. We needed a system that mimicked the old-fashioned way of looking through prescription packets. Integra bridged this gap for us by creating Audit Assist,” says Johnston.

According to Johnston, Audit Assist is used to load a range of prescription numbers, sort the documents attached to them, and bring them up in order. The interface with the QS/1 system will bring up the linked prescriptions in that system at the same time. Audit Assist will be available to the entire DocuTrack customer base in a general release of DocuTrack 6.

Health Business Systems has added a pharmacy service portal as an extension of its pharmacy management system. The portal is designed to engage...
ScriptPro

Leading the Way in Pharmacy Automation

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“The efficient operation of the SP 200 expedites the filling of prescriptions. Our pharmacists have more time to spend on complicated prescriptions, on reviewing patient profiles, and on patient counseling.”
– MD Anderson Cancer Center Pharmacy

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– Live Oak Pharmacy

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“ScriptPro Customer Service is always there and you get immediate results. Installation was flawless and the training was the best. It is fun to work with a company that does what it says it will do in a time when most companies don’t. The quality and service is everything you were promised it would be.”
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patients at the point of service to improve outcomes and star ratings. Pharmacists are given quick access to review and update patient information on the fly through any existing PC, POS system, or mobile device and to determine a patient’s prescription status, e.g., which are in the process of being filled and which are in will-call ready for pickup.

The portal will tell pharmacists the prescriptions that are in process or ready for pickup. It can be used to update preferred contact method and pickup/signature capture. Pharmacists will also receive message alerts to discuss with the patient.

**AdvanceNet Health Solutions** has announced that WellDyneRx has successfully completed data migration and begun dispensing prescriptions using ePostRx as its primary pharmacy management and fulfillment solution. The ePostRx Open Source Solution was adopted by WellDyneRx and integrated with its other proprietary software to accommodate all prescription distribution models, including mail and specialty pharmacy, on a single platform across multiple dispensing locations.

Matt Walko, VP of business/software development for ANSHealth, says that, “We’ve proven that ePostRx provides pharmacy owners a much lower cost per script, as well as lower error rates, while increasing operational efficiencies.”

**The RxSafe 1800 robotic storage and retrieval system from Innovation, makers of PharmASSIST pharmacy automation solutions, gets high marks from Matthew Maker, owner of Donlon HealthMart Pharmacy in Decorah, Iowa. Following his recent implementation of RxSafe, Maker has found that the system has helped to reduce unneeded stock.**

Maker generates a 90-day returns report every weekend and sends back to the wholesaler any sealed stock bottles that are not needed, receiving full credit as long as the wholesaler receives it before the 90-day window expires. He sees RxSafe as part of keeping a leaner inventory.

His pharmacy fills between 275 and 300 prescriptions a day. The RxSafe 1800 is integrated with the pharmacy’s Computer-Rx WinRx pharmacy management system.

**Yardi** has announced the launch of the Yardi EHR browser-based electronic health record solution that is built into its suite of products for the senior living industry. According to the company, Yardi EHR is the first electronic health record solution to operate within a complete enterprise resource-planning platform designed specifically for senior living providers, namely Yardi Voyager Senior Housing.

Core functions of Yardi EHR include resident assessments, care planning, staff assignment oversight, medication administration, incident tracking, wound care, and behavior management. As Yardi VP of Senior Living Eric Kolber points out, these are features that help Yardi clients reduce their risk exposure through real-time alerting and enhanced clinical leadership oversight to eliminate incomplete service plans, poorly written notes, improperly documented medication records, and data inconsistencies across nonintegrated software.

**MillerWhite Marketing’s turnkey Rx Retail Booster package, recently introduced, is designed to help community pharmacies compete with the drug chains.**

“The anchor product is a website built with a content management system that lets the pharmacy owner take control of content,” notes Bill White, co-owner of the company.

In addition to the customized websites, Rx Retail Booster also offers a social media component and a mobile app that can be downloaded for Android and iOS. The website can also be networked to the Rx30 and other pharmacy management systems and can be built to include an e-commerce component.

**RNA Holdings LLC dba Mobile MedSoft** now offers the integration of the iAMOS Doctor EPCS
(electronic prescriptions for controlled substances) application to allow physicians to transmit electronic prescriptions from workstations or mobile platforms to pharmacies.

The iAMOS Doctor application is fully integrated through Surescripts with the EPCS module within Mobile MedSoft’s Helix Pharmacy System, and is fully certified and compliant with all DEA and state regulations related to e-prescribing.

Retail Management Solutions has been selected as the approved point-of-sale vendor by the Independent Pharmacy Cooperative. With this agreement, over 4,500 member pharmacies have immediate access to a variety of enhanced capabilities to increase store profitability, while receiving significant purchase discounts on RMS pharmacy POS solutions, such as the company’s Star-Lite and Star-Plus point-of-sale systems.

PrescribeWellness and TeleManager Technologies have agreed to integrate their cloud-based platforms to improve medication adherence and provide patients with advanced clinical services. Through the partnership, PrescribeWellness customers will have access to TeleManager’s iRefill Connect products and VoIP phone and call center systems. TeleManager customers will have access to PrescribeWellness’s medication synchronization and other clinical services.

Surescripts is working collaboratively with PDR, LLC, a leading provider of drug information, to expand coverage of PDR’s CompletEPA electronic prior authorization solution, which is available to more than 290,000 physicians nationwide.

Between Surescripts’ direct connections with all the largest pharmacy benefit managers and PDR’s library of electronic prior authorization forms, CompletEPA offers the capability to process benefit data for close to 100% of patients in the United States.

CompletEPA is integrated into existing electronic health record software to provide a fully electronic real-time solution, and when coupled with the existing electronic prescribing workflow prior authorizations can be processed, in many cases, before the patient leaves the office, avoiding the need to use Web portals, calls, or faxes.

FDS has announced partnerships with Transaction Data Systems (Rx30) and Computer-Rx for use of FDS’s myDataMart. This is a service offered by FDS that provides an array of dashboards and graphical reports to help manage patient adherence that will reflect on a pharmacy’s five-star performance measures. Pharmacies can also benefit from the use of myDataMart’s population health management tools and business tools designed to improve profitability.

In commenting on the partnership, Steve Wubker, president and CEO of Transaction Data Systems, says that he sees myDataMart as offering “tremendously valuable data analytics . . . to give our stores powerful real-time information to keep them ahead of the competitive curve.” Roger Warkentine, founder and CEO of Computer-Rx, says that by providing data to myDataMart he sees the service helping pharmacists grow their business by better understanding their business with the data they will have access to.

Still another partner announcement by FDS is American Pharmacies, a member-owned buying cooperative that will provide its members with not only the benefits from myDataMart but also eNGAGE, another offering from FDS that automates patient messaging.

Intelligent Hospital Systems has acquired the AmerisourceBergen Technology Group and combined the businesses to form a new company that will operate under the name ARxIUM. IH Systems’ RIVA technology is a fully automated IV compounding system, while ABTG provides workflow and scheduling software.

IH Systems is a medical device company focused on the hospital market.
Rick and Marge McCoy, innovative pharmacy practitioners over the years, have developed a collaborative drug therapy agreement (CDTA) at their Lopez Island Pharmacy to fill a void in clinical care due to limited staffing at the island’s only clinic. Here, Rick McCoy explains to ComputerTalk’s Maggie Lockwood the process and the web-based program that allows the pharmacy to support the CDTA.

**CT:** Share with us your experience in pharmacy and what led to your practice today.

**Rick McCoy:** Our first pharmacy was actually in Denver, Colo., in 1978. Marge, my wife, and I ran it and morphed it into a new pharmacy in 1988. We bought out several area pharmacies during our years there. In 1994 we sold our Denver operations and moved to Lopez Island, Wash., and bought out the owner here at the time. We ran a full-line pharmacy from 1994 to 2011, when we moved into a new building. The move was prompted by our desire to get out of the t-shirts and tourist trinkets, which were becoming increasingly harder to manage. At the time the pharmacy business was growing and doing well enough that it could stand on its own.

From the inception of the new building we wanted to focus on prescriptions, make a first-class counseling area, increase our compounding offerings, expand our braces and DME, and start offering vaccinations. Doing CDTAs did not enter into our thinking at the time.

**CT:** You established an arrangement with Lopez Island Clinic to create the CDTA. How did this come about?

**Rick McCoy:** Our clinic facility is owned by the people of Lopez; however the staffing and infrastructure is handled by Island Hospital, Anacortes, Wash. We have one full-time physician and one full-time nurse practitioner.

The nurse practitioner has been on staff for many years. When she reached retirement age she started to cut back her hours, all the while hoping the hospital would find a full-time replacement for her. The process of getting a replacement has been a long and arduous one, and as of this date, a suitable replacement has not been found. It’s very hard to get professionals to come here. There were lots of roadblocks: housing, schools, cost of living.

There were many days when simple procedures and office visits had to be turned away from the clinic, just due to the fact that only one physician was there. So we saw many of the minor ailments falling through the cracks, and that’s what first got us thinking about the CDTA. We spoke with a colleague in Seattle who had already done some of
the legwork on the CDTA process. She had been successful doing many of the CDTA items we did, and shared with us her knowledge in getting it set up with the board of pharmacy.

We spent most of the summer and early fall of 2014 tweaking her CDTA, and then adding more on top of hers, ending up with a 22-point CDTA offering. The creation kind of took on a life of its own and grew and grew. I think the project started out with about 20 pages and ended up over 80 pages.

When we brought up the idea to the clinic physician and the retiring nurse practitioner, they thought it was a great idea — a win-win for everyone. If memory serves me right I think the physician only nixed one of our CDTA points.

CT: How did you decide on the services to offer, and what was required from the state of Washington to offer the CDTA?

