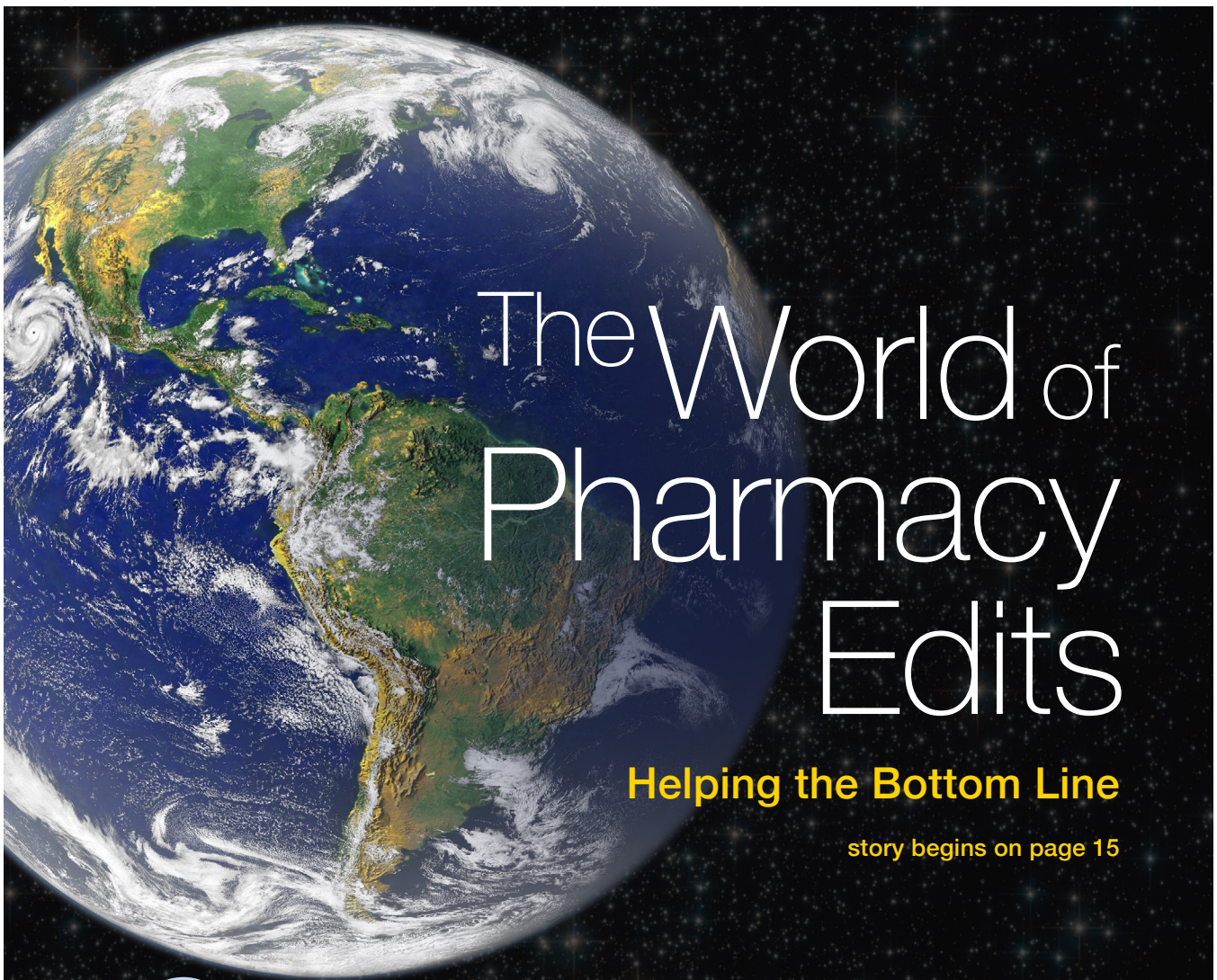
computertalk
JAN/FEB 2019
FOR THE PHARMACIST



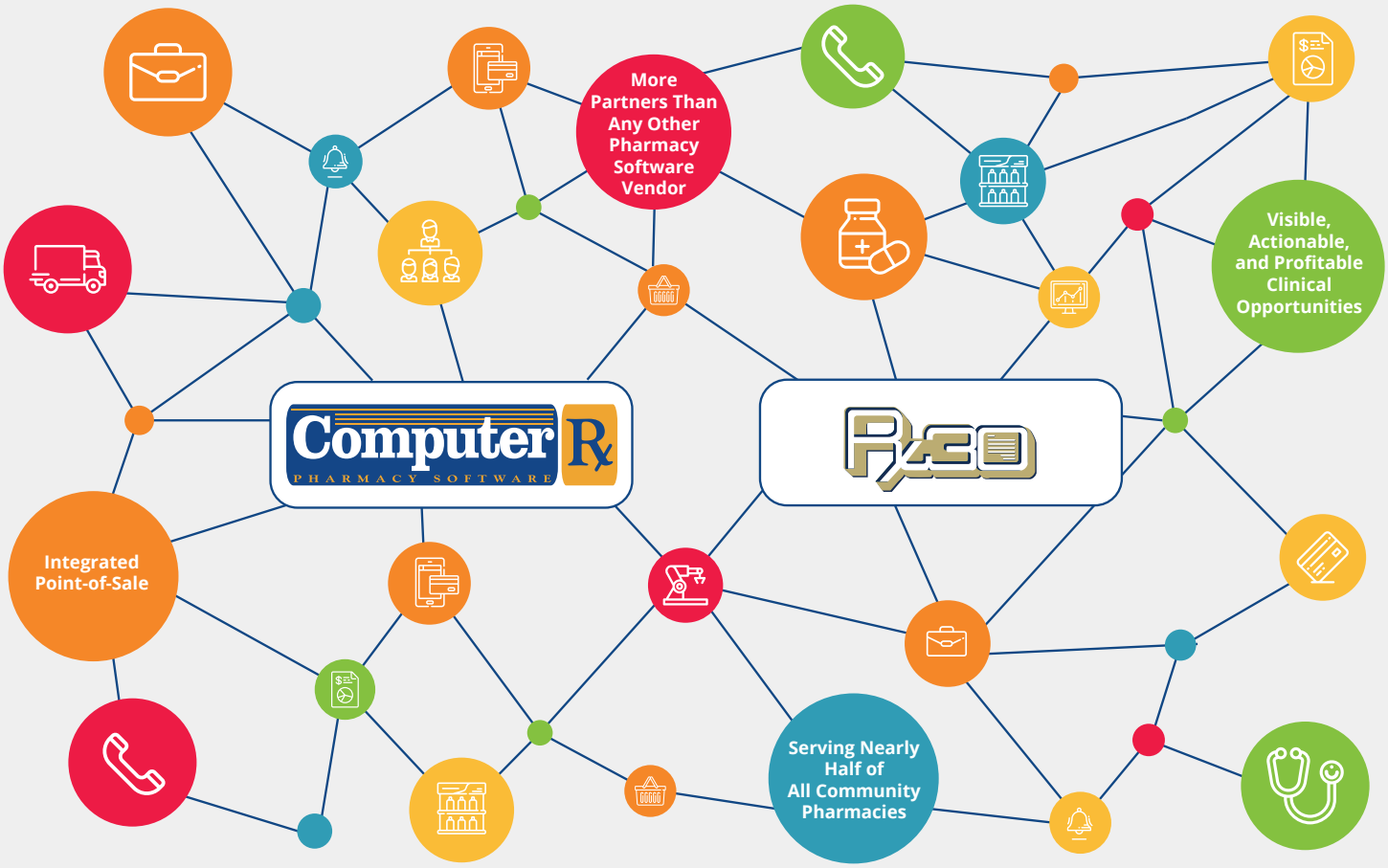
The World of Pharmacy Edits

Helping the Bottom Line

story begins on page 15

An interview with NCPA President Bill Osborn.

Your Pharmacy Management System Should Facilitate Your Success



Discover the possibilities with Computer-Rx and Rx30

Computer-Rx
800.647.5288, ext. 4
sales@computer-rx.net
computer-rx.com

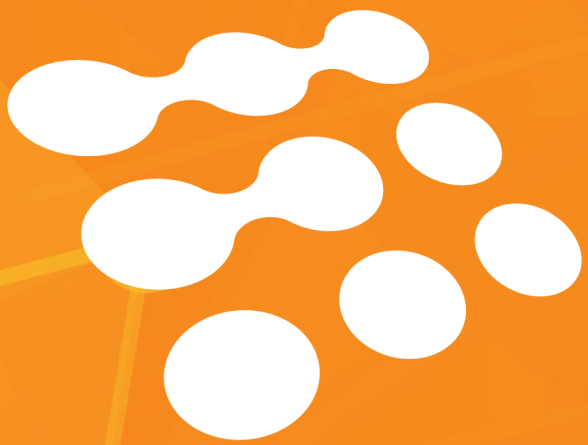
Call today for a custom demonstration.

Rx30
800.289.7930
sales@rx30.com
rx30.com

THE TECHNOLOGY HEALTH EXPERIENCE CONFERENCE

March 28-30, 2019 | St. Louis, MO | techhealthexperience.com

Don't miss **the only** pharmacy technology conference designed to benefit and inspire independent pharmacy professionals with a passion for innovation and technology.



FrameworkLTC®

A SoftWriters Solution

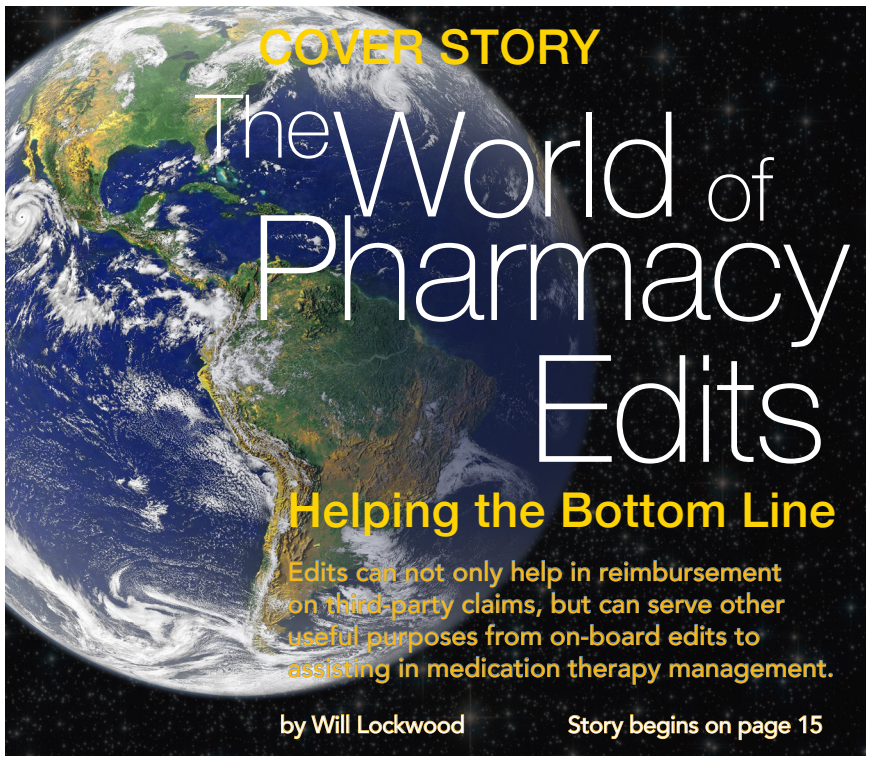
The Leading Long-Term Care Pharmacy Software Platform

With fewer touches and greater accuracy, your pharmacy is able to **compete effectively**, **maximize margin**, and **grow efficiently** with integrated solutions from SoftWriters.

