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Pharmacy aims to further post-COVID transformation

Sustaining the momentum for provider status for pharmacists was a major focus of a Chain Drug Review *roundtable at the NACDS Total Store Expo. Panelists also discussed the industry's battle with pharmacy benefit managers and the investigation of PBMs by the Federal Trade Commission, as well as friction between pharmacy and the AMA.*

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WOLDT: *Brian, as the current chairman of NACDS, we'll ask you to lead off the discussion and give us your thoughts on where pharmacy stands today.*

NIGHTENGALE: I think that what you're going to hear throughout this meeting is that our industry is in a time of unique transformation, in a positive way.

There have always been times within the pharmacy industry where things happen, and it takes the profession and the industry to the next level or the next phase. And I'm convinced that we're in one of those phases right now that will reshape the role of community pharmacy well into the future. If we think about our stature within the health care ecosystem coming into the pandemic — everybody knows — highly accessible, highly trusted by the American public, within the limits of what the Americans thought and think of what a traditional pharmacy is. I think what the pandemic did was open the American public's eyes to a whole new possibility for what pharmacies can do, and the role that pharmacy can play and should play in a broader health and wellness ecosystem for this country. So, I think, all that put together, we came into the pandemic with a pretty good reputation, and we're coming out of the pandemic with an even greater one.

So, as industry leaders, we've got a great opportunity and, quite frankly, a big responsibility to work together, and to collaborate, to design the next phase of what retail and community pharmacy is and means to this country. We all know that there are challenges and barriers to that evolution right now, which we are all working together to overcome. But while we're advocating for those barriers to be removed through legislative and regulatory pathways, we can't take our eye off of that long-term future. And that's what we're going to be talking about here with NACDS 2023.

And Rina, you're leading that for us. Thank you. And you're the perfect person for it because of your vision and passion towards what the future of pharmacy should be. So I just think it's a unique time in our industry. And I could not be more proud and certainly humbled to be part of such an amazing group of leaders that, in my opinion, are going to drive the future.

WOLDT: *Steve, do you want to expand on that?*

ANDERSON: I would like to start off by thanking Brian for chairing this year. NACDS has this capacity to always have the right leader at the right time and the right place. And he's been extraordinary while being on our board, and as an officer. And I totally agree with everything that Brian said.

Some people thought the world stood still during COVID. We know it didn't happen for us. And it's just been a great opportunity to show what pharmacy can do. And that's been our role, is working with Doug and others in the pharmacy association world to develop a policy framework, so our members can do all the things they're doing.

> ***'An existential battle is going on for the survival of pharmacy right now.'***

I always ask for this number, and I think I have the latest one. But I think 260 million shots have been administered in a pharmacy setting, two out of every three, which is pretty extraordinary, if you think about it. And I mention this wherever I go, and people are just stunned. And then I ask them, did they get their shot at a pharmacy. And they say, yeah, they did.

But we're talking about a lot of issues that have rapidly accelerated, and we'll get to that today, with provider status, reimbursement. Brian was appointed by our previous chairman, Colleen Lindholz, to head up the board reimbursement task force we had. He did a stellar job in working on a whole host of issues. I guess his PhD in health economics didn't hurt either for all of us.


Steve Anderson


Brian Nightengale

But in terms of PBM reform, I think that there is an existential battle going on for the survival of pharmacy right now, and it's going to be hot and heavy for the coming years, and particularly with this FTC investigation that they announced in June. And if you want to understand where the FTC is going on this, there's a press release you can pull up pretty easily on their website, in terms of what they're going after. But we've had great success with the Rutledge decision. We'll get to that. It's amazing how much action we've had in the states. So I would just like to thank all of you for your support of NACDS, hanging with us during the pandemic. It's hard to believe we haven't had this meeting in three years. We are back in Boston, like déjà vu all over again.

Our attendance is really strong, and the NACDS Annual Meeting was extraordinary too. There was such a vibe at that meeting. This industry is all based on relationships. And, as I say, there's power in associations, by associations working together. But there's also power in *association*, where all of us get together and do good things for our industry and for the patients that you all serve.

WOLDT: *Doug, would you like to add anything at this point?*

HOEY: It's hard to add to both of those. I think the pandemic has shown the strategic importance of community pharmacy to the United States — the strategic importance, not only from a health care standpoint but just having a place that people could go.

People remember the first three or four months of the pandemic. Physician offices were shut down. Dentist offices were shut down. And it was the pharmacy where people could go to get health care. And even though that's now a year and a half old, I think part of our responsibility is to never forget, not let any of these policy makers forget — the consumers aren't going to forget. The consumers were already getting there, understanding that pharmacists are vital to their health care. And I think what this has done is propel them along the way.

Some of the federal policy makers are a little bit slower to act than the state policy makers. But I think we've created some mind space with the state policy makers on the role of pharmacy.

And I think the other extraordinary thing that's happened in the last couple of years is the Supreme Court ruling. And if you think about that, that was not looking good early on. Iowa had already lost a similar case. Arkansas was about to — or did lose in the Eighth Circuit. And unsung hero, Leslie Rutledge from Arkansas, decides to appeal to the Supreme Court, and they accept the case. And that has been a tremendous tipping point for state legislation in the regulation of PBMs. PBMs are the arch-nemesis that we have to overcome. So there's a lot of positive momentum for community pharmacy right now. There are plenty of challenges, but it's an exciting time for our industry.