Rick McCoy: There are really no limits on what we can do in Washington state as far as the CDTA goes. I listed the 22 items we are doing now [see box on page 12]. What we learned is that the state does not approve the CDTA, they only accept or reject it. I think they'd only reject someone's CDTA if it was put together in a haphazard manner, which wasn't our problem, with 80 pages. When you think about the process, the state would be ill-advised to “approve” any CDTAs, instead opting for the safer, from a legal standpoint, “acceptance.” The accepted CDTA simply needs to be on file with the state, and as soon as it is on file, you're good to start use of the CDTA.

CT: When did you first start offering the services, and how did you get the word out?

Rick McCoy: Our first CDTA was in the fall, and it was a regular patient who just happened to mention a problem and who could not be seen at the clinic. We then explained the CDTA process to him, and he said, let’s do it. We did some social media posting on this service and did a video. Being a close-knit community, word of mouth should be all we need. However, we intend to be more aggressive in marketing, with brochures left at our various lodging facilities.

CT: What was the initial reaction from patients?

Rick McCoy: The patients have been very happy, with one caveat that I’ll mention later. They all got better. Seems late Fridays are a prime time for our service. One of the things the state likes is follow-up with the patients, so I developed an online survey through surveymonkey.com.

We tell patients to expect to receive an email and that we'd appreciate their filling it out. It has about 10 questions and requires no names.

CT: Give us a brief overview of how the CDTA works.

Rick McCoy: When someone comes in and asks us about doing a CDTA, they generally start with “I've heard you can do XYZ.” We explain the process, and then it’s up to them to decide whether to proceed or not. Sometimes in our general counseling we determine that the CDTA would be of benefit and we bring up the subject. Here is that caveat — cost to the patient. We have a fee for this service ranging up to $30, but we can adjust this based on circumstances. Everyone has been happy to pay, but they would have preferred to use their insurance, and that is the biggest hurdle we have yet to overcome. However, there appears to be a legislative fix on the horizon. Before the Affordable Care Act, we had in Washington state a program called “Basic Health.” There was a Washington law that stated that any service that was provided by a pharmacist (for example, CDTAs) that would have been paid for by the Basic Health program to any other provider had to be paid for. But now the Basic Health program went away with the start of the ACA. We have an updated piece of legislation now working its way through the legislature that will correct this problem. The original bill had the effective date as Jan. 1, 2016, but the insurance carriers got an amendment tacked on that pushes it to Jan. 1, 2017. Their excuse was they needed more time to gear up.

Once we start the actual CDTA we assess the situation using “SOAP” notes, standing for subjective, objective, assess, and plan. Most electronic medical records systems continued on next page
in use today in MD offices use this process. First we have the patient fill out a questionnaire with name, address, etc. (if not already on file), and their complaint. We then go into a small private area where we do our vaccinations and start the SOAP process. We have some templates for each CDTA type, with some boilerplate questions and steps we need to do. Some examples are blood pressure, pulse, and temperature. Then in our paper templates we enter the information and move on to the next step.

**Subjective** — Usually this means listening to the patient describe their problem, asking questions, and making notes as you proceed.

**Objective** — Usually means what we see and feel is the problem, again morphing into the next step.

**Assess** — What our thought process will be in determining what information we need. We have steps in each CDTA that are hard stops — an example being a woman who is pregnant, and at that point referring her to her primary care provider.

**Plan** — What, if anything, we’re going to do. It could be to send them back to primary care, but usually it involves the necessary drug therapy.

The Web-based EMR we use (Practice Fusion) is set up to do the SOAP notes just as I’ve gone over. Providers are familiar with SOAP notes, so when they get a copy of our encounter they already know how we’ve proceeded. Also, it is a great way to track the encounter from start to finish. We use our paper templates to work from during the actual encounter and then transfer our handwritten notes to Practice Fusion. At that point we can automatically forward the SOAP notes via fax to the primary care provider for their reference.

I’ve tried to bill for a couple of CDTAs using a free online system called Office Ally and have failed. We do use Office Ally to bill for many of our vaccinations that won’t go through regular pharmacy billing, and have a 99% approval rate on these. It’s a Web-based system that allows us to develop templates and then plug and shove. The end result is a clean billing that is done as a CMS-1500 sent electronically.

But back to Practice Fusion. The clinic, through their association with the hospital, has been in a multiyear project to get an integrated EMR system up and running at the hospital and all the satellite clinics, like our clinic. We’ve been working with our clinic on this project, starting with e-prescribing. Their choice of

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**Lopez Island Pharmacy’s CDTA Offerings**

**As of April 13, 2015**

**Immediate-Needs Treatments for Minor Ailments**

Provided by Clinical Community Pharmacist

1. Albuterol inhaler or albuterol sulfate for nebulization, for use as a rescue for bronchospasm.

2. Antihistamine or anti-inflammatory eye drops, for relieving allergic eye symptoms.

3. Antihistamine nasal spray, for relieving hay fever symptoms.

4. Antiviral tablets, for relieving symptoms of cold sores or shingles, for recurring episodes of HSV, and a 4-day start-up supply for possible shingles cases.

5. Bee sting treatment, for reducing swelling from bee sting — 60mg prednisone as a single dose or three tablets (60mg) daily for one day, then two tablets (40mg) daily for one day, then one tablet (20mg) daily for one day.

6. Epinephrine auto-injector 0.3mg, for replacement of outdated units or misplaced units.

7. Mupirocin ointment, for treatment of cuts and scrapes.

8. Ondansetron, for 24-hour treatment of nausea and vomiting — with extensive screening.

9. Hormonal contraceptive, one- to three-month supply of a previously prescribed contraceptive (may also include NuvaRing).

10. Scopolamine patch, for prevention of motion sickness.

11. Silver sulfadiazine cream, for treatment of minor burns.

12. Steroid nasal spray, for relieving sinus inflammation.

13. Swimmer’s ear drops, for treatment of symptoms of outer ear infection.

14. Traveler’s diarrhea remedy, for treatment of diarrhea while traveling.

15. Uncomplicated urinary tract infection treatment, (for females only).

16. Vitamins, supplements, and OTC medications, to meet insurance requirements when use is indicated as an adjunct to patient healthcare and the patient is referred to the pharmacy by a healthcare provider to obtain OTC medications.

17. Oral antifungal or nystatin for treatment of oral yeast infection (thrush).

18. Ketoconazole shampoo, for treatment of dandruff and fungal scalp symptoms.

19. Morning-after pill (Plan B or equivalent), to reduce the chance of pregnancy after unprotected sex or failure of birth control method (only for insurance coverage; available as OTC now).

20. Triamcinolone cream or ointment, for relieving minor skin irritation, itching, eczema flares, and insect bites.

21. Nystatin cream or ointment, for treatment of fungal diaper or heat rash.

22. Devices — peak flow meter, spacer for metered dose inhaler, nebulizer, supplies for nebulizer, and diabetic blood glucose monitors and supplies, for aiding in the delivery or monitoring when using either metered dose inhalers or nebulized medications. For measuring diabetic patient’s blood glucose levels and to provide necessary supplies.

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**continued on page 14**
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INNOVATION
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an EMR system has been very trying on everyone involved, with the e-prescribing causing more problems than it fixed. During this time the clinic had a student nurse practitioner doing a rotation who had been to a number of clinics in her training and remarked to me that the clinic’s EMR system was worse than the free ones on the Internet.

I did a search for the systems she was alluding to, and found two free Web-based EMRs: Practice Fusion and drchrono. Both products had a way to try them, so that is what I did. I really liked drchrono better than Practice Fusion, but to get the features I wanted you needed to upgrade to a paid version. Not knowing how many CDTAs we’d be doing, I went with Practice Fusion. Like with any free product, there is some advertising to view, but nothing that greatly impacted one’s ability to use the product. They offer free training, and Marge and I both took advantage of a Web-based session.

CT: How do you coordinate the online portal with your pharmacy system to track outcomes?

Rick McCoy: The Practice Fusion website can be accessed from any computer. They do have some security built in, so that when you log in from a computer that hasn’t been used before they send you a token to enter from the new computer. We use Rx30 (since 1984 — I think I’ve got one of the oldest licenses). We can make memos in Rx30 that the prescription is from a CDTA, but it is pretty obvious when the prescriber is either Marge or me. We are prescribing pharmacists, as some call us. We each have our own NPI number, as well as the pharmacy’s NPI. The person who helped us get started uses conventional prescription pads to write the prescriptions, in case some choose to have the prescriptions filled elsewhere. Using electronic prescribing costs us virtually nothing, and again gives us a nice leg up.

I’ve seen some providers use laptops in their patient visits and skip the paper trail step, but both Marge and I feel it gets in the way of the exam, plus it’s easier after the fact to enter your paper notes. In Practice Fusion you can pre-enter macro templates that either you enter yourself or you can pick from all their other providers’ practices. It’s pretty handy to look for macros from, say, a dermatologist or and ENT provider to use yourself. Pick the macro and edit the particulars, and off you go — no reinventing the wheel. Plus, you can grow your macro template over time, tweaking it as needed. Tracking outcomes is just done with a phone call or if we see them in person. As a side note we can use Practice Fusion to set appointments, and it has the ability to let patients set their own appointments. Maybe down the road we might try it.

CT: Explain how you can write the prescriptions.

Rick McCoy: In the “plan” section of the SOAP notes we can prescribe. You can print out a prescription or do an e-script. Because in the state of Washington all paper prescriptions need to be on specially approved security paper if you print them, it’s just easier to do an e-script. Plus, if need be you can send it to any pharmacy. Practice Fusion does drug interactions, but our experience is that it’s not as good as a dedicated pharmacy system.

CT: How do you coordinate with the clinic for follow-ups?

