

*America's*

March 2020

# PHARMACIST<sup>®</sup>

THE VOICE OF THE COMMUNITY PHARMACIST

## *Supreme* decision

AFTER A YEARS-LONG BATTLE, COMMUNITY PHARMACY BRINGS  
ITS CASE AGAINST THE PBMS TO THE HIGHEST COURT IN THE LAND



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# Rx TRACK AND TRACE: ARE YOU READY?

The Drug Supply Chain Security Act (DSCSA) enhances the FDA's ability to protect patients from exposure to drugs that may be counterfeit, stolen, contaminated, or otherwise harmful.

DSCSA outlines requirements that build a supply-chain wide system to "track and trace" Rx drugs as they are distributed in the U.S.



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	FDA REQUIREMENT	IMPLICATION
<b>JAN 2015</b>	Conduct business with licensed and authorized trading partners	You need to ensure the supplier you are purchasing from is currently licensed in your state and authorized to distribute pharmaceutical products
<b>NOV 2015</b>	Track and store lot-level T3 data, including: Transaction History (TH); Transaction Information (TI); and Transaction Statement (TS)	You must retain 6-years' worth of securely stored data and be able to retrieve it within 48 hours
<b>NOV 2015</b>	Verify that product received is not suspicious, and have procedures in place to quarantine and investigate suspect shipments	You must have the ability to quarantine and investigate suspect product to determine if illegitimate (including validating applicable TH and TI); and a process to notify trading partners and the FDA of illegitimate product within 24 hours of determination
<b>NOV 2020</b>	Only buy and sell products encoded with product identifiers (2D bar code)	You will need to include product verification as part of your check-in/receiving process unless products are otherwise grandfathered or excluded
<b>NOV 2023</b>	Complete unit level traceability including aggregation throughout the entire supply chain	You will need to implement changes to your pharmacy systems and workflow processes

## WHERE CAN I TURN FOR HELP?

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### HOW CAN I LEARN MORE?

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## Supreme Court will present clarity to PBM issues

“Thanks ... but it isn’t enough.” It was the kind of candid conversation you can only have with someone you have known for years.

I was talking to a state government official about changes his state was making to have greater PBM oversight. The changes were a positive step toward “Changing the Pharmacy Payment Model,” which NCPA has been highlighting for more than a year. In my view, however, the state was only making a modest change. The current pharmacy payment model is confusing, complex, and convoluted for everyone — especially consumers — which only benefits the PBMs. This particular state official I had known for years and is super smart. But, I feared that even he didn’t understand that the change the state was making would not have nearly the impact it could. So I told him so.

“Look,” he said. “It has taken 30 years for the pharmacy payment model to get in the current mess that it’s in. I hear you and we’re working on fixing it, but three decades of degeneration isn’t going to be fixed overnight.”

This month’s issue features two topics that are enormous steps forward to fixing the broken pharmacy payment model. The Supreme Court case, led by Arkansas Attorney Gen-

eral Leslie Rutledge versus PCMA, is one of the biggest court cases for pharmacy in a decade. At the heart of the case is a 2015 Arkansas law that the PBMs say can’t be enforced because of ERISA. Unfortunately, the U.S. Eighth Circuit Court ruled in favor of PCMA. NCPA believes that the PBMs and the lower court have taken an overly broad interpretation of ERISA, and so does the state of Arkansas. So do 32 states attorneys general and the District of Columbia who wrote the U.S. Solicitor General asking him to review the ruling. So does the U.S. Solicitor General, when he was asked his opinion by the Supreme Court.

NCPA has worked with the Arkansas Pharmacists Association from the very first court challenge in 2015 and we continue to work side by side with APA to support the state’s efforts. We are hopeful that we hear the one word we want to hear from the Supreme Court justices: Reversed. However, no matter the outcome, the fact that PBMs are in front of the highest court in the land for the first time in history will produce a result PBMs hate: clarity.

While the Supreme Court case is vitally important, it is only one part of Changing the Pharmacy Payment Model. Today’s payment model is centered on dispensing prescriptions that lead to pharmacy services.

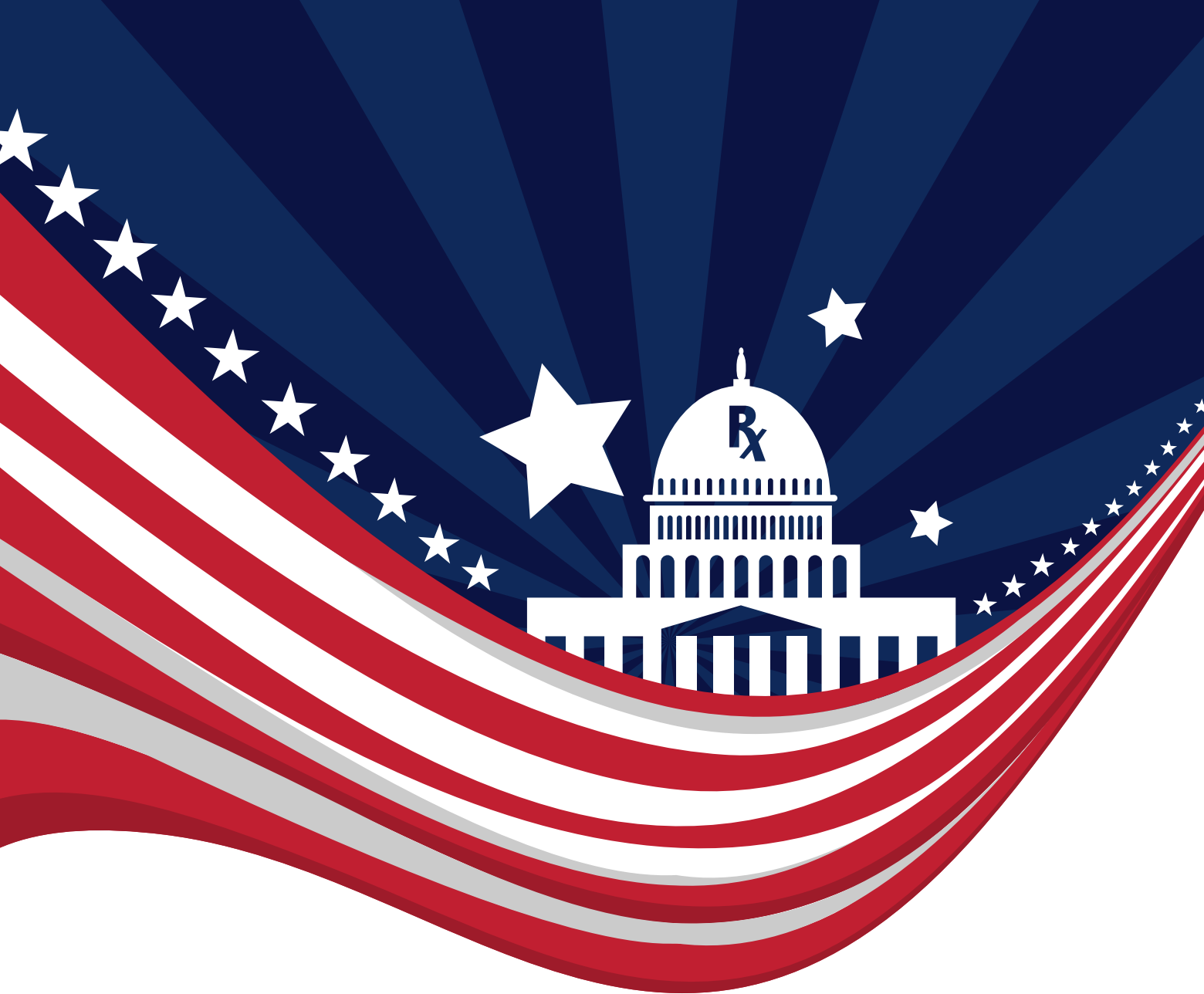


To be sustainable as a profession and a business, the future pharmacy payment model must be centered on pharmacy services that lead to dispensing prescriptions. CPESN® USA is the vehicle to get to this envisioned future, and this month’s SurThrival topic is about clinically integrated networks — what are they and how do they factor in the future of pharmacy.

The third annual NICE Awards from the NCPA Innovation Center are also announced in this issue. This is one of the features I look forward to every year. Have some fun looking at the spectacularly creative ways your fellow pharmacy owners are promoting and growing their businesses. Find at least one idea you like from their work and make a plan to implement it into your business before the NCPA Annual Convention Oct. 17-20, in Nashville. Some changes take time but borrowing from some of the most inventive minds in the industry via the NICE awards is something you can start today. ■

Best,

B. Douglas Hoey, Pharmacist, MBA  
NCPA Chief Executive Officer



# 2020 CONGRESSIONAL PHARMACY FLY-IN

Join your peers as we storm Capitol Hill to meet with members of the House, Senate, and their staffs to discuss the issues that affect your business. There's no better way to make an impression on members of Congress, and there's no one better qualified than you to deliver the message.



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**PHARMACY:** Owner, Remedies Pharmacy, Birmingham, Ala.

**AGE:** 53

**FAMILY:** Married to Tom; two children, Carly, 16, and Chace, 13.

**EDUCATION:** B.S. in Pharmacy, Samford McWhorter School of Pharmacy.

**NO NEEDLES, PLEASE:** Lea grew up in a family of nurses. She worked in a hospital for a time and gravitated toward a medical career, specifically in anesthesiology. But she didn't like needles or blood. A doctor she worked with suggested that she might consider pharmacy.

**CHANGE AGENT:** Lea opened KidsMeds, a pediatrics and compounding specialty pharmacy in 2002. She was successful for years, but she came to realize that the name limited her business. She sold the business and opened Remedies in 2018.

**PASSION FOR PARTNERSHIP:** "Pharmacists are another cog in the healing process. I think there's too much of a piecemeal approach now, and we need a more integrative model. I like the idea of balancing ... focusing on wellness, diet, exercise, working in partnership with doctors."

**SHE'S A BELIEVER:** Lea has seen the power of CBD at work in her practice, and she hopes other pharmacists will explore the opportunities. "I love it," she says. "I have seen it work in so many cases."

**THE VALUE OF NCPA:** Lea has been involved with NCPA since pharmacy school and now serves on the board of directors. She values the relationships she's developed with other pharmacists and their willingness to share what's working for them. "I love NCPA because so often you're told what to do, and you have to figure it out. But NCPA gives you the tools, the knowledge, and the education."

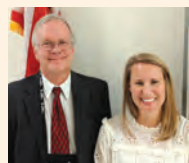
**Lea Wolsoncroft, RPh**

# NCPA IN ACTION

What have we done for you lately? Here's the lowdown on NCPA's recent advocacy activity — and why it matters.

## NCPA Congressional Pharmacy Fly-In coming up

Registration for NCPA's 2020 Congressional Pharmacy Fly-In is open. The April 21-22 Fly-In allows pharmacy owners to meet with legislators or their key staff about community pharmacy's legislative priorities. You'll fly in, spend a few hours with the NCPA Advocacy Center staff, and then have some face time with your members of Congress and/or their staff. It's your chance to tell them how their votes affect your business and the patients you serve. This year, there is also the added possibility that the Supreme Court may hear oral arguments in *Rutledge v. PCMA* during the Fly-In week. Don't miss out.



## DOJ, FTC CONSIDER CHANGES TO VERTICAL MERGER GUIDELINES

**What happened:** The Department of Justice and the Federal Trade Commission have proposed an overhaul of antitrust rules for vertical mergers. A vertical merger is the merger of two companies that operate in the same supply chain but don't directly compete with one another, such as CVS/Caremark/Aetna, Cigna/Express Scripts, and UnitedHealth/Optum Rx.

**NCPA's take:** NCPA believes guidelines need to be stricter and submitted comments to that effect by the Feb. 26 deadline. And NCPA also provided draft comments for NCPA members to submit prior to the deadline.

## NCPA ASKS FOR PROTECTIONS IN TRANSPARENCY IN COVERAGE PROPOSED RULE

**What happened:** NCPA submitted comments to the IRS, Employee Benefits Security Administration, Department of Labor, and CMS on the Transparency in Coverage Proposed Rule.

**What it does:** The departments propose to require group health plans and health insurance issuers to make cost-sharing information available through an internet-based self-service tool.

**NCPA's take:** NCPA urged the departments to establish clear operating rules around such a tool, prohibit plans and issuers from using this tool to steer patients to select pharmacies, and ensure accurate information is provided to avoid the dissemination of misinformation regarding the cost of prescription drugs. NCPA also recommended that the departments work with NCPDP on a national standard for this tool to offer consistency throughout the industry.

## NCPA JOINS INDUSTRY TO ENHANCE BIOSIMILAR INSULIN ACCESS

**What happened:** NCPA joined industry stakeholders to show support for FDA's assessment that if a manufacturer demonstrates its proposed biosimilar insulin is "highly similar" to its reference product, the agency may waive the need for the manufacturer to conduct additional immunogenicity studies in order for the product to be deemed interchangeable with its reference product.

**NCPA's suggestions:** NCPA and other organizations encouraged the agency to use its experience with insulin to further streamline regulatory requirements for biosimilar and interchangeable biologics broadly to enhance biosimilar availability.



# THE AUDIT ADVISER

## **PBMs enforcing return to stock policies**

It is common practice for PBMs to recoup claims in full for prescriptions with a patient pick-up (or delivery) date after the return-to-stock (also known as unclaimed prescriptions) timeframe listed in their provider manuals. An integrated point-of-sale system can generate a list of prescriptions near the end of the timeframe. This list can be used to call patients and remind them to pick up their prescription, offer delivery, or identify claims that should be reversed and the medication returned to stock. The Pharmacy Audit Assistance Service recommends that pharmacies implement a procedure to only allow medications to remain for the shortest outlined time, which is 10 days.

Major PBM return to stock timeframes:

- MeridianRx: 10 days
- Express Scripts: 13 days
- Aetna: 14 days
- Caremark: 14 days
- EnvisionRx: 14 days
- MagellanRx: 14 days
- MedImpact: 14 days
- OptumRx: 14 days
- Prime Therapeutics: 14 days
- Humana: 15 business days

Return-to-stock policies are not the only pick-up date issue that pharmacies should be aware of. PAAS has recently seen PBMs try to recoup for not having the “Do Not Dispense After” date noted on isotretinoin prescriptions. While the only isotretinoin risk evaluation and mitigation strategy (REMS) requirement is to have the RMA number from iPledge noted on the hard copy, pharmacies should have a system in place to make sure the prescription is not sold after the date iPledge mandates. This could be as easy as ordering stickers to place on prescription bags from iPledge or even simply writing the date on the bag itself.

Another frequent target for recoupment is dispensing a medication before the date it was billed. PAAS recommends setting up your pharmacy billing to make sure medication is billed the same day, or before, it is picked up or delivered.

Finally, Medicare Part B only allows a medication to be filled on the same day it is picked up or delivered. Remember that if patients are coming into the store to pick up their medication, you need to have documented proof of the refill request.

By Jason Crawford, RPh, PAAS National®, the Pharmacy Audit Assistance Service. For more information, call 888-870-7227 toll-free, or visit [www.paasnational.com](http://www.paasnational.com).