WOLDT: *There are a lot of points we could pick up. Let's start with COVID and pharmacy's experience with the pandemic. You*

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‘We did an amazing job in the sheer number of vaccines’

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said there’s positive momentum, and there no doubt is. I think we’d all agree how well pharmacy performed. What I’d like to ask the group is what lessons have been learned, both by the industry itself and by payers and government that are going to take us forward?

JHAVERI: Thank you, Jeff. I think the biggest learning, the value, the patient care is apparent. It’s simple, right? You can see it. But I think the biggest thing that I see, which gives me a lot of hope, is that we’re speaking with one voice now. And Steve and Doug, I give you guys a lot of credit for that. One of the things that I see over my 30 years in the industry is sometimes we don’t speak with one voice. And I think what we’re achieving and why we’re achieving a lot of the wins that we’re seeing is we are coming back. And I think the second thing is, while we’re all members of this industry and while we’re all competitors, to a certain extent we also work together.

And I think there is, in itself, a huge learning in how do we, competitively and collaboratively, work together for the betterment of the profession? I think those are the two big things that — I think Brian and I were on the phone every week, and Doug and I were on the phone every week. And it seemed like Rina and I were on the phone every week. And that’s never happened to this level. And I think there is a huge takeaway for all of us in that.

SHAH: There’s definitely been internal and industry collaboration across the entire supply chain. Going forward, what we’ve learned is if you want to move fast, you really need to bring all the partners to the table together. This was the first time, I think, that we had seen all of the barriers taken down, specifically from a health plan, PBM perspective, but also from a supply chain contribution perspective, to what we do in the pharmacy scope of practice.

Moving forward, what we have seen — and what we see in Florida right now — is that legislation has passed where we can have our pharmacists test and treat. This helps alleviate the extra pressure on the health care system for non-complex types of therapies that can be provided in a community-based setting. We have payers willing to come to the table because it’s a lower-cost alternative. Iinstead of an individual getting a flu test at their doctor’s office, for example, and wasting time and effort doing so, their local pharmacy can do that.

The silver lining with COVID is that there has been momentum. It’s not as great across all 50 states or at the federal level, so we still need to ensure that we’re pushing our foot on the accelerator. At the same time, at the state level, there is quite a bit of movement.

So that has been fantastic. The other piece is that we know the legislation has been submitted. We’re focusing in on provider status. We’ve done our job of narrowing the scope as much as we can so that it feels digestible. There is a lot of excitement around that. We’ve been talking about provider status for pharmacists for 20 years.

This is the first time in my career that we’re seeing movement on this, because there is value that’s being provided to the health plan. which That value is a lower cost of care. It’s just been great to see. I’m also interested to see that this is where NACDS comes together. And so, I ask myself, what are the research studies that we can bring about to demonstrate the impact of what COVID has done to the economics, to the health care ecosystem? By being able to look at socially vulnerable areas across the country, we can better understand the impact we’ve been able to make as an industry, which will then become another value proposition that we can leverage going forward.

> ***‘Let’s remind ourselves we can achieve more, and quicker than we thought.’***

WOLDT: *Karen, you were nodding your head when she was speaking about provider status.*

STANIFORTH: I was, because it’s true that maybe more than 20 years we’ve been talking about it. And I agree with you that we’re closer now than we’ve ever been, even if it is limited and small, any start is a start. I think the other thing, from the industry perspective, with COVID was why pharmacists came together. But I think the common goal that we all had was taking care of our customers. And pharmacists all went to college for that reason. Most people went to college to become pharmacists because they wanted to — they had a higher purpose in what they wanted to do. And I think COVID truly ignited that passion again in our pharmacists, and how they took care of customers was part of that driving force as we really set out as an industry to “save the world.”

We really did an amazing job, in just the sheer number of vaccines. So many people said to me, “You know, until COVID I didn’t know I could get a shot at a pharmacy.” I took that for granted, that everybody knew that. There were so many people that didn’t realize that. So I think that was sort of the beginning of everything that we’re going to work on now together, over the next few years.

And the other thing that we all showed during COVID was — you asked about learning. You know, we figured it out. And we figured it out very quickly. Things that maybe we had talked about in a previous time we took too long to get done, we were able to make those decisions and do what we had to do, because speed was imortant. That showed as well that if we all put our minds together and work together, what can we really achieve? And I think that point is what’s going to be really important for the future of the work we do together. Let’s just keep reminding ourselves that we can achieve more, quicker than we thought, based on what we did *together*.

BELKNAP: From a manufacturer standpoint, it was really the best practices and learnings around supply chain. And it came down to collaboration and transparency. We never had this level of collaboration before, between manufacturers, the wholesalers and the downstream retailers and hospitals. The system worked; we just had to let it. Those learnings have helped us with other issues that we’ve faced beyond COVID. So I think that was a very positive thing that came out of it.