Rick McCoy: For follow-ups we have already sent our fax SOAP notes, and the clinic puts it in their chart for reference if needed. This is working very well.

CT: Does offering a CDTA work for your pharmacy, because of its unique location? Or do you feel this is something all independent pharmacies could offer?

Rick McCoy: It definitely works for us because of our unique location, but quite a few pharmacies could adapt what we do based upon having a good relationship with a provider. How much different is this from some of the Minute Clinics? CT

Maggie Lockwood is VP and a senior editor at ComputerTalk. If you’d like to share an innovative business solution that’s working at your pharmacy, email details to maggie@computertalk.com.
The Effect of Appointment-Based Medication Synchronization on Clinical Services in a Community Pharmacy


A known solution for busy pharmacies is appointment-based medication synchronization (ABMS), which lets patients keep up with their medications thanks to the help of someone they trust — their pharmacist. ABMS lets pharmacists build good will, as well as see potential increases in revenue. This study shows, as with any new program, challenges can be expected and solutions offered as we work to move the profession forward.

Improving patient care is considered a top priority for many pharmacies. In order to provide innovative services to help patients, busy community pharmacists must seek ways to allow more time to do so. One such process that has been offered as a solution to helping patients with medication adherence specifically is the appointment-based model (ABM), which allows patients to receive most or all of their medications on one appointment date each month. ABM was first implemented by pharmacist John Sykora in Long Beach, Calif., in 1995, and was more widely implemented and evaluated in 2009 by the Alliance for Patient Medication Safety (APMS) (http://goo.gl/5F4WQx). Although the model was originally associated with improved patient medication adherence (3.4 to 6.1 times greater odds of adherence compared with control group patients), it may also offer a way to improve prescription workflow and allow pharmacists more time to devote to medication therapy management (MTM), immunizations, and other clinical services, as shown by a study published in 2013 by the Journal of the American Pharmacists Association (http://japha.org/article.aspx?articleID=1765641).

When our study team reviewed the literature in PubMed and Ovid, we found that there are no studies published in the literature that measure the impact of appointment-based medication synchronization (ABMS) on changes in prescription or clinical revenue or reallocation of time spent per patient.

Broadening the Scope

With this in mind, we had two objectives for our study. The first objective was to assess the impact of ABMS in community pharmacies on revenue from prescription sales and clinical services sales. The second objective was to explore the effects on pharmacists’ time spent on prescription filling and clinical services. Our hypothesis was that the use of ABMS would allow for the realloca-
Impact of ABMS

continued from previous page

tion of time from prescription filling to clinical services such as MTM and immunizations.

Study Design

Two separate Kroger Pharmacy locations were selected, and patients meeting inclusion criteria, shown below, were identified and flagged at each site in the pharmacy's dispensing software. Senior pharmacy technicians were selected to lead the project at each store. These technicians discussed the project in person or by telephone with each eligible patient. The patients were informed that should they choose to participate, they might be responsible for paying out-of-pocket costs for their prescriptions if not covered by insurance during the first month of the synchronization process. An ABM brochure based on the APMS operations manual was used to assist patients in their understanding and consideration of the program. The identifying flag in the computer system was removed after three attempts to enroll or upon patient refusal. If the patient agreed to enroll, he or she was instructed to sign an “opt-in” patient agreement form similar to the one provided in the APMS manual.

Once enrolled, the patients’ medication profile was reviewed to determine the appropriate appointment date. The appointment date was determined by the prescription that had the greatest cost to the patient if it was not billed on their insurance (i.e., their “anchor prescription”). The technician contacted the patient by phone to confirm that this date was acceptable to the patient. During the months after the appointment schedule was set, all medications requested by the patient were synchronized to be due on the specified appointment date. The technician called the patient each month of the study seven days prior to the patient’s specified appointment date to verify which prescriptions needed to be filled, whether or not the patient had a doctor or hospital visit in the last month, and whether the patient would like to receive any clinical services during his or her scheduled pickup time. The technician documented all patient responses on a verification sheet similar to the one listed in the APMS manual, processed all prescription requests, and filed the information for a pharmacist to review before the patient’s appointment date. If the technician was unable to contact the patient on the first attempt, the technician continued to try to contact the patient by phone once per day until the specified appointment date. If the patient was not successfully contacted, the pharmacy did not fill or refill the prescriptions as part of the synchronization process.

Collected data included the number of prescriptions purchased in the pharmacy, total revenue from prescription sales, number of clinical services performed, total revenue from clinical services, and amount of time spent per month per patient.

The Results

Average monthly prescription sales per patient for the sample stayed constant before and after the intervention ($142.89 versus $143.27; p=0.21). Average monthly clinical sales per patient increased significantly after the intervention ($4.69 versus $24.21; p=0.02). We saw little difference in the average time spent on prescription workflow, which included all normal functions such as reception, data entry, filling, verifying, etc. (60.5 versus 56.8 minutes per patient; p=0.37). Three areas of particular importance to pharmacy workflow were each affected, though insignificantly. The average difference for time spent on reception was decreased by 1.25 minutes per patient, the average difference for time spent on release to patient was decreased by 1.55 minutes per patient, and the average difference for time spent on return to stock was increased by 1.66 minutes per patient. The average difference in time spent performing clinical services such as MTM, immunizations, and health screening was increased by 56.78 minutes per patient.

The two specific clinical services that were most affected by ABMS implementation were comprehensive medication reviews (CMRs) and target medication reviews (TMRs). No time was spent on CMRs or TMRs prior to the intervention for the sample patients. The aver-

<table>
<thead>
<tr>
<th>Inclusion Criteria</th>
<th>Exclusion Criteria</th>
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<tbody>
<tr>
<td>Patients who are currently eligible for clinical services at Kroger via OutcomesMTM or MirixaPro MTM platforms.</td>
<td>Patients who cannot establish an appointment date, miss their appointment date, or who are unable to be synchronized due to the scheduling of their insurance coverage.</td>
</tr>
<tr>
<td>Age at least 18 years or older.</td>
<td></td>
</tr>
<tr>
<td>Patients having their prescriptions filled or refilled at selected Kroger pharmacy sites.</td>
<td></td>
</tr>
</tbody>
</table>
Impact of ABM

The average time post-intervention spent was 61.11 minutes per patient on CMRs and 10.78 minutes per patient on TMRs. Also notable was that the average number of prescriptions filled each month increased from an average of 9.93 to 10.12 for the sample, while the average number of monthly clinical services provided to each patient increased from 1.22 to 3.11.

Time spent on implementing ABMS was measured separately from time spent on prescription workflow and clinical services. An average of 8.35 minutes was spent per patient on enrollment into ABMS, which included time spent contacting the patient, determining an appointment date, and documentation. For each additional month the patient was enrolled, an average of three minutes was spent on follow-up, which included monthly phone calls and documentation by senior pharmacy technicians. The number of phone calls regarding ABMS per month per patient also tended to decrease the longer the patient was enrolled.

What We Found

Several studies, including one done by the Thrifty White company (http://goo.gl/LVH8iC) have shown that ABMS has been associated with helping patients achieve better medication adherence. Some patients who participated in this study were enthusiastic about the service and believed it relieved some of the burden of keeping up with their medications by putting that responsibility in the hands of someone they trusted — their pharmacist. For pharmacists, that can mean more goodwill from their patients and potential increases in revenue. But as with any new program, challenges can be expected and solutions should be offered as we work to move the profession forward.

When performing the actual synchronization for this study, all work was done manually by the pharmacy staff. Had a computerized system been employed, it is expected the amount of time spent on implementation could be decreased, and it could be possible to enroll a greater number of patients using such technology. However, it is also important to consider the greater startup costs that are incurred initially to use such a system. For this study, the majority of costs were related to pharmacy technician time and the use of a pharmacy resident. The American Pharmacists Association (APhA) Foundation has many excellent resources for anyone wanting to implement ABMS on their own (www.aphafoundation.org/appointment-based-model).

Also of note, this study targeted only patients who were eligible for MTM services through OutcomesMTM and MirixaPro in order to examine the reallocation of time spent in workflow to time spent on clinical services. This limited the number of eligible patients and presented issues when spouses and caretakers who carried different health insurance plans were interested in enrolling. For purposes of data collection, only those patients who met inclusion criteria were included. However, spouses and caretakers were also allowed to receive the service at the pharmacy outside of the study.

We expected that the use of ABMS to facilitate time for MTM could lead to more clinical interventions being identified. Immunizations were one such intervention that we expected to increase. However, the increase was not realized and was most likely attributed to seasonality. It was mid-flu season when the study began enrolling, and many patients had already received their annual influenza vaccines prior to the study.

Patient and Site Characteristics and Barriers to ABMS Implementation

<table>
<thead>
<tr>
<th>Site One</th>
<th>Site Two</th>
<th>Both Sites</th>
</tr>
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<tbody>
<tr>
<td>Primarily publically funded insurance payers.</td>
<td>A mix of privately and publically funded insurance payers.</td>
<td>A total of 13 patients were enrolled in the study.</td>
</tr>
<tr>
<td>Average of 1,100 prescriptions per week.</td>
<td>Average of 2,700 prescriptions per week.</td>
<td>Nine completed the study and were included in data analysis.</td>
</tr>
<tr>
<td>Barriers included:</td>
<td>Barriers included:</td>
<td>Barriers included:</td>
</tr>
<tr>
<td>Lack of patient transportation.</td>
<td>Short-staffed pharmacy.</td>
<td>Use of multiple pharmacies.</td>
</tr>
<tr>
<td>Patients without working telephone number.</td>
<td>Lack of intervention champion.</td>
<td>Syncing medications without regular refill intervals.</td>
</tr>
<tr>
<td>Low patient education level.</td>
<td></td>
<td>Lack of belief in healthcare as a priority.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Patient follow-through.</td>
</tr>
</tbody>
</table>
Overall, the study results showed an increase in both revenue from and time spent on clinical services, specifically in the first month of ABMS implementation. The study suggests that a similar increase could be expected in patients who were not previously receiving any MTM services.