## **NCPA COMMENTS ON PROPOSED CALIFORNIA REGULATIONS**

**What happened:** NCPA submitted comments to the California Board of Pharmacy commending its efforts on adopting regulations for the independent furnishing of HIV PrEP and PEP medications by pharmacists.

**NCPA's comments:** NCPA urged the board to allot sufficient training time to address the challenges and knowledge gaps in counseling unique populations, recommending appropriate vaccinations, and understanding HIV disease state and HIV medications along with how and when to exercise appropriate patient follow-up or refer the patient to necessary resources and health care providers. NCPA recommended a minimum of three hours of HIV training to ensure a high standard of care in carrying out the responsibilities to lower the rates of HIV infection throughout the state.

## **NCPA URGES OIG TO INCLUDE PHARMACIES UNDER NEW SAFE HARBORS**

**What happened:** HHS released two proposed rules in October to modernize and clarify the regulations that interpret the federal anti-kickback statute and physician self-referral law (Stark Law). The anti-kickback statute and Stark Law proposed rules are part of HHS' sprint to remove potential regulatory barriers to care coordination and value-based care.

**NCPA's involvement:** NCPA submitted comments to HHS' Office of Inspector General on the anti-kickback statute proposed rule, which modifies existing safe harbors and creates new ones. Of particular concern to community pharmacy was OIG's proposal to not include pharmacies under its new value-based arrangement safe harbors. These safe harbors aim to promote care coordination and remove barriers to value-based care. OIG expressed concern that because pharmacies

primarily provide items, that pharmacies' participation in value-based arrangements may not further care coordination. NCPA provided numerous examples of how pharmacies are successfully providing value-based services to their patients on a regular basis through medication adherence counseling, chronic disease management, and by participating in clinically integrated networks.

### NCPA URGES CMS TO RECOGNIZE PHARMACIST SERVICES BEYOND DISPENSING

**What happened:** Following President Trump's *Protecting and Improving Medicare for Our Nation's Seniors* executive order, CMS requested additional input on eliminating specific Medicare regulations that require more stringent supervision than existing state scope of practice laws or that limit health professionals from practicing at the top of their license.

**NCPA's take:** In comments to CMS, NCPA said that pharmacists improve patient care and outcomes when they collaborate with health care professionals. However, restrictive regulations hinder pharmacists' ability to continue providing this care at the federal level, especially when state laws are already expanding scope of practice. NCPA urged CMS to enhance coverage of pharmacist-provided care services and reevaluate strict supervision requirements as well as coverage policies for incident-to services. NCPA also joined forces with other national pharmacy organizations encouraging increased access and reimbursement for pharmacist provided services at the federal level.

**Going forward:** NCPA will continue engaging with CMS to educate the agency about the importance of allowing pharmacists to practice at the top of their professional licenses and education.

### HHS RELEASES FINAL RULE ON SCHEDULE II PHARMACY TRANSACTIONS IN MEDICARE PART D

**What happened:** HHS issued a final rule modifying the requirements for use of existing standards for the electronic transmission of retail pharmacy transactions for drugs subject to Schedule II of the Controlled Substances Act.

**About the rule:** HHS indicates that HIPAA requires HHS to adopt standards for the electronic transmission of certain health care administrative transactions conducted between health care providers, health plans, health care clearinghouses, and other entities. HHS indicates the modification in the final rule will enable covered entities to determine whether a prescription is a "partial fill," or a



refill. According to information in the final rule, the standards apply in the Medicare Part D program. Once the rule goes into effect 60 days from its Jan. 24, 2020, publication in the *Federal Register*, pharmacies should be able to use "quantity prescribed" and "quantity dispensed" fields when dispensing CII prescriptions.

**Why the change:** The department said this is a technical fix to take advantage of a clarification that incrementally filling a CII prescription is not the same as a refill, which DEA still forbids.

### USP HOLDS HEARING ON <795> AND <797>

**What happened:** The USP Appeals Panel heard from compounding industry stakeholders during a hearing to review compounding pharmacies' concerns with overly restrictive beyond-use-dates in USP chapters <795> and <797>.

**NCPA support:** NCPA attended the hearing to support these concerns, as outlined in a letter submitted to USP with the American Pharmacists Association.

**Going forward:** Due to these appeals, USP has indefinitely postponed enforcement of <795> and <797> until the current appeals process resolves. The decision of the Appeals Panel will be final.

### IN THE STATES

#### Florida

**What happened:** A report released by the Florida Pharmacy Association and American Pharmacy Cooperative Inc. exposes the way PBMs and Medicaid managed care organizations push prescriptions and taxpayer dollars to pharmacies they own or control.

**NCPA's take:** "This report reinforces the need for Congress to reform Medicaid managed care," NCPA CEO Douglas Hoey said. "It's also a bright red flag for policymakers in every state to scrutinize their respective Medicaid programs for this kind of anti-competitive, anti-patient behavior."

**What happened:** Florida pharmacists also rallied in Tallahassee to show support for PBM legislation under consideration in the Florida Legislature, demonstrating that it's time the state legislature puts patients, taxpayers and Floridian-owned community pharmacies before the interests of out-of-state unregulated PBMs.

**NCPA's involvement:** NCPA was a sponsor of the PBM reform rally and will continue to work with pharmacy allies in the state to enact meaningful PBM reform.

#### Pennsylvania

**What happened:** Pennsylvania Auditor General Eugene DePasquale (D) urged the state Senate to pass legislation to increase PBM transparency and accountability

in the commonwealth, specifically highlighting HB 941, HB 943, and HB 944. In December 2018, DePasquale released an audit that found that the commonwealth's Medicaid drug spend more than doubled since PBMs begin administering the Medicaid drug benefit in 2013. Additionally, PBMs were able to operate with little to no state or federal oversight.

**NCPA's involvement:** NCPA has been working with DePasquale since 2018 to shed light on PBM abuses in Pennsylvania. During that time, NCPA staff has testified before the auditor general in Harrisburg, attended a press conference at a community pharmacy outside Scranton, and hosted the auditor general and his staff at NCPA's offices.

### New Mexico

**What happened:** NCPA, along with the American Society of Health-System Pharmacists, National Association of Chain Drug Stores, and National Alliance of State Pharmacy Associations, sent a letter urging New Mexico Gov. Michelle Lujan Grisham (D) to support HB42.

**About the bill:** The bill would require reimbursement of patient-care services provided by appropriately-certified pharmacists.

### Virginia

**What happened:** The Virginia Senate Committee on Commerce and Labor reported SB 251 is out of committee.

**About the bill:** The bill would require PBMs to register with the commonwealth, limit PBM adjudication fees, and protect patient choice of pharmacy. NCPA sent a

letter to the Virginia Senate Commerce and Labor Committee supporting the bill.

### Wisconsin

**What happened:** The Wisconsin Assembly Committee on Health heard testimony on AB 114.

**About the bill:** Bill advocates say AB 114 provides common-sense solutions by increasing PBM transparency and accountability. Specifically, AB 114 prohibits clawbacks greater than the patient's copay, prohibits penalizing pharmacies for sharing lower-cost payment options with their patients (gag clauses), limits drug substitution, and prohibits misleading advertising by PBMs for the purpose of steering patients. NCPA Director of State Government Affairs **Matt Magner** testified at the hearing.

### NCPA ON THE ROAD

- NCPA's Director of Policy and Regulatory Affairs **Reema Taneja** presented on a 2020 Federal Update for Community Pharmacies at the Florida Pharmacy Association's Regulatory and Law Conference.
- NCPA's VP of Policy and Government Affairs Operations **Ronna Hauser** was a panelist at the 2020 State of Reform Health Policy Conference in Austin. Hauser presented on "Measuring Value in the PBM and Pharmacy Space" with representatives from Navitus and Methodist Hospital.

*Information is current as of Feb. 10, 2020.*



*Above: Matt Magner and Wisconsin pharmacists rally in support of AB 114. Left: Magner testifies at the hearing on Wisconsin AB 114.*

# INVESTOR RECOGNITION



## Investing in the NCPA PAC is investing in your practice.

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(\*NCPA PAC's fundraising year runs July-June)

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Edmund Horton, Stephenville, Texas  
Jonathan Marquess, Woodstock, Ga.  
Bill Osborn, Miami, Okla.  
Darrin and Deb Silbaugh, Harrisburg, Pa.

### **PAC CHAMPION INVESTORS (\$2,500 - \$4,999 IN PERSONAL FUNDS ANNUALLY)**

Michele Belcher, Grants Pass, Ore.  
Ralph Bouvette, Frankfort, Ky.  
Hubert Bryan, Enterprise, Ala.  
Victor Johnson, Augusta, Ga.  
Lonny Wilson, Oklahoma City

### **PAC SUPPORT INVESTORS (\$1,000 - \$2,499 IN PERSONAL FUNDS ANNUALLY)**

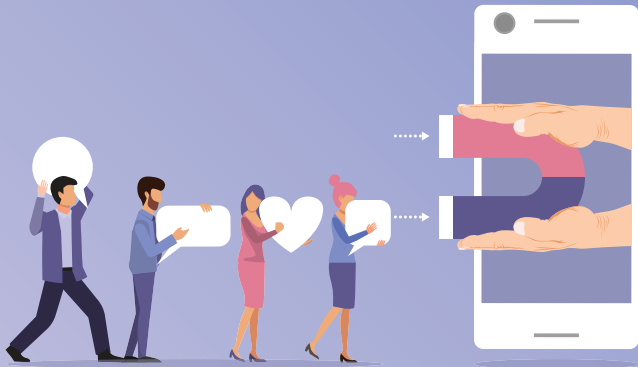
Greg Adams, Clinton, Okla.  
Stephen Albert, Alexandria, Va.  
Selma Alami, Oklahoma City  
Carl Allison, Lake City, Fla.  
Ryan Armstrong, Kannapolis, N.C.  
Donald Arthur, Tonawanda, N.Y.  
Donald Arthur III, Tonawanda, N.Y.  
Ralph Balchin, Fayetteville, Ga.

Dustin Beaty, Jasper, Ala.  
Byron Berry, Carrollton, Ill.  
Patrick Berryman, Alexandria, Va.  
Michael Blaire, Scottsdale, Ariz.  
Andy Blansett, North Little Rock, Ark.  
Bill Bloodworth, Little Rock, Ark.  
Bianca Bradshaw, Red Bluff, Calif.  
Anthony Budde, Highland, Ill.  
Buddy Bunch, Guntersville, Ala.  
Denise Burns, La Cygne, Kan.  
David Carter, Chetopa, Kan.  
Vincent Chiffy, Utica, N.Y.  
Barry Christensen, Ketchikan, Alaska  
Joseph Cioli, Bronx, N.Y.  
David Cippel, Ford City, Pa.  
C. Mel Collier, Fayetteville, Ark.  
Stephen Coomes, Aubrey, Texas  
Thomas Cory, Fall River, Mass.  
Erich Cushey, Claysville, Pa.  
Danny Dang, New York  
David Darby, Andalusia, Ala.  
Jennifer Davis, Smackover, Ark.  
Al Dixon, Richmond Hill, Ga.  
Robert Frankil, Skippack, Pa.  
Ira Freeman, Valley Village, Calif.  
Cheri Garvin, Leesburg, Va.  
Lori Gebo-Shaver, Pocatello, Idaho  
Russell Gellis, New York  
David George, Blanchard, Okla.  
Zachary Giroux, Tonawanda, N.Y.  
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Peter Pogany, Plainfield, N.J.  
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Stuart Rabinowitz, Rockaway Park, N.Y.  
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Rodney Skinner, Elk City, Okla.  
Donald Smith, Post Falls, Idaho  
David Spence, Angleton, Texas

James Spoon, Sand Springs, Okla.  
David Stevens, Canyonville, Ore.  
Hugh Stewart, Scottsboro, Ala.  
Rick Stone, Hutchinson, Kan.  
Michael Stuart, Branson West, Mo.  
Kumar Suraneni, New York  
Stacey Swartz, Alexandria, Va.  
Christian Tadrus, Moberly, Mo.  
Virgil Todd, Oklahoma City  
Paul Turner, Inola, Okla.  
Lisa Umfleet, Desloge, Mo.  
Michelle VanMeter, Grundy, Va.  
Chagan Vasoya, Pomona, Calif.  
Mike Vinson, Montgomery, Ala.  
Stephen Ward, Ellicottville, N.Y.  
Justin Wilson, Midwest City, Okla.  
Terry Wingo, Huntsville, Ala.  
James Wood, Roanoke, Ala.  
Donald Young, Acworth, Ga.

# PHARMACY MARKETING



## The importance of having a customer referral program

by Liz Tiefenthaler

I think we can all agree that an important part of business growth is referrals from satisfied customers. Not only is it the most cost-effective way to bring in new people, but it accomplishes two things. First, you have gained a new customer who is confident about doing business with you, as someone else sold him or her on the value of using your services. Second, it gives you an opportunity to further strengthen your relationship with a current customer. What a win-win. I believe in referral marketing to the point where I think it should be a formalized program in every pharmacy. It should involve your entire staff and include data and ROI measurements.

What would a formalized patient referral program look like? It would start with a budget, just like every other marketing activity, and would have defined and measurable goals. For example, for \$5,000 I expect to gain 500 new customers in one year through patient referrals, and also have a defined way to thank and strengthen my relationship with referring customers.

This is how my plan would look. To begin, I would define the costs involved in a formalized program. How will we let patients know that we would like them to refer family and friends to our pharmacy? We will no doubt need brochures, in-store signage, and perhaps some social media to promote and support the program. Then, how will we reward or thank our referring patients? I have talked to many store owners, and referral rewards ran the gamut from \$10 OTC coupons to \$50 Amazon gift cards. Having just received a \$50 card for a referral, along with a lovely personalized thank you note, I can tell you that the net effect was for me to think of other people to refer. I would budget around \$5,000 or more for your program, assuming printed marketing materials, thank you notes, and a fairly meaningful thank you gift.

Once you have established a budget, your next job will be to get staff involvement. Bring everyone in for a meeting before your store opens and include coffee and sweets so that you can explain what you want to do and get their input. You are looking for staff ideas on ways they will help promote this program, along with who will be in charge of thanking referring patients. My pharmacy takes the time — and they are diligent about this — to ask every new patient how they heard about the pharmacy and then record the responses. (This will also help you measure how your other marketing is working, or where improvements are needed.) Sometimes people forget to volunteer that they were referred, and this way you don't miss an opportunity to thank someone.

Finally, be sure to formalize your thank you and welcome process. Someone needs to run point on this or it will never get done. All new patients deserve a thank you and welcome from your store, whether they are a referral patient or because of other marketing that brought them in. And of course, you want to be sure that you thank your current patient who brought you a new customer. After all, that person just proved how much he or she believes in you and want you to do well. That is pretty powerful stuff. ■

Liz Tiefenthaler is the president of Pharm Fresh Media, a full-service marketing company focused on helping independent pharmacies gain new customers and build loyalty with their current customers. She can be reached at [liz@pharmfreshmedia.com](mailto:liz@pharmfreshmedia.com).