Reach out today to learn more: 412-492-9841, option 3 | sales@softwriters.com | FrameworkLTC.com

computertalk®
FOR THE PHARMACIST

Jan | Feb 2019
The intersection of technology and management.



PLUS

Reducing Claim Rejects with Electronic Prior Authorization*, pg. 20

by Caitlin Graham, VP and General Manager, Pharmacy Business, CoverMyMeds

Focus on Medicare and Medicaid Claims, pg. 22

by Ronna Hauser, Pharm.D., VP of Pharmacy Policy and Regulatory Affairs, The Na-

departments

features

*Sponsored Content

MISSION OBJECTIVE

SAVE + REVITALIZE

INDEPENDENT PHARMACY

JOIN THE MISSION

BOOTH **1101**

CALL FOR DEMO
866.201.8958

PioneerRx's mission is to ***Save*** and ***Revitalize*** independent pharmacy. With customizable features and powerful support, we have created what we call Tactical Pharmacy.

PioneerRx Pharmacy Software

PIONEERRX.COM

computertalk
FOR THE PHARMACIST
www.computertalk.com
Volume 39, No. 1
jan/feb 2019

ComputerTalk (ISSN 0736-3893) is published bimonthly by ComputerTalk Associates, Inc. Please address all correspondence to ComputerTalk Associates, Inc., 492 Norristown Road, Suite 160, Blue Bell, PA 19422-2339. Phone: 610/825-7686. Fax: 610/825-7641.

 Annual subscription in U.S. and territories, $50; in Canada, $75; overseas, $95. Buyers Guide issue only: $25 Printed by Times Printing LLC.

Bill Lockwood
Chairman | Publisher
Bill can be reached at wal@computertalk.com

Cyberattacks

CYBERATTACKS ARE A REAL THREAT to our national security and to every one of us personally.

Just how bad is the threat to our national security? The Nov. 30 Kiplinger Letter painted a bleak picture. It stated that "nearly all new weapons systems are at risk of being penetrated," according to a federal report issued after a team of government hackers was able to break into the Department of Defense networks undetected.

What's at risk? According to the Kiplinger Letter, everything from defense-related electrical grids to missile targeting systems. In the event of war, cyberattacks on that infrastructure could be deadly.

The Kiplinger Letter went on to say that with the cyberthreats constantly evolving, the Department of Defense is recruiting technology specialists but faces competition from the private sector in terms of the salaries that can be offered. Cybersecurity specialists in the private sector can earn $200,000 a year, while the same job for the Department of Defense pays $86,000, on average. To me this is a real problem that Congress needs to address.

Then there is the recent Marriott data breach that involved the personal information on millions of guests in its Starwood brand. We are all sitting with our personal information a target for hackers. And our healthcare data is a prime target. About 16,000 medical records are being exposed online per hour, according to researchers from IntSights. This company evaluated 50 healthcare databases and found that 15 were exposed online, compromising 1.5 million patient records. Hackers target our medical records because there is a market for this information and they can demand ransom to free up the infected computers.

The Health Insurance Portability and Accountability Act (HIPAA) was designed to protect our personal health information. HIPAA spelled out the security requirements that covered entities must comply with to protect our privacy. The HITECH Act went a step further and included business associates of the covered entities as having the same compliance requirements. But this isn't stopping the hackers. Every week I read about data breaches of medical records.

And the HHS Office for Civil Rights is coming down hard with monetary penalties. Case in point is a medical center in Colorado that was fined $111,400 when it failed to terminate a former employee's access to its scheduling calendar, which contained patients' protected health information. The investigation found that the employee accessed the calendar more than once and that there was no business associate agreement between the medical center and Google, the scheduling calendar vendor.

Bottom line: Pharmacy owners need to check with their system vendors to determine what safeguards are in place to protect against a hacker gaining access. Don't wait for the problem to happen. More importantly, make sure to have signed agreements with your business associates and your security procedures are documented and updated on a regular basis. **CT**

Be like Miral-

Save valuable time without losing valuable space.

Do you need affordable and reliable tabletop counting technology but lack counter space? The RM1™ is a compact, vision-based tabletop counting system perfect for growing or space-limited pharmacies. The RM1 quickly and accurately counts solid oral medications, has an easy-to-clean surface and saves you valuable time without taking up scarce counter space. Less than 8 inches tall and lightweight at only six pounds, the RM1 packs efficiency and affordability into one powerful and portable automated counting system.

See the future of pharmacy automation and what it can do for you.
Visit rxmedic.com or call 800.882.3819.

"It definitely improves our workflow efficiency and it's very easy to use. We've tried other counters in the past and they didn't work well for us. The RM1 works and it's a great value. We have seven, one for each of our locations."

Miral Patel, RPh – Owner, Curlew Pharmacies, Clearwater, FL

RxMedic

Liberty Software announced that Jason Mattson has joined the company as business development manager. In this role, Mattson will be managing the Midwest territory and developing business relationships with prospective and current pharmacies within the territory.


Jason Mattson

"I've know Jason for years, and he is a talented pharmacist who cares about independent pharmacies, and he loves technology," says Jeremy Manchester, executive VP at Liberty Software.

"From the very beginning of my relationship with Liberty, it was evident that there was a mentality of care. Liberty cares for their employees and their customers," says Mattson. "My hope is that we can grow the independent pharmacy industry, because independent pharmacy is where the best patient care can take place."

Mattson has over 15 years of experience in pharmacy. Prior to joining Liberty he was a staff pharmacist at Walgreens for three years, and before that he worked as a pharmacy manager for 12-plus years at an independent pharmacy in Illinois. He is a licensed pharmacist with experience not only in retail, but also in long-term care and assisted living.

Mattson holds a doctor of pharmacy degree from the University of Illinois and a bachelor of science in mathematics from Wheaton College.

At **Tabula Rasa HealthCare** (TRHC), Kevin Boesen, Pharm.D., has been appointed chief sales officer. In his new role Boesen will be responsible for all direct and channel sales efforts in the United States and Canada, with a focus on expanding the adoption of the company's signature product, MedWise, into health plans and healthcare systems, programs of all-inclusive care for the elderly, and other financially at-risk healthcare organizations.

Boesen was the founder and CEO of SinfoniaRx, which was acquired by Tabula Rasa HealthCare in 2017. He brings more than 15 years of experience in healthcare sales, including healthcare information technology solutions and services. He built SinfoniaRx into one of the largest medication therapy management platform companies in the United States. SinfoniaRx provides medication management services for more that 450 health plans, representing more than 10 million patients, including 8 million Medicare beneficiaries. SinfoniaRx's technology is also integrated with thousands of community pharmacies.

Boesen says he has seen great opportunities to help current and new health plan clients enhance quality and reduce costs through the use of Tabula Rasa's technology platforms. "The problem we are addressing is adverse drug events, the fourth leading cause of death in the United States." The various TRHC sales functions will be expanded for future growth and new markets under Boesen's leadership. To assure a smooth transition, Sandra Leal, Pharm.D., and COO of SinfoniaRx, will assume the role of CEO of SinfoniaRx.

Pharmacy packaging and automation provider **TCGRx**, a portfolio company of Frazier Healthcare Partners, has announced the acquisition of **Parata Systems**. Together, the companies have more than 4,500 medication adherence packagers, inspection systems, and vial-filling robots installed in retail, long-term care, hospital, government, and mail-order pharmacies throughout North America. The company plans to expand on existing growth with central fill, inventory control, and automated blister-card packaging technologies.

Mark Longley, Parata EVP of sales, sees the combination as allowing the company to accelerate the pace of innovation and better meet the rapidly evolving needs of its customers.

The combined company will operate under the Parata brand and will be headquartered in Durham, N.C., with additional facilities in southern Wisconsin. Current TCGRx CEO Rob Kill will lead the combined organization. TCGRx founder Duane Chudy has left the company to pursue other career interests, as has former Parata CEO D.J. Dougherty.

Micro Merchant Systems has released version 3.06 of its PrimeRx software. Among the many enhancements in the latest version is a new electronic Rx exceptions report.

With this report, users will have the ability to identify, validate, and correct all instances in which data contained in existing records does not match data listed in incoming electronic prescriptions.

PrimeRx will automatically generate an exceptions report in which all inconsistencies are clearly identified. This will allow the user to specify the mismatch criteria against where the mismatch is detected. The user is then provided with options to tag a record for follow-up for verification or edit the record to correct the inconsistent data.

Once the edits are made, the system will

continued on page 8

From our family to your pharmacy

As a family owned and operated company, we know the value of a hard day's work and believe good business starts with partnerships, not profits.

Since 1985, BestRx has served the needs of independent pharmacies with innovative solutions to streamline business, increase revenue, and enhance the care you provide to patients. With BestRx, you can rest assured knowing our product isn't a one and done deal - it's an ongoing relationship to grow businesses and strengthen communities.

BestRx
PHARMACY SOFTWARE™

Let's talk.

1200 Jorie Blvd Suite 310
Oak Brook, IL 60523
1-877-777-5758
sales@bestrx.com

continued from page 6

reconcile the changes. When all the data inconsistencies have been addressed, the record will be removed from the exceptions report.

"As pharmacists become increasingly reliant on technology, they need to have full confidence in the pharmacy management system's reporting and processing capabilities," notes Ketan Mehta, CEO of Micro Merchant Systems. "The innovative PrimeRx exceptions report provides pharmacists with confidence that all data inconsistencies have been automatically flagged to help prevent dispensing errors and improve medication safety."

Nimesh Jhaveri, M.B.A., R.Ph., has joined the **Health Mart** family of community pharmacies as president. With 30 years of hands-on pharmacy experience, Jhaveri is responsible for developing strategies supporting the goals and success of more than 5,000 Health Mart pharmacies. In his role, Jhaveri will work hand in hand with independently owned Health Mart pharmacies and help them provide quality healthcare in their local communities.

Nimesh Jhaveri

"My priority is to listen and learn, specifically by spending time with Health Mart owners and their customers. With stores across the U.S., we are impacting communities and patients in a meaningful way," says Jhaveri. "I look forward to experiencing the powerful spirit of independent community pharmacists firsthand. With our industry in a period of unprecedented change, it is a rewarding opportunity to lead the way for independent pharmacy."

Read an in-depth interview with Jhaveri at wp.me/p9LtTd-1Dw. **CT**

Success Through Technology

Bill Osborn, president of Osborn Drugs in Miami, Okla., has watched community pharmacy evolve for more than 30 years since he graduated with a Pharm.D. from the University of Oklahoma. He was installed as the newest president of the National Community Pharmacists Association (NCPA) in October. In this interview with ComputerTalk*'s Maggie Lockwood, Osborn shares his passion for pharmacy, technology, and growing a business in a competitive landscape. Hear more from Bill Osborn online at https://wp.me/p9LtTd-1DD.*

ComputerTalk: Congratulations on being named NCPA president.