For some patients, it was not possible to sync all prescriptions to one day of the month, but all patients were able to establish a maximum of two appointment dates per month. For example, some patients received narcotics that were required by their physician to only be filled every 30 days. If the patient’s other medications fall on the third of the month with insurance, while the narcotic fill date is on the 20th, the patient will need to make two trips to the pharmacy. With inhalers, insulin, and diabetic testing supplies, the days supply of the prescription may be 25, 40, etc., thus preventing those medications from being filled on the patient’s insurance with all the others on the patient’s appointment date. It is important that both the patient and pharmacist are aware that one appointment date may not be possible for every patient, and that they work together to achieve the best solution.

**Finding a Trend**

The study showed a trend that suggested implementation of ABMS significantly increases sales of clinical services in a community pharmacy. The trend also indicated that when ABMS is introduced, time spent on dispensing decreases as time spent on clinical tasks increases. It is important that ABMS and other programs continue to be researched and considered as tools for improving the way patient care is offered by pharmacists. CT

**About the Authors:** At the time of the study Sarah Lewis was a pharmacy resident for Kroger Pharmacy, Delta Division, in Little Rock, Ark. She is currently a clinical pharmacist for Coram CVS specialty infusion services. She can be reached at Se.butler89@gmail.com. Jacob Painter is an assistant professor in the division of Pharmaceutical Evaluation and Policy at the University of Arkansas for Medical Sciences, College of Pharmacy, Little Rock, Ark. He can be reached at jtpainter@uams.edu. Holly Price is pharmacy manager for Kroger Pharmacy, Delta Division. She can be reached at holly.price@stores.kroger.com. Rachel Stafford is an assistant professor at the University of Arkansas for Medical Sciences, College of Pharmacy, and a pharmacist for Kroger Pharmacy, Delta Division. She can be reached at rawagner@uams.edu.
Pharmacists are working harder than ever to elevate the level of engagement with patients and with the other members of the care team. This is being driven by the ongoing shift to clinical models and the increasing importance of performance measurements such as Part D star ratings, among other factors. Fortunately, pharmacists are also finding that there’s a wide array of technology that can help them in their efforts, whether it’s cutting-edge services built in response to current needs or old stalwarts that forward-thinking pharmacists are deploying intelligently.

continued on next page
Patient engagement and subsequent opportunities to drive pharmacy performance ultimately start with knowing just who your patients are. From there you can begin to focus your efforts and find your opportunities for care. There are many good examples of how to do this, with some being driven by pharmacy system reporting, and others relying on services specifically designed to analyze patient data to support engagement and adherence programs.

Michelle Farrell, for instance, uses functionality within her QS/1 pharmacy system to data mine for diabetics who qualify for services such as MTM, comprehensive med review, or immunizations. “There are many ways to proactively find patients who you will want to work with,” says Farrell. “This spring we’re looking to target patients with respiratory problems and use CarePoints to give them information on pollen counts and educate them about having an asthma control test with an inhaler refill.”

Brent Dunlap has looked to Mevesi for reporting to track the demographics of his patient base. He offers several different examples of how he likes to use this data. For example, he runs reports that look for patients on specific medications such as ACE inhibitors, and then narrows down the list so that he’s focusing on the ones that have the greatest need for adherence support. He’s also sorting by different criteria such as age, to see which patients might be more text savvy, or how far patients are traveling to come to his pharmacy. Dunlap continued on page 22

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has also found success in using his data analytics to support his Sweet Spot diabetic education classes, a turnkey program from Creative Pharmacist. “Diabetes patients are one of the groups specifically monitored for star ratings,” he explains. Dunlap created a simple report in Mevesi and did a mail merge to send reminders about the class. “This communication and the relationships it develops are a way to drive the outcomes that we need and want for our patients,” he says.

Laura Wagner has found a focused approach to be of great value for her patients — and for Mount Ida Pharmacy, too — following a recent move to bring in a new synchronization program tool from FDS, called eNGAGE. Sync programs are fast becoming a central feature for creating convenience and value for patients, as well as ramping up engagement and driving important performance metrics for the pharmacy. But as Wagner demonstrates, it’s best to be able to apply sophisticated logic to the process to really rationalize it for the pharmacy.

Wagner is using eNGAGE to help her understand her patient population and pick the ones who are prime candidates for the service. This is a tool in use on a daily basis, according to Wagner. “We will pull the system up and browse the patients that eNGAGE has identified as having the best potential for the sync program,” she says. The Mount Ida Pharmacy staff then reaches out with a call to try to get patients enrolled.

You can’t overestimate the contribution that an effectively organized sync program makes to moving a pharmacy’s care model in new directions. “I want to use med sync so that our workflow become smoother and more manageable,” says Wagner. “It’s better for us when we know that somebody’s coming in on a certain date rather than walking in the door at any time for 10 prescriptions.”

“We talk with patients and let them know that we’re trying to help them make their lives easier,” Wagner says. “We are filling more prescriptions for adherent patients, which helps increase our revenue, and as we improve their adherence with sync we are also increasing our performance as measured by star ratings.”

Mike Rudge reports using PrescribeWellness to buttress the work he can do within Loop Pharmacy & Home Medical’s PioneerRx software. “If we have an educational event coming up, PrescribeWellness can look through our database for us and give us a data set of all the patients we should contact about it,” he says. Rudge can then use PrescribeWellness to schedule a prerecorded message to go out to this group that features an invitation from Erin Rudge, Loop’s chief pharmacy officer.

Laura Wagner, Pharm.D.
Owner, Mount Ida Pharmacy
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Reinvigorating Reliable Channels

Loop Pharmacy & Home Medical also offers an excellent example of how some of the old reliable channels such as IVR- and pharmacy system-driven messaging are underpinning important contacts with patients, albeit with a heavy dose of modern features to make them as efficient and useful as possible.

Mike Rudge reports using a combination of outbound messaging tools, including capabilities within the PioneerRx pharmacy system as well as integration between TeleManager Technologies’ IVR and PK Software’s The Compounder Rx platform.

As Rudge describes it, within PioneerRx it’s a simple matter of selecting the patient’s preferred contact method. Then a completed prescription triggers an automated pickup reminder call or text. Rudge notes that texting is important among certain demographics, but that more than 80% of Loop Pharmacy’s patients haven’t indicated a preference. In that case, they are automatically flagged for phone reminders. Rudge says patients have really taken to the reminders. “When people get a message from Loop Pharmacy now,” says Rudge, “they immediately assume they have a prescription waiting.”

Next, TeleManager’s IVR outbound capabilities have proven to be a critical addition to Loop’s compounding practice. “We do up to 75 compounds a day,” says Rudge, “so we’d have a lot of phone calls that we’d have to make without the IVR interface to The Compounder Rx.” Rudge reports seeing an even greater return on messaging for compounds than he has for standard prescriptions. “We’ve really seen a substantial impact on time savings and how promptly patients pick up compounds,” says Rudge.

Michael Ambrosio is enthusiastic about a new offering in his HBS pharmacy management system that’s adding useful logic to the reminder messaging process. The feature, called the Pharmacy Service Portal, lets Ambrosio set key parameters such as how long the system waits to send a message after the pharmacist completes the final verification. It also sends reminder messaging for prescriptions in

continued on page 26
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ule. “This reminder helps with our star ratings, too,” notes
Ambrosio, “because when patients are picking up their
prescription sooner they are getting their prescriptions
regularly, and that improves their adher-
ence.” Ambro-
sio notes that he
also asked HBS to
allow for logic that
ensures a patient
who has waited
to pick up a prescrip-
tion doesn’t then get a potentially confusing text message.

But perhaps even more important, in Ambrosio’s view,
is the way the portal creates improved integration with
the pharmacy’s point-of-sale system from Retail Manage-
ment Solutions. The HBS Pharmacy Service Portal inserts
a button at the bottom of the POS screen, according to
Ambrosio, which gives the cashier a much more complete
view of a patient’s prescription status than normal. “You
can quickly click into the portal, enter the patient name,
and see important information about prescription status
and patient contact details right there at the point of sale,”
says Ambrosio. There is also now an alert button that lets
the cashier see a message, for example, if the pharmacist
would like to see the patient. The portal also shows not
just the list of the patient’s prescriptions, but where they
are within the workflow too, which means that the cashier
can have a meaningful conversation with the patient with-
out any distraction for the pharmacy staff.

Ambrosio also sees this portal really streamlining the
pharmacy’s patient engagement efforts, since his staff now
has the ability to update patient contact preferences easily,
both at intake and pickup. “The beauty of the portal is
everything is there and we’re updating one central record,”
says Ambrosio. “We have more chances to make sure
we have the current cell phone or email in the patient’s
record, and that we have the patient’s preferences for re-

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Developing New Engagement Models

There are also pharmacists who are looking at new models for increasing patient engagement, and even bringing pharmacy services into underserved communities as effectively as possible. In fact, there are many communities out there either without access to a local pharmacy or with the prospect of losing the pharmacy they have, points out Brett Barker. “What we see when we look across rural America is this big demographic bubble in a lot of rural towns where the pharmacy owner is near-retirement,” says Barker, “and it’s going to be a struggle for a new owner to keep that pharmacy open, given the current operating environment.” When patients don’t have access to a local pharmacy, the quality of care can decline. As Barker explains, these are the circumstances in which patients end up going to multiple pharmacies spread out among the various towns that work and life take them through. Not only that, but these patients may also be seeing multiple prescribers, depending on which is most convenient to work or home. “Lack of local access fractures care,” says Barker. “And fractured care is not good for either the patient or for the pharmacy.”