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- Class 2: Value Expression by Payer Type (part 1)
- Class 3: Value Expression by Payer Type (part 2)
- Class 4: Expressing Value Beyond the Product
- Class 5: Selling Your Value and Your Network (part 1)
- Class 6: Selling Your Value and Your Network (part 2)
- Class 7: The Contracting Cycle
- Class 8: Resources, Work Groups, and Continued Training
- Class 9: Preparing to Go to Market

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### COMMUNITY HEALTH WORKERS EDUCATION

This series is an accredited continuing education with three hours of self-paced education modules. You'll learn from industry experts, practicing community-based pharmacists, and community health workers. Associates from CPESN pharmacies can utilize these educational modules as well by visiting [www.ncpalearn.org](http://www.ncpalearn.org) and clicking on the CPESN tab at the top of the page.

If you are a CPESN pharmacy, please take advantage of these free educational opportunities. Reach out to your local network luminary or email [info@cpesn.com](mailto:info@cpesn.com). ■

**If you haven't heard of CPESN USA, it is the only clinically-integrated accountable pharmacy organization in the United States. To learn more, join us for a short, informational webinar hosted by independent pharmacy owners who are leading the CPESN effort. Visit [www.cpesn.com/pharmacies](http://www.cpesn.com/pharmacies) and click the LEARN button.**





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\*Exclusive to NCPA members.



## Understanding the FDA's stance on CBD

by Harry Lattanzio, RPh;  
and Tim Gregorius, RPh

Obviously there is exciting potential for community pharmacies in the CBD market. Still, it is important that pharmacy owners be well versed and educated when it comes to the legality of selling CBD to customers. There are innumerable confusing and conflicting laws, rulings, statements, letters, and announcements by the various entities that influence and control the legal status of CBD. Federally, the 2018 Farm Bill has stated that if CBD is derived from hemp and has no more than 0.3 percent THC by weight, it is legal. However, the Food and Drug Administration and each state board of pharmacy have something to say about that.

Let's discuss the FDA's stance on its mandate to protect public health. In December 2018 when the Farm Bill (Ag-

riculture Improvement Act of 2018) removed cannabis and cannabis derivatives that are very low in THC from the definition of marijuana in the Controlled Substances Act, the legislation specifically preserved the FDA's jurisdiction over such products. In the time since passage of the 2018 Farm Bill, the FDA has made several clear and concise statements regarding that mandate. The primary statement that should be of interest to CBD marketers and sellers is that the FDA is very clear in stating its top priority, that there shall



be no therapeutic claims about the ability of CBD to prevent, diagnose, treat, or cure disease. It has already sent out dozens of warning letters to CBD companies and marketers for making therapeutic claims. The fact that CBD is already the sole ingredient in the FDA-approved legend drug, Epidiolex, only further complicates matters, not only for us, but admittedly for the FDA as well.

The other important mandate the FDA has is to validate the safety of food and drugs. But CBD products are already flooding U.S. stores and homes. The FDA does not have much confidence that there is comprehensive knowledge of its safety and efficacy, and this puts it in a tough position. There are known warnings and concerns with CBD from Epidiolex studies, but the FDA is equally concerned about CBD safety and efficacy outside of the approved drug context. For example: How much CBD is safe to consume daily? What are the drug interactions that need to be monitored? Are there any long-term risks?

The FDA understands the importance of communicating its approach about CBD to the public, and it is taking an agency-wide, integrated, and collaborative approach to addressing CBD regulation that falls under its jurisdiction. In the meantime, where does that leave you and your pharmacy?

Each state has reacted to these federal directives in different ways. As many as 40 state boards of pharmacy have either remained silent on CBD or have regulations that allow the marketing, transport, sale, and use of CBD. It is especially important that you check with your state board in the 10 remaining states to make yourself aware of rulings that affect your business when it comes to CBD. For more information about state level board of pharmacy regulations, visit the NCPA CBD Source, powered by PRS ([www.NCPACBDSource.com](http://www.NCPACBDSource.com)), or call 833-786-6522 to set up an appointment with one of our CBD experts. You owe it to your customers to be the community CBD expert. The NCPA CBD Source is here to help you and is dedicated to the continued education, growth, and prosperity of independent community pharmacists. ■

**Harry Lattanzio, RPh, is PRS president. Tim Gregorius, RPh, is PRS vice president of operations.**

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## Pharmacy shakedown under the ADA

by Jeffrey S. Baird, Esq.

There is a cottage industry of attorneys who “shake down” businesses for inadvertently violating the law. The latest example is related to the Americans with Disabilities Act, or ADA. Pharmacy websites are being targeted as not being in compliance with the ADA. For example, a pharmacy recently received a letter from a law firm that says, in part:

“We have the distinct pleasure of representing [John Doe]. John does not like to be labeled a disabled individual, but John’s blindness and low vision cannot be denied ... Fortunately, John uses the Internet to facilitate his access to goods and services.

The United States Department of Justice (DOJ) and various federal courts have concluded that businesses which offer goods and services to the public through websites are public accommodations that must comply with the general accessibility mandate of the Americans with Disabilities Act.

Experts working with our client, on a similar matter, have identified access barriers on your website in violation of the ADA, including, but not limited to your failure to provide text equivalents for every non-text element, such as unlabeled buttons, throughout the website.

Before you incur significant cost by engaging outside experts of your own, we invite you to first contact us directly to explore a far more cost-effective and pragmatic approach to resolving these issues.

In addition to limiting equal access to goods and services to John, these accessibility failures, and [ABC Pharmacy] data practices, limit or deprive other potential clients and other stakeholders of rights and opportunities that other visitors (sighted visitors) to [ABC’s website] enjoy.”

This letter briefly notes the accessibility failures on the website and the privacy and legal consequences of those failures. The firm proposes a plan to work “constructively” with the pharmacy on behalf of its client John and others similarly situated to achieve equal accessibility for disabled individuals who visit the site. The letter continues:

“In lieu of immediately filing a lawsuit in federal court, we are, in the first instance, proposing a collaborative approach that we have successfully utilized in another similar context to resolve claims successfully, and for access to public accommodations by the disabled community.

Toward this end, the monetary demand of fifteen thousand dollars (\$15,000) absent litigation will remain on the table for twenty (20) business days from the date this correspondence is delivered to you.

Should you continue to willfully turn a blind eye to disabled individuals throughout the United States who use the Internet to facilitate their access to goods and services, we will have no choice but to demand at least two hundred and fifty thousand dollars (\$250,000.00) which is the low end of damages in these class action suits.”

There you have it ... Tony Soprano could not have written a better letter. The law firm is suggesting that it is performing a public service, that it can help the pharmacy become ADA compliant, and all the pharmacy needs to do is to pay the law firm \$15,000. In fact, we have found that in many of these cases, a law firm will send out a number of demand letters listing the same person as the law firm’s client.

Pharmacies should be proactive by taking steps to ensure that their physical accommodations, and their websites, are ADA compliant. ■

Jeffrey S. Baird, Esq. is chairman of the Health Care Group at Brown & Fortunato, P.C., a law firm based in Amarillo, Texas. He represents pharmacies, infusion companies, home medical equipment companies, and other health care providers throughout the United States. Baird is board certified in health law by the Texas Board of Legal Specialization. He can be reached at 806-345-6320, or at [jbaird@bf-law.com](mailto:jbaird@bf-law.com)



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# Supreme

# decision



## **After a years-long battle, community pharmacy brings its case against the PBMs to the highest court in the land**

*On Jan. 10, community pharmacy received news that had been some 15 years in the making. On that day, the Supreme Court decided to hear the Rutledge v. PCMA case. It marks the first time in history that the high court will rule on a case involving PBMs. NCPA and the Arkansas Pharmacists Association jointly commissioned an amicus to support Arkansas Attorney General Leslie Rutledge's appeal to enforce the 2015 pro-pharmacy, pro-consumer legislation that prohibited PBMs from paying pharmacies below cost and allowed pharmacies to refuse to dispense below cost prescriptions. While the case involves an Arkansas law, this Supreme Court appeal poses an impact on the pharmacy community throughout the entire country. The path to the highest court in the land was not a straight line or a smooth path. NCPA's involvement in PBM-related legal cases began 15 years ago, and NCPA's efforts and collaboration with APA began nearly five years ago. Oral arguments are expected in April, with an opinion issued by the end of June*

*In the following pages, America's Pharmacist® talks to leaders from NCPA and APA to reflect on the fight to get to the Supreme Court, their thoughts on the case, and what it means for community pharmacy going forward.*



All photos by David Hunsinger



*Arkansas Pharmacists Association  
CEO John Vinson (left) speaks with  
NCPA CEO Douglas Hoey outside the  
U.S. Supreme Court.*

## Beating the odds: Arkansas PBM case part of the 1 percent to reach Supreme Court annually

Each year, the U.S. Supreme Court receives 8,000 petitions asking it to review lower court rulings. And each year, the Court agrees to listen to about 80.

“Having a case heard before the Supreme Court is quite the achievement – it’s less than a 1 percent probability,” says NCPA Vice President and General Counsel Mustafa Hersi.

Fortunately for community pharmacy, one of those 80 was *Rutledge v. PCMA* (the PBM lobby), which evolved from a 2015 Arkansas law that the PBMs say can’t be enforced because of ERISA, with the U.S. 8th Circuit Court subsequently ruling in favor of PCMA. Hersi says that the case was among the last 5-10 that the Court chose to pick up when it announced its decision Jan. 10.

“It will be a landmark case that affects the industry one way or another,” Hersi says. “This is an opportunity to make the case that the ERISA preemption shield that PBMs have essentially relied on to avoid meaningful oversight and regulation by states is not something that should be allowed to continue to persist. This will have national implications because while a state law involving Arkansas is at issue, this case will affect pharmacy across the country.”

Hersi says that many states are reluctant to enact legislation to control PBM practices if such measures seem to lack teeth.

“State legislatures don’t want to pass laws that don’t have the effect that they are intended to have,” he says. “States don’t want to be bogged down in expensive litigation over whether they have the right to enact laws to protect their citizens’ health and welfare.”

Hersi cites what happened in New York with Gov. Andrew Cuomo (D).

“States are often chilled from pursuing regulation of PBMs because of this ERISA argument,” he says. “In New York, Gov. Cuomo recently vetoed a PBM regulation statute, citing ERISA as one of the reasons. If we were to take that off the table, it would allow states to engage

in meaningful deliberation as to how PBMs should be regulated.”

Hersi says that NCPA worked closely with the Arkansas Pharmacists Association and state government officials.

“We’ve partnered with Arkansas from the beginning, and we’ve supported them wherever we can,” he says. “At the court level we have done our best to be a meaningful partner to the Arkansas Attorney General office and the APA. The clarity that the court will give, regardless of the outcome, will be helpful to pharmacy. It is incredibly important to work hand-in-hand with our partners at the APA to make sure that our memberships’ voice is heard, is advocated for, and is present in this important time of deliberation.”

Hersi notes that NCPA is always willing to assist with community pharmacy-friendly initiatives at the state level, and lists Maine, Iowa, and North Dakota as just several examples.

“We don’t want states to think they are out there all alone,” he says. “We are supporting state stakeholders to address this really important issue. The way this case has made its way through to the Supreme Court is a reflection of that cooperation and partnership that NCPA has forged across the country.”

Hersi says that NCPA will continue to be community pharmacy’s biggest advocate.

“As an organization we have put a tremendous amount of resources toward supporting and making sure that this is the fight that we will win for our members and the communities that our members serve,” he says. “It’s a long and arduous process. There have been setbacks. There have been losses. But throughout it all NCPA has persisted and will continue to persist until we are able to achieve our goal, which is to allow states to make choices on how they want to regulate PBMs with respect to the health of their communities.” ■

**Chris Linville is America’s Pharmacist® managing editor.**



# Rutledge v. PCMA: 15 Years in the Making



'05

## **PCMA v. Rowe, No. 05-1606, (1st Cir.).**

- Maine's Unfair Prescription Drug Practices Act ("UPDPA"), enacted in 2003, was one of the first PBM laws in the nation to be challenged by PCMA.
- NCPA provided support to Maine attorney general in successfully defending statute before the First Circuit.

'14

## **PCMA v. Gerhart, No. 14-cv-345 (D. Iowa), on appeal, No. 15-3292 (8th Cir.).**

- PCMA files lawsuit against an Iowa law regulating PBM-pharmacy relationships arguing federal ERISA preemption.

'15

NCPA works with the Iowa Pharmacy Association to oppose PCMA.

- The District Court dismisses PCMA's lawsuit.
- PCMA appeals to the Eighth Circuit.

'16

- NCPA and IPA file an amicus curiae brief with the Eighth Circuit defending Iowa's PBM regulations

## **PCMA v. Rutledge, No. 15-cv-510 (E.D. Ark.), on appeal, No. 17-1609 (8th Cir.), pet. for cert. granted, No. 18-540 (U.S.).**

PCMA files lawsuit against an Arkansas law regulating PBM-pharmacy relationship arguing federal ERISA preemption.

'17

- Eighth Circuit reverses the District Court, ruling that Iowa's law is preempted by ERISA.
- NCPA and IPA support Iowa's effort to seek rehearing, Eighth Circuit denies the state's petition.

- District Court rules that Arkansas's law is preempted by ERISA and Arkansas appeals to Eighth Circuit.
- NCPA and APA file an amicus curiae brief with the Eighth Circuit defending Arkansas's PBM regulations.

'18

- Eighth Circuit rules Arkansas's law is preempted by ERISA, and in response, attorney general's office files a petition with the Supreme Court to review the Eighth Circuit's decision.
- NCPA helps secure an amicus curiae brief from 32 states and the District of Columbia urging the U.S. Supreme Court to review the case.

'19

- Supreme Court calls for the U. S. Solicitor General to file a brief expressing the views of the federal government.
- Solicitor General files brief on behalf of the United States arguing that the Eighth Circuit's decision was wrongly decided and urges Supreme Court to take the case.

'20

- Supreme Court agrees to review case and its decision could have far-reaching implications for the authority of the states to regulate PBMs that process claims for employer- or union-sponsored health plans.

**PCMA v. Rowe**

**PCMA v. Gerhart**

**PCMA v. Rutledge**

*This summary is not an all-inclusive analysis of our efforts, but a highlight of major NCPA activity.*

## ‘David versus Goliath’ as Arkansas takes on the PBMs in the Supreme Court

Friday, Jan. 10, was not just another day in the office at the Arkansas Pharmacists Association.

Everyone was on high alert on that afternoon in Little Rock. They were waiting for word on whether the U.S. Supreme Court would agree to hear arguments in the *Rutledge v. PCMA* case.

“They said that if we didn’t hear anything by 3 p.m., it might be Monday,” says Jordan Foster, APA’s director of communications. “A lot of folks were hitting refresh, refresh ... 3 o’clock came and went, and we kind of gave up.”

But then came the news they were waiting for: The Supreme Court announced that it would hear the case, one that APA had worked with for nearly five years. The staff had changed over the years, but one thing remained constant: the association was committed to fighting for this case.