Bill Osborn

Bill Osborn: Thank you! It's been a 14-year journey, during which I've gotten to know pharmacists from around the country. When people congratulate me, I tell them I am successful because of the people around me and our philosophy at Osborn Drugs: Take care of patients, take care of our partnerships, and they will take care of us. I feel the same way about NCPA. I hope it serves as a forum for pharmacists to come together and learn about innovations in the industry.

CT: What do you feel are the priorities going forward?

Osborn: As I said in my acceptance speech, we are at a point where we should capitalize on the momentum of the past few years. Three years ago we were talking about DIR [direct and indirect remuneration] fees, and no one knew what they were. Last year we spoke to our congressman about it and he asked, "How can we fix this?" The legislative work NCPA does makes a difference, and government agencies are listening to us. I think that has a lot to do with NCPA Executive Director Doug Hoey's leadership and the staff. NCPA is helping pharmacists at the state level, as well as in the background, to make ownership a better opportunity.

CT: What made you get involved with NPCA?

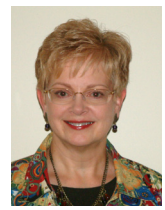
Osborn: Back in 1988, I was attending pharmacy meetings, learning about pharmacy technology. There was an article with the headline: "Independent Pharmacy Is Dead." I asked my dad, "Should we be selling?" But we felt that if you could innovate and adjust to the times, you could be successful as an owner. At that time we had four partners and eight locations. We grew to 18 partners with 24 locations. It's easy to be negative, and if we had listened to that article, we wouldn't have been successful.

CT: Technology keeps community pharmacy competitive?

Osborn: Technology gives pharmacy the ability to adapt. When we first put in our RxSafe adherence packaging system, it was with the idea that we would offer it to patients. Now Amazon comes out with a packaging solution and starts calling our customers to transfer their scripts. But doctors can tell their patients, "You can do that at Osborn." We make sure that we have alternatives and offer programs that help us compete with the big guys.

When we first started with a new vendor in the late '80s, the accounts receivables module randomly added a nickel to the charge accounts. We called the vendor to have them fix it for the next month. Meanwhile, we put a nickel into the statements to cover it. That's why I call independent pharmacists problem solvers. When there is a challenge or a change, you look at how you can fix it through your software, and you learn to adapt and make it work for your pharmacy. **CT**

Prescription Monitoring Programs
The Errors and Omissions Problem



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

MUCH HAS BEEN WRITTEN about the opioid epidemic in recent years. While it has certainly garnered a great deal of attention, the abuse of prescription drugs, particularly opioids, is not new. Health professionals have known for decades that the difference between medical opioids and street opioids is that medical opioids have been recognized by the U.S. Food and Drug Administration and are intended for use in the treatment of disease in humans or animals. The chemical structures of heroin, morphine, and oxycodone are nearly identical. Therefore, the human body's opioid receptors produce the same results regardless of the source of the drug.

Because legal opioids are used in medicine, prescribers and dispensers of these drugs are required to keep detailed records of acquisition and distribution. Pharmacy dispensing records are the most accessible healthcare record of legal drug acquisition and distribution. These records are used both by healthcare practitioners and by government agencies as a reliable source of information for investigating violations of professional practice or drug-related crimes. States and jurisdictions created prescription monitoring programs (PMPs) or prescription drug monitoring programs (PDMPs) to maintain centralized prescription records, which have come to be critical in the fight against opioid abuse. It should be noted that opioids are not the only prescription drugs of abuse; therefore, PMPs contain records of numerous drugs that are subject to abuse, including stimulants for the treatment of attention deficit disorder, sleeping pills, anti-anxiety drugs, and some of the nonopioid pain relievers.

The purpose of every PMP is to provide a prescription drug history to help healthcare providers and regulatory officials monitor use of controlled substances and other drugs of abuse. This information is essential to the provision of appropriate healthcare by healthcare professionals and the investigation of illegal activity by regulatory officials. However, the data was never intended to be a primary record nor absolutely correct in every regard. It was intended to be another tool in a professional's toolbox to identify trends in prescription drug use or misuse.

As PMP records are used more and more often, the errors and omissions in the data come to light. The PMP record consists of selected data fields within the data required for prescription recordkeeping. However, whenever humans are involved, errors will occasionally occur.

PMP errors can occur throughout the process of filling a prescription and are the result of omission or commission. Errors of commission are the result of inaccurate data being submitted to the PMP. Errors of omission result from data that is never submitted to the PMP or incorrect data that is never corrected.

It is important to understand where errors arise or could arise in order to accurately interpret a PMP report. While errors may exist in any data field, patient identity and prescriber identity are the most problematic. The identity of the dispensing pharmacy is a critical piece of information that the reviewer of a PMP report may need if further details are necessary.

PRESCRIBER NAME

Prescriber name or prescriber identification is the most frequently identified error in PMP databases. It comes to light in several ways. A prescriber or pharmacist may be reviewing PMP data with a patient and the patient denies ever having been treated by a particular prescriber. In other cases, a prescriber receives communication from his or her state PMP or a regulatory agency about one or more prescriptions attributed to him or her. The prescriber has no record of the patient and denies that he or she authorized the prescription. In either case, the dispensing pharmacy must be contacted. The pharmacy staff reviews the original document and finds some of the following:

- The wrong DEA or NPI number was entered or selected at the time of dispensing.
- The prescriber on the prescription cannot be identified (such as an emergency department prescription).
- There is an error in the database of prescribers that the pharmacy uses.

The first scenario occurs most frequently and is easily corrected by the dispensing pharmacy. However, it should be noted that, as with many PMP errors, the pharmacy might correct its own record but fail to amend the PMP record.

continued on next page

continued from previous page

PATIENT NAME — PERSON IDENTIFICATION

There's a common misperception that any person in the United States can be identified by first name, last name, and date of birth. If you Google someone, even with a relatively uncommon name, you often find multiple people. Even adding the date of birth does not narrow the search sufficiently. I personally know of two women with the same first name, last name, and date of birth who live three miles apart, in the same state. PMP data is unlike health insurance data, credit card data, and many other large databases because there is no unique identifier that can be assigned. Based on my experience as a PMP director, even Social Security numbers (SSNs) are not the answer. Today there are very sophisticated algorithms that use a wide variety of details and extraneous data sets to match patient identities. Still, this is not perfect.

Patient identity is probably the most prone to error and arguably the most critical data field for understanding all the rest of the information. The reasons for patient identity errors are numerous:

- Women change or hyphenate their last name upon marriage or divorce.
- People use nicknames, which occasionally morph over time.
- Nicknames may bear no semblance to a given name. For example, Bob is usually a nickname for Robert, but Bubba or Sissy can be an affectionate term for any first name.
- Some people are called by their middle name instead of their first name, and few people realize that fact.
- Some cultures reverse the last name/family name and the first name/given name.
- Twins often have very similar first names along with the same date of birth, and for many years have the same address.
- Similar-sounding names may be spelled differently.

DISPENSING PHARMACY

The identity of the dispensing pharmacy is seldom an issue, since data is submitted to the PMP by the dispensing pharmacy. Yet sometimes prescription records may be duplicate or nearly duplicate. It is not uncommon for a prescription to be delivered via phone, fax, or e-prescribing to a pharmacy, and the prescription will be prepared. Later, the patient chooses to pick up the prescription at a different pharmacy. Then the original prescription information will be transferred to the second pharmacy, which creates its own record of dispensing. The original pharmacy usually makes all the appropriate and legally required changes or amendments to its own record, but often fails to amend the record that has already been sent to the PMP. The result is two prescription records in the PMP, but the patient only received one prescription.

While patient, prescriber, and dispensing pharmacy are not the only sources of errors in PMP reports, they usually cause the most concern and are the most highly visible inaccuracies.

The key to evaluating PMP information is critical thinking:

- Does the information provided match or support what I already know about the person?
- If there are outliers, can I verify the accuracy of the outlier or determine that the information should be excluded?
- What does the patient say? Ask for details in an open-ended manner such as "Tell me about the visit to Dr. X on a specific date." or "Did you see a dentist or go to an emergency room back in June?"
- Look at the prescribers. Are they local? What is their specialty? Are they associated with a major medical center or a teaching hospital? Does the patient regularly travel to other states?

It is also helpful to remember that PMP reports are tools to identify trends. The report cannot be used in isolation; it must be combined with additional information about the persons involved to properly assess the situation.

As more and more states require prescribers and dispensers of controlled substances to review a patient's PMP report prior to prescribing or dispensing, the identification of real and potential errors is increasing. Pharmacists and their staff should be cognizant that their data is no longer maintained in a silo for their own use but is commingled with data from all pharmacies, and errors in recordkeeping can require labor-intensive corrections in the future. **CT**

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

TABULA RASA HEALTHCARE®

MEDICATION SAFETY SOLUTIONS

TRHC offers a suite of solutions proven to identify and mitigate medication-related risk.

TRHC's proprietary Medication Risk Mitigation Matrix™ is embedded in our MedWise™ software that delivers a simultaneous, multi-drug, precise review to identify medication-related risk and provide decision support to reduce that risk. **MedWise™ is offered as a standalone cloud-based service, and beginning in 2019, can be integrated with your EHR and pharmacy systems through SMART on FHIR.**

We have experience

TRHC participates in the Enhanced Medication Therapy Management (EMTM) Model test. The EMTM Model focuses on reducing costs and improving therapeutic outcomes across a Medicare Part D population. TRHC also provides medication safety services for a variety of healthcare organizations.

Actionable Clinical Intelligence
TRHC has helped health care organizations reduce their medical spend (e.g., hospitalizations) by up to 25% and their post-discharge readmissions by as much as 50%.

Medwise Proven Technology

Medwise improves outcomes and has exhibited a return on investment of greater than 4:1.

Contact us today to learn more

info@trhc.com | www.trhc.com | 866.648.2767

New Dynamics in Drug Management

by Maggie Lockwood

IN THE LATE 1970s, A DRUG INTERACTION feature was added to pharmacy management systems. These interactions were based on manufacturers' package inserts and the drug literature available. However, they were and still are one-dimensional interactions. They do not capture the more complex issue of multiple drug interactions and competitive inhibition.

While the opioid crisis has rightfully received much attention in the press, a more common danger is overprescribing. Statistics from the Centers for Disease Control and Prevention show that people 65 or older who are on five or more medications have a 50% chance of an adverse drug event (ADEs). It's now not about how one drug interacts with another, but a web of interactions. Throw into this mix personalized medicine, with the understanding that everyone metabolizes drugs differently, and the potential for adverse drug reactions increases dramatically. With all the medications out there, doctors, pharmacists, and other healthcare providers can't be expected to know all the metabolic pathways of each drug in real time. So this is where the Medication Risk Mitigation (MRM) Matrix from Tabula Rasa HealthCare comes into play, with its multidimensional perspective. The MRM lets pharmacists analyze drug absorption, distribution, and metabolism, as well as accumulative drug interactions and drug-gene interactions. The MRM Matrix is the backbone of the clinical support tool MedWise Advisor. Both systems give a patient a risk score, with a color-coded visual alert and detailed clinical analysis. This takes medication management to the next level, as it illustrates competitive inhibition, and pharmacists can recommend not just a different drug, but the same drug at a different time of day or in a different dosage.