WOLDT: *Debbie, the supply chain is your area of expertise. Maybe you could talk a little bit about what you saw and the challenges that you faced during COVID.*

WEITZMAN: The pharmaceutical supply chain held up incredibly well during COVID. And while we are beyond that time and essentially back to business as usual, we are dealing with challenges that are a by-product of the pandemic period, including product disruption due to inflation and labor shortages. We are experiencing a continuum across the supply chain and while we have more challenges now than we did in the height of the pandemic, we are resilient, and we are finding ways to overcome whatever challenges are thrown our way. That could include changes in legislation or changes in the way products are priced or distributed.

The pharmaceutical supply chain is lean and efficient. Together with manufacturers and customers, we find a way to deliver for our customers and their patients. What you are seeing across the pharmaceutical supply chain now is a heightened version of what we did before and what we have continued to do since the pandemic.

ROTSART: I think one of the things COVID brought to the table was highlighting the competence of pharmacies as a center of care. Finally, pharmacy was seen by others outside of the industry as having that competence. We’ve talked about becoming the center of health care in the community for many years. We’ve been moving in that direction. But this was the opportunity to say hey, in the beginning of COVID, if you remember at the time, how are we going to get the vaccines distributed? Oh, we’re going to nationalize. We’re going to get the National Guard out. Pharmacy said, “Wait a minute. We’ve got this.” We never closed the doors. We were everywhere, within miles of every American. And we took on the challenge. And I think that understanding of competence is what’s going to lead to a quicker move to health care being that center that we’ve always talked about.

WEITZMAN: We have been doing this for more than a year and a half and now we must convert what that means for the future.

ROTSART: That’s good, yes.

WEITZMAN: We cannot lose the momentum. We have turn it into action now or the moment will be lost.

ROTSART: Nim and I were talking earlier. We were saying that one of the things that changed was pharmacy used to sit there and wait to react. What’s hitting us now? What do we have to do? And now we have leaders like you guys that are out there saying, “No, we’re not waiting. We’re proactive. We’re moving in this direction.”

Doug Hoey

Nimesh Jhaveri

And I think that’s what you said. We have to act, and I expect we will act after this one. It’s a golden opportunity for pharmacy, as you said.

NIGHTENGALE: Before the pandemic, the public health mindset was let’s get the people to health care. Let’s get the people to the vaccines. And pharmacy flipped that completely around — pharmacists showed that they could get the vaccines to the people. Well, let’s translate that into health care in general. We’re the most accessible sites of health care anywhere. There are so many more opportunities to reverse that public health mindset of transporting people to health care versus bringing health care to them and have pharmacy play a role.

ROTSART: And you not only did it there, you went to senior citizen and nursing homes. You went everywhere. And it was the pharmacy teams that did it.

JHAVERI: I think we also expose the practice of pharmacy and what we do, to a different demographic, right? We’ve always said let’s go after that older patient, that senior patient. But the 20-year-old walks into our stores now. The 3-year-old was brought in by their parents. I think there is a magic there that says hey, we’re not just some old store on a corner that nobody wants to go to, only when you need a prescription. We’ve become the center of a solution, and I think that’s what’s so magical about all this … as people look at it, of all ages, as a solution for their sick-

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‘We need to make sure that we don’t go backwards’

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ness, and that’s new.

SULLIVAN: There is a convenience there that you don’t get out of a primary care office with a physician, where if I were to go in and have certain things taken care of, that can be an appointment many, many weeks out in an office that’s not just down the street from me. And when I can do those same things in my local pharmacy, suddenly that changes my perception of well, why would I go to the doctor’s office for this sort of thing? And we can make better use of the leaders that we have in those retail stores.

COUGHLIN: Pharmacy is a huge business, about half the size of the defense budget. There are a lot of smart people in this business. That was demonstrated by how people got together and pushed on all these different fronts simultaneously.

Debbie made a comment about we’ve got to convert. There has been a rapid adoption of technology: robotics, telecommunications and mobile apps. This has converted many pharmacies from the days of doing certain things manually, because those options weren’t there anymore. I think these conversions are going to stay with us. The smart people are still here. They have made the conversion, and I believe they will stay converted.

HOEY: I think one important thing with all of this is that there was a reasonable economic model for the services. There was a reasonable payment model that propelled the engine. When pharmacists are paid fairly, good things happen.

HARDING: On average, the vaccines became roughly 5% of the revenues in the pharmacy. And 50% of the patients that were coming in were new patients to the pharmacy, so that was a real opportunity. And I think it’s a catalyst, because the other interesting turn that we’ve seen is that pharmacist prescribing is up to 1% now, and that’s twice what it was last year. And that doesn’t even include collaborative practice agreements, where on records is the physician. So you can see the changes happening, and we’ve got to keep that momentum going.

WOLDT: *As I hear you talk it seems that people are now accustomed to going to pharmacy when there’s a pandemic. But are they going to have that same mindset when the world goes back to normal?*

STANIFORTH: This is normal. This is where we are. And so we have to accept that this is where we are, and we need to make sure that we don’t go backwards. We have to keep the door wide open and move through it as fast as we can and get the changes made that we need to keep all the services expanding, growing in all the states, not just in a few states, and get the reimbursement models right, and really be recognized for what we can truly do to take care of more people in a very cost-effective way.