With all of this in mind, NuCara has been developing several models of telepharmacy, leveraging a platform from TelePharm. “With these models, we may have two towns that are both struggling,” explains Barker, “and rather than facing the prospect of no pharmacy at all, we’re going to share the pharmacist 50/50.” NuCara’s first telepharmacy pilot began in Zearing, Iowa, a town of just over 500 people that is 20 miles from its flagship community pharmacy in Nevada. In this pilot, TelePharm let the pharmacist at NuCara Nevada remotely verify prescriptions and privately counsel patients. The result, as Barker notes, was that patients got the same level of service while NuCara was able to spread the pharmacist expense out in order to make it work financially. This might sound as simple as setting up a secure...
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video conference link between the two sites. But Barker is quick to emphasize that it’s not this easy, if you really want to integrate telepharmacy smoothly into pharmacy workflow.

NuCara’s technology from TelePharm creates a record of all the steps the remote site technician takes while filling a prescription. Then, much as in any pharmacy workflow, this work is cued up in the off-site pharmacist’s system for verification. “The pharmacist is able to review the prescription at the managing pharmacy at the right time within his or her workflow,” says Barker, “and then engage with the patient by video later as needed.”

NuCara has developed a second pilot as well, to further refine its model and increase the opportunities for patient engagement with what Barker calls hybrid telepharmacy. The pilot this time is happening in State Center, Iowa, and the concept is to have the pharmacy open five days, while the pharmacist is there one day a week to start. “Our goal is to increase the pharmacist’s time on-site as the location grows,” says Barker. “We really think that based on the demographics of the town we will eventually be able to have a full-time community pharmacist there. It’s just that you have a lot of work to get there. Telepharmacy will let us do that. And this hybrid model means that we’re able to offer services on-site, such as immunizations and medication therapy management, that will really increase the level of care available within the community.”

NuCara’s commitment to keeping care within the community is really paying off. For example, notes Barker, the rural healthcare clinic in Zearing hired a second nurse practitioner because they saw more patients after NuCara opened its location. “It’s been a big improvement for a lot of the patients in the community who were having to use mail order or drive long distances to the pharmacy,” says Barker.

Quarterbacking Clinical Care

Two other pharmacies are demonstrating how to use technology to successfully take a position at the center of the care network. For example, Geneva Woods Pharmacy is using the ALMSA eMAR from Yardi to help its staff quarterback the medication management process for patients, facilities, and prescribers. “We have an interface between our pharmacy system and ALMSA that means that as we take orders in, the eMAR is constantly updating as well,” says Lynette Caldwell.

Geneva Woods Pharmacy has control over access to the eMAR at the user level, which Caldwell points out allows the pharmacy to easily loop prescribers into a patient’s record in real time. For example, a primary care physician can then see the patient’s whole medication list, including what other providers, such as pain care, cancer, or cardiac specialists, have written for a patient. The physician can also view other patient data that’s been entered into

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ALMSA by facility staff, such as blood pressure or blood sugar histories. Similarly, the facility staff is granted appropriate access with user-level tracking of changes and additions. “By compiling all this information in one live record, we’re able to help everyone be cognizant of what is going on,” says Caldwell.

What results is a high level of collaboration that creates real accountability for all caregivers and a central role for the pharmacist, who has a greater potential for catching interactions and contraindications. The benefits extend even to patients who don’t use the pharmacy, but still reside in a facility that Geneva Woods Pharmacy serves with the ALMSA eMAR. “This definitely keeps us on hand and in a constant mode of involvement with patients and facilities,” notes Caldwell.

In another example, Jeff Kirchner has been using collaboration to build more clinical services at Streu’s Pharmacy. Over the past year he has brought on a pharmacy resident to launch a transition-of-care program with a local hospital. The primary goal is to reduce readmission rates, with a focus on cardiac patients. “CMS has been putting a lot of emphasis on the transition from hospital back home or to a nursing home,” he explains. Streu’s Pharmacy identifies patients through a scoring system that indicates the degree of risk for rehospitalization. Patients often feel overwhelmed at the time of discharge and have difficulty understanding and retaining directions and information presented. With this in mind, the Streu’s team follows up with those at highest risk 72 hours after discharge. Kirchner states that this time period is critical to support understanding and retention of the information presented. “We meet with the patient to perform a comprehensive review of their medications to identify potential risks and complications and provide guidance to improve adherence and enhance safety,” he says.

Technology is elevating the collaboration in this case because the pharmacy has access via the hospital’s electronic medical record (EMR) to data such as labs, diagnoses, and preadmission medication list. Kirchner notes that this saves the hospital and pharmacy time and resources by removing the need for fax communication. This enables a pharmacist to easily review and study patient information before meeting with the patient. The results, which Kirchner plans to make the basis of a publishable study, speak for themselves. “We are finding the average patient has three recommendations that need to be sent to the physician for review,” he says. “And so far none of the patients we’ve seen have been readmitted.”

Moving the Needle on Adherence

Automated adherence packaging is another technology that’s supporting the achievement of clinical goals through patient engagement. At its simplest it’s a matter of gaining valuable staff time, as Michael Levy has found by adding SynMed robotics for filling multidose cards at Andrews Pharmacy. “When we first got the robot, it was an interesting experience to figure out what we were going to do with the employees who had been filling the cards,” says Levy. “We kept everyone, and, really, the robot has worked out to free up valuable time that we use to communicate on the phone or in person with a patient, or to review medication lists.” In fact, Levy sees the pharmacy as a manager of patient care as the wave of the future, a vision that’s been...
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ing borne out not just at Andrews Pharmacy, but at other forward-looking pharmacies as well. Jeff Kirchner, who is using Medicine-On-Time and its Versi-Fill automation, has had success with adherence packaging for long-term care, and so now he is looking to encourage its use among Streu’s Pharmacy’s retail patient population as well. “We are coming up with ways to use Medicine-on-Time to improve adherence for our patients in the community, since it has been reported that 26% of nursing home patients are admitted due to non-adherence,” Kirchner reports. In addition, he is working with home health agencies to offer packaging to their patients. “It’s easier for caregivers to manage and allows patients to remain safe in the home environment,” he says.

Advanced Pharmacy Solutions is also building a successful model of patient care with a focus on using adherence packaging to help the behavioral health patients it serves remain independent. When these patients are adherent, they can successfully receive care at outpatient clinics, notes Mark Bradford. Advanced Pharmacy Solutions’ efforts are based around a suite of adherence packaging automation from TCGRx, including the ATP for multidose pouch packaging; InspectRx to create an exception-based QA process that reduces the verification burden on pharmacists; and Collector, which automates the cutting, rolling, and taping of large batches of filled pouches by patient and saves substantial amounts of staff time. Advanced Pharmacy Solutions then layers a synchronization program on top of this packaging offering for dramatically improved adherence. The success of the program is evident from one key number: Advanced Pharmacy Solutions is now dispensing 75% of its oral solids in adherence packaging.

And much like at Andrews Pharmacy, Advanced Pharmacy Solutions is finding that it can put the time automation is saving to good use. “It is giving us the time to send staff out to speak directly to the clinics we work with and demonstrate the product for them,” Bradford says. He is finding that the clinic executive staff, in particular, is interested in managing readmissions to community mental health centers or behavioral health hospitals that are sharing risk based on 30-day readmission rates. Advanced Pharmacy Solutions also employs staff members called care coordinators, who work to connect with the patients themselves inside the community mental health centers. This creates a virtuous cycle in which Bradford is able to bring more patients into the packaging and sync program and reduce care fragmentation by filling all of a patient’s medications — not just those for mental health, which in turn builds his ability to demonstrate the success of the system. “We’re working with a manufacturer today to gather data to substantiate what the numbers for this program are,” says Bradford.

Together, these efforts have significantly increased patient count, according to Bradford. “We’ve grown our prescription volume by 85% compared to our pre-launch numbers,” he says. And while this is clearly good for Advanced Pharmacy Solutions as a business, it’s even more important for one of the main goals Bradford had when he launched the packaging initiative: keeping care for these patients as close to home as possible. “When we keep the care in the community, we can significantly reduce the cost of that care and the burden on
local, community, and state systems,” says Bradford. “That really is what drove us to implement this system.”

Adherence is ultimately more than the sum of how many times a year a patient picks up their medications. You also need to know whether they are taking each regimen as prescribed. This is where adherence packaging, whether for long-term care or retail patients, shines as an adherence feedback tool, according to Brian Beach. Kelley-Ross is using Synergy Medical SynMed robotics to fill perforated multidose cards and Parata PASS to fill unit-dose and multidose strip packaging. “This means that caregivers can hand out a day’s worth and ask the patient to bring it back so that they can monitor adherence,” says Beach. This is a good process for managing large groups of patients with diverse medication regimens, notes Beach. It gives the nursing staff the ability to monitor adherence and ask informed questions.

**Measuring Results**

As pharmacies shift to focusing more on patient engagement and the clinical outcomes they are achieving, two important questions come up: How and what do you measure to see if you are being effective?

Michelle Farrell reports using an outcomes module in QS/1’s NRx pharmacy software to track performance and keep all key documents available for interactions such as comprehensive medication reviews. This module allows Farrell to formalize the documentation of patient interventions and run reports of the outcomes that are then used to code the patient interaction for billing.

“I think the key is being prepared to document the interaction with patients so they aren’t out the door and we’re trying to follow up with them,” says Farrell. “We’re using QS/1’s tickler function to remind us beforehand to create a report, to call a doctor on behalf of a patient, and be prepared for the patient when he comes in. And then after the patient’s visit, we’re printing a file that a tech uses to bill for a counseling session.”

And when you talk about measuring pharmacy performance these days, you have to talk about star ratings, and a corresponding need for pharmacists to track these ratings and ultimately do their best to manage them.