"When we looked at it back in 2011 and 2012, when we started this, we said, there's got to be a different way that looks at the root cause — and that's how we turned to the science of adverse drug events," says Cal Knowlton, Tabula Rasa HealthCare chairman and CEO. "Maybe there's a way to look at the underlying science that's behind these drug interactions, and then maybe we can work to fix something — because with the one-to-one drug interaction all you can really do is say, I'm going to stop that one medication."

Cal Knowlton

"With older folks, they are seeing multiple physicians, and every physician has his or her own med for a specific problem. So what we're seeing is a confluence of problems. It's usually not one physician overprescribing. It's usually the notion that it's cumulative," says Knowlton.

Over the past 18 months, MedWise Advisor was used in a pilot program for 240,000 patients in Midwestern health plans. The company risk stratified the population, coming up with 34,000 patients at risk for adverse drug events based on such factors as number of medical conditions, type of medications, and age. Pharmacists were then trained on MedWise Advisor to evaluate multidrug simultaneous interactions. This sort of approach takes medication therapy management to a new level, since it tweaks not just the actual medications, but how each metabolizes for a specific person. The key here is preventing an adverse drug event or reaction (harm by a drug at normal dose) and puts the pharmacist in the driver's seat when it comes to seeing when this might happen, and letting prescribers know it's a possibility.

SUCCESS STORIES

Randy McDonough, Pharm.D., co-owner and director of clinical services at Towncrest Pharmacy in Iowa City, Iowa, had an early look at the MedWise Advisor program. He was impressed by the amount of evidence-based information available, like the sedation properties of specific drugs, competitive inhibition of different drugs, and adverse effects. "It really gives a full picture of the safety of a specific mediation to a specific patient," he says.

The matrix is visual, so pharmacists can see where the problems are. "Pharmacists will be able to quickly assess potential risks and make a decision, quickly and accurately, in recommending a different dose or a

Randy McDonough

Technology companies continue to innovate with clinical intelligence to support pharmacists' decision-making. Case in point is Tabula Rasa HealthCare's risk management matrix, MedWise Advisor.

different time of day for the medication," says McDonough. The training requires pharmacists to go beyond what they are used to in evaluating clinical interactions. "At this point it is one of the most sophisticated platforms for evaluating medication interactions," says McDonough.

There is a six-hour training program on pharmacokinetics and pharmacogenomics with MedWise Advisor. While pharmacists have had this in school, they might not have used it, and the refresher includes reviewing cases to show how to apply the MedWise Advisor program. The result is a medication safety review that can be attached to a patient record and shared in a documentation system. "The goal," says Cal Knowlton, "is to have this integrated into the pharmacy system."

Towncrest's Director of Clinical Operations Kelly Kent agrees. "I graduated in 2003, and I knew about the many competitive inhibitions that exist between drugs," she says, "but I didn't have all the information in one place to effectively manage it." The software illustrates the inhibitions, as well as details like how long a dose remains competitive. Pharmacists then have the knowledge to make a recommendation to a prescriber.

Kelly Kent

""We were very impressed by its comprehensiveness," says Randy McDonough. "When you say, 'What can we do for that patient?', the MedWise Advisor gives a lot of information about medication safety."

Kelly Kent says that her staff can see how morning prescriptions are interacting with each other, for example, and click on each drug for a discussion on the clinical significance. Then there are recommendations on how to manage it.

MedWise Advisor is a stand-alone system right now in the beta pharmacies. Knowlton says the hope is to have it integrated into pharmacy systems later this year.

THE FUTURE OF PHARMACY

The pilot did have funding, and pharmacists were paid for reviewing risk scores and discussing these with patients. Tabula Rasa HealthCare's research shows a direct relationship between a higher risk score and more money spent on healthcare. Reviewing the risk scores, and finding ways to lower them, can mean actual savings for health plans. While grants currently fund the payments to pharmacists for the evaluations, the hope is that insurance companies will see the value in paying pharmacists for this.

At Towncrest Pharmacy the clinical decision-making is tracked on its in-house documentation platform, PharmClin. Kelly Kent shared a number of success stories: changing the time of day when medications were taken; changing from one statin to another drug to eliminate competitive inhibition; reducing full-dose aspirin; and moving a patient to compliance packaging as part of the medication review.

A NEW WAY TO WORK

The matrix is a new way to look at patients, explains Randy McDonough, giving pharmacists many variables to evaluate. But this type of information is what can make pharmacists stand apart and get away from the silo system of healthcare. "Pharmacists have got to make these interventions, doctors have to see where they are coming from, and we need to be compensated," he says. "Through the interventions, when you've shared this comprehensive information and offered a clinical intervention alternative based on good literature, that's impressive. Doctors don't get a lot of training on interactions. We are the experts, and it elevates how doctors view pharmacists."

And McDonough is clear: Don't wait until the payments are there to make changes. Prepare now and have a process. "We are ready for this," he says. "This is an added tool to assess and make recommendations. There are a lot of benefits from this, including reimbursement." **CT**

Maggie Lockwood is VP and senior editor at ComputerTalk. *She can be reached at maggie@computertalk.com.*

Complete financial control. Right at your fingertips.

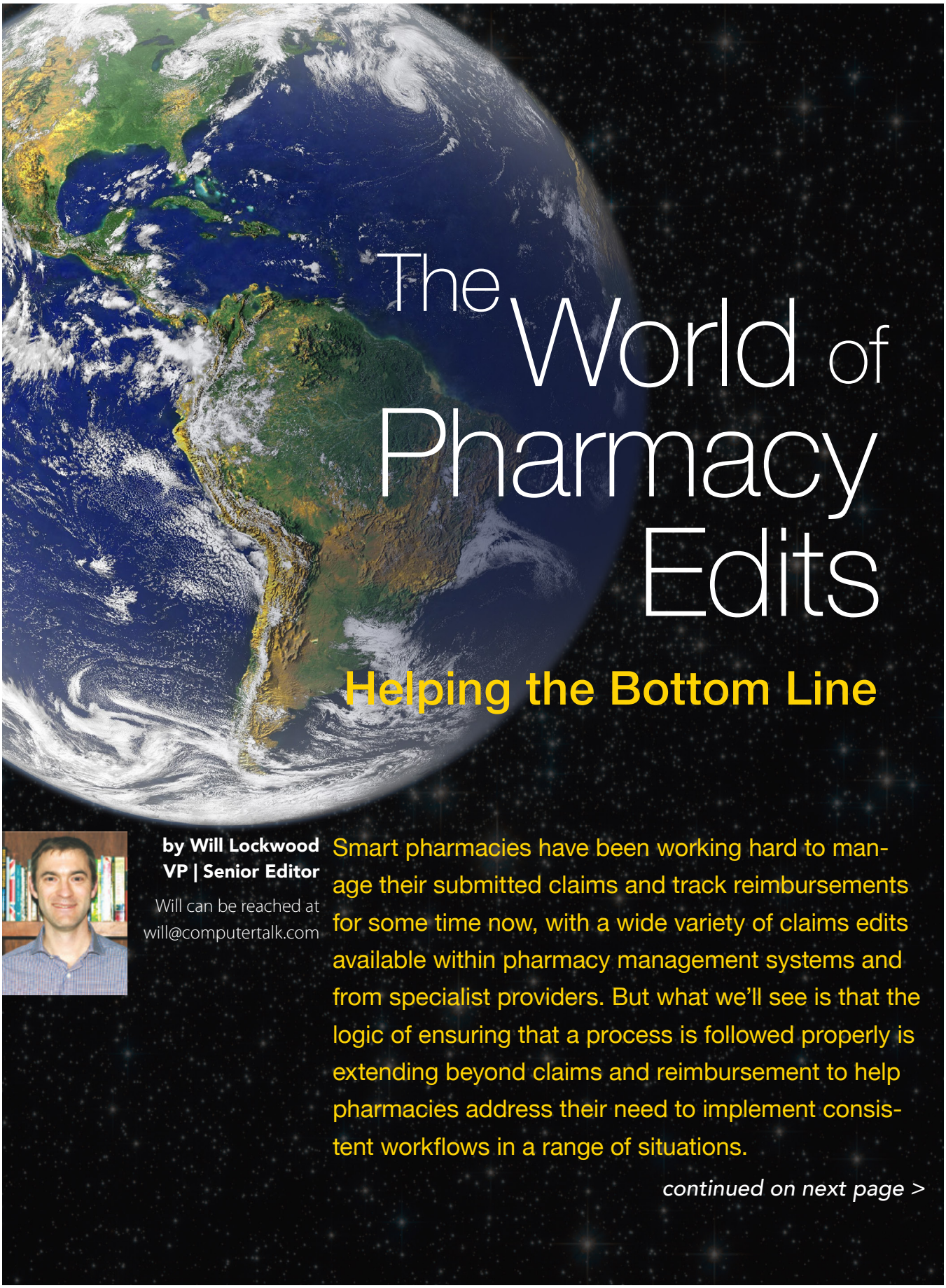
ScriptPro's powerful **Third Party Management System** (TPMS) shines a light on DIR fees and maps the dots to source transactions, giving you real-time visibility on the fees you pay.

Gain accountability with contract performance monitoring, internal auditing, and streamlined focus on the financial issues that matter. TPMS is the powerful end-to-end financial solution you've been needing to run a sound pharmacy operation.

Take charge of your pharmacy's financial success with **ScriptPro TPMS**.

800.673.9068 | www.scriptpro.com |

TPMS
Third Party Management System



The World of Pharmacy Edits

Helping the Bottom Line

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

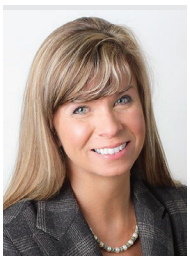
Smart pharmacies have been working hard to manage their submitted claims and track reimbursements for some time now, with a wide variety of claims edits available within pharmacy management systems and from specialist providers. But what we'll see is that the logic of ensuring that a process is followed properly is extending beyond claims and reimbursement to help pharmacies address their need to implement consistent workflows in a range of situations.

continued on next page >

BUILDING ON THE BASICS

Cathy Romanick is director of network solutions for RelayHealth. Romanick's team of product managers is responsible for a variety of claims, reimbursement, and audit protection services for chain, independent, and outpatient pharmacies, beginning with a base package of pre- and post-editing (PPE) services. This is a set of services that pharmacies should already be familiar with, including edits for AWP (average wholesale price) comparison, DAW (dispense as written), quantity/days' supply, NDC validation, and more.

Romanick highlights two examples of the practical value of a PPE suite. First, she explains that there's the opportunity to ensure that the quantity dispensed used during data entry is a logical quantity. "A common example is epinephrine injectors," says Romanick. "These come in a package of two, but sometimes at data entry pharmacy staff will enter a quantity of one, because they're thinking that they're going to dispense one package to the patient. The payer will reimburse based on the quantity that was sent on the claim."



Cathy Romanick

A pharmacy using a claims-editing program that checks for quantity/days' supply, as does RelayHealth's, will get that claim for an injector bounced back before it reaches the payer, with a message about the quantity not being in increments of the package size.