ROTSART: One of the things I was going to say, given we work between the retail and pharmaceutical manufacturers and we’ve seen a shift in the dialog around vaccines. The vaccine manufacturers have come to us to ask can you help us get with the retailers because we saw what they can do with vaccines. And so whether it’s pneumonia, shingles, whatever the disease state is, now they want to come to retail to say, “Hey, we need to get these vaccines out. The public trusts the pharmacy, and how do we better leverage that point of care? So I think you’re going to see that as a trend that’s going to continue as well.

SPEARS: It is great to be back in person, and I think this is the meeting that really is going to move us forward as manufacturers. I think we all love meeting people face to face, and three years is a long time to go without this meeeting. And we have not been able to do that for a long, long time. This is the first time at NACDS in three years. NACDS Annual in April of this year, after a three-year break, was great.

HARDING: It was awesome.

SPEARS: I am glad you agree. It continues to be a venue to build strong relationships that can help us with the Eisai HHC mission to focus on patients and their famiies.

ANDERSON: To summarize this discussion, I’d cite Clayton Christensen. Some of you know I would do that anyway, and it’s even more likely given that we’re just down the street from Harvard. But he advances the principle of disruptive innovation. You need to disrupt yourself because if you do that, there are incredible opportunities. And we disrupted ourselves over the last several years. We’re disrupting ourselves in different ways. Our

Rina Shah

Karen Staniforth

NACDS 2023 initiative that you’ll hear about at this meeting and throughout the year is one of those disruptions. And as the case that we are taking to our audiences is new, we’ve got to think anew and act anew. And that’s what we’re doing as an industry and as associations representing our members. Members are disrupting themselves in a positive way, and that means the association has to do it as well, to make sure we keep adding value.

So all the great work that we’re doing — I mean, we are looking at developing coalitions, partners with so-called nontraditional allies that we would have in a lot of different areas, focusing on the health and wellness space with pharmacy as the anchor. To me, that’s the most exciting thing that has come out of this.

Now you’ve got to remember, I guess it was not until 2009 when all 50 states allowed pharmacists to give the flu shot, as a result of H1N1. And just think how far we have come since that time. And there’s a story to tell. The great story I loved was when President-elect Biden said he wanted to do 100 million shots in 100 days, right? Remember that, before he was inaugurated? So we modeled it. And we declared that we can do 100 million shots in 30 days if you give us the supply. And that’s what they did, and you all did the rest.

SHAH: What has also evolved is the definition of the “care team.” It used to be that the concept of a pharmacist or a pharmacy administering vaccinations the pediatric community was very much a no-no. That was something that physicians were not willing to accept. But when you have the entire world shut down, people start thinking a bit differently.

So I think what has also transformed or shifted is the mentality of the health care community of accepting that pharmacists can play a different role than they have before; it’s much more complementary than competitive. That’s been something that, as we think of NACDS 2023, I would frame as “How do we continue to play a complementary role within the health care ecosystem, where we’re not taking value away from another provider?” because the concern that everyone has had is “Is it going to cost too much, or are you taking my bread and butter?”

In reality, there is so much out there that we need to solve for. Pharmacy is a key component. The intent is to determine how we expand scope and how we actually have reimbursement models. Between the two we will be able to make a difference. That’s where the combination of what Karen was referring to, and Doug, too, is that we need the continued partnership across the industry. And, as much as AMA is against it, there are a ton of other potential partnerships out there that are looking to partner with us to advance the health care ecosystem.

> ***Several companies are willing to manage additional health care risk.***

WEITZMAN: A key angle on that perspective is the consumer or patient expectation. What is their expectation now, having gone through this experience? For example, a busy mom may not want to wait for a vaccine appointment with the pediatrician. She might prefer to go online, schedule an appointment, and get a vaccine, maybe even same day from the local pharmacist. That consumer lens is driving a lot of decision making.

Pharmacy also needs to keep up with technology to meet consumer expectations, as Mike referenced. I think about technology from the pharmacy perspective and that we have something almost as critical for pharmacists to keep their eyes on, their business from that lens, as well as the financial reimbursement side, is a key part of financial health.

HUSEBY: I really like Rina’s and Debbie’s points. They highlight the importance of pharmacy becoming truly omnichannel for the patient’s journey. As Debbie points out, busy moms have a ton of real needs that are unmet today. Beyond the prescription, she also needs more time in her day … she also needs the peace of mind of seeing in her app that her parents got and took their meds … she also needs someone to remove the hassle of assuring her husband’s HBP meds are renewed and delivered. In so many parts of her daily routines she is finding these problems can be solved for her through digital innovations. She’s expecting these more and more from her pharmacy too.

And then to Rina’s point about the role our pharmacists can play. Rina highlighted that pharmacies need to be complementary — not taking away anyone’s bread and butter. I totally agree that as pharmacies continue to solve critical customer needs, the size of the pie can expand. And pharmacies can earn their fair share of the expanded pie. I’d also add that competition is to be embraced. Those parts of health care that stifle collaborative care do so at their jeopardy in the long run.