The Court is expected to hear arguments in April, and a decision will be handed down in late June. APA’s current CEO, John Vinson, who calls the case a “once-in-a-lifetime opportunity,” will be in Washington for the arguments, as will Mark Riley, former APA executive vice president, and Scott Pace, former APA CEO. Since Jan. 10, Vinson has been busy; along with running the association as usual, he’s reaching out to associations across the country, building coalitions, and raising money to defray legal expenses.

“This case comes down to this,” Vinson says. “Do states have rights or not? This case has national significance. It’s not just for Arkansas.”

Pace was CEO when the legislation at issue was passed in 2015. In fact, Pace, who holds pharmacy and law degrees, helped to craft the original legislation. Just a few weeks ago, Pace found the notes he made when he was helping to draft the law.

Looking back, he believes that legislation is groundbreaking in that it does more than just rein in PBMs. “It expressly makes self-dealing by PBMs illegal,” Pace says. “It prevents PBMs from paying their own pharmacies more than they pay other pharmacies.” This part of

the bill is sometimes overlooked, Pace says, because the focus is on the ERISA challenge, and that is indeed what the high court will consider.

As described in the docket of the U.S. Supreme Court, the Court’s focus is on one question: “Whether the Eighth Circuit erred in holding that Arkansas’s statute regulating PBMs’ drug-reimbursement rates, which is similar to laws enacted by a substantial majority of States, is preempted by ERISA, in contravention of this Court’s precedent that ERISA does not preempt rate regulation.”

But from the beginning, PBMs fought the bill. They won in the Eighth Circuit, but when the U.S. Solicitor General reviewed that decision, he strongly disagreed with the Eighth Circuit. That opinion cleared the path to Supreme Court consideration. “The Supreme Court won’t opine on something they weren’t asked,” Pace says, adding that he doesn’t expect a broad, sweeping decision on PBMs. “They will decide whether the Eighth Circuit erred in their decision.”

And with a chuckle, Pace says that the decision could be “providential.” PBMs started the challenges to the Arkansas law, and if the Supreme Court goes against them, it will be because they pressed the issue, he says.

Riley is excited to see PBMs and ERISA in the Supreme Court’s crosshairs. He’s worked on exposing PBM behavior for years, and he puts it bluntly: “What PBMs have done has been gradual. At first, employers thought they were the greatest thing since sliced bread. They just let them PBMs handle it. And I don’t know if the PBMs were that smart, or if it was just serendipity. Hey, nobody knew jack squat about PBMs back then.”

Add ERISA into the mix – as PBMs always do, Riley says — “and they just fold their cards. This case, I think, can change the game.”

*Rutledge v. PCMA* is “the classic story of David and Goliath,” Vinson says. “We’re fighting for pharmacists and for patients. It’s time to peel back the PBM curtain.” ■

**Jayne Cannon is NCPA director of communications.**



*“This case comes down to this. Do states have rights or not? This case has national significance. It’s not just for Arkansas.”*



## *APhA Joins the Fight*

*The American Pharmacists Association (APhA), the largest association of pharmacists in the United States, recently joined forces with NCPA and APA in their landmark legal fight against the PBMs. APhA Executive Vice President and CEO Thomas E. Menighan (left) appears above with NCPA CEO Douglas B. Hoey and APA CEO John Vinson*



## Hoey sees a much needed PBM spotlight in Supreme Court case

The U.S. Supreme Court's decision to hear a case (*Rutledge v. PCMA*) will put PBM practices into the spotlight as never before. At the heart is a 2015 Arkansas law that the PBMs say can't be enforced because of ERISA, with the U.S. Eighth Circuit Court subsequently ruling in favor of PCMA. NCPA and the state of Arkansas believed that the PBMs and the lower court took an overly broad interpretation of ERISA. Oral arguments are expected at the Supreme Court in April and a final ruling is expected by the end of June.

In this issue of *America's Pharmacist*<sup>®</sup>, NCPA CEO B. Douglas Hoey provides his opinions and analysis about the Supreme Court decision.

**Q WHAT WAS YOUR INITIAL REACTION WHEN YOU HEARD THE SUPREME COURT WILL HEAR THIS CASE?**

"It was relief and celebration! When we saw the strong, strong opinion from the Solicitor General, it made us very optimistic. Certainly the 32 states and the District of Columbia attorney general weighing in with the Solicitor General asking that this ruling be reviewed was also in our favor."

**Q WHAT DOES THIS MEAN FOR COMMUNITY PHARMACY?**

"It's huge. It's not every day that community pharmacy gets to have its day in front of the Supreme Court, and it's the first time that PBMs have been hauled in front of the Supreme Court. That's impossible to believe considering the misdeeds they have done over the years – that this is the first time that the top court in our land gets to hear about their behavior."

**Q ARE YOU SURPRISED THAT THIS HAS GONE ALL THE WAY TO THE SUPREME COURT?**

"Could I have predicted that it would take this path to the Supreme Court five years ago? No. Really I hoped that it would have been ruled, from our point of view, with the correct interpretation in the lower courts. But I am a big believer that the cream always rises to the top, and that the truth will come out at some point. And so whether it's the Supreme Court or some other venue, I have maybe an unrealistic expectation that truth will win out. If truth wins out this way, then it's as it should be. If it's

not through this avenue, it will be through another. But I think persistence, tenacity, never giving up never losing faith, is really important – and really hard.”

**Q WHAT DO YOU SEE AS THE KEY ASPECTS OF THE CASE?**

“We don’t want to presume victory. It could go either way, but either way it goes there will be more clarity in the marketplace. PBMs thrive on opaqueness, so they hate clarity. The old adage that the best disinfectant is sunlight surely applies to PBMs. If the court rules in favor of the state of Arkansas, it will clarify the state laws under which PBMs must operate. I know NCPA will be very active as we currently are in states to support similar state laws across the country to benefit patients and to help small business.”

**Q WHAT ARE OTHER ASPECTS THAT COMMUNITY PHARMACY SUPPORTERS NEED TO KNOW?**

“There will still be ERISA preemptions, and there will still be plans that ERISA affects that these laws won’t impact. There will be ERISA preemptions that will stay in effect even if the Court rules in our favor, but this is a narrower question about the ERISA preemption. Right now the PBMs are saying essentially that the courts have ruled that ERISA pre-emption protects them from any laws. And we of course believe that is a WAY overly broad interpretation of the pre-emption, and while there are some laws where ERISA does pre-empt them from being affected, it’s not nearly as broad as the PBMs are arguing.”

**Q WHAT ARE YOUR THOUGHTS ABOUT THE WORK DONE IN ARKANSAS?**

“Without Mark Riley (former NCPA president and Arkansas Pharmacists Association CEO when the 2015 legislation was passed) explaining the impact of the legislation to legislators in his plainspoken way and providing leadership, it wouldn’t have happened. It wouldn’t have happened without his relationships in the state legislature. He also had help from Scott Pace, who was the APA COO at the time. John Vinson, the current APA CEO, has been a great partner in carrying the torch for Arkansas pharmacists. And, of course, a huge amount of credit goes to the Arkansas Attorney General’s office. The state attorney general Leslie Rutledge could have waved the white flag after the setback in the

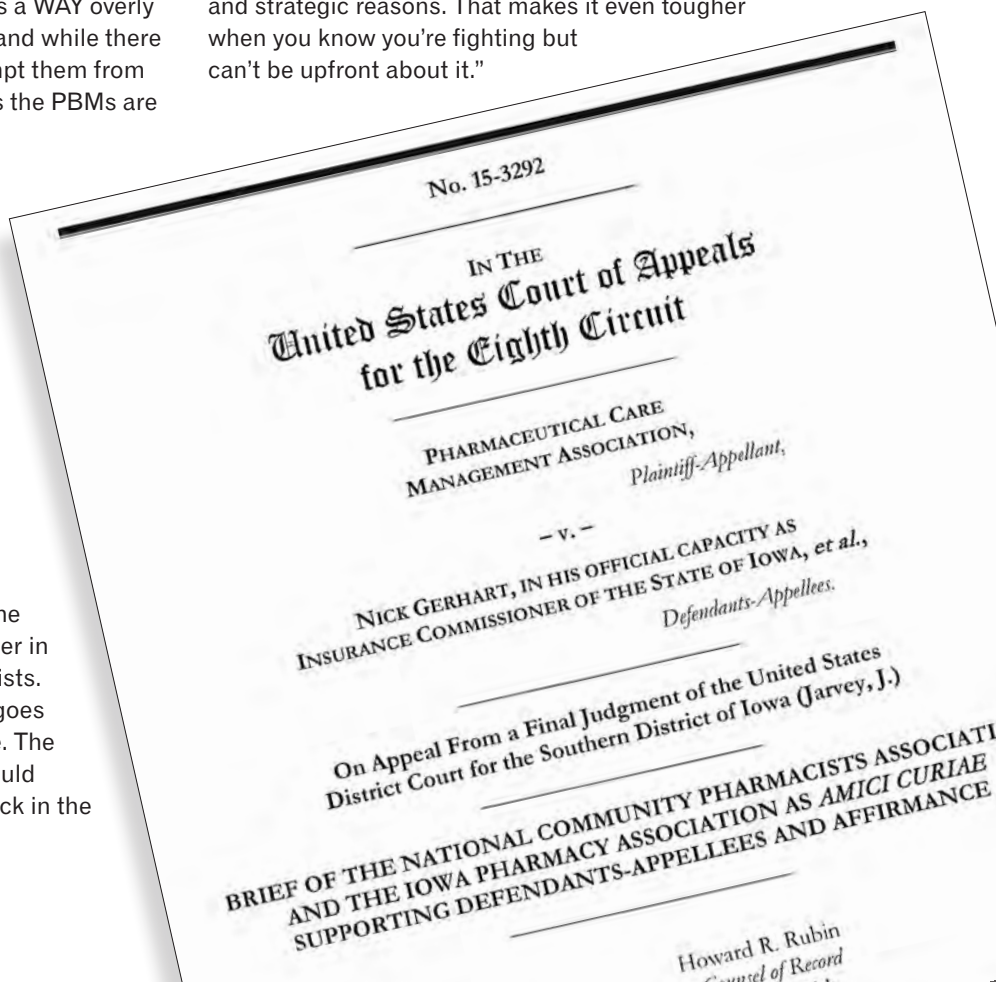
lower courts but she didn’t – she kept going. So just a huge shout out there to all of them.”

**Q WHAT ARE YOUR THOUGHTS ABOUT NCPA MEMBER ENGAGEMENT?**

“It’s a tribute to our membership. Because it has not been an easy path, and there has been a series of two steps forward, one step back and, sometimes, one step forward, two steps back. We always appreciate those who contribute to the NCPA Legal and Legislative Defense Fund. And, a special tip of the hat goes to those regular contributors to the LDF. That’s a long-term investment, and it’s paid off in a trip to the Supreme Court. I understand at times it’s a leap of faith for them because most issues take years to reach resolution. The LDF folks go above and beyond that and put their money where their mouth is.”

**Q WHAT ABOUT NCPA’S ADVOCACY EFFORTS?**

“We’ve been there from the very beginning, supporting the Arkansas effort, advising the Arkansas effort, providing resources, and providing our meaningful expertise. We’ve done that in Iowa (see below), Maine, North Dakota, and other states across the country. It is a testament to the work of the NCPA team and their work with states. A lot of this work was behind the scenes for necessary and strategic reasons. That makes it even tougher when you know you’re fighting but can’t be upfront about it.”



**Q IN A RECENT WEBINAR YOU AND THE LEGAL TEAM OUTLINED SOME 'DO'S AND DON'TS' REGARDING THIS CASE (FOR EXAMPLE, DON'T WRITE LETTERS TO THE JUSTICES). WHAT IS THE OVERALL MESSAGE?**

"It's important to coordinate through NCPA and the Arkansas Pharmacists Association. We are taking our cues from the lawyers experienced in Supreme Court cases. NCPA engaged some of the top-notch ERISA lawyers in the country — the same lawyers that we recommended going back 4-5 years to the Iowa legislation. The risk of multiple amici being sent to the Supreme Court is dilution of the comments, and confusion. This case has come too far and is too sensitive for preventable missteps to occur. We've often talked about the overly complex, confusing pharmacy pricing system — the pharmacy system is a pretty complex world, and to have multiple voices and sort of self-appointed experts espousing to the court what they think is important is very dangerous. Go through the process, let the experts earn their pay, and have a careful and coordinated effort. I can't stress that enough. The objective that we have to stay laser focused on is support of work that leads us to the one word we want to hear: 'Reversed.' Any person or group going rogue in this matter, doesn't have the best interests of community pharmacy at heart."

**Q WHAT ARE THE NEXT STEPS?**

"This is not a lobbying activity, and it's not a legislative activity. The NCPA amicus will have been filed (at print time). We are planning to have a rally at the

Supreme Court. We are fundraising, we are asking for support for the immense costs that have accrued to get to this point, are accruing, and will continue to accrue. So that's a big focus. And then we are making preparations for whatever the outcome is. Whatever that is, we'll be ready. We are excited for more clarity, and again, PBMs hate clarity. They operate in the shadows so they are averse to clarity."

**Q WHAT ARE YOUR LONG-TERM HOPES FROM THIS CASE?**

"This is a major milestone. Having the opportunity for community pharmacy to be in front of the Supreme Court and to bring PBMs in front of the Supreme Court is amazing. As I said, no matter the ruling from the Supreme Court, there will be greater clarity. And, also, no matter the ruling from the Supreme Court there will still be an imperative for the pharmacy payment model to change. The movement for pharmacists to be able to practice at their full scope doesn't change with the ruling from SCOTUS. The outcome of the Arkansas case will be very important for appropriate payment for pharmacists and access for patients. But pharmacy has to continue to evolve into the CPESN® USA model. A payment model centered around dispensing prescriptions that *may lead to pharmacy services* to one that is centered around *pharmacy services that lead to dispensing prescriptions*; that is the end game. And, we can't lose sight of that." ■

**Chris Linville is America's Pharmacist® managing editor.**

*"We are excited for more clarity, and again, PBMs hate clarity. They operate in the shadows so they are averse to clarity."*





**JOIN THE FIGHT**

SUPPORT OUR  
**SUPREME COURT FUND**



**Rutledge (Arkansas) v. PCMA is an unprecedented opportunity funded by years of financial investment by hundreds of community pharmacists like you. Their preemptive giving funded the legal and legislative work that has dragged the PBMs before the Supreme Court for their first time ever.**

Now, as we work through this final round of litigation, please consider joining with hundreds of your colleagues and investing and making a onetime investment in NCPA's Legislative/Legal Defense Fund.

A well-resourced LDF pays the significant legal bills for this case and the ongoing work to engage and educate key stakeholders such as state attorneys general, insurance commissioners, and state lawmakers about the need to stand up for pharmacy patients and more effectively regulate PBMs.

**There are two easy ways to contribute:**

1. *Via credit card online:* [www.ncpanet.org/ldf](http://www.ncpanet.org/ldf)
2. *Mail:* NCPA LDF  
100 Daingerfield Road  
Alexandria, VA 22314

If you have any questions regarding the LDF, please contact NCPA Senior Director of Political and External Affairs Eric Lundberg at [eric.lundberg@ncpanet.org](mailto:eric.lundberg@ncpanet.org), or 703-600-1184.