The EQuIPP (Electronic Quality Improvement Platform for Plans and Pharmacies) performance information management platform got mentions from several pharmacists as the best way to find and track a pharmacy’s rating, with Brain Beach, Brent Dunlap, and Michelle Farrell all reporting using it to understand and ultimately manage their ratings.

continued on next page
For example, Michelle Farrell has begun looking at the medication possession ratio data report in her QS/1 system and looking to tie that back to her star ratings. Brent Dunlap looks at the EQuIPP dashboard to gain insight into outlier patients who are causing their numbers to dip and who may have health issues they can help with. And Brian Beach runs a report out of Kelley-Ross’s PioneerRx system when something doesn’t look right in EQuIPP.

“We’ll use our ability to drill down into our data to look at an adherence metric like proportion of days covered, for example,” says Beach. “We see which patients we are not hitting our benchmarks with, and then we’ll reach out to the patient or the provider to try to resolve any issues.” For Beach, this is all about providing value by showing that the pharmacy is being proactive in its interventions that benefit patients, and can even help prescribers meet benchmarks, too.

Medication adherence has a big impact on star ratings. “We create reports to check for late refills,” says Jeff Kirchner, “which allows us to counsel patients with adherence problems.” This is a task that Kirchner sees as increasingly important, as third parties begin to place greater emphasis on disease state management and positive outcomes. The result is a need for pharmacists to take an active role in managing these patients and the medications they are prescribed. “If a patient has hypertension, but is only refilling the prescription five times a year, then we are not managing the condition,” says Kirchner. “Pharmacists can identify reasons why the medications are not refilled in a timely manner and provide guidance and education in order to avoid negative outcomes.”

There are tools available to monitor your adherence data, notes Kirchner,
who is also using EQuIPP. “You can check your score for the past month,” he says, “and identify areas that require improvement.” If Kirchner finds such an area, for example the rating for diabetic care, the pharmacy can use QS/1 reporting to identify high risk patients requiring a higher level of clinical management of medication therapy. Kirchner believes star ratings offer pharmacies useful feedback regarding the quality of their clinical services. “This feedback tells us there’s an opportunity for pharmacists to expand their active role in disease state management,” he says. This opportunity to take an active role in the patient management process is likely almost all to the good for pharmacy, though Steven DiLollo, Pharm.D. Colonia’s director of specialty pharmacy, does warn that sometimes being in the middle doesn’t work out in the pharmacy’s favor. “We’ll get a list of 30 problems from the insurance company, and we’ll fax it to the doctor,” DiLollo explains. “Then we get a response saying he’s not changing anything. We document this. But it can impact our rating if a prescriber insists on keeping a patient on medication that might increase falls, for example, even though the insurance company doesn’t want the patient on that. Our hands are tied, since we can’t change a patient’s therapy, only make recommendations to the prescriber.”

Finding the Future in Patient Engagement

Patient engagement is, of course, an ongoing effort, and the pharmacies profiled here illustrate many good tools and models for the effort. The future of pharmacy care will rest with these and others that keep looking for the latest and best ways to stay connected with patients and be involved in their care. As Michael Levy puts it: “There really is a spot for pharmacy if we take a full role in healthcare. That role is going to involve spending time with the patient, understanding the full drug regimen, and making recommendations. The doctors of yesterday would get offended if I called about a drug interaction or change. Today doctors look at it as a team approach.”

While having performance measured may not be a comfortable experience for some pharmacies, Brian Beach looks to the positive in the trend, as exemplified by star ratings. “This helps you refocus the goals of your work toward the clinical,” says Beach. “You look at payment models and value, and the fact that we want to be seen as a provider. Star ratings are a wake-up as an industry. There is value in what we do, and we have to be more deliberate in interacting with patients.”

And as Jeff Kirchner sees it, the time pharmacists spend with patients today on disease state management and wellness initiatives will have a significant influence on the continued health of patients in the future. Kirchner anticipates that patients will soon recognize the pharmacist as not only a medication expert, but their personal health coach as well.

And Michelle Farrell has her eye on the future and where consistent patient engagement can take pharmacy. “We have to be ready to step up to the plate and have the software ready to be able to deliver services,” she says. “My goal is to have the pharmacy on an appointment-based model with patients coming in an anticipated manner so I can say okay, ‘John Smith is coming in. We should run an immunization check on his record so we know what vaccines he’s due for — or we can plan for a comprehensive drug review.’ Rather than taking four or five episodes to check or verify his medications, we can do it smoothly in one swoop and layer in the more clinical aspects of an appointment-based model.”

Making a connection with patients and taking an active role in their care has been part of the way community pharmacy does things from the start, of course. But if there’s one thing we can learn, it’s that the opportunity now is in formalizing these efforts, connecting them with performance measures, and using the right technology to build the new models that create a new center for a pharmacy’s business.
This column has two parts.

The first is about the changing changes that are changing what we do, how we do it, and who we do it for/to.

The second is about how people make decisions. You and me and everybody that we try to get to make the “right” decisions.

**CHANGING CHANGES**

“The Only Thing that Is Constant Is Change”
– Heraclitus (Greek Philosopher)

I think we can add: Change is happening fast. And it’s going to get faster.

I remember telephones that had rotary dials, and that you had to talk to an operator if you wanted to call someone in another city. Now I pull out of my shirt pocket a computer that I can use to call just about anyone, anywhere in the world. (It also does a bunch of other stuff for me.)

There are all kinds of changes happening in healthcare. Two basic groups:

1. Things

Just to mention a few: Smart watches, do-it-yourself EKG readers, automatic insulin administration, fantastic (literally) diagnostic and treatment things. How about injecting something that goes and finds individual cancer cells and explodes them?

If you want to know what is in the future, talk to those who are making it. Better yet, be one.

If you want to try to keep up with the changes and changing technology in the healthcare world, get a daily update from the Fierce folks at www.fiercehealthcare.com.

2. What people do

All of the medical professions are changing what they do. Physicians are closing practices and becoming employees instead of employers. (Side effect is a diminishing AMA influence.) Clinics are popping up and replacing ERs as an entry into the system. Nurses, optometrists, and others are expanding their scope of practice. Patients are communicating with their healthcare providers using the Internet and smartphones to converse, send data, and share images and get faster, better care.
Decision-Making

The first thing to recognize is that the basics of human decision-making have not changed. Literally built into our brains are three levels of decision-making: what, how, and why.

The “what” level decides that we want that new Corvette — faster, prettier, and sexier. No consideration of function or basic need. This is the level that most salesmen focus on. It ignores the fact that most of the time I will not get there sooner and that the opposite sex will look but probably not jump in.

The “how” level is more rational and decides based on quantifiable facts. The automobile analogy is gas mileage, cup holders, number of seats, safety. The salesman will use it when “what” does not work.

The “why” level is deeper in our brain and controls without being recognized. That portion decides on a much more emotional level. The airline pilot has a deep voice, so he must be good. The driver of the Corvette is probably not trustworthy. These are often referred to as “gut level” decisions. Or this is my “heart” speaking. These decisions are made rapidly and are hard to change. The axiom that “You never get a second chance to make a first impression” is built on this truth.

Jack Welch says that only two words matter for leaders today: truth and trust.

If, starting with that first impression, you establish that you are always truthful and can always be trusted; your advice will be taken.

So

As you go about introducing change, make sure that you are not selling the Corvette and have the desired reputation. Then go about explaining how your change is good to the people who are ready to decide because the why has been established. They are ready to buy.

Of course you need to know that your idea is good. Otherwise the truth factor is not trustworthy.

Dr. Oz sells all kinds of stuff because he uses the why level. He is all why. No how or what.

CVS pharmacies is now CVS Health. Healthcare is a why.

Pharmacies are a what.

The Affordable Care Act (ACA) is in place. Those who are still fighting it don’t have any idea what they would do if they won.

The ACA needs fixing. Costs need to go down and quality needs to go up. All of those deals chronicled in the book that I wrote about in the last issue “America’s Bitter Pill,” need to be repaired. They are keeping costs high and not doing much to improve quality.

Problems are opportunities.

Think of problems as puzzles. (Puzzles are more fun.)

Times of crisis are times of opportunity.

The crisis is the cost and quality of healthcare in the United States.

The puzzle is what can be done about it.

If you want to know what is in the future, talk to those who are making it. Better yet, be one. I believe that you will succeed if you pay attention to the above considerations.

As always, your comments are appreciated.

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Comparing e-Prescribing in the United States with Australia’s Model

Do you realize that it's been nearly 10 years since the Centers for Medicare and Medicaid Services (CMS) published the initial “foundation” standards for electronic prescribing (eRx)? The standards were effective Jan. 1, 2006. You may recall that eRx was included in the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003. The law also included some other programs very important to your patients: Medicare Part D prescription drug coverage and medication therapy management services. MMA also required testing of the standards for eRx. Pilot tests were conducted and additional standards were adopted, with the final eRx rule being published in January of 2009. At the time, use of eRx was not required, but MMA required the use of endorsed standards for any Medicare Part D prescriptions that were to be sent electronically.

Today, a top-down approach is still the primary driver of eRx. The meaningful use program, found in the American Recovery and Reinvestment Act (ARRA) of 2009, includes minimum requirements for electronic prescriptions sent by eligible providers and hospitals. If you are not familiar with the meaningful use program, you can read more about it here: http://www.healthit.gov/providers-professionals/meaningful-use-definition-objectives or you can read our column in the January/February 2015 issue of Computer Talk. As the meaningful use program marches forward, requirements for the use of eRx grow. We wonder, however, are your patients’ voices growing in support of eRx? Are your patients creating a bottom-up demand for eRx? As patients, we appreciate the convenience of not dealing with paper prescriptions. We also recognize that you face challenges with eRx, such as the patient arriving before the prescription or before it is ready, prescriptions that are filled upon receipt but that the patient actually wants on hold, transmission errors, selection of the drug, wrong dose, route, etc., and a host of other problems that you (unfortunately) experience on a regular basis.