We look at the moves companies are making. Many are eager to add to their breadth of care. And many are willing to manage additional health care risk. Some seem to be keen to do both, becoming more integrated payor-provider-pharmacies. And as that occurs, and it may take a while, we will see integrated payors making decisions that are more collaborative and which make tasks easier for patients — the busy moms we talked about.

In the meantime, we need to keep educating the public on what’s available from pharmacies and how easy it’s becoming at our pharmacies.

ANDERSON: I think everybody with a Pharm.D. ought to have “doctor” on their name badge. That would be just a simple thing that would send a message that “I’m here to do more than you think.”

WOLDT: *Selena, how do things appear from your perspective?*

REYES: Listen, I hope we don’t go back to the way it was. I hope that it continues to be this way. And we see it from our perspective, as well. Just the pharmacies — I remember in the beginning, there was this panic. Can I get supply? Can I get this? And there were real patients behind that. We would

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'The number of doctors decreased by 20,000 in 2019'

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receive letters at times like "My patient really appreciated that, and thanks for getting it to us."

And we just hope that that connection with community pharmacy and treatment stays this way. It can only expand. I think we just need to continue to expand. It's more — as Karen said, it's more of a conversation, right? How do we keep that momentum going? We can't go backwards. And so I'm agreeing with everyone here that it needs to continue.

STANIFORTH: I just want to go back to a point that Rina made, about the AMA. So I think that if we can clearly demonstrate the role that we're going to play or we want to play in that ecosystem as pharmacists, where we can clearly manage a limited scope of conditions and treatments, write prescriptions and do the whole thing, test and treat, whatever that is. I think there has to be some clear understanding of there's so much for the doctors to still do and take care of, right? And just think about if they didn't have to deal with — I'm going to make this up — pinkeye or UTIs or some simple things, the time they could truly spend on helping patients with chronic disease. They would have more quality time to spend with them.

You always hear from a provider, "Oh, I only have 15 minutes to see every patient." If we were able to articulate the role that we would play — I think that's an important step, for us as pharmacists in how we would fit into the ecosystem to do that. And the other point I just want to make is that the thing about kids is that a pharmacy is a much less intimidating place for a child to go to get a shot than a doctor's office.

And a perfect example. My grandson, who is eight years old, hated getting shots. They used to hold him down on the table to give him a shot. But he went and had his COVID shot and his flu shot last year at a pharmacy. And he went there and he said the pharmacy lady was so nice, Gigi. And he was not even afraid. He said we had his shot in a little room. And he just didn't associate it with a doctor. So there's a lot to be said about that factor as well, for us as pharmacists and the way that we can interact with customers.

ANDERSON: As long as doctors don't put a candy counter in.

STANIFORTH: Or ice cream.

SULLIVAN: So the point I was going to make dovetails with what you said, Karen, in the fact that getting that message out can better delineate what pharmacy is providing for the patient and gets that threat away from the doctors, right? And I wanted to go back to Debbie's comment. At the end of the day, we come to a point where it's the patient. Are we providing everything that the patient wants, in the easiest way for that patient? And in our space we're seeing more and more of that, more of if you lean on the supply chain side of our business, more of an omnichannel kind of view. That patient got used to saying, "Hey, I can come in at off hours and get my prescriptions because I'm not threatened by crowds here."

And then they got used to the fact that well maybe I want to just have it delivered to my house, or maybe I want to just pick it up because it's convenient at these off hours. Are we offering that to them? And when we do that, if we're automating that process, are we now lifting up the pharmacist to be able to offer more of those value-added services?

ROTSART: Yeah, adding onto what you said, Karen, about taking the burden off physicians. So going back to the AMA, they said, "Hey, we want to protect our turf" — and yet there's less and less people going into medicine. The number of doctors decreased by 20,000 in 2019 - that's fewer than what was needed to meet the country's healthcare needs. And that trend continues. And more patients are coming into the system. Who is going to pick up the burden of taking care of these patients? So I think the AMA at some point might look and say, like you said, Karen, ear infections for infants, pinkeye. And that's where hopefully pharmacists prescribing starts to grow.

Test-and-treat is a big opportunity, although prescribing will be resisted.

STANIFORTH: The key will be to get them to understand, how can we work together.

ROTSART: Yes.

NIGHTENGALE: And I think part of that is our story, right? I do think that test-and-treat is a big opportunity for us, but prescribing is always going to have that pushback. I think we need to rely on data as part of our storytelling and continue to remind physicians that pharmacy is not trying to take their patients away, or their role away. It's about adding support, access and efficiency, and there is data to back that up.

Consumers in the U.S. go to their pharmacy for lots of different reasons and visit, on average, anywhere from 10 to 20 times more a year than they go see a physician. That's if they go see a physician at all. Part of our value proposition is we actually can be a referral source to you, physician. And we become a stop-gap in areas with high social vulnerability. Again, the message has to be that we're not taking anything away. We've got access. We need to talk about our role in health and wellness screening. And we need a reimbursement pathway to do that.