# TOP 10

# TIPS

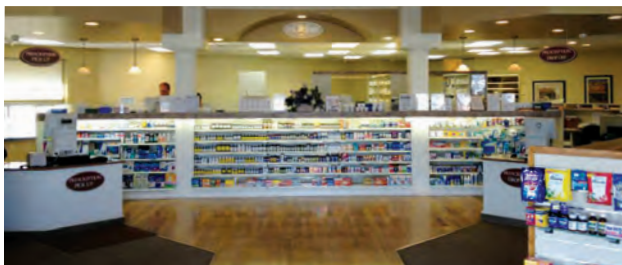
**Some simple, common-sense suggestions to help your pharmacy succeed**

by Bruce Kneeland

Yogi Berra, the late, great Yankee baseball star and erstwhile philosopher, is reported to have said, "You can observe a lot just by watching." With that as the foundation, here are 10 things I have "observed" during visits to scores of successful pharmacies across the country. Perhaps one or two of these tips will inspire you do something new to improve your pharmacy's performance.

## LOOKS MATTER AND NEATNESS COUNTS

Dirty floors, worn-out carpet, and burned-out light bulbs are impediments to success. For you to be successful, you must look the part. Having a clean, well-organized, and pleasant facility will boost sales and inspire your patients to recommend you to a friend, neighbor, or co-worker. Clean, neat, and orderly does not happen by accident. Good managers have a formal process where they identify, assign, train, and follow up on staff members tasked to perform specific housekeeping duties.



*The Apothecary Shoppe (top) is located in a major hospital in Salt Lake City. Patients and providers appreciate its clean look and artfully merchandized shelves.*

*El Tejon Pharmacy (bottom) in Bakersfield, Calif., takes the idea of having the pharmacy look good to a whole new level, with clean floors, well stocked shelves and a bright and spacious interior.*

## TRAIN YOUR STAFF

Gen. Norman Schwarzkopf, who led an international coalition to victory in the 1991 Gulf War, was famous for saying, "When you are placed in command, take charge." Too many pharmacy owners fail to take charge. They allow employees to resist necessary changes and slack off on their duties. Successful managers know how to delegate, train, and hold team members accountable. Those unable or unwilling to perform are invited to leave. These managers not only get team members to perform their assigned tasks, but also get them excited about taking on new ones. You can't run an above-average pharmacy with average employees.

## GET OUT OF THE PHARMACY

Networking is a proven success principle. The number and variety of places you can go is large, and what you can say is varied. Making carefully planned visits to doctors' offices, beauty salons, day care centers, and other places in your trade area generates awareness. If done with a professional purpose, these visits will develop into relationships that will spur referrals. Keeping track of where you went, who you saw, what information you shared, and what you learned on each visit is a critical success tactic.

It might help to remember this undeniable truth: at any one time there are more people outside your pharmacy than in it. If you want more people to come to your pharmacy, get out of your pharmacy and go meet them. You do not need to be pushy or be a salesman. The task is to take information you believe will be of value to them, listen, and then follow up.

## HAVE REALLY GOOD SIGNAGE

It is not uncommon for a pharmacy owner to hear new patients say something like, "I never knew there was a pharmacy here." Sometimes shopping center restrictions make it impossible to put up a large sign, but even then, you can find creative ways to let people know your pharmacy exists. For example, some pharmacists make a point of parking their attractively branded delivery car in a spot where it can be seen from the highway. But for most pharmacies, the real answer is to invest in a new, large, and well-lit sign. People won't come to you if they don't know you are there.



*Butt Drug (top) in Croydon, Ind., is located on the town's historic main street. Its storefront is attractive and does the job.*

*Vic's Pharmacy (bottom) in Nampa, Idaho, located in a former bank building, added a new outdoor digital sign as part of a renovation project.*

## HAVE A NEW CUSTOMER PROGRAM

Successful pharmacies have carefully orchestrated procedures for impressing first time prescription customers. They realize the truth of the cliché, “You only get one chance to make a good first impression.” These programs often include having the owner or pharmacist-in-charge stop what he or she is doing and take a minute to greet the new patient. Taking time to explain some of the unique services the pharmacy provides and giving the person a new customer welcome packet with a gift certificate to encourage them to come back soon is a good practice. It is also a good idea to count, report, track, and talk about how many new patients you see each week, month, and year. Then make it a part of every staff meeting to discuss what you can do to improve those numbers.



*Having carefully designed customer referral cards, customer service programs, and information to give to new patients will convince them that they have found the right pharmacy for them.*

## DON'T OVERLOOK THE FRONT END

While the front end may only account for 5-10 percent of your sales, it accounts for 80-90 percent of your pharmacy's image. Making sure shelves are fully stocked, artfully merchandised, and properly priced is critical to your image. This applies no matter if you have a traditional front end with cards, gifts, and other general merchandise or a very small and clinically-oriented front end. In either case you find many items to sell. Some of my favorites are vaporizers, blood pressure devices, compression hosiery, and professional-grade nutraceuticals. You can source, display, and sell a lot of health care items if you



present them effectively and train your staff on how and why a patient would benefit from the product, service, or device.

## ENGINEER POSITIVE WORD-OF-MOUTH

The age-old adage that word of mouth is your best marketing tool is only true if you are “engineering” ways to get people to say good things about you. Think about it — if you greet a person by name, fill their prescription quickly, and accept their insurance card, you have done a good job. But nothing remarkable has occurred, and it is not likely anyone will go out of their way to talk about that experience.

What is more likely to cause comment is when product is out of stock, or the doctor has not yet called in the prescription, or your clerk can't find the prescription in the will-call bin. The sad fact is people talk more about the negative than the positive.

So creating socially acceptable and creative ways to encourage people to talk about how great you are when you have pleased them is a good idea. Many pharmacies have special cards they provide patients that can be shared with friends. The card provides a cash incentive for the friend and when redeemed by the friend provides a reward to the customer who shared the card.



## FOLLOW UP WITH A PHONE CALL

Texts are fine but be sure to pick up the phone as well. People-to-people connections go a long way toward making a person feel special. One great idea is to create a tickler file and follow up on children who have just had an antibiotic filled. A phone call three days later to the mother to inquire about the child is a powerful relationship builder. And reminding the mother to ensure the child completes the entire course of therapy is an important professional service.

Other examples might include calling adult patients on antibiotics to see how they are doing, inquiring about their recovery, and perhaps even suggesting a probiotic. And, since most phone calls go unanswered, you should be prepared to leave a carefully scripted, personalized, and HIPAA-compliant voice message. This is the kind of above-and-beyond personal service that generates word of mouth recommendations.

## PLAY THE NAME GAME

Calling customers by name is a great way to build loyalty. Names can be found on prescriptions, insurance cards, checks, and credit cards. Teaching your staff to look for and remember patient names is a great way to impress customers.

But, have you thought of the inverse opportunity? Making it easy for your customers to call you by name is also important. Answering the phone with the staff member's name and position is a good policy. Providing every staff member with a name badge is a practice used by many pharmacies. Some pharmacists provide team members with business cards and encourage them to hand the cards out at social or other functions.

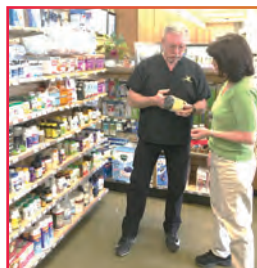
Early in my career I was told by a successful owner that he trained his staff to never say to a customer, "Can I help you?" as the nearly universal consumer reply is, "No thanks, I am just looking." Instead, he trained his staff, when they saw someone looking at items on the shelf to simply say, "Hi, my name is Sally, let me know if I can help you." This put the customer in charge and, according to him, resulted in many more chances for his team member to help the customer.

*The staff of The Apothecary Shoppe in Salt Lake City proudly show off their name tags.*



## DO SOMETHING ELSE EXCEPTIONALLY WELL

Successful pharmacies not only run a great pharmacy, but they also do something else exceptionally well. The idea is that having two – or more – destination-type products or services to draw people to the pharmacy can be synergistic.



For example, one owner told me that one-third of the prescriptions he filled were for hypertension, diabetes, or high cholesterol. He said that it occurred to him that helping people eat right and exercise

more was a better way to treat those problems. He enrolled into a commercial program that helps him run a successful nutritional service business that people pay for out-of-pocket.

At the other end of the scale is a pharmacy that makes and sells fudge. It is delicious, presented in a cute kiosk, and provides



customers with a great reason to visit whether they need a prescription or not. The pharmacy has a nice DME department, and the owner says the fudge is a perfect "leave behind" when they make visits to their referral sources.

As you review this short list of success tips, I hope it will inspire you to improve in an area or two where you are weak. Perhaps you'll decide to add a new product, program, or service to your current offering. Despite low third-party reimbursement and egregious PBM practices, it is still possible to succeed. But doing so will require creative thinking, careful planning, and effective implementation. ■

**After a long career in the pharmacy supply chain, Bruce Kneeland is a semi-retired industry consultant who interviews successful community pharmacy owners and managers all across the country. He shares what he learns by delivering live CE programs and writing for several pharmacy journals. He can be reached at [bfkneeland@gmail.com](mailto:bfkneeland@gmail.com).**

# GIVE A **HAND** TO THESE *NICE PHARMACIES*

*Meet the NCPA Innovation Center's  
2020 NICE Award recipients*

by Chris Linville

These days, community pharmacies are facing pressures from all angles. Low and slow reimbursement, DIR fees, chain and online competition, abusive PBM practices ... you get the picture. Knowing that the days of surviving on prescription sales alone are long gone, many pharmacies are looking for alternative ways to market their business and different approaches to bring customers into their stores to see everything they have to offer.

With that in mind, the NCPA Innovation Center is once again recognizing pharmacies that have demonstrated excellence in their marketing and merchandising with the third annual NICE Awards.

"Since 2018 the NICE Awards have showcased the best in community pharmacy branding and marketing – the innovations and redesigns that make promotions more effective and patients' experiences more rewarding," says NCPA Innovation Center President Kurt Proctor. "As we know, marketing is the lifeblood of a community pharmacy. The aim of the NICE Awards is to spotlight what good pharmacy marketing looks like – and what it accomplishes for a pharmacy business. We think it's nice if others could see and learn and achieve success as a result of these examples."

If you want a NICE-style pharmacy, NCPA has programs to help members be successful beyond the prescription department, led by our own front-end guru, Gabe Trahan. These include live programming at our conferences, a focused one-day Front-End Profit Building Seminar sponsored by Good Neighbor Pharmacy, the twice-monthly *Profit Makers* publication, and regular columns in *America's Pharmacist*®, along with a plethora of great advice, examples, tools, and resources on the NCPA website. Gabe's newest offering is *Gabe's Favorite Tips*, a compilation of his favorite tips and suggestions for your store.

The NCPA Innovation Center accepted nominations for the following award categories:

- Best Internal Remodel
- Best Customer Convenience Improvement
- Best Marketing/Promotion
- Best Delivery Vehicle
- Best In-Store Display
- Best External Remodel
- Best Exterior Sign

In the following pages we highlight the NICE-est entries, as determined by this year's judges — Bruce Kneeland, Dave Wendland, and Becky Schiller.

Thanks to all who submitted entries for the 2020 NICE Awards. If you are planning on making pharmacy improvements this year, take plenty of pictures, let us know, and you could be named among the nicest of the NICE in 2021. Look for nomination information coming this fall.

## Meet our judges

**Here are the nice judges who decided which pharmacies were NICE.**



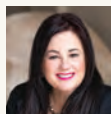
### **BRUCE KNEELAND**

After a long career in the pharmacy supply chain, Bruce Kneeland is a semi-retired industry consultant who interviews successful community pharmacy owners and managers all across the country. He shares what he learns by delivering live CE programs and writing for several pharmacy journals.



### **DAVE WENDLAND**

Dave Wendland has more than 25 years of experience in the packaged goods industry and is passionate about optimizing results across the retail supply chain. As vice president of strategic relations and a co-owner of Hamacher Resource Group, he has connected, counseled, and offered business-improvement solutions to a variety of manufacturers, distributors, retailers, and technology providers.



### **BECKY SCHILLER**

Becky Schiller spent 21 years as a dental hygienist before becoming a second-generation pharmacy owner. She and her husband Chris Schiller, PharmD, own and operate four Economy Pharmacy locations in Oklahoma. Her background in design helped Economy Pharmacy with a remodel of its primary store in 2018, earning a special Overhaul of the Year NICE Award in 2019.

# BEST INTERNAL REMODEL

## Mac's Pharmacy, Oak Ridge, Tenn.



After



Before

When Mac's Hometown Pharmacies was looking to purchase a facility to expand into Oak Ridge, Tenn., staff members scouting the area stumbled upon an old bank that had been abandoned for 20 years. Needless to say the building was in a serious state of neglect.

"As you can imagine, it was pretty disgusting," says Matt Parton, director of sales and marketing.

Not only had it been a bank, but prior to that it had been a gas station and had oil tanks still in the ground from the 1940s. Mac's first inquired about the building in September 2017.

It had to wait for a soil sampling assessment to determine if it could be inhabited. Once that was done, the building was purchased the following spring. After more than a year of renovations, the pharmacy had its grand opening in September 2019.

During the renovation process, the building was completely gutted, which provided a clean slate. "We wanted a touch of old with the technology of new," Parton says. "The store is decorated with an old phar-

macy feel of instruments and bottles of old pharmacies, yet the inside now includes a new compounding lab (USP <800> certified), consultation room, and an ice cream float station."

Parton says that Mac's is excited to be in Oak Ridge, known to most as the birthplace of the atomic bomb in World War II. He says that the town had fallen on some hard times but seems to be bouncing back of late.

"We wanted to show support and be a part of building back this community," Parton says. "Word of mouth has been a main part of advertising for us because people come in and see what we've done with the building. Then they call their friends saying they need to check it out, because it's not just a pharmacy. We're grateful for the response we've received."

### Fast Facts: Mac's Hometown Pharmacies (five Tennessee-based retail locations, one LTC pharmacy)

<b>Established:</b>	1989
<b>Management:</b>	Mike Wilhoit, president
<b>Products &amp; Services:</b>	Includes standard retail, medication synchronization, immunizations, free delivery, long-term care services, men's and women's health services, compounding, skin care products, and durable medical equipment.
<b>NCPA member since:</b>	1989

# BEST CUSTOMER CONVENIENCE IMPROVEMENT

## Keeseville Pharmacy, Keeseville, N.Y.

In the fall of 2017, pharmacist Dan Bosley, owner of Keeseville Pharmacy in Keeseville, N.Y., was approached by ADKAction, a local nonprofit, as a potential hub for an indoor daily farmers' market. "With no local grocery store, our community depended on gas stations and dollar stores to make daily food choices," he says. "We were an enthusiastic partner, so we started the Keeseville 'Farmacy.'"

Bosley donated space in his store and initially operated as a consignment model, with local vendors moving product in and out each week. After a few months, he decided to change the model and just buy the product outright. "Our mission is to support local businesses and farmers, then regional and state, with organic being the top choice when possible," he says. "Sales were stronger than we had imagined, and we began accepting SNAP benefits and working with the county health department on a healthy food program using local foods."