Despite the technical, financial, and “human” challenges to eRx, over 90% of community pharmacies are connected to Surescripts’ e-prescribing network, and more than 70% of office-based physicians have e-prescribed. One area that was hindering growth was e-prescribing of controlled substances. You likely know that all schedules can now be sent electronically, per federal law. However, the additional requirements both for prescribers and technology vendors to meet the DEA’s interim final rule are proving quite challenging to really seeing a large volume of Schedule II medications sent via eRx. Additional barriers include potentially conflicting state laws and general confusion. Despite the challenges and previous hiccups, we anticipate that eRx will become the norm, not the exception, in the near future.

But how do we compare to other countries? Well, it’s extremely difficult, if not impossible,
to directly compare the United States to other countries due to differences in healthcare structure and financing, as well as our approach to regulation. However, there are some similarities with Australia that do allow us to make some interesting comparisons. If you want to go straight to the source for some of the information we present below about Australia, go here: http://www.crx.com.au.

**The Australian Model**

While the United States and Australia are similar in total landmass, Australia’s population is roughly 15% of that of the United States. Based on what you know about Australia’s interior being desert or desert-like (i.e., the “outback”), you may have expected this difference. Currently, 72% of Australian doctors and 87% of pharmacies use eRx Script Exchange (Australia’s electronic prescribing system). While these percentages represent smaller raw numbers of users, these numbers are very similar to rates in the U.S. The difference in raw numbers is exemplified by the number of eRx’s sent: 782 million total in Australia so far compared to six billion annually in the United States.

The approach to launching eRx was quite different in the two countries. In Australia, the government worked with Fred IT (Australia’s largest IT services provider to pharmacy) to develop the service. In the United States, NCPA and NACDS created Surescripts, due to recognition that eRx was coming and that pharmacy needed to be a leader in the effort. Surescripts is not the only eRx network in the United States and it does not set policy, but it is arguably the major player and has been a leader, working in conjunction with private and public groups (e.g., government) to advance and expand the service.

Because the two countries’ approaches to developing eRx were different, Australia was much quicker to launch than the United States. Fred IT began the process to develop eRx Script Exchange in 2008 and launched the service in 2009. In the United States, Surescripts was founded in 2001, MMA included eRx for Part D patients in 2003, and eRx was legalized nationally in 2007. Despite the slower ramp up, the United States has experienced steeper adoption rates than Australia.

The Pharmacy Guild of Australia is the primary professional association for community pharmacy. Pharmacies known as “Friendly Society Pharmacies” are not-for-profit, regulated by jurisdictional legislation, and are professionally organized in the Australian Friendly Societies Pharmacy Association. Together, the guild and the Friendly Societies Pharmacies Association purchased over 11 million eRx transactions around the time that eRx Script Exchange was launched, to provide free transactions for their members. That was 2008/2009. Today, the Australian government essentially subsidizes eRx transaction fees, which are paid to the pharmacies, who then pay the eRx Script Exchange. The money is then divided between eRx Script Exchange and the prescribing and dispensing software vendors. Clearly, this is not the financial model found in the United States.

Safety, efficiency, and connectivity: shared drivers for electronic prescribing in the United States and Australia. Expectations of decreased costs and increased collaboration among providers are additional important drivers for eRx. The approaches to development and payment for eRx services are quite different.

Safety, efficiency, and connectivity: shared drivers for electronic prescribing in the United States and Australia. Expectations of decreased costs and increased collaboration among providers are additional important drivers for eRx. The approaches to development and payment for eRx services are quite different. Looking at percentages, adoption rates are fairly similar. There are certainly other metrics that would greatly inform any comparison of the two countries’ experiences — both at the provider and the patient level. For example, are users satisfied with the experience? What error rates are being observed? What has been the impact on workflow? Ultimately, we can probably each learn valuable lessons from our colleagues’ experiences. Maybe it’s time for a site visit down under.

We also continue to welcome your comments and questions. **CT**

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The ONC’s Draft Roadmap Recognizes Pharmacy

Continuing work toward achieving its strategic plan, the Office of the National Coordinator for Health Information Technology (ONC) released a draft interoperability report in January entitled “Connecting Health and Care for the Nation: A Shared Nationwide Interoperability Roadmap.” The ONC accepted public comments through April 3, and will now be studying those comments with the goal of releasing an updated report later in the year. Of note, the report mentioned both pharmacists and pharmacy in various sections when referring to healthcare providers.

The draft roadmap’s purpose is to provide a three-year framework for moving toward an interoperable health IT system that allows information to be collected, shared, and used to improve health, facilitate research, and support clinical outcomes. The roadmap is based on a core set of actions needed to achieve interoperability, which include:

- Core technical standards and functions.
- Certification to support adoption and optimization of health IT products and services.
- Privacy and security protections for health information.
- Supportive business, clinical, cultural, and regulatory environments.
- Rules of engagement and governance.

According to the roadmap, the most critical areas to produce near-term wins toward the goal of interoperability are four-fold, and include:

- Establishing a coordinated governance framework and process for nationwide health IT interoperability.
- Improving technical standards and implementation guidance for sharing and using a common clinical data set.
- Enhancing incentives for sharing electronic health information according

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**Figure 1. Federal Health IT Strategic Plan Goals. Source:** [www.healthit.gov/sites/default/files/nationwide-interoperability-roadmap-draft-version-1.0.pdf](http://www.healthit.gov/sites/default/files/nationwide-interoperability-roadmap-draft-version-1.0.pdf).
to common technical standards, starting with a common clinical data set.

- Clarifying privacy and security requirements that enable interoperability.

To achieve the first goal, the ONC is working to establish a governance framework with overarching rules of the road for interoperability of health IT, a public/private process for addressing implementation or operational-level issues, and a method for recognizing the organizations that comply with the rules and holding them accountable for continuing to do so. The goal is to finish this work by 2017.

With regard to the second goal of improving technical standards and implementation guidance for sharing and using a common clinical data set, the roadmap notes that both clinical documents and discrete data element access will continue to be used. The authors note, however, that the purpose for health information sharing should drive technical standards. The common clinical data set that is proposed is in the box at right.

Pharmacy system vendors would be wise to review this list, as well as the best standards to achieve interoperability recommended by the ONC. Those standards are part of a separate report, called the 2015 Interoperability Standards Advisory. The report may be found at http://www.healthit.gov/standards-advisory. The advisory is the way the ONC will identify, assess, and determine the best available interoperability standards and implementation specifications for industry use toward specific healthcare purposes.

With regard to the area of incentives, the roadmap says the Medicare and Medicaid Electronic Health Care Record Incentive Programs alone do not create enough economic incentives to achieve interoperability across the care continuum. As a result, the authors of the roadmap call for federal, state, and commercial payers to evolve policy and funding levers to incentivize information sharing according to technical standards designated through the ONC’s Health IT Certification Program.

Regarding privacy, the roadmap simply reinforces that most health information still resides in provider systems that are bound by HIPAA, and that covered entities and business associates need to remain vigilant.

Pharmacists and pharmacies are among the specific stakeholders for whom the roadmap is applicable. The roadmap says that by 2024, individuals, care providers, communities, and researchers should have an array of interoperable health IT products and services that support continuous learning and improved health. They consider pharmacists and pharmacies among the set of care providers noted. Specifically, the roadmap states:

“For purposes of this Roadmap, the term care providers is broadly inclusive of the care continuum and includes individuals and organizations that hold professional licenses and certifications that grant them permission to play a role in the treatment of individuals as part of a community. This includes providers such as primary care physicians, specialists, nurses, physical therapists, pharmacists, dentists, social workers, optometrists and other allied health professionals, as well as organizations such as hospitals, public health departments, mental health and substance abuse services, long-term and post-acute care facilities, home and community-based services, other support service providers, care managers and other authorized

continued on next page
individuals and institutions.” Pharmacy system vendors, as entities that provide for data and information exchange, should note the roadmap’s related governing principles to ensure that standards are prioritized, developed, and implemented to support the public interest, national priorities, and the rights of individuals. Specifically, vendors are to:

- Use federal vocabulary, content, transport, and security standards and associated implementation specifications when available.
- Use standards that support data portability from one health IT product to another.
- Develop and implement technical requirements to meet current and future user needs.
- Use standards that do not unfairly provide an advantage to one sector or one organization over others.

In addition, for 2015–2017 providers are called upon to routinely leverage standards-based health IT to support prioritized workflows, including:

- Closed-loop transitions of care.
- Secure clinical communications.
- Prior authorizations, medication co-pays, and imaging appropriateness.
- Computerized physician order entry (CPOE) for services and diagnostic testing.
- E-prescribing of controlled substances with concurrent availability of PDMP data.

By 2018–2020 expanded use should address the following plug-and-play clinical decision support services:

- Electronic consultations.
- Reporting to specialty society registries.
- Reporting to value-based payment programs.
- E-prescribing supported by complete medication fill history.
- Discovery and incorporation of information from patient-owned devices with tools for reconciliation and validation.
- Recommendation of patients to relevant studies and trials.
- Exchange of information to support comprehensive medication management and medication therapy management (MTM) services.

So what’s up next for the roadmap? The ONC plans to publish future versions of Connecting Health and Care for the Nation: A Shared Nationwide Interoperability Roadmap, which is intended to be a living document that will be guided and evolved by all health and healthcare stakeholders.

That section of the roadmap concludes that, in regard to pharmacist’s efforts, “technological barriers to information exchange limit the ability of MTM documents and associated recommendations to be shared with ease between settings of care.”