And when we're actively engaged in that health and wellness counseling and screening, we're going to find issues that they have to go see that physician and they need to go do it soon. And then we have the capability to remind them, and follow up, and be that advocate. So I think it is test-and-treat, and it is the ability to take some of that burden off. But it's also the flip side, which is we're the best referral source there is in the entire industry, for physicians.

JHAVERI: Brian, I would add to that. In my opinion if you want to look at where the future is going, start to look at where the academic institutions are going. And most of the medical, nursing and pharmacy education is an interdisciplinary approach. How do we start to get in front of that? I was just at one of the academic institutions, a large university, where I actually observed a medical student, pharmacy student and a nursing student working together in a simulation lab.

And so the future is there, coming. And I don't think we should concentrate on any particular association. What we need to be thinking about is exactly what you said, Brian, tell our story. Tell our story well. Tell our story in a strong way, and be proud of that story.

I think the word that you used, Rina, was complementary services. I think that's a great word. We are complementary to that. And I will tell you, my wife is a nurse practioner. And there isn't a day that goes by that I don't get a text that says, "I have a patient. What should I give her or him?" And, of course, my response is "I'm an outdated pharmacist!" But the point here is that even as a provider, they are looking towards pharmacists for that complementary service. And I think that's where we have to continue to tell our story.

SULLIVAN: So I was just out at MUSC, where my daughter is a first-year medical student. And I was able to hear the introductory conversation to all the students and the families that came in for their white coat ceremony. And the person who was leading the charge from the doctors in the building said, "Every one of you has to know that the people that you're working with — whether it's a tech or whether it's a medical assistant or a pharmacist — are one day going to save your butt. So you better plan on working with them." And I'll try to bring back that quote from the event for people to share. But I think that message is getting out to the medical community about the collaboration with the pharmacy teams and others. And we'd be well served to amplify it.

Bob Belknap

Debbie Weitzman

WOLDT: *Can payers become an ally in this transition by directing patients to seek more services to the pharmacy? You guys do it cheaper. You do it faster. You do it more efficiently. If I'm a payer, why do I want to pay a physician $200 to do something you can do for $75?*

NIGHTENGALE: They can be an accelerator if they want to.

WOLDT: *Steve, you were referring to reaching out and trying to broaden coalitions. It would seem that maybe there's one here to be had with the payers, where you're going to save them money, and they're going to shift the business to pharmacy. Doug, were you going to comment?*

HOEY: I was going to say it's a weird juxtaposition because you've got payers and PBMs that are owned by the same companies, so you have that tension of this old model of PBMs that want to control everything in the prescription drug process. But then you have people that own their company, that are saying "Well, wait a second. These pharmacists can fill primary care gaps that are going to save us money." So, unfortunately, I have not been a fly on the wall with any of those meetings. I'd love to be. But I imagine that would probably create some tension.

SULLIVAN: They might recognize you.

HOEY: They might. My reputation may precede me. But I think sorting out that tension — so is it going to be the old model of PBMs controlling every aspect of the prescription drug experience? Or is it going to be a more holistic look at health care, and how are we going to save dollars for this patient, and also get them to the best-quality outcome? I am always optimistic. And I believe that right wins, eventually. So I think, eventually, the holistic look and the lower overall economic cost will win. But there are all of these growing pains as they transition from the old PBM model into whatever a PBM model is going to look like in the future, hopefully something less than what it is today.

NIGHTENGALE: And I think we're overcoming some of the technology barriers to that, right?

HOEY: Yeah.

NIGHTENGALE: And that's always been a challenge, to connect with payers is technology. And I think we've now got really good, solid ways to submit claims and document outcomes that weren't there 15 years ago.

HOEY: And there's momentum around transparency. We've been using the word transparency forever. Transparency can mean a lot of things to a lot of people. But I do think there's momentum around

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The AMA has long opposed pharmacist provider status

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transparency around prescription drugs. And just what we've seen in our careers of the opaqueness, other people are now seeing it and saying, "This makes no sense." And state governments in particular are saying, "Why are there all these layers?" And in Ohio, I'm paying $220 million more than I'm supposed to? And California is going to save $150 million by going from Medicaid managed care into a fee for service. I mean, the shell games that have been around forever — their eyes are being opened to needing to have a more straightforward, transparent model. And I think that bodes well for everything we've been talking about this afternoon.

SHAH: And earlier you said when pharmacists are paid fairly.

HOEY: Yes.

SHAH: That's another key thing about this shift from perhaps the doctor's office to the pharmacy. It can't end up being that the pharmacist gets paid a 10th or a fraction of what a doctor gets paid for the same service. So, yes, it's a lower-cost site of care, but it has to be fair.

HOEY: And we reach the socially vulnerable, those populations that often are some of the biggest drivers of health care costs. So yeah, there's some more evidence on preventative health care, but you're lowering overall health care dollars.

ANDERSON: And don't forget, the AMA has opposed pharmacist provider status every step of the way. The AMA didn't even want you to do vaccinations. But I think this FTC investigation of PBM issues and practices is going to be really, really interesting.

COUGHLIN: You just have to look at their financial statements, and see where the money is going.