Another commonly used edit, according to Romanick, is for pricing updates. This is especially important so that the pharmacy can receive appropriate reimbursement for brand drugs. "The payer typically reimburses the pharmacy for a brand drug based off the AWP price minus a certain percentage," says Romanick. "If the pharmacy is sending in a low, out-of-date AWP, the payer will likely only reimburse based on that lower price. RelayHealth will update the submitted AWP to the most current AWP when needed." In this case RelayHealth does not message back to the pharmacy, according to Romanick.

LOOK FOR FLEXIBILITY

A basic claims-editing suite is, without doubt, a tool box that no pharmacy should be without. But you should also be on the lookout for opportunities within your pharmacy software to deploy customizable edits to address your pharmacy's specific needs. This is the advice Erica Mahn, Pharm.D., offers. Mahn is director of community pharmacy at Alps Pharmacy in Springfield, Mo., which comprises two community pharmacies, a specialty pharmacy, and a long-term care pharmacy.

Erica Mahn

In this role, Mahn has come to rely on the highly customizable nature of the Rx Edits module in the pharmacy's PioneerRx software. This includes as standard a long list of edits for prescription claims and immunization reporting, but it also allows Alps Pharmacy to set edits specific to its needs. "We can turn on an edit based on a specific drug or drug class," says Mahn. "For example, we are an accredited diabetes education center, and we have several edits set up in PioneerRx for our diabetic patients based on drug class." This edit generates an on-screen prompt for the pharmacist whenever a new drug for this class is added to a patient's profile. "We make sure that our pharmacists are going over all the right counseling points," says Mahn, "and we can quickly sort and categorize these patients just based off the drug class."

Mahn offers another great example of a customized edit, this time for a specific drug. The SHINGRIX vaccine requires two doses two months apart, and Mahn saw the need for an automated reminder within the system. "We were able to set this up based off the NDC number for the vaccine," she explains. "When we fill a prescription for SHINGRIX we automatically apply a care action edit to that patient's profile so that we are reminded to follow up with them when they're due for the second dose."

Mahn has also found that the edit process is useful for supporting Alps Pharmacy's patient adherence initiatives. "You may think you're filling everything a patient needs," says Mahn. "But it's easy to miss something when a patient isn't enrolled in your med sync program or auto refill, for instance. We have an edit set up in PioneerRx that's looking for any patient who falls below a certain percentage rate on their filling. So even if they're not enrolled in any other program, we're catching that it's been 94 days since they've filled their metformin prescription, and it was due at day 90. We know we need to give them a call to find out what's going on."

ENFORCING RULES FOR DME

Alps Pharmacy has set up edits within PioneerRx to create protocols for its DME (durable medical equipment) business. "We have several edits established to ensure that our DME claims are handled correctly and by the staff we've designated as responsible for them," says Mahn. These edits will lock a DME claim until it can be reviewed by an appropriate staff member. For a good example of this edit in action, Mahn points to the need for Alps Pharmacy to have chart notes on file when processing a claim for test strips through Medicare Part B.

PRESCRIBER VALIDATION

For one final example, Alps Pharmacy is also using an edit that alerts staff if the claim is using an out-of-date DEA number or the DEA number is for the hospital rather than for the individual prescriber. "We're able to correct this ahead of dispensing to make sure that we're billing under the right provider information," says Mahn.

RelayHealth's Cathy Romanick agrees that validating prescriber data is critical for pharmacies. There are two important areas here, Romanick notes: the Office of Inspector General (OIG) prescriber exclusion list, which a prescriber can land on for a variety of reasons; and prescriber DEA schedule authority, which reflects the fact that prescribers have different licenses that give them the authority to write for specific schedules of controlled substances.

The risks for pharmacies in making mistakes here are substantial. For example, explains Romanick, if a pharmacy adjudicates a claim from an excluded or sanctioned provider, it may lose its ability to process Medicare and Medicaid claims and may be subject to substantial fines.

The fines can add up quickly, since a claim can go through with an excluded provider on it and then be refilled repeatedly using the same information before being flagged in an audit. " There can be instances where it may only be on the eighth or ninth refill that it comes to light that that prescriber was on the OIG list from the very

continued on next page

continued from previous page

beginning," says Romanick.

In the case of the prescriber schedule authority service, Romanick explains that RelayHealth is looking at both the drug and the prescriber's license information. If the prescriber gets flagged by the switch either for being on the exclusion list or for lacking the appropriate schedule license, the claim is stopped right there and messaging goes back to the pharmacy.

ADDRESSING REJECTS

Not all potential rejects are going to get caught before reaching the payer, though. And reject levels can reach a point where they're a real burden on a pharmacy's efficiency. That, unfortunately, was the case at Gayco Healthcare, a long-term care pharmacy currently serving over 5,000 beds out of locations in Dublin and Alpharetta, Ga. These range across skilled nursing, assisted living, personal care homes, group homes, behavioral health homes, and correctional facilities. The pharmacy has been on a growth path in recent years, with CEO Bent Gay as the visionary and COO Jon Martin working to execute the plan.

"As you bring on more business, you have to be sure you are still focusing on the fundamentals," Jon Martin says. "We have to maintain our focus on our key performance

Jon Martin

indicators." For example, Gayco Healthcare has daily order entry targets that the staff needs to hit in order to get the last order of the day filled by 6 p.m. and delivery drivers on the road by 6:30 p.m. every day.

But another key metric is the percentage of the claims for those orders that is rejected by the payer. "We were seeing 8% rejection rates," says Martin, "spiking to as high as 12% sometimes." Billing staff were frustrated and stressed, and Gayco Healthcare,

continued on page 20

BROUGHT TO YOU BY QS/1®

NRx® allows you to be all the things you ever wanted to be - for all the right reasons.

As a community pharmacist, we know you have many responsibilities. NRx helps you run your pharmacy more efficiently with e-Care plans for better reimbursement rates and customized medication therapy management (MTM) options. As the most comprehensive pharmacy management system on the market, NRx gives you more time with your patients – and more time with your family.

Go for NRx. / qs1.com/NRx/Go / 800.231.7776

continued from page 18

which Martin reports had moved to shorter fill cycles and a post-consumption billing model, was really struggling to get billing statements out on time to facilities at the end of the month. Gayco first tried a preadjudication service, but that did not reduce rejects, while adding cost.

But another part of the growth plan had brought in the FrameworkLTC pharmacy management system from SoftWriters, which also ended up bringing with it the company's expertise in long-term care pharmacy workflows and the expertise Gayco Healthcare needed to really address its claim rejects problem.

After seeing no impact from preadjudication, Martin decided to take a step back and sit down with an expert from SoftWriters. "There were some basics that needed attention, and for that we really needed to be looking to our partners at FrameworkLTC software," says Martin. "We came away from that conversation with an actionable handful of ways within our workflows and utilizing FrameworkLTC more effectively to move the needle on claim rejects." Among the areas Martin reports addressing were how unit-dose composites are managed and establishing edits to ensure that patient codes are correct and stay correct. "We felt like we were doing things right," says Martin, "but when we really looked at our process with SoftWriters and looked at the logic within the system that we can use, we realized that there are edits and other tools available to ensure we are taking the right steps each and every time."

Getting back to basics led to success. "We laid out a structure for how to leverage the tools within our pharmacy system, and we started moving things very slowly," explains Martin. "And now we're averaging rejection rates below 2%, and some months we've even been just under 1%. We have cleaner claims, we have better statements that we're producing for our customers, and we also have been able to reassign an FTE [full-time equivalent] in the billing department over to another department, which has improved our overall operations as well. All this while our volume is higher today than it was a year ago."

BATTLING RETROACTIVE FEES

Direct and indirect remuneration

(DIR) fees are another area getting a lot of well-deserved attention when it comes to managing claims. Erica Mahn at Alps Pharmacy puts it this way: "You can know the cost of your prescription, but retroactive fees such as DIR mean that you really don't know what your reimbursement is until what's often months later."

"This is the biggest place that we've had to rely on our PioneerRx system to help us get a real handle on reimbursement," says Mahn. "We need to be able to track in a consistent way what a given payer is likely going to be taking off the top of our reimbursement with those DIR fees."

Mahn reports that Alps Pharmacy is using a feature within PioneerRx to log known retroactive fees for a given payer and automatically apply them to new claims in order to generate an estimate of what reimbursement will be in the end. "These are estimates based on the data," notes Mahn, "but we've found that they've been very helpful in allowing us to predict at dispensing what our profit should be."

PREVENTING AUDITS AND CLAWBACKS

Then there are audits and the resulting clawbacks, an area in which a less-than-rigorous claims-editing process can be a real problem. Addressing this audit risk is a significant area in which RelayHealth's Cathy Romanick sees pharmacies searching for help.

As she reports, RelayHealth has done research that found that between a third and one-half of all the audits are based off actions that a pharmacy is taking that could be prevented through more-effective use of edits. One scenario Romanick offers is when a pharmacy submits a claim for 90 tablets covering 90 days, which is then rejected because the payer only covers 30 days. It's not uncommon for pharmacy staff to simply resubmit the claim as a 30-day supply of 90, which is going to cause trouble. "The patient walks out the door with 90 tablets that were supposed to be a three-month supply," says Romanick, "but the insurance pays for it as a one-month supply. This is then an audit trigger for the payer." The payer may request documentation to support the change in daily dose. If no documentation is found, it typically results in a clawback of the original reimbursement.

continued on next page

continued from previous page

This is a prime example of a case where an edit can help mitigate the audit risk. "We see that original claim," says Romanick. "We see the reject. We then monitor claim activity to confirm subsequent submissions of that claim contain a daily dose that matches the original daily dose."

EDITS FOR OPIOIDS

Prescriptions for opioids are a new area where pharmacies are finding a need to apply edits during the dispensing process, with new requirements for Medicare Part D opioid claims now in effect (see the sidebar with NCPA's Ronna Hauser at right). Alps Pharmacy is stepping up here and has established an edit that automatically alerts the pharmacy if someone is paying cash for an opioid prescription or someone with a new prescription has no record of taking an opioid. "We need to be able to identify these patients immediately," says Erica Mahn, "so that the pharmacist can assess the appropriateness of dispensing the opioid and, if needed, have the right conversation with the patient."

KEEPING AN EYE ON AR

Crystal Reed

Crystal Reed is the controller at ReCept Pharmacy, a multiple-location operation that owns or operates pharmacies with retail, specialty, and compounding services in 13 states.

As controller, Reed is tasked with monitoring claims reconciliation across the group's pharmacies, an impossible task without the right tools and the right partner. In ReCept Pharmacy's case, Reed is using ScriptPro's

Focus on Medicare and Medicaid Claims

The National Community Pharmacists Association's (NCPA) Vice President of Pharmacy Policy and Regulatory Affairs Ronna Hauser, Pharm.D., offers insight into challenges that pharmacies are facing right now, including retroactive fees and challenging Medicaid managed care reimbursements.

Ending retroactive fees is one of NCPA's top priorities, according to Hauser, who reports that there is a proposal on the table at the Centers for Medicare & Medicaid Services (CMS) that would end the retroactive nature of pharmacy DIR fees potentially starting as early as contract year 2020. But right now pharmacy DIR fees and the uncertainty they create are here to stay for 2019, especially for Part D claims.