The Farmacy partnered with a local chef and held cooking classes. Grant monies helped it hire a full-time employee who oversees the project, works with Bosley's staff, markets the products and outreach programs, and plans cooking classes and in-store demonstrations/tastings.

"We brought in new shelving units, ordered additional coolers, and remodeled a large portion of our store to accommodate this new grocery section," Bosley says. "Our bulk food bins have been a hit.

We've created a tool kit that shows other businesses and pharmacies how to duplicate this model in their own stores. We believe the ripple effect from this project will bring healthy, local food to those most in need. We are so proud to be a partner in true wellness initiatives within our community."



### Fast Facts: Keeseville Pharmacy, Keeseville, N.Y. (two locations)

<b>Established:</b>	1983
<b>Management:</b>	Dan Bosley, owner
<b>Products &amp; Services:</b>	Along with the Farmacy, includes standard retail, medication adherence, medication synchronization, medication therapy management, home delivery, private consultations, durable medical equipment, flu shots and immunizations, and long-term care services.
<b>NCPA member since:</b>	1989

# BEST MARKETING PROMOTION

## Louis Morgan #4 Pharmacy, Gifts and More, Longview, Texas

For Louis Morgan #4 Pharmacy, Gifts and More, in Longview, Texas, 2019 marked 50 years in business, so the pharmacy wanted to come up with creative ways to mark the occasion. Starting in January, the pharmacy teamed with a local business to give gift cards in a monthly door-prize drawing. The pharmacy would usually buy \$250 worth and the other business would generally double it, so it was about \$500 monthly.

“Since our doors first opened in 1969, we have supported our community and it in turn has supported us,” says co-owner and pharmacist Shawn Sams.

As the year went along, Louis Morgan collected all the entries that had been accumulating for the monthly gift cards for its annual Boo to the Flu event in October, when it does “drive-thru” flu shots where people can drive their cars into the parking lot and receive a vaccination without leaving their vehicle. For the event they had a drawdown, with the winner receiving an \$8,000 travel voucher for a trip to Disney World. Sams says that Louis Morgan

teamed with a local radio station to help organize the entries. People could be put into the drawing by doing things such as “liking” the pharmacy on its Facebook page or on Instagram posts. (Sams says the pharmacy gained 1,000 likes in the run-up to the event.)

From some 6,000 entries, the radio station’s computer randomly selected 50 names the week before the event. Those 50 were called and told they needed to be present to win. Of those, about 20-25 showed up, and several other people were entered when they showed up on the day of the event to get a flu shot. From 30 entries, names were steadily picked from a hat, and the last name picked won the trip.

“It was a boy and his mom,” Sams says. “The little boy jumped into his mom’s arms. It was an exciting day for all of us.”

Along with the radio station, a local television station covered the event, and there were several articles in the *Longview News Journal*.

“Word of mouth is key, but there is so much competition from the chains that you have to make sure that you stand out,” Sams says. “We’ve tried to be very creative in the ways that we can do that. Whether it’s TV, radio, print media, or social media, we’re a big believer in that, along with community involvement. We want to show them that we care.”



### Fast Facts: Louis Morgan #4 Pharmacy, Gifts and More, Longview, Texas

<b>Established:</b>	1969
<b>Management:</b>	Mike Holbert and Shawn Sams, owners
<b>Products &amp; Services:</b>	Includes standard retail, home delivery, curbside pickup, vaccinations, compounds, medication counseling, Medicare plan consultations, vitamin depletion counseling, flavor additions, digital app for refills, and OTC products.
<b>NCPA member since:</b>	1987

# BEST DELIVERY VEHICLE

## *Family Pharmacy, Aiken, S.C.*



Johnson says that when the pharmacy opened its second location about 10 years ago, it began working with a marketing company. “They said you need to have a car with some personality, where people don’t just say it’s the delivery vehicle, but that it’s part of the family, to give it a bit of a persona,” she says.

The first Scrippy was a Nissan Cube, followed by a Mini Cooper. Scrippy “3.0” is the Insight, purchased for \$24,000. Family Pharmacy Vice President of Operations Stuart Johnson says the vehicle averages 76 miles per day on deliveries (Monday-Friday). In 2019 the pharmacy’s delivery driver drove 19,265 miles. The promotional wrapping was \$1,955 (including installation).

If you’re in Aiken, S.C., you may come across Scrippy, a 2019 Honda Insight. With a cover wrap that says “Scrippy Rx on the go!” on both sides, it’s kind of hard to miss. And that’s sort of the point. Scrippy is a combination delivery vehicle/advertisement for Family Pharmacy, a two-store business in Aiken owned by pharmacist Brandi Johnson and her father, pharmacist Jay Watts. Johnson says she always

considered her father to be ahead of the curve and recalls that years ago he had a Chevy S-10 pickup with information about the pharmacy and its services plastered all over it. Since then, Johnson says, “He’s always wanted something that was not flashy, but different. It’s kind of like in the early 2000s when the new Beetles came out. When wrapping became a thing, we started wrapping our cars.”

“I think we get a lot of interest from people becoming patients at Family Pharmacy based on the delivery service,” Brandi Johnson says. “That is probably due to the visibility in the community. They are used to seeing Scrippy driving around. The ability to offer local delivery in a stylish ride has enhanced our patient experience greatly.”

### Fast Facts: Family Pharmacy, Aiken, S.C. (two locations)

<b>Established:</b>	1986, purchased by Jay Watts in early 1990s.
<b>Management:</b>	Brandi Johnson and father Jay Watts
<b>Products &amp; Services:</b>	Includes standard retail, prescription refills and transfers, home and business delivery, medication adherence/synchronization, medication therapy management, travel vaccinations, compounding, Dispill multi-dose packaging, health screenings, wellness programs, immunizations, Medicare open enrollment, and OTC products.
<b>NCPA member since:</b>	1995

# BEST IN-STORE DISPLAY

## *Jasper Drug Store, Jasper, Ga.*

Pharmacist Jack Dunn, owner of Jasper Drug Store in Jasper, Ga., doesn't like to brag, but he would like to think he has achieved a certain level of respect within the profession through years of service. And with that he says comes the responsibility to be honest and knowledgeable.

"People ask me questions and look up to me, so I don't want to let them down," he says.

Dunn had that in mind with some new initiatives in his pharmacy. He does a lot of wound care, and in the latter half of 2019 he introduced a line of wound care products from a company called Patch. Dunn says that some patients are allergic to standard commercial bandages and find the Patch products to be more comfortable. But he knew that it needed publicity, so he enlisted a woman on staff with an artistic bent who drew a panda, and an end cap was created.

"When you walk into the store, it's the first thing that you see," Dunn says.

Dunn also became interested in

the emerging CBD market. But he wasn't going to just jump in without doing his homework. "I'm not going to put my name on something I haven't investigated thoroughly," he says. Dunn heard about a particular company that tweaked his interest. Wanting to find out more he traveled to the company's headquarters last fall for some educational sessions and a tour. He left convinced it was a company whose products he could endorse and sell in his pharmacy. Dunn created a display with his photo in a field, surrounded by what he considers commonly asked questions patients might ask about CBD. He also created signs for the store and distributed 35 others in his



market area ahead of a presentation and Q&A about CBD he held at a local technical college.

As a tireless advocate for community pharmacy, Dunn says that having distinctive items publicized effectively can provide a competitive edge.

"It gives us an opportunity to have things that the chains don't have because they don't know about it, and more millennials are going toward more natural products," he says. "And products aren't going to sell themselves. You need to market them, and you need good signage."



### **Fast Facts: Jasper Drug Store, Jasper, Ga.**

<b>Established:</b>	1952
<b>Management:</b>	Jack Dunn, owner (his father, Lee, opened the pharmacy in 1952)
<b>Products &amp; Services:</b>	Includes standard retail, CBD and other natural products, wound care, compounding, medication therapy management, medication synchronization, immunizations, diabetes products and education (including socks, shoes and fittings), weight management, blood pressure control, smoking cessation, natural medications, and long-term care services.
<b>NCPA member since:</b>	1973

# BEST EXTERNAL REMODEL

## *Cheek and Scott Pharmacy, Lake City, Fla.*



Cheek and Scott Pharmacy, a northern Florida-based company with three locations, was leasing some property in Lake City, and was eyeing a bank building a block away that was expected to come up for sale. President and pharmacist Jeff Scott said it was located on a corner with a red light, which made it desirable for traffic flow purposes. Eventually, it did go on the market, Cheek and Scott purchased it in July 2018, and it was opened for business in March 2019.

As buying old bank buildings has become something of a trend, Scott says he talked to a few others who had done so and they joked about the vaults and the giant doors, and what to

do with them.

“I was told it might be \$10,000 to remove the door and get it outside,” Scott says. “I was like, ‘OK, we’ll figure something else out.’”

Scott said the entire back of the building had bullet-proof glass. Much of that was replaced by solid walls, with an atrium-style window installed for natural lighting.

The building had four drive-thrus, and as Scott says, “I don’t know of any pharmacies that have four drive-thrus.” So two were removed, leaving two that are roomy enough for any type of vehicle to go through.

The top of the roof in the center of the building has a cupola, and Scott says he was unsure what to do with it. Eventually a large “Rx” was installed. “People were like, ‘That is great.’ And we laughed because we were just trying to fill a hole, and it turned out spectacular,” he says.

The interior was also completely gutted and designed for maximum efficiency and modern amenities. Six people work there on a typical day, Scott says, with the pharmacy primarily doing standard retail prescriptions and a weight management program. He says the community has reacted positively, with a steady flow of new patients.

When asked what advice he would give to others considering a similar project, Scott says with a laugh, “Pray a lot and get a great contractor.”

Scott says a strong faith plays a large role in many of the pharmacy’s decisions, such as purchasing the new building. “We’re super happy with how things have turned out,” he says, before adding, “Of course I will be happier when we pay the mortgage off.”

### Fast Facts: Cheek and Scott Pharmacy (three locations in Florida)

<b>Established:</b>	1965
<b>Management:</b>	Jeff Scott, president
<b>Products &amp; Services:</b>	Includes standard retail, online refills, medication synchronization, OTC, weight loss, immunizations, medical equipment, free delivery, and text notifications.
<b>NCPA member since:</b>	2001

# BEST EXTERIOR SIGN

## *Elmore Pharmacy, Red Bluff, Calif.*

Pharmacist Bianca Bradshaw is a bit of a history buff when it comes to Elmore Pharmacy in Red Bluff, Calif., which she has owned since 2014. R.H. Elmore purchased the lot at 401 Walnut St., in 1906 and constructed the pharmacy that exists today. She keeps plenty of antique pharmacy items and documents on display at the store. From her research Bradshaw knows that a pharmacy has operated there since 1861, and she believes it is the oldest continuously operated pharmacy in California. “I have the list of everyone who has ever owned it,” Bradshaw says.



Another part of the pharmacy’s history is its distinctive sign mounted on the building’s exterior. Bradshaw has not been able to determine when the sign was first installed, but her best educated guess is sometime in the 1950s.

In 2017, that part of history was threatened when a windstorm knocked the sign loose from its mountings. “It was it was literally flapping in the wind, which was quite scary,” Bradshaw says.

Bradshaw says a sign company came

by quickly and removed it from the building. But she says it took more than a year to get it refurbished and back in its familiar perch.

“Apparently there’s a lot that goes into getting the measurements and calculations right on neon,” Bradshaw says. She says the Red Bluff community rallied around the pharmacy, with people offering to make donations toward the repair and restoration.

“Fortunately I had exterior sign insurance included in my plan, which

was amazing because I had no idea I even had that,” she says. “One person offered \$1,000. Of course I didn’t take it, but it was so generous to offer.”

Bradshaw says the sign went back up in March 2018. Other than the repair, nothing was changed. “We tried to stay true to the original sign as much as possible,” she says.

The community quickly noticed when the sign was back. “We had people come in off the street and say what a beautiful sign it was,” Bradshaw says. “It was amazing.”

### Fast Facts: Elmore Pharmacy, Red Bluff, Calif.

<b>Established:</b>	1906 (A pharmacy has been in continuous operation on site since 1861.)
<b>Management:</b>	Bianca Bradshaw, owner
<b>Products &amp; Services:</b>	Includes standard retail, combo med program (combination of long-term care and retail), bubble packing for patient facilities and outpatient mental health patients, free local delivery, and gifts. Plans include increased focus on homeopathic solutions through natural and functional medicine.
<b>NCPA member since:</b>	2014

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**"I see this program as the future of our profession. This fits into what I am planning to implement in our pharmacy practice. Thank you for providing this to us. Let's keep the conversation going."**

*- Tim Mitchell, Mitchell's Drug Stores, Oct. 2019*



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# SURTHRIVAL

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## SERIES™



## The value of clinically integrated networks

by Chris Linville

*In November 2019, NCPA announced the SurThrival series. Through October 2020, America's Pharmacist® is assembling some of the country's top experts in the pharmacy industry each month to share their insights on business, marketing, technology, personnel management, and much more. It's what every independent pharmacist needs to know to survive and thrive in a changing marketplace.*

The term “clinically integrated network,” or CIN, is fairly new to pharmacy, so some pharmacists might not be familiar with what it is. In basic terms, a clinically integrated network is a collection of health care providers that demonstrate value to the market by working together to facilitate the coordination of patient care across conditions, providers, settings, and time to improve care and decrease overall health care costs. In pharmacy world, proponents believe – and have evidence to support this belief – that clinically integrated network of pharmacies provide value to the overall health care system. In doing so, and agreeing to be accountable for the results, a clinically integrated network of pharmacies is able to engage with payers to receive a share of the dollars that payers save in patient care costs as a result pharmacies clinical integration efforts.

### MEDICAL SIDE IS THE MODEL

“When considering the necessary steps to ensure that community pharmacy practice is sustainable, I often look to the medical side to see how they are doing things,” says Troy Trygstad, PharmD, MBA, PhD, executive director of CPESN® USA. “Clinical integration has been around for decades on the physician and hospital side. A clinically

integrated network consists of separate providers joining together and agreeing to be accountable for the quality and value of care that the network participants provide. By clinically integrating, the participants express value, both individually and collectively, to the marketplace. Being accountable gives the participants an incentive to achieve the quality improvements and overall cost savings promised by the network as a whole. A clinically integrated network successfully and lawfully implements the concept of separate entities engaging in a group effort that promotes competition by lowering costs and delivering value. In short, a better ‘mousetrap.’”

An accountable care organization is an entity that is operating as part of the Medicare ACO programs. But often, Medicare ACOs operate as CINs outside of the Medicare payer space. That is because of the similarities between the purpose and operation of an ACO and that of a CIN. For example, both the Medicare ACO program and CIN engage with payers on population management, and scaled-clinical care opportunities. Based on numbers in *Becker's Hospital Review*, Trygstad says there are more than 500 CINs on the medical side of the house.

Pharmacies are not permitted to participate in the Medicare ACO program, but the term ACO is widely known. So, because of the similarities between ACOs and CINs, in Trygstad's view, it made sense to bring the concept of accountability to the pharmacy world. “There are thousands of pharmacies out there that want to bring new services to the marketplace, but cannot do it individually.” He says CPESN USA is the nationwide network of accountable pharmacy networks that can fill that void.