SPEARS: We realize that mild cognitive impaired patients sometimes slip through the cracks. Oh, my goodness. If we could do a better job of testing for mild cognitive impairment, we would get a better handle on dementia. Eisai has approached two pharmacy schools to offer cognitive testing be pharmacists. The schools have responded enthusiastically around a pilot program. It is in the beginning phase, and we are excited about the outcome and opportunity to work with these two schools and develop a possible curricuum for others.

Jim Rotsart

Brian Sullivan

WEITZMAN: They would never even think they need to go to the doctor, but the pharmacist might pick up on it.

SPEARS: Exactly. We feel very strongly that if we get this into other curriculums, it will widen the opportunity in the future for pharmacists to help patients.

SHAH: That, coupled with having a method where a payer pays the pharmacist to provide those services is critical. Which is great, because I think the technology infrastructure that, Brian, you were referring to, has opened up the gateway for pharmacies to submit for payment. That was our first barrier. We had to fix our own house, internally. The expectation that I think we, as an industry, had was that maybe health plans will go ahead and start submitting via pharmacy, and maybe the entire industry will change to support what pharmacy does.

If we want to be like every other provider, we have to bill like every other provider. And if that's the case, we need the technology infrastructure to do that, maybe under the medical side so that it isn't confusing for a health plan to understand where the costs are being spent. Because, at the end of the day, they're also managing a cost infrastructure.

From a screening perspective, that's exactly where we can go. We can refer. But there is this balance. It's like a seesaw that they're playing of "How much do you want to open up screening?" and "How much do you want to pay for that?" — because then it might increase versus preventative care.

To your original question about if payers can be at the table and be partners — there are payers at the state level that are not vertically integrated that would be willing to be at the table because the total cost-of-care implications would benefit them. We have seen them come to the table to see what we can pilot. It is the underserved communities that are the hot topic everyone is trying to solve for. So, we might as well leverage that focus, utilize it for the benefit of our patients and be able to solve for it from a preventative care perspective. I think there's some momentum that we're able to get from that. But we definitely need data to demonstrate the impact that we've been able to make as an industry.

WEITZMAN: Some payers and some PBMs are already at the table on this topic.

SHAH: Yes.

WEITZMAN: There is a lot of creativity with state and regional players and governments that want to do very interesting technology-driven pharmacist-led interactions and interventions with specific targeted populations. It's a great model. I don't know how scalable it is. And it's pretty bifurcated right now, into the smaller, more transparent players, versus the big three.

> ***'Members of Congress came inside your stores and got vaccinated too.'***

SHAH: I think that's the great piece of NACDS 2023. It stems off of what we learned with COVID. If you get all of the industry experts together, they can figure out a solution. One was saying, "Well, we do this in Minnesota." And then there's another saying, "We can do this in Florida." And you start really ideating on what is the best, most efficient and effective way we can do something sooner rather than later and demonstrate impact, similar to what we did with COVID. It's just been really great to see the ideation that's happening within this group to help us maintain that momentum. That includes partners across the entire supply chain.

WOLDT: *We've already heard technology mentioned a few times. Mike, maybe you could talk a little bit about where technology needs to go to make some of these things possible.*

How well integrated is the system at this point?

COUGHLIN: Well, medical billing, like has been discussed, needs to be integrated into the operating system. There's another technology angle that I think is important, and it has to do more with protecting the reputation of the industry and the supply chain. That relates to the Drug Supply Chain Security Act, which requires 2D barcodes with a lot of information in them. We need to protect our reputation as having a quality product. There are some horror stories out there, and I think more to come about what can happen with some of these imported drugs. The state of the industry right now seems to be that the new data matrix barcodes are being put on the products, but there are also the old linear barcodes on the product, so you can scan them one way or the other. The data matrix barcode has got a world of information in it that you can use. Many systems are able to scan one of the barcodes to identify the product, but are they using all of the information that's in the barcode? It's really not getting us where we need to go until the lot number, expiration date and other available information are ingested into the system and utilized. This may not be as interesting as some of the things we've discussed here today, but it's important. Our systems provided and our industry as a whole should commit to fully using the information. Coming down the road is serialization of products. When you get to this level you have fully protected the reputation of the drug supply system.

ANDERSON: And everything we talk about is what the American people want. As you know, at NACDS, we poll on almost anything, using a polling firm called Morning Consult. And we can break it down by congressional district, so we can go into a member of Congress's office, saying here is what your constituents feel like, which is a big difference, or we can break it down by state for senators. But in early March, we did a survey with Morning Consult, which we commissioned, that found that 70% of adults supports extending policies that allow Americans to access essential services from their pharmacies during the pandemic, and 68% support those policies to make them permanent. And then similarly there are the results from another survey that the Future of Pharmacy Care Coalition is communicating. That is the Coalition advocating for federal legislation, the Equitable Community Access to Pharmacist Services Act, H.R. 7213. The survey of older Americans, 65-plus, indicated broad support for congressional action to enhance access to testing and treatment services administered by pharmacies. 82% of Americans want government to reimburse pharmacies so they can access testing and treatments for pandemic, flu, strep throat and other infectious diseases beyond the pandemic. So what we do is we take that research, as you know, and we put it probably in every press release we write. But we take it to every member of Congress. Another way we communicate these findings and other information is through a congressional pharmacy tour program that is part of the NACDS RxImpact grassroots initiative. Many NACDS member companies represented at this table have had their member of Congress, from the House or the Senate, in their stores. And this is pretty extraordinary. Just in 2022 alone, and we're only coming into the end of August, we've done more than 80 congressional pharmacy tours. We talk about provider status. We talk about PBM reform and other reimbursement issues. We're making great strides, but it's that grassroots involvement that's so important. Don't forget, members of Congress came into your stores and got vaccinated too. They got their kids vaccinated. And that is a built-in validator of what we are communicating.