Hauser also reports that the NCPA is focusing heavily at the state level on issues with Medicaid managed care programs and underwater reimbursements There's little transparency in the contracts between the states and the managed care organizations (MCOs), with the result that if you try to chart the connections between states and MCOs, you end up with a complicated web of relationships that can leave it unclear which plan a pharmacy is truly filling a given prescription for. Hauser notes an example in which a state was contracted with two different pharmacy benefit managers (PBMs), not realizing the overlapping services that were being paid for. With Medicare Part D and Medicaid making up more than 50% of a typical NCPA member's business, it gets to be a big headache trying to submit clean claims and reconcile reimbursements.

Then there are new CMS Part D rules for opioid dispensing safety edits that went into effect Jan. 1, which now require hard safety edits for seven-day initial fill limits for opioid prescriptions for the treatment of acute pain and an opioid care coordination edit at 90 morphine milligram equivalents (MME) per day for certain beneficiaries. This is something that likely won't have a major impact on pharmacy operations, but it's another detail that you need to be sure you are attending to.

Visit wp.me/p9LtTd-1Do for a PDF of the CMS memo "Additional Guidance on Contract Year 2019 Formulary-Level Opioid Point-of-Sale Safety Edits" and visit www.ncpanet.org/advocacy for other information and resources. CT

Third Party Management System (TPMS) and the supporting staff there to reconcile payments at the claim level, with the detail broken out by store. ReCept Pharmacy's X12 835 healthcare claim payment EDI (electronic data interchange) transactions flow into TPMS, where ScriptPro's staff can match them up against the claims data while working closely with ReCept Pharmacy's accounts receivable (AR) supervisor. "There's no way we'd be able to manage reconciling these 835s in-house," says Reed. "It's just a huge amount of data in the 835, and it all needs to be broken out and matched to claims effectively."

TPMS is actually housing all of ReCept Pharmacy's accounts receivable data, which allows Reed to leverage the platform for a variety of other AR tasks, such as tracking and aging AR, identifying payers that are not providing timely reimbursements, and tracking any DIR fees or adjudication costs associated with claims. Reed reports using the data on prescription DIR fees and adjudication costs to create appropriate entries in ReCept Pharmacy's general ledger, so that the group has a handle of what these costs are.

PHARMACY PROCESS EVOLVING

The processes and tools around pharmacy claims and reimbursement management have certainly developed beyond the familiar set of edits and reports. As we've seen from the example of Alps Pharmacy, edits have become customizable to the point where their use can extend to any pharmacy process that needs software-based checks and assurances. "We've just been very happy with how much we can customize each part of our process using the edits within our PioneerRx software," says Erica Mahn. "We are able to make what we need out of the system, which is important because we have a lot of different situations at different stores in different types of pharmacies."

There are multiple ways to make an impact on your pharmacy operations with edits and reconciliation services. There are benefits from having an eye in the sky, as described by Cathy Romanick, that applies edits at the switch level to help ensure that only clean, properly priced claims are making it to the payer. And you may well want to get deeper into the nuts and bolts of your pharmacy system to figure out how to use what you've got to reduce claim rejects, as was the case for Gayco Healthcare. Or it may involve getting smart and looking for support to manage the huge amount of data flowing through your pharmacy, as ReCept Pharmacy has done for its AR and claims reconciliation. Choose the right set of tools, and you can bring order to what would otherwise be some messy areas of pharmacy operations. **CT**

3 Steps to Buying Smart

Pharmacies focus a lot of attention on what they get paid for dispensing a medication, but it can be very important to the bottom line to spend some time addressing your costs. PharmSaver President Michael Sosnowik suggests taking a good look at your prime vendor agreement (PVA) to ensure that it's structured to be mutually beneficial for your pharmacy and your primary wholesaler. Here are Sosnowik's three keys to improving your PVA.

1. Don't get wrapped up in cost minus on brands.

Often pharmacies will look at the discount off brands in isolation, without taking a look at the generic side of the equation, too. For example, if you negotiate minus 5% on brands, that's great. But you also need to take a close look at the PVA terms for your generic buy to make sure the terms there aren't eliminating the savings on brands.

2. Pay attention to your tiered rebates based on generic compliance.

Ask yourself, are the percentage tiers that trigger rebates actually achievable given your pharmacy's buying patterns? Here you have to keep in mind that not all generics count toward your compliance. For example, most OTC (over the counter) items are probably not going to count toward your rebate tiers, and in fact will be counting against you, since they're adding to your total dollar spend without correspondingly adding to your generic purchases. That's because with most tiered rebate structures the only generics that count are "source" generics, and there may be many other generics that you are purchasing — on GPO (group purchasing organization) contracts, for example — that add to your total spend without adding to your generic spend.

3. Don't overcommit to your primary wholesaler.

Don't forget that, overall, your prime vendor may well be your highest-cost option on many products. If you contract for too high of a top-line dollar amount in your PVA, you don't leave yourself any wiggle room to purchase outside of that contract when you find better pricing. Keep your total PVA commitment as low as you possibly can. Aim for no more than 80% of your total volume. **CT**

The Directions, the Drugs, and the Real World

George Pennebaker, Pharm.D.

TID PC HS

That abbreviation when "de-abbreviated" says: "Take three times a day after meals and at bedtime." Some questions arise:

- Is it based on the assumption that the patient eats three meals a day?
  - What if there are only two meals a day?
- What is the total number of doses each day? Three or four?
- How soon after meals? And why?

How about "bid pc"?

- Should the doses be 12 hours apart, or does that matter?
- What if the patient never eats breakfast? Is the important part that the drug is taken after a meal, or that it is taken with 12 hours between doses?

How about "qid pc hs"?

- Is that the same as "tid pc hs"?
- It is clear that this is the four-times-a-day version.

PATIENT VARIABLES

If the patient is hospitalized or in a good nursing facility, the above issues are either seldom found or are resolved before being scheduled.

However, if the patient is at home things are different. A working adult has more consistent days. Waking up, coffee, breakfast, lunch, dinner, and bedtime are usually consistent for five days of the week. That consistency spills over into the weekend, with some changes. However, taking meds at the right times each day should be rather consistent.

Obviously, only expensive drugs are advertised. Less-expensive drugs that may be just as effective are not advertised. It is hard to find out about the inexpensive drugs because pharmacists are stuck behind the dispensing counter.

A retired adult (e.g., me), not having work hour requirements, readily becomes inconsistent. Or becomes consistent in having things happen at the same time each day but at times that are totally different from those expected by others.

Some of us like to sit in bed or a recliner and read late into the night or early in the morning. Others have TV addictions that govern our days and/or nights. There are a couple of daily TV shows that are obviously designed to attract retired adults. Jeopardy and Wheel of Fortune commercials clearly define their target markets. Over-the-counter (OTC pharmacist recommended) and Rx "ask your doctor about…" drugs dominate their commercials.

Comment: I believe that the United States is the only country that allows the TV advertising of prescription drugs. I was once told by a physician that, when asked to prescribe a drug that was obviously an advertised drug that he felt the patient did not need, he was faced with arguing with, and losing, the patient or, if safe, prescribing it and keeping the patient happy.

Second comment: Obviously, only expensive drugs are advertised. Less-expensive drugs that may be just as effective are not advertised. It is hard to find out about the inexpensive drugs because pharmacists are stuck behind the dispensing counter.

Comment about the second comment: During my last few years as a practicing pharmacist, I did relief work in many different pharmacies. I kept an eye on the people who were in the OTC aisles next to the prescription area. If I saw people looking at several products in an OTC area, I went out to help them. They ended up getting what they really needed and learned about the alternatives.

I especially remember one man who was looking at nasal sprays. I asked him how he was using the spray. He said he sprayed it up his nose, tilted his head

back and tried to sniff it back to where it needed to be. I told him to spray it, then put his head between his legs and sniff so that gravity would get the drug up into the nasal sinuses where it needed to be. He came back on another day I was at that store, reached over the counter and shook my hand. I asked why. He said sticking his head between his legs worked!

There are important drugs and there are not-so-important drugs. It's important that patients take their blood pressure drugs. High blood pressure can kill you, especially if it is very high. How important the drugs are is different depending on the individual's condition. Prescribers need to make clear to the patient which drugs are the most important. Pharmacists also need to emphasize the importance of some drugs over others.

Side effects need to be understood. Some side effects are very minor and frequent. Some are very serious but don't occur very often. A one-in-a-hundred side effect happens in 1% of the people who take the drug. This patient may be that one.

Side effects need to be understood. Some side effects are very minor and frequent. Some are very serious but don't occur very often. A one-in-a-hundred side effect happens in 1% of the people who take the drug. This patient may be that one.

A common side effect is drowsiness. It can be a good thing if taken at bedtime by a person who has trouble getting to sleep. On the other hand, it can be very bad if the "cold" drug with this side effect is taken by someone who is tired from sneezing all day and is starting a long drive to the vacation cabin.

I recall one patient who was having trouble with diarrhea. The usual anti-diarrhea drugs were not working well. She tried a drug whose side effect is constipation. It stopped her diarrhea.

Every one of us is a unique individual. I am unique. You are unique. Each of the patients that we serve is unique. When working with individuals, we need to appreciate their uniqueness. When creating systems, we need to allow those unique characteristics to be accommodated and respected.

I don't fit into most boxes. You don't either. Nor does the next person. **CT**

George Pennebaker, Pharm.D., is a consultant and past president of the California Pharmacists Association. The author can be reached at george.pennebaker@sbcglobal.net; 916/501-6541; and PO Box 25, Esparto, CA 95627.

Index of Advertisers

Prescription-Only Mobile Applications

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

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

OUR NATION CURRENTLY FACES SEVERAL epidemics, including the opioid epidemic, the obesity epidemic, and the epidemic of chronic illness. In 2015–2016, drug overdose deaths in the United States increased by more than 20% (from 16.3 to 19.8 per 100,000 people). According to the CDC's most recent National Vital Statistics Report (Volume 67, Number 9), which examined drug mentions on death certificates from 2011 to 2016, fentanyl topped the list in 2016 in terms of the drug most implicated in overdose deaths. In 2011, it was oxycodone, and from 2012 to 2015, it was heroin. In total, opioids were responsible for two-thirds of the overdose deaths in 2016. As for the obesity epidemic, nearly 40% of adults and 20% of children were obese in 2015–2016. These are the highest percentages ever documented, and there are few, if any, signs of the issue shrinking anytime soon. In fact, no states saw a decrease in obesity rates in 2016–2017, and the prevalence increased in six states during this time. Closely linked to the obesity epidemic, chronic illness has also reached epidemic proportions. Sixty percent of U.S. adults have at least one chronic disease, such as heart disease, chronic lung disease, or diabetes, and 40% have two or more chronic diseases. More than 100 million U.S. adults have diabetes or prediabetes. In addition to wreaking havoc on those individuals and families directly affected, these epidemics are leading drivers of healthcare costs. Something must be done, and it will likely take multiple concerted efforts across the continuum of care. One such approach that is becoming more and more available is the use of prescription-only mobile medical applications.

WHAT ARE THEY?