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Biosimilars: Facts and Future Decisions

With the first biosimilar approval in March and the FDA’s publishing of biosimilar industry guidance documents in April, it is essential to evaluate different stakeholder perspectives concerning what is already known about biosimilars and what still remains to be determined. In this article, we will review the knowns and unknowns for five key stakeholders: drug compendia, payers, wholesalers, pharmacies, and manufacturers.

Drug Compendia The FDA has created the “Purple Book,” a listing of biological products, including any biosimilar or interchangeable drug products. While this reference will categorize biosimilars, drug compendia product categorization may have a larger impact on the functionality of dispensing software used by pharmacies. Wolters Kluwer projects that biosimilar products will be categorized in unique generic product identifier (GPI) numbers in their Medi-Span drug compendia. In anticipation of Zarxio’s launch, Medi-Span published a substitution file in March 2015, which states that the anticipated GPI for Zarxio 300mcg/0.5mL will be alphanumeric. Meanwhile, the equivalent strength of Neupogen is categorized under a purely numeric GPI. Along with the biosimilar rating in the FDA’s Purple Book, the creation of a new, alpha numeric GPI for the first biosimilar illustrates the fact that biosimilar products will not be substitutable with the reference product. Once the FDA finalizes guidance on interchangeability status, it will be interesting to see how Wolters Kluwer plans to incorporate these interchangeable products into the current GPI structure. While it is anticipated that First Databank will mirror Medi-Span’s approach and create unique generic code numbers (GCNs) for biosimilars, their exact methodology has not been published.

Payers Pharmacy benefit managers (PBMs) and health plans will carefully review formulary placement for biosimilars. The potential cost savings will be one of the primary decision criteria. Payers will also have to evaluate the clinical factors, such as potential immune responses and neutralizing antibody development. We expect that each biosimilar will be its own unique case. Formulary placement and utilization management will be used, but the specific tactics for Zarxio and other biosimilars are unclear at this time. Will payers take an aggressive stance and force patients to switch to the biosimilar, or will they grandfather those who are responding to the originator and drive the use of the biosimilar in patients new to therapy? Payers may employ prior authorization tactics to help determine conversion criteria for biosimilars. Diligent pharmacists should review the payer’s formulary and utilization management strategies to prepare for prescription claim challenges and patient questions.

Wholesalers Pharmacy access to purchasing biosimilars shouldn’t vary much from the current procurement of drugs and biologics. But there are some key questions that pharmacies may ask current and prospective wholesalers. Will wholesalers conduct their own analysis and select a preferred biosimilar(s)? Will the selected biosimilar(s) be included on

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the wholesaler source program, just like generic drugs? Will all biosimilars be made available through the wholesaler, either through stocking or drop shipments, to account for payer-specific requirements? These are important questions, as a pharmacy would not want to lose a patient prescribed a specific biosimilar due to wholesaler lack of access to the specific biosimilar preferred by the payer.

Pharmacies As of Jan. 1, 2014, eight states had enacted statutes detailing pharmacy substitution of biosimilar drugs, while another 23 states have considered legislation. We know that pharmacies will be affected on a state-by-state basis, depending on legislation, but there are several features often included in the state legislation already passed. For example:

- Biosimilars must be approved as “interchangeable” for substitution to take place at the pharmacy.
- Pharmacies must notify both prescribers and patients of the substitution, and in some cases, state legislation also requires that individual patients give consent before substitution can occur.
- Pharmacies will also be required to maintain records of substituted biologic medications. The length of record keeping will vary by state, but some states have mandated that records be maintained for a minimum of five years, longer than most other prescription record-keeping requirements.
- In some states, pharmacists are required to complete the onerous task of explaining to patients the difference in price between a biologic and the interchangeable biosimilar.

Although we do not know what legislation will be passed in each specific state, we can assume that the above features will be included, at least on some level, in each state.

Manufacturers Due to the April 2015 publishing of several industry guidance documents, manufacturers now know a great deal about the biosimilar approval process. Among other things, the guidance discusses the following:

- Factors to consider in assessing similarities.
- Evidence needed to demonstrate biosimilarity.
- Study data required.

For example, the guidance confirms that applicants may extrapolate clinical data from one indication to support the licensure of the product for additional indications for which the reference product is listed. Interestingly, unlike with traditional small molecules, the guidance notes that biosimilar manufacturers may use non-U.S.-licensed products to demonstrate that a proposed product is biosimilar to a reference product. Since biosimilars are already prevalent in Europe, this could expedite the approval process for many products in the United States.

While manufacturers may now better know what is expected of them as biosimilar applicants, we still do not know how manufacturers will market biosimilars. For example, for biosimilars that are not interchangeable, it is likely that manufacturers will need to employ a sales force to educate prescribers and drive sales. Whether or not manufacturers use co-pay cards to increase uptake remains to be seen, and this strategy would contrast with how generics are currently sold in the small molecule space. Furthermore, it is feasible that brand manufacturers may increase rebate offerings in an attempt to compete with biosimilars and secure preferred tiering status on plan formularies.

Many Changes Coming The marketing of biosimilars will bring many changes and challenges for the industry. We expect manufacturers to pilot strategies and try to home in on tactics that prove effective in driving market share to the new biosimilar. These strategies will most likely differ, based on the level of interchangeability of the biosimilar.

Industry stakeholders will play an important part in driving acceptance or not. The drug compendia have provided a current view into the biosimilar drug groupings, but how will interchangeability impact these groupings? Payers will use managed-care edits to drive preferred product usage, but the strategy is not defined. Pharmacists should start asking their wholesalers about access to procuring biosimilars and the wholesalers’ strategies for identifying preferred products, if any. State laws will impact product launch and market acceptance. Finally, pharmacists should start preparing to take full advantage of the opportunity with the introduction of biosimilars. CT

Alan Sekula, Pharm.D., and Ann Johnson, Pharm.D., are consultants with PHSI. Sekula has an expertise in MAC pricing, generic drug launch analysis and forecasting, drug database, data and process analysis, adjudication and reimbursement, rebate analysis, pharmacy management systems, and business processes. Johnson currently has a focus in analytics and pricing reimbursement, financial models, and market research. The authors can be reached at asekula@phsirx.com and ajohnson@phsirx.com.
2015 Integra User Seminar

The 8th Annual Integra User Seminar in San Antonio, Texas, attracted nearly 200 pharmacy professionals from over 100 pharmacies. A full schedule of educational product classes and breakout sessions was complemented with general sessions by American Society of Consultant Pharmacists (ASCP) Executive Director and CEO Frank Grosso, R.Ph., and NCPDP expert Gary Schoettmer, R.Ph. Private one-on-one sessions and a discussion-based Stand Up Hall provided attendees personalized access to Integra staff, and an exhibit hall with representatives from 23 industry partners presented an excellent platform for attendees to explore new, cutting-edge technologies.

![Image of seminar attendees](image1.png)

Seminar attendees listen to Frank Grosso’s presentation on Maximizing New LTC Opportunities.

![Image of Integra staff](image2.png)

ASCP Executive Director and CEO Frank Grosso, R.Ph., left, with Integra CEO Kevin Welch.

Integra’s Jeff Ross and Amy Johnston of Good Day Pharmacy enjoy the welcome reception.

Kelly Coleman and Betsy Serapiglia of Brockie Pharmacy, Michael Santorelli and Frank Tucci of ChemRx Pharmacy Services, and Nathan Doucette of PharMerica.

Integra’s Louie Foster, Jodi Dinello of Senior Care Pharmacy, Jim McDonald and Evelyn Beach from Integra, and Lisa Lassiter, also of Senior Care Pharmacy.

Brent Atwell, R.Ph., from Wellness Concepts and his wife, Amanda, admiring the lights of downtown San Antonio.

Attending from QS/1 Jim Hancock, Kevin Sloan, and Lisa Fowler.

John DiFiore and Amber Murray, of MHA, with Paul Butler of NetRx in the exhibit hall.

Gary Schoettmer, R.Ph., discusses NCPDP SCRIPT standards and 10.6 in a general session.

![Image of Talyst team](image3.png)

Vince Fasano, Steve Hood, and Derek Taylor of Talyst at the dinner event at the Briscoe Western Art Museum.
The American Pharmacists Association (APhA) held its 2015 Annual Meeting & Exposition in San Diego, with close to 6,000 attendees turning out. The programming emphasized the central role that pharmacists play in collaborative patient care, with APhA President Matthew Osterhaus highlighting the ongoing Pharmacists Provide Care campaign to support state- and federal-level provider status (www.pharmacistsprovidecare.com). A core group of technology vendors were in the exhibit hall to show what they offer to support these efforts.

From left, Derek Jensen and Bob McFarlane from Rx Systems give a demonstration to pharmacist Michael Toscani from the Rutgers Institute for Pharmaceutical Industry Fellowships.

Pharmacist Kimberly Christoff from North Country HealthCare in Flagstaff, Ariz., with QS/1’s Michael Lynch, left, and Jay Williams.

Pharmacist Leigh Moore from Walla Walla General Hospital with PioneerRx’s Jeff Key.

iMedicare’s Flaviu Simihaian, left, and pharmacist Sam Haddadin from Associated Food Stores.

Pharmacist Kate Schaafsma from Froedtert & the Medical College of Wisconsin talks with Phil Samples from Innovation.

From left, pharmacists Debra Parker and Suzie Lifer from The University of Findlay College of Pharmacy with ScriptPro’s Maxine Thomas.

Pharmacist Kate Schaafsma from Froedtert & the Medical College of Wisconsin talks with Phil Samples from Innovation.

Brian Hille, left, from Albertsons Safeway Pharmacies and pharmacist Shah Malik, right, with Erin Michael from PCCA.

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