“Engaging in health care provider contracting that rewards clinically integrated, accountable providers in 2020 is expensive. It requires a lot of infrastructure, legal and data and otherwise,” Trygstad says. “So to have a shared services provider that is managed and governed by the providers themselves, that collects clinical data to reduce

*“A clinically integrated network successfully and lawfully implements the concept of separate entities engaging in a group effort that promotes competition by lowering costs and delivering value. In short, a better ‘mousetrap.’”*



variation in practice, and brings new services to the marketplace with accountability, selectivity of pharmacies, and practice transformation – all those efforts make it easier for payers to enter into contracts as compared to individual contracts with each provider.”

Kacee Blackwell, PharmD, works with Pharmacy Providers of Oklahoma in Edmond, Okla. PPOk is a pharmacy services administration organization founded in 1985 to help pharmacies contract with PBMs when negotiating or dispensing. Since 2016 Blackwell has led PPOk’s CPESN efforts through its Rx Select network.

“As we know, most people look at pharmacies all the same, that they are just providing drug products, and that’s not what we are trying to accomplish with CPESN,” Blackwell says. “That perception is outdated. We are trying to be reimbursed for the services that we provide” as a CIN. “When it comes to contracting [being a CIN] is a big benefit because they don’t have to contract with something like 200 different pharmacies; they can sign a single signature contract that can cover the entire network.”

#### **SHOW THEM THE VALUE**

Blackwell says demonstrating value and flexibility within the network usually gets a good response.

“We’re working with a health system to bring a pharmacist on board a couple times a month to do medication management appointments with their patients,” she says. “And in those first meetings we brought the pharmacist in and he spoke to the primary care physicians, and they immediately asked who the contract is between – is it between [physicians] and the pharmacy, or [physicians] and the network? And when they found out they could contract with the network and potentially expand this to other clinics and other pharmacies within our network and with theirs, it was really positive for both sides.”

#### **DOCUMENTATION IS CRITICAL**

As Blackwell points out, “If you have not documented your services, nobody knows that you did it. So documenting everything comes in handy in a lot of ways – with liability and also payer level of reimbursement, so they know you have provided the services that you said you provided.” She says they can also see the value that those services provided in terms of improved patient outcomes, which help to reign in overall health care costs. “Internally it [enables] [participants] to measure and track all of the things that you do that are beyond dispensing. So get engaged with eCare plans, find a platform that works for you and your staff, and make sure that you know how to use it.”

*“If you have not documented your services, nobody knows that you did it. Documenting everything comes in handy in a lot of ways – with liability and also payer-level of reimbursement. That way payers know you have provided the services that you said you provided.”*



### BREAKING DOWN BARRIERS

When pharmacies have basically been doing their own thing for so long, Blackwell working with other pharmacies to offer a new type of health care delivery to the marketplace is a new experience. But although some participants are competitors in services outside of the network, they understand the value of working together in an integrated way to improve performance.

"It's a barrier sometimes to engage those who aren't quite ready, and when you have some of them doing clinical services for quite some time on their own," she says. "One thing that our network will use eCare plans and other data for is to create and share a scoreboard with the entire network on how each pharmacy is doing on eCare plan documentation. Data collection will give payers the opportunity to see network performance and value of contracting with the network."

### ENSURING CONSISTENCY OF CARE

In terms of short-term goals, Blackwell says they include aligning efforts with the Flip the Pharmacy initiative and getting a standard service level across the pharmacies in the network.

"There is quite a bit of variance in the level of service provided at Pharmacy A versus Pharmacy B," she says. "If we are going to get engagement from payers, they want to know that they are paying for a specific service set. It's important that they can be assured that members are going to get that same level of service regardless of which pharmacy they go to in the network." ■

Chris Linville is *America's Pharmacist*® managing editor.

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### KEY TAKEAWAYS

- Demonstrate your value as a network to potential payers.
- Thoroughly document all of your services.
- Don't be afraid to delegate tasks to staff.
- Have standard consistency of care across all network pharmacies.

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# CONTINUING EDUCATION

## Care planning in community pharmacy

by Cody Clifton, PharmD; Simon Anderegg, RN, BSN; and  
Cody Turner, PharmD candidate.

**Mar. 1, 2020 (expires Mar. 1, 2022)**

**Activity Type: Knowledge-based**

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**ACPE UAN: 0207-0000-20-300-H04-T**

**Upon completion of this article, the pharmacist and pharmacy technician should successfully be able to:**

1. Discuss the need for interoperability standards in health care technology.
2. Describe the Pharmacist eCare Plan and how it is used in community-based pharmacy practice.
3. Identify the benefits to implementing care planning into community-based pharmacy workflow.



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Breakthroughs in modern medicine have created antiviral drugs that could help prevent HIV and identified methods to grow entire body parts in labs from stem cells. Real-time language translation has been achieved by coupling voice recognition technology with artificial intelligence. These innovations are changing the world as we know it, while the health care technology industry is simply trying to figure out how to take patient information from one system and transfer it to another.

Exchanging patient information between health care settings may not seem like a revolutionary concept, but it has been an ongoing effort for decades. We must continue to strive for advancement and innovation in this facet of our health care system just as we do elsewhere. The Pharmacist eCare Plan aims to break interoperability barriers, improve chronic disease management, and leverage the unique skill set of pharmacists as integral members of healthcare teams.

**A brief history of health care interoperability**  
In 2009, the Health Information Technology for Economic and Clinical Health Act was passed to promote the adoption and meaningful use of health information technology. Specifically, the act required the establishment of an incentive program by the Centers for Medicare & Medicaid Services and technical standards from the Office of the National Coordinator for Health Information Technology which would promote the “meaningful use” of electronic health records. This was one of the first major efforts to improve health information technology capabilities and work toward achieving seamless exchange of patient information electronically to provide better continuity and quality of care to patients.

Once foundational requirements were in place, the technological focus shifted from building out data-sharing capability to finding the optimal method of conducting data exchange. However, because health care providers were the ones incentivized, not the contracted EHR vendors, each EHR platform was built using unique data elements, data models, and reporting specifications, and often tailored to the organization being contracted. Needless to say, modifying these already complex platforms with the capability of readily exchanging data with other platforms has proven to be an arduous task.

### **DATA EXCHANGE FORMATS**

Since each EHR software platform is uniquely complex and dissimilar, one platform cannot exchange every fragment of data collected with another. Instead of redesigning each system from the ground up, systems exchange electronic clinical documents which follow

a simple, *standard format* and are coded using a *standard language*, allowing for seamless data transfer that is readable by any system. This results in the ability to accurately transmit health information between organizations.

One standard format called C-CDA, consolidated-clinical document architecture) defines how electronic clinical documents should be organized at the data field level so the intended clinical purpose and meaning is preserved during an exchange. Examples of C-CDA document templates in EHR software include the history and physical continuity-of-care document, discharge summary, and progress note. Each C-CDA document contains patient information for a specific-use case. For example, the H&P contains background information that is relevant for a routine checkup or hospital admission, including the patient’s problem list, allergies, current medications, family history, and past procedures, to name several.

Think of C-CDA format as a guideline or a table of contents for exchanged clinical documents, providing a framework for communication between completely different systems. Any health care organization can exchange data with another if they can query, or access, its own stored patient data, organize that data into C-CDA documents, and send C-CDA documents. Likewise, their software platform must have the capability to read C-CDA documents, parse data from them, and store data in the appropriate areas of the EHR. It matters little where data is stored in each system, how data is pulled into the documents, or how data is pulled out of the documents. What matters is that the system is able to manage data based on the C-CDA framework.

Over the past few years, the industry has transitioned from C-CDA to a newer data format standard called FHIR (fast healthcare interoperability resources), which helps to further improve interoperability. FHIR opens the door to exchanging not only clinical documents, but all health-related data. It essentially breaks C-CDA format into smaller, more modular pieces of data. Those smaller pieces of data can be used for multiple purposes.

Structuring data in a standard format using C-CDA or FHIR provides a framework for exchange, but systems must also understand the content down to the data element level. For incoming data to be interpreted effectively, it must also be written in a standard language. For two people to communicate, they must understand the meaning of all (or most) of the words spoken to each other; they must have a common vocabulary. Technology is no different. In the context of health information

exchange, this is achieved by establishing public clinical vocabularies for terms used in health care settings. These clinical terminology vocabularies are massive databases that simply assign clinical terms with a corresponding numeric or alphanumeric code. They are so comprehensive that each specializes in specific types of clinical data. SNOMED CT, RxNorm, LOINC, and CVX are all examples of clinical data vocabularies that have been made into language standards. SNOMED CT contains codes for all clinical findings and procedures, RxNorm for all medications, CVX for immunizations, and LOINC for laboratories and vitals.

When “metoprolol succinate” appears on a patient’s medication record, clinicians see just that, but what lies beneath is a code that represents “metoprolol succinate” like “ABC123.” Codes are used to represent clinical terms because computers and software cannot process free text as humans can. Even humans have occasional difficulty interpreting free text due simply to the nature of written language and the endless variation it yields. Take the following medication order for example.

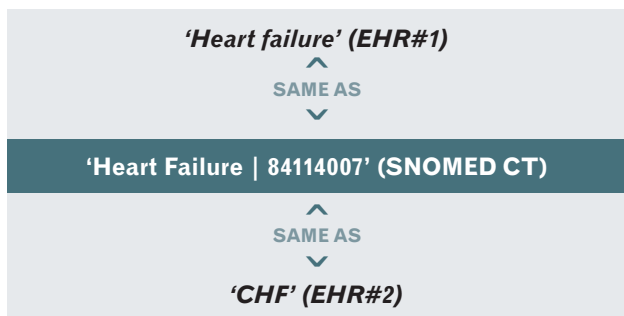
**Medication order** Metoprolol 1 50 mg tablet twice daily for seven days

Not only is this entry difficult to read but imagine the many ways it can be interpreted. It is not a stretch to assume the person reading this medication order doesn’t know what specific type of metoprolol is ordered here and that “1 50 mg tablet” could easily be read as “150 mg tablet.” The way interpretation errors are avoided in this instance is by breaking the free text order down into as many specific fields as possible. Because every medication order includes the same basic elements (such as dose quantity, dose strength, and frequency), they can be displayed by default in every medication order, so clinicians are only left with the responsibility of simply filling in the respective box. The following is the same medication order written using discrete data elements.

Medication order using discrete data elements	
<b>Medication name</b>	Metoprolol succinate
<b>Dosage quantity</b>	1
<b>Dosage strength</b>	50 mg
<b>Dosage form</b>	Oral tablet
<b>Frequency</b>	BID
<b>Duration</b>	7 days

These boxes can even be connected to our standard clinical vocabularies. The field “Medication name” can be linked to the entire RxNorm library containing every medication that can be prescribed. Using discrete data elements in this manner avoids the variability and potential errors introduced by free text and lends clinical documentation the ability to be codified so it can be exchanged among different organizations.

The contents of our standard clinical vocabularies amount to millions of codified clinical terms. Theoretically, almost everything in a patient’s chart can be documented using only discrete data elements from standard clinical vocabularies. The health technology industry is striving toward EHR software systems achieving that capability, but because the standard clinical terminology databases are so expansive, they can be used as a place to start to help organizations communicate. Systems that assign clinical terms with their own, non-standard internal codes can use standard clinical vocabularies as a translator when exchanging data via C-CDA or FHIR documents.



### THE PHARMACIST ECARE PLAN

Care plans have proven to be critical for chronic disease management, as most chronic disease interventions require ongoing monitoring, periodic assessment, and frequent adjustment. People often suffer from chronic diseases for several decades of their lives, during which unexpected hospitalizations, switching health care providers, and facility changes are likely to occur. These circumstances require continuity of care. The Pharmacist eCare Plan takes one of the most important tools in chronic disease management and extends its potential to allow for ongoing utilization by multiple providers and health organizations.

The Pharmacist eCare Plan is an electronic care plan, but it is much more than that. The eCare Plan contains all the basic information of a traditional care plan residing in an EHR but with a focus on medication management (see pharmacist eCare Plan basics figure).

### Pharmacist eCare Plan basics

- Patient demographic information
- Encounter reasons & type
- Payer information
- Allergies
- Medications (prescription fill history and/or active medications)
- Interventions & education
- Referrals
- Care coordination
- Patient goals
- Outcomes
- Problem observation & encounter diagnosis
- Assessments
- Self-care activities
- Mental status observation
- Smoking status
- Functional status observation
- Lab results
- Social history
- Vital signs
- Caregiver characteristics
- Immunization

The Pharmacist eCare Plan was built with interoperable data standards to allow for integration with any clinical documentation software at any health organization. The eCare Plan Standard is structured using the standard formats, C-CDA and FHIR, so it can function just like discharge and progress notes.

The Pharmacist eCare Plan also leverages standard clinical languages, so any organization anywhere will be able to understand its data contents. The same basic principles from the “metoprolol succinate” medication order example provided earlier have been applied to a traditional care plan below. Every possible segment of free text and unstructured data in each section was replaced with discrete data. For example, below is the allergies section of the Pharmacist eCare Plan and what it could look like when completed.

### Pharmacist eCare Plan: allergies

<b>Allergen code</b>	735029006
<b>Allergen display name</b>	Shellfish (substance)
<b>Allergy reaction</b>	Anaphylaxis
<b>Allergy onset date</b>	04/12/2018
<b>Allergy onset time</b>	19:00

The Pharmacist eCare Plan can capture information pertaining to all aspects of medication management, along with a variety of other non-medication related information about a patient’s health, which provides benefit to the entire care team. It may be called the “Pharmacist” eCare Plan, but one of the benefits of this electronic document is its multi-provider utility. Many of the components that exist in the eCare Plan overlap with the components in other electronic clinical documents such as EHR. This makes the eCare Plan an excellent tool for care coordination. Since structured data documentation (such as C-CDA and FHIR) are all built using the same interoperability principles, entire data sections from one document can be pulled into another document that includes the same section. For example, the allergies and medications section of an H&P can be used interchangeably with those sections in the eCare Plan.

Americans average approximately three primary care visits each year. According to North Carolina Medicaid claims data, a portion of their high-risk population visits the pharmacy more than 35 times each year. More direct patient encounters mean more opportunities to collect patient information, update active medications, track intervention outcomes, give immunizations, take vitals, obtain lab results, and provide education. All this information and these interventions, which are supported by the Pharmacist eCare Plan, are critical in chronic disease management, a facet of our health care system that desperately needs greater attention.

### WHAT COMMUNITY PHARMACISTS NEED TO KNOW AND WHY THEY SHOULD CARE

The Pharmacist eCare Plan is complex and has many facets. Community-based pharmacists are not expected to be experts on the detailed technical requirements, implementation specifications, or so called “behind the scenes” logistics of the eCare Plan. However, community-based pharmacists should be able to understand how to implement care planning into practice in order for the value provided to be expressed.