Prescription-only mobile medical apps are mHealth (mobile health) apps that have been tested, usually in randomized clinical trials, and subsequently cleared by the FDA to be used in the treatment of disease. These apps are sometimes referred to as "prescription digital therapeutics." However, since the term digital therapeutics also includes technologies such as wearable devices, telemedicine platforms, and digital pills, let's call them Rx apps. Rx apps, often prescribed alongside drug therapy, aim to help patients better manage their illness. To do so, they employ clinically proven treatments, such as cognitive behavioral therapy, self-monitoring, and other evidence-based approaches. As with the distinction between a drug and a dietary supplement, FDA clearance is required before any claims are made that an mHealth app treats or manages a disease. Rx apps often include a desktop application in addition to the mobile app, as well as a dashboard to be used by healthcare providers to monitor patients' progress. They are adjudicated as a pharmacy benefit like other prescription products. After downloading an Rx app, the patient must first enter a prescription access code before he or she can actually use it.

In addition to providing some assurance of safety and efficacy, FDA clearance also helps Rx apps stand out in the marketplace. While there are more than 318,000 mHealth apps available today in the mobile app stores, there are currently only a handful of FDA-cleared Rx apps. However, this number is likely to grow quickly in the coming years. Since they are prescription-only, and pharmacists fill prescriptions, you can anticipate patients inquiring about their use. Let's take a look at some of the Rx apps that are available now and that could play a role in addressing the epidemics mentioned above, as well as some Rx apps that are currently in development, undergoing clinical study, or awaiting FDA clearance.

BLUESTAR

BlueStar, an Rx app by WellDoc that received FDA clearance in June of 2013, is touted as a digital diabetes management platform. In addition to collecting patient data, such as blood glucose readings and food and physical activity logs, and sharing this data with the patient's healthcare team, the app also provides automated and personalized behavioral coaching, motivational messages and challenges, access to diabetes educators, and educational content. The app can also be used to keep track of medications and set dose reminders. In multiple clinical trials, use of the platform resulted in clinically significant reductions in A1C, above and beyond usual care alone. In March of 2017, a nonprescription version of the BlueStar app was FDA cleared, and in July of 2018, WellDoc expanded the platform to include focus on weight loss and hypertension in patients with diabetes. The

company is currently working on a standalone product for hypertension.

RESET

reSET, developed by Sandoz (a division of Novartis) and Pear Therapeutics, is the first Rx app that aims to help treat substance-use disorder, including use and abuse of cocaine, alcohol, marijuana, and stimulants. It was cleared by the FDA in September 2018 for use in conjunction with outpatient therapy. The app is derived from a web-based addiction therapy program, which was based on established in-person cognitive behavioral therapy for substance-use disorder. The app contains over 60 therapy lessons that include quizzes and exercises on particular topics. The recommended dose is four lessons per week. The aim is to modify patient behavior by facilitating the development of the skills needed to maintain abstinence, such as recognizing and avoiding triggers and coping with thoughts about using. Patients receive encouraging feedback and rewards, such as gift cards, after completing a lesson and after testing negative for substance abuse. In terms of efficacy, clinical trial results showed that abstinence rates at 12 weeks were higher for patients who used the reSET system versus those who did not. However, at six months, abstinence rates were about the same across the two groups.

RESET-O

In December of 2018, the FDA cleared reSET-O. Also produced by Sandoz and Pear Therapeutics, reSET-O is the first Rx app developed specifically to treat opioid use disorder. Similar to reSET, reSET-O uses cognitive behavioral therapy and a compliance reward system, and it is intended to be used in conjunction with outpatient therapy and pharmacotherapy, such as buprenorphine. In the 12-week, multisite, unblinded clinical trial reviewed by the FDA, retention rates in the behavior program were 82.6% for those participants who used the reSET-O system in addition to buprenorphine, versus 68.4% for those who did not.

MORE RX APPS ON THE WAY

There are several Rx apps that are currently being developed, studied clinically, or awaiting FDA clearance. Novartis announced in March of 2018 that they plan to collaborate with Pear Therapeutics on Rx apps to treat patients with schizophrenia and multiple sclerosis (MS). Novartis says that the Rx app for multiple sclerosis, which is presumably under development, will "address underserved mental health burden in patients with multiple sclerosis." Early clinical trials with THRIVE, their Rx app for schizophrenia, has shown some promise in terms of usability, retention, and preliminary efficacy. The digital medicine start-up Akili Interactive Labs is currently developing Rx apps that use mobile games to treat cognitive deficits associated with several disease states, including childhood attention-deficit/hyperactivity disorder (ADHD), autism spectrum disorder (ASD), major depressive disorder (MDD), multiple sclerosis, and others. Akili says that, although they look like typical high-end video games, its products "target cognitive deficits at the specific sources in the brain to improve cognitive function." Akili has submitted AKL-T01, its prescription video game for childhood ADHD, to the FDA and is currently awaiting the agency's decision on clearance.

It is early days for Rx apps, and we believe pharmacy integration is a key component of the future adoption and utility of these apps. The long-term impact that these technologies can have in terms of disease management, improved quality of life, and cost containment is largely yet to be seen. Time will tell. And despite the seemingly obvious innovation, there are some who argue that Rx apps are simply repackaging of existing treatments. However, we feel that this view does not take into account the increased accessibility of a proven treatment, once repackaged in an Rx app. Smartphones, which are almost never out of arm's reach, are now used more widely than desktop or laptop computers. As more Rx apps are developed, tested, FDA cleared, and brought to market, we hope to see more integration with pharmacies and pharmacy management systems. As we're all well aware, pharmacists are an integral part of the healthcare team, across which coordination of care is key. To this end, Rx apps could play an integral role, facilitating communication and planning between patients and providers. Pharmacists, empowered by the data Rx apps provide, could help address medication adherence and other medication-related concerns, thereby improving the overall quality of care.

So what are your thoughts? Do you have any experience with Rx apps? Have patients asked you about them? We welcome your comments and suggestions. **CT**

Joshua C. Hollingsworth, Pharm.D., Ph.D., is an assistant professor, Pharmacology and Biomedical Sciences, Edward Via College of Osteopathic Medicine, Auburn Campus, Auburn University, and Brent I. Fox, Pharm.D., Ph.D., is an associate professor in the Department of Health Outcomes Research and Policy, Harrison School of Pharmacy. The authors can be reached at jhollingsworth@auburn.com.edu and foxbren@auburn.edu.

Pharmacy HIT Collaborative Updates Roadmap

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

THE PHARMACY HEALTH INFORMATION TECHNOLOGY (HIT) Collaborative released its updated integration roadmap in mid–November, entitled, "The Roadmap for Pharmacy Health Information Technology Integration in U.S. Health Care: 2018 to 2021 Update." The accompanying press release notes:

"The revised roadmap reflects the areas the pharmacy profession needs to continue its focus and updates the Collaborative's vision, mission, goals, and objectives to ensure the U.S. health information technology (HIT) infrastructure better enables pharmacists to optimize person-centered care. It provides guidance to provider organizations, policymakers, vendors, payers, and other stakeholders striving to integrate pharmacy HIT into the national (U.S.) HIT infrastructure."

The purpose of the new release is to align the 2011 to 2015 roadmap to the Pharmacy HIT Collaborative's 2018 to 2021 strategic plan's mission, goals, and objectives. The roadmap is updated to reflect areas of focus for the profession. In particular, the updated roadmap outlines three strategic goals as the underpinnings to move pharmacists further into the national HIT infrastructure:

Interoperability: Advance the adoption by pharmacists of systems capable of standards-driven health information exchange.

Workflow and Usability: For systems and providers and support for the Joint Commission of Pharmacy Practitioners' (JCPP) Pharmacists' Patient Care Process (PPCP) and the provision of patient care services.

Quality: Support national quality initiatives enabled by HIT.

The goals reflect the collaborative's efforts to drive cultural technology changes for how pharmacists interact and collaborate with others on the healthcare team. Importantly, a key change has been to change emphasis to patient-centered care — a focus of the Office of the National Coordinator's (ONC) strategic plan as well. The collaborative's revised mission and vision now reflect this.

VISION

The U.S. health IT infrastructure will better enable pharmacists to help optimize person-centered care.

The collaborative's former vision was "The U.S. health system is supported by meaningful use of health information technology and the integration of pharmacists for the provision of quality patient care."

MISSION

As the leading authority in pharmacy health information technology, the Pharmacy HIT Collaborative advances and supports the use, usability, and interoperability of health IT by pharmacists to help optimize person-centered care.

The former mission was "To advocate and educate key stakeholders regarding the meaningful use of HIT and the inclusion of pharmacists within a technology-enabled integrated health care system."

The collaborative's new plan notes it will accomplish its mission by:

- Identifying and voicing the health IT needs of pharmacists.
- Promoting and influencing awareness of pharmacists' use and functionality of health IT.
- Collaborating, facilitating, and convening stakeholders on topics related to health IT.
- Providing resources, guidance, and support for adoption and implementation of standards-driven health IT.
- Guiding health IT standards development and other activities to address the health IT needs of pharmacists.
- Supporting the collection, documentation, and exchange of information among health IT systems.

The changes to the roadmap reflect the collaborative's significant accomplishments in areas related to government outreach, education, standards development, and coding impacting the pharmacy profession during the past eight years. Since 2010, the government has been working on building a health IT foundation. The collaborative works with the ONC to assure that pharmacists are recognized as an integral part of the health IT infrastructure.

Some of those significant achievements have included:

- Working to ensure pharmacists providing patient care services are able to collect, document, and share clinically relevant medication-related information. This information promotes the delivery of high-quality healthcare and satisfaction of requirements for value-based payment models.
- Stewarding the clinical documentation codes and value sets for the pharmacy profession and responsibility for vetting and approving documentation codes and value sets for use in national electronic health information exchanges.
- Participating and leading national standards development work representing pharmacists providing patient care services (e.g., Pharmacist eCare Plan, Pharmacist EHR).
- Serving as the unified voice of pharmacy representation on the American Medical Association Health Care Professionals Advisory Committee (HCPAC) CPT Editorial Panel and endeavoring to enhance the recognition of pharmacists and their patient care services.
- Participating in the United States Pharmacopeia's (USP) allergy and intolerance technical expert panel to standardize electronic allergy and adverse drug event reporting within electronic health records (EHRs).

The collaborative is a shining example of what happens when pharmacy organizations work together cooperatively to identify and solve issues. I had the good fortune to facilitate early strategy sessions with a number of organizations to understand how the profession's patient care service could fit into the nation's growing HIT infrastructure. The passage of the Health Information Technology for Economic and Clinical Health Act (HITECH Act) was the motivator. The HITECH Act is part of the American Recovery and Reinvestment Act of 2009 (ARRA). It was created to motivate the implementation of EHRs and supporting technology in the United States.

Those conversations in 2009 led to the formation of the collaborative in 2010 by nine national pharmacy professional organizations. It now leads the pharmacy profession in integrating pharmacist-provided patient care services into the national health IT infrastructure by working in collaboration with accredited standards development organizations (NCPDP, HL7, and X12) and U.S. government regulatory agencies (HHS, CMS, and the ONC). The following year, the collaborative structure was opened to associate members. The collaborative council currently has 20 member organizations.