Care planning and documentation are two sides of the same coin; both bring value to the pharmacy and patient care in multiple ways. For example, when a patient requires your attention or time over the phone and by the end of the call you know what needs to be done and what the patient wants when they arrive, does everyone (or anyone) else know what was discussed? How do you communicate this information to other staff? Now, you might have written down the highlights on a paper note in the pharmacy, but what if you leave before the patient arrives? What happens if the note gets lost? This is why consistent documentation and continuity of care in your system are so valuable. By documenting what was discussed in a care plan for this patient, you create an environment where everyone in the store is capable of continuing the care that you were providing, without the need for time delays and disruptions trying to find an answer or clarify a point, allowing everyone to be on the same page with what this patient needs.

Another important aspect of the eCare Plan is its utility to third-party payers. This type of documentation allows pharmacists to not only effectively communicate their contributions to the health care team, but also to payers, thus demonstrating the value pharmacists bring to patient care. By documenting patient interventions and health information, pharmacists are creating a “paper trail” of the ways they improve patient outcomes and reduce cost to the health care system.

The quality of the information that is collected in these records has been tied to third-party contracts that allow pharmacies to be paid through new revenue streams such as the medical benefit (as opposed to the standard prescription benefit). The importance of this to the pharmacy business warrants taking proactive steps to prepare your pharmacy to implement care plan documentation into workflow sooner instead of later to be prepared for this new payment mechanism.

Implementation is not something that happens overnight. It takes time. Documenting the services performed in your pharmacy can take place at different steps in your workflow and can vary among pharmacies. Analyzing your workflow now to determine where documentation best fits will prepare you when payments through the medical side begin to occur. Taking the initial steps of knowing how to use these platforms to create that internal continuity for your staff can allow you to learn the best way to implement documentation in your pharmacy.

To best start care planning in your pharmacy, start small. Identify one service to focus on at a time. For example,

every time you add a new patient to your medication synchronization process, you can document that intervention and patient encounter in a care plan. There are several examples and templates that can guide you as you begin to revamp your workflow. These templates can be accessed at [www.flipthepharmacy.com](http://www.flipthepharmacy.com) and [www.ecareplaninitiative.com](http://www.ecareplaninitiative.com).

Another best practice for care planning is to engage your entire staff in the process. For care plan documentation to be successful, effective, and efficient as discussed earlier, you need to generate buy-in from the whole team.

### **THE PHARMACIST ECARE PLAN IN PRACTICE**

Today, the Pharmacist eCare Plan is being used by more than 2,000 pharmacies across the country. Initially, the Center for Medicare & Medicaid Innovation provided a grant to Community Care of North Carolina where the eCare Plan standard was developed and implemented. Pharmacy software vendors tested the eCare Plan standard within North Carolina. North Carolina pharmacies embarked on a value-based payment model in order to be reimbursed for enhanced services offered to patients which were documented and submitted to CCNC as an eCare Plan. This is a practical example of the eCare Plan used successfully as a clinical documentation system for sharing among care team members and to receive reimbursement.

CPESN<sup>®</sup> USA, an accountable pharmacy organization/clinically integrated network of community-based pharmacies from across the country, was developed from the multi-state collaboration that began in North Carolina under the CMMI grant. CPESN pharmacies that have been members for at least six months are required to document using the Pharmacist eCare Plan as a reporting standard. Currently, there are 13 technology solutions partners who offer the capability of submitting eCare Plans. The goal with this strategy is to aggregate clinical care data from community-based pharmacies providing care across the country to support reimbursement for enhanced services by payers.

Another example of pharmacies utilizing the eCare Plan is within the Flip the Pharmacy initiative, in which the Community Pharmacy Foundation is providing an opportunity for pharmacies to undergo practice transformation efforts. These efforts include additional direction about eCare Plan documentation. In the first cohort, which lasts for 24 months, more than 500 pharmacies across the country are receiving direction from CPESN USA, the Flip the Pharmacy Coordinating Center, and practice transformation coaches to transform their practices from

prescription-level (moment-in-time) to patient-level (care plan-over-time).

One last set of examples are those CPESN pharmacies involved with eCare Plan documentation, in which they document the care they provide to patients by using the eCare Plan. The care plan acts as a way to communicate care plan information to the payer and in return, this supports the pharmacies to receive a per-member-per-month payment. There are many instances of this happening across local CPESN networks and their CPESN pharmacies.

The eCare Plan may also be used to exchange data between providers for care coordination purposes within interdisciplinary teams. In one specific instance, the eCare Plan is being used as an interoperable exchange of data between pharmacies and an EHR system. Even though this is not universal at this time, the eCare Plan is ready for this capability with EHR systems operating under the C-CDA and FHIR standards. Additional opportunities will arise in the next few years as pharmacies and health systems continued to be incentivized to collaborate in value-based care models.

Support for further adoption is starting to take place in other organizations. For example, the Pharmacy Quality Alliance is testing quality metrics that leverage SNOMED CT codes, which are used in the eCare Plan. As more organizations adopt standards such as SNOMED CT for clinical reporting and the eCare Plan for interoperability, the need for the eCare Plan will continue to increase.

Innovations in health care data interoperability present an opportunity to improve health outcomes and communication. The Pharmacist eCare Plan targets needs in chronic disease management by using a proven tool and expanding its potential use among multiple providers and health organizations. Incorporating the eCare Plan in practice gives pharmacists the opportunity to apply their medication management expertise in chronic disease care teams and assume leading roles in patient care coordination ■

Cody Clifton, PharmD, is director of practice transformation at CPESN® USA. Simon Anderegg, RN, BSN, is clinical systems analyst at DocStation. Cody Turner is a 2020 doctor of pharmacy candidate at the UAMS College of Pharmacy.

# CE QUIZ

## Continuing Education Quiz

Select the correct answer.

1. What is the name of the act passed to promote the adoption and meaningful use of health information technology?
  - a. MACRA
  - b. ACA
  - c. HITECH
  - d. 21st Century Cures
2. Match the following clinical terminology vocabulary codes to their type of data:

a. SNOMED CT	1. Laboratories and vitals
b. RxNorm	2. Immunizations
c. CVX	3. Clinical findings and procedures
d. LOINC	4. Medications

  - a. A3, B4, C2, D1
  - b. A2, B4, C1, D3
  - c. A1, B2, C3, D4
  - d. A4, B1, C2, D3
3. Health care data exchange:
  - a. Includes standard format examples such as C-CDA and FHIR.
  - b. Involves transfer of data following a standard format.
  - c. Uses codified standard language.
  - d. All of the above
4. The Pharmacist eCare Plan contains all the basic information of a traditional care plan residing in an EHR, but is focused on:
  - a. Telepharmacy
  - b. Medication management
  - c. Electronic prescribing
  - d. Transitions of care

- 5.** The Pharmacist eCare Plan was built with interoperable data standards to allow for integration in any clinical documentation software at any health organization
- True
  - False
- 6.** Technological standards are needed for electronic health information exchange because:
- They allow two different systems to speak the same language.
  - They allow two different systems to communicate in the same manner.
  - They improve the quality of patient information being transmitted.
  - All of the above
- 7.** The benefits to care planning include:
- Continuity of care.
  - Workflow efficiency.
  - Third-party payer opportunities.
  - All of the above
- 8.** When implementing care planning into workflow, it's best to:
- Pick one staff member to do all of the care plans.
  - Expect to be an expert overnight.
  - Start small and focus on one type of intervention at a time.
  - Wait until the end of the day to document everything.
- 9.** There are currently no examples of eCare Plan integration with EHRs.
- True
  - False
- 10.** Which of the following are not sections of the Pharmacist eCare Plan?
- Care coordination
  - Vital signs
  - Allergies
  - All of the sections listed are part of the Pharmacists eCare Plan.
- 11.** Care planning is important for third-party payers because:
- It shows how much time is wasted getting prior authorizations.
  - It demonstrates the value pharmacies bring to patient care.
  - It provides robust dispensing analytics.
  - None of the above
- 12.** Community-based pharmacies are currently documenting eCare Plans within their practices utilizing technology solutions partners who have adopted the eCare Plan standard.
- True
  - False
- 13.** The Pharmacist eCare Plan is used in practice today:
- For sharing patient information among health care team members.
  - To support reimbursement for enhanced services.
  - To communicate patient information to payers.
  - All of the above



## How technology can mitigate challenges with medication-related transitions of care and readmission

By Brent Fox, PharmD, PhD

There are two persistent challenges that continue to vex health care professionals because of costs and their consequences for patients – the culprits being unplanned 30-day hospital readmissions and transitions of care.

Here's a bit of background on transitions of care. The National Transitions of Care Coalition defines it as the “movement of patients between health care locations, providers, or different levels of care within the same location as their conditions and needs change ... within settings, between settings, across health states, and between providers.” The Centers for Medicare & Medicaid Services is the primary player in the readmissions domain, which focuses on reducing unplanned readmissions to the same or another acute care hospital within 30 days of discharge from the original admission.

According to its *Medication Safety During Transitions of Care Toolkit*, the American Society of Consultant Pharmacists notes that nearly 80 percent of serious medical errors involve communication during transitions between care settings. Of the 20 percent of patients who experience an adverse event transitioning out of the hospital, 66 percent are related to medications. Also, approximately 13 percent of nursing home residents require an emergency department visit or hospitalization within 30 days of transitioning home. Clearly, transitions are complex events that require coordination and collaboration.

### THE PHARMACIST'S ROLE

This is where community pharmacists can step in to help. As the medication experts, pharmacists are the ideal providers to counsel patients on appropriate medication use. Adherence methods and tools are additional low-hanging fruit. Additionally, pharmacists should collaborate with other providers to optimize medication therapy, including reconciling medication lists. These and other interventions rely on information, which in today's pharmacy world is largely digital in nature. However, as pharmacists know, access to and the sharing of this information can be problematic.

### SIMPLE TECH INTERVENTIONS BRING RESULTS

Pharmacists should equip their tool belts with a variety of methods to obtain information about patient medication-related behaviors. For example, is a 75-year-old patient a likely candidate for short message service-based (text-based) adherence interventions? You might be surprised to learn that 40 percent of adults born before 1945 (the Silent Generation) own a smartphone. Granted, not every 75-year-old patient wants a text message, but the smartphone is a viable information-sharing method for nearly half of the oldest patients, who are often transitioning between levels of care. Other data suggests that technologies found in virtually all community pharmacies can positively affect the transition process.



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# UPCOMING EVENTS

[www.ncpanet.org/calendar](http://www.ncpanet.org/calendar)

- March 18-20**    **Ownership Workshop,**  
sponsored by McKesson  
Washington, D.C. metro area
- April 21-22**    **Congressional Pharmacy Fly-in**  
Washington, D.C.
- June 12-14**    **Ownership Workshop,**  
sponsored by McKesson  
Dallas
- Oct. 15-17**    **Ownership Workshop,**  
sponsored by McKesson  
Nashville, Tenn.
- Oct. 17-20**    **NCPA 2020 Annual Convention**  
Nashville, Tenn.

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### IVR PROVIDES ENCOURAGING RESULTS

One study explored the role of interactive voice response (IVR) and videos in heart failure patients transitioning home from the hospital. IVR-based calls explained concepts and behaviors related to heart failure, with visual aids provided in brief videos. Among patients who answered the IVR calls, 66 percent reported their weight at 14 days, while 93 percent reported their weight after 45 days. An encouraging sign is that patients who viewed the videos seemed willing to take specific actions related to their health condition. This project reinforces the notion that simple technology-based interventions can yield meaningful results.

### LINKING PROVIDERS

What about sharing information between providers? Considerable effort has focused on increasing links between physician offices and hospitals, but pharmacy has not been the prime focus of these efforts. Existing tools that allow standardized data sharing include the continuity of care document and the direct protocol. These functions are already found in some pharmacy systems today. An important pharmacy-specific initiative is the Pharmacist eCare Plan, which can be implemented in more than one communications standard, thus making it more likely the receiver can consume

the data. The standards-based nature of the Pharmacist eCare Plan allows medication-related information sharing among the patient, pharmacist, and other members of the care team. The ultimate Pharmacist eCare Plan goal is to bring a holistic understanding of medication-related aspects of a patient's care, including the pharmacist's assessments, plans, and interventions. Pharmacy management system vendors must implement the Pharmacist eCare Plan in their systems prior to its use.

Despite the challenges pharmacy faces, the pharmacist's ultimate responsibility is the patient. Today's patients and the health care environment they navigate is quite different than just 10 years ago. The focus on readmissions and transitions of care creates an opportunity for pharmacists to help their patients while addressing a costly problem for the health care system. Existing and emerging technologies can provide valuable methods to engage patients and share information with the care team. ■

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# FRONT-END OVERHAUL



## What kind of rumors are the front of your store spreading?

by Gabe Trahan

When Hugh Chancy, RPh, purchased Arwood Drug, he wanted the people of Moultrie, Ga., to know that something good was about to happen. A new life was about to be given to a treasured neighborhood landmark.

On day one, Hugh knew that the exterior of the Arwood Drug store was looking worn, outdated, and was sending the wrong message. The front of the store was spreading rumors, and those rumors had to change. New and more positive stories needed to be spread as financing and designing the facelift became a priority. Making the facelift priority one makes good sense, as the front of the store is in charge of first impressions, and with potential new customers, first impression is paramount.

Most business owners calculate a budget by looking at a history of sales. Hugh's budget was based on

future sales, not old business. After all, the old business was about to change. The new look started with a fresh coat of paint accented with red awnings both on the front and side walls showcasing a bright white logo. The matching road sign has a classy look, from the top to the base of the pole. The landscaping at the ground level of the pole and in front of the store has added to the "we are here to stay" look. Hugh didn't stop there. At his own expense, he painted the exterior wall of the building next to his store. Hugh doesn't even own that building! Who does that kind of thing? Hugh Chancy does.

Ask yourself what kind of rumors are your storefront spreading? What would be the impression of someone first approaching your store? What steps must you take to improve the curbside appeal of your location? And what will your budget be based on?

Here are some ideas to get improvement in motion. Consider power-steaming the sidewalk and upgrading the lighting over the entrance. If you have tinted windows, add neon signs to the interior side of the windows and get away from that I-wonder-if-they-are-open look. Have a schedule for windows and doors to be cleaned. Fill a few potholes and stripe the parking lot. Look for missing signs! The two signs that I often find missing are "Drive-Thru" and "Compounding Pharmacy." Once you have new customers interested in your store, impress them by leaving the best parking spots for the customers. A policy that the entire staff parks away from the front of the store is just good business practice.

To complete the re-do, the store name had to be changed. With a name change, the store no longer had a history, but instead had a future. Nice work, Hugh.

Be sure to grab a copy of my new book, *Gabe's Favorite Tips*, a compilation of my favorite tips and suggestions for your store. It's now available in the NCPA bookstore at great member savings. Visit [www.ncpanet.org/gabebook](http://www.ncpanet.org/gabebook). Also, don't miss our twice-monthly *Profit Makers* publication. Find out more at [bit.ly/profitmakersignup](http://bit.ly/profitmakersignup). ■

Gabe Trahan is NCPA's senior director of store operations and marketing. Visit [www.ncpanet.org/feo](http://www.ncpanet.org/feo) to watch videos, read tips, and view galleries of photo examples by Gabe. Follow him on Twitter @NCPAGabe for additional tips.



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