The collaborative and its members use the roadmap for outreach to health IT stakeholders, and it provides one common set of pharmacist health IT goals. In reviewing the plan with system vendors in mind, several goals and strategies stand out. The collaborative notes "pharmacist awareness of the importance of working with their system vendors to adopt standardized processes for interoperable collection, documentation and exchange of clinical information regardless of pharmacy practice setting or other healthcare providers." Regarding workflow and usability, they note the support for the JCPP PPCP and that they will "participate with and influence standards development organizations and system vendors' activities to facilitate use and usability by pharmacists." A recommended strategy is to support pharmacists to work with system vendors to incorporate the JCPP PPCP into systems capturing pharmacist-provided clinical services. They also note they "support pharmacists to work with system vendors to incorporate Systematized Nomenclature of Medicine — Clinical Terms (SNOMED CT) and value sets into systems to capture pharmacist-provided clinical services."

The collaborative maps out how its activities are meeting the nine elements of the ONC's 10-year vision for achieving interoperability, including to:

- Build upon the existing health IT infrastructure.
- Recognize one size does not fit all.
- Empower individuals.
- Leverage the market.
- Simplify.
- Maintain modularity.
- Consider the current environment and support multiple levels of advancement.
- Focus on value.
- Protect privacy and security in all aspects of interoperability.

Many of its actions will impact system vendors in the coming years. I encourage readers to review the updated roadmap by downloading the document at http://pharmacyhit.org/. It is a wealth of information that can guide your organization's HIT work as well. **CT**

Marsha K. Millonig, B.Pharm., M.B.A., is president and CEO of Catalyst Enterprises, LLC, and an associate fellow at the University of Minnesota College of Pharmacy Center for Leading Healthcare Change. The author can be reached at mmillonig@catalystenterprises.net.

Considerations for Opening a Specialty Pharmacy

Alan Sekula, Pharm.D.

SPECIALTY PHARMACY DEVELOPED

SPECIALTY PHARMACY DEVELOPED as a segment of pharmacy to meet the needs of patients who didn't require hospitalization, but their medication, administration, training, and monitoring were more complex than most traditional retail pharmacies could provide. Specialty pharmacy is the fastest-growing pharmacy segment, as most new FDA approvals are for specialty medications. Specialty sales are increasing dramatically and are expected to approach 50% of all prescription sales in the next couple of years. Here we will highlight and discuss seven areas that an entrepreneurial pharmacist would need to consider before opening a specialty pharmacy.

DISEASE STATES

Defining the disease focus of the specialty pharmacy will set the process in motion. The following questions will guide your disease identification process:

- What disease states do you want to provide services for?
- What will be your service niche that will differentiate you from other specialty pharmacies that are working in these disease states?
- How many patients receive treatment for these diseases and are in your target market area?
- What insurance coverage do these patients have, and will their insurance limit their access to your pharmacy?

Diligent preparation through these seven areas will put you on the right path to determine if you should open a specialty pharmacy.

- What is your likely capture rate?
- Are new specialty drugs in the pipeline for these diseases, or is the market mature and facing generic or biosimilar competition?
- Will you have access to purchase the drugs for your targeted disease states, or are the drugs only available via limited distribution?
- If there is a REMS (Risk Evaluation and Mitigation Strategies) program for the drug, what is involved for the pharmacy?
- Is there enough business to support a specialty pharmacy?

IT

The IT requirements differ for a specialty pharmacy when compared to a retail pharmacy, and should be factored into a budget for your business plan. As with any pharmacy, the specialty pharmacy will require a pharmacy management system to fulfill regulatory needs for prescription records and prescription claims submission. Additional required software components for specialty pharmacy include clinical functions, patient management, medical benefit billing, reporting, and an interface with suppliers. These components will support processes for benefits verification, adherence management and measurement, and data reporting to pharmaceutical manufacturers. A specialty pharmacy needs more extensive clinical documentation for reporting to pharmaceutical manufacturers, including patient interactions and clinical touchpoints. Requirements may include freezers for cold storage of drugs and shipping supplies to expand your reach beyond the local population.

PHYSICAL LOCATION

Will the pharmacy be freestanding or located on a medical facility campus? The proximity should be a key consideration for determining the physicians who will be marketed to for directing prescriptions to your specialty pharmacy. Will your goal be to dispense all of your patients' medications, or limit dispensing to the specialty medications only? In most situations, you will be shipping medications

to the patient's home, so you will need to consider state board of pharmacy licensing requirements based on the location and states where your patients reside.

REIMBURSEMENT

Third-party coverage is essential for high-cost specialty drugs because patients have difficulty affording this therapy if they must pay out of pocket. Furthermore, if the drugs are approved for coverage, what are the reimbursement rates? What ability will you have to secure contracts with the payers for the specified disease(s)? Commercial payers may lock out new specialty pharmacies from gaining network access. Any-willing-provider plans include Medicare Part D and fee-for-service Medicaid. Do the math and estimate your potential revenue and profit margin by the third-party payer. Consider the likelihood of negotiating more favorable pharmacy reimbursement rates with payers. Treatment affordability for the patient will be a key focus, so use of co-pay cards with commercial plans or patient assistance programs must be included as a specialty pharmacy service model.

PURCHASING

Verify that your wholesaler discounts provided for brand drugs apply to the specialty drugs. We have seen situations where wholesaler discounts are less for specialty drugs compared to small-molecule nonspecialty brand drugs. This can severely impact the profitability of specialty medications. If possible, explore direct purchasing relationships with pharmaceutical manufacturers or join a buying group.

Prospective specialty pharmacy owners should generate financial statements and prepare a business plan that realistically demonstrates the ability to be financially viable.

For rare diseases, some manufacturers may provide the drug on consignment, where you only pay for the product when it is dispensed.

ACCREDITATION

URAC (Utilization Review Accreditation Commission) and the Accreditation Commission for Health Care (ACHC) were the initial accrediting bodies for specialty pharmacies. The Center for Pharmacy Practice Accreditation (CPPA) Specialty Pharmacy Practice Accreditation Program is the latest offering. Gaining accreditation is a requirement for your pharmacy. Accreditation ensures that specialty pharmacy services are documented and fulfilled (i.e., benefits verification and coordination are comprehensive and patient centered, and not just words on paper). The specialty pharmacy compliance with standards, quality, value, and patient-centered focus is verified through the accreditation process, instead of each payer or manufacturer performing its own rigorous review.

PUTTING IT ALL TOGETHER

Once you have determined the targeted diseases that your pharmacy would focus on, assess how to acquire patients, determine the pharmacy location, and determine the technology required. Prospective specialty pharmacy owners should generate financial statements and prepare a business plan that realistically demonstrates the ability to be financially viable. Obtain guidance from a trusted team of accounting, legal, and regulatory advisors before making a final decision on whether the business is feasible. Creating a pessimistic financial projection is worthwhile to see if the business can survive this projection, at least in the short term.

Entering the specialty pharmacy sector requires more than adding specialty drugs to your inventory. Specialty pharmacies have more hurdles and challenges with payers and manufacturers, and gaining prescriptions from physicians, all while assisting patients through the process. Diligent preparation through these seven areas will put you on the right path to determine if you should open a specialty pharmacy. **CT**

Alan Sekula, Pharm.D., is a consultant with Pharmacy Healthcare Solutions, Inc.. His experience includes community, hospital, specialty, long-term care, and managed care pharmacy. He can be reached at asekula@phsirx.com.

ASAP 2019 Annual Conference

MORE COVERAGE AVAILABLE: www.asapnet.org

The American Society for Automation in Pharmacy (ASAP) held its annual conference on Kiawah Island, S.C. The ASAP Midyear Conference will be held in June at The Mayflower Hotel in Washington, D.C. More details available at www.asapnet.org.

From left, VUCA Health's Richard Waithe, Rite Aid's Jermaine Smith, and Integra LTC Solutions' Louie Foster.

From left, Jeffrey Pinaula, program coordinator, and Remy Suva, administrative officer, Guam Department of Public Health and Social Services, with the National Community Pharmacists Association's Lisa Schwartz.

From left, Doral Services Group's Tim Garofalo, speaker Don Dietz from Pharmacy Healthcare Solutions, Inc., QS/1's Sonny Anderson, and Jerry Reeves from Wolters Kluwer. Dietz presented on next-generation pharmacy data metrics.

AmerisourceBergen's Bob Jones, left, and Dawn White, with eRx Network's Ryan Kelly, right.

PioneerRx's Paul Carrig, left, and Mark Conners from HPOne.

PerceptiMed's Terry Cater with speaker Marsha Millonig from Catalyst Enterprises. Millonig's presentation provided a look at the latest on the Amazon-Berkshire-JPMorgan health venture.

InfoWerks' Sondra Heffernan with Sean Ramsey from Updox.

ASAP

American Society for Automation in Pharmacy

2019 Midyear Conference | June 26–28, 2019

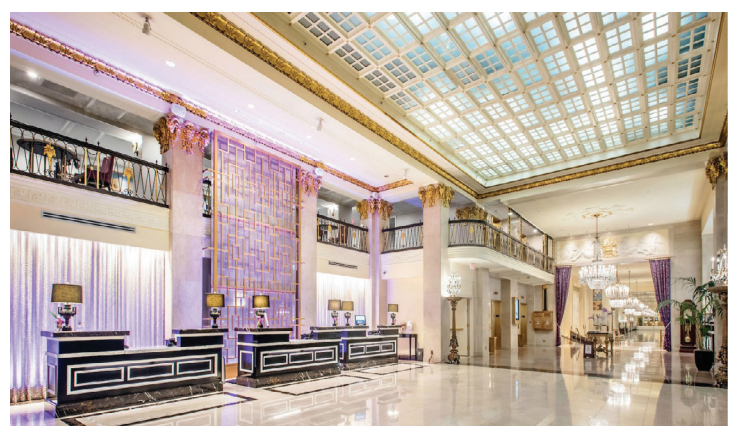
The Mayflower Hotel, Washington, DC

The ASAP conferences keep you in the mainstream of developments impacting pharmacy.

The schedule allows for plenty of opportunities to network and hold business meetings.

The June conference location, The MayflowerHotel, has been providing signature hotel experinece in the nation's capital for over 90 years with refined rooms, innovative culinary explorations, and unique experiences.

If you've never attended a conference, make the June conference a priority. You will be glad you did.



VIEW OUR CONFERENCE SPEAKER TOPICS AT www.aspanet.org

American Society for Automation in Pharmacy | 492 Norristown Road, Suite 160 | Blue Bell, PA 19422
610/825-7783 | Fax: 610/825-7641 | www.asapnet.org

PHARMACY SOFTWARE FOR **PHARMACY SUCCESS**

ENHANCE PATIENT CARE

IMPROVE PROFITABILITY

INCREASE PATIENT SAFETY

"I love the way Liberty developed a workflow queue system so we can find where a prescription is in the process."

JIM HRNCIR, Owner, Pharmacist,
Las Colinas Pharmacy

"What I really like about them is if we have something that isn't working for us, we can call them and say what can you guys do to help us do it better."

STACHIA BAXTER, Pharmacy Manager,
Roanoke Pharmacy

"The system is user friendly and because every pharmacy is different, they will customize it to your needs."

JUDY HARRIS, Owner, Pharmacist,
All-Care Pharmacy

Liberty
SOFTWARE

Revolutionary Pharmacy Software

www.libertysoftware.com** or call us at **800-480-9603