HOEY: I'll just echo that the importance of having a legislator in the pharmacy is so that when he or she gets behind the counter they can see where the magic happens, because they have no idea, you know? It used to be a patient would hand a paper prescription across the counter and 10 minutes later out would come a medication. Wow, how did that happen? And now an electronic prescription. But the need for that sharing all that pharmacists do to get that medication safely to patients is so important because members of Congress don't know. The need for pharmacy visits with members of Congress never ends, because their turnover is pretty darn high. And August is our month of action. We weren't able to do our fly-in this year because visits were pretty much shut down. So we've had 60 members of Congress in pharmacies this month. And that really

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DIR fees have been the No. 1 issue for four or five years

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changes their minds. The other thing, being in a midterm election year, they're even more eager to have that picture behind the counter with the local pharmacist and their team. For some reason that just incents them even more.

I'll just echo that the importance of having a legislator in the pharmacy is so that when he or she gets behind the counter, I would say, "See where the magic happens," because they have no idea, you know, where formerly you'd put a paper prescription and out would come a medication. Wow, how did that happen? And now an electronic prescription. But the need for that is so important because members of Congress, the turnover is pretty darned high. And the other thing that's happened is because of COVID because so many of the lobbying visits have been virtual, this actually allows a member of Congress to get behind the counter. And August is our month of action. We weren't able to do our fly-in this year because visits were pretty much shut down. So we've had 60 members of Congress in pharmacies this month. And that really changes their minds. The other thing, being in a midterm election year, they're even more eager to have that picture behind the counter with the local pharmacist and their team. For some reason that just incents them even more.

SULLIVAN: And tweet all about it.

HOEY: And tweet all about it. Here I am with the local business. But it does really help them understand that it's not just counting by fives back there. It gives them a purpose. They're able to see the patients come in and the value of that business, that pharmacist and their pharmacy team to the entire community. So any efforts we can do globally to get 535 visits in a year — I'm sure we want to do.

ANDERSON: We'll be starting our in-person fly-ins pretty soon. And before the pandemic we were reaching all 535 congressional offices in Washington, D.C., in one day, which is great. And at NCPA you have your fly-in, and it's very effective. They come out of these meetings and these tours back home and they say, "What's that bill you want me to cosponsor? I'll do it."

NIGHTENGALE: How many years did it take for them to even understand what DIR stood for? Now we're not having those conversations. We're having discussions about the impact, not the definition.

Mike Coughlin

Lari Harding

HOEY: And before that, they couldn't spell PBM.

NIGHTENGALE: Right.

HOEY: I mean, it took a decade.

WEITZMAN: And these issues are not partisan.

ANDERSON: Oh, they're totally bipartisan, totally. You look at every one of our bills, they've got broad bipartisan support.

WOLDT: *But why are they so tough to get over the finish line?*

ANDERSON: Because you have people like the AMA that will make a call in the middle of the night and scuttle it, right? That's the case on pharmacy services, which, by the way, the American public wants and has come to expect.

SHAH: You know what's interesting is that there are so many physicians that are not in favor of the AMA. They're like, "Please disassociate us from that."

ANDERSON: But we work with the other groups that are more specialized. The action is in the more specialty associations, which "get it" because they're more forward thinking and more informed of what the practice of medicine is all about right now.

SHAH: They grew up in the era of what we were talking about earlier, the interdisciplinary team, where everyone has their own path. We all have expertise that can help the patient. There isn't competition. I know I'm not a neurosurgeon, nor am I a cardiologist, nor am I an expert in that space. We have a place in that system, and we need them to focus in on that. It's just different associations, so we need to help them get bigger voices and help them become that much more influential within the administration, within the overall political landscape, so that it aligns with our values. I think that is the shift, then. It's not just pharmacy saying "pharmacy is amazing." It's all these other organizations that say, "If you can do this, it helps me tremendously." That just shifts the momentum.

JHAVERI: And I think we have to be careful that we don't confuse the size of the voice with the size of the representation. We focus sometimes on one group, but there are other voices, other specialty organizations, that need to be included too. And as you think about 2023 work, how do we approach the medical community as a whole, not focused on only one association that may not be representative of the entire base.

ANDERSON: I hate to get too raw in politics, but groups like the AMA show the importance of having a strong political action committee.

NIGHTENGALE: I think another answer to your question around why it has taken so long or why there are so many barriers is it's just the way that Congress quantifies impact. And when you've got a CBO process looking at a narrow impact of a bill and not able to quantify the overall impact on total quality of care, that's just a constant bear that's going to be there forever. And so that's what causes us to water down some of these provider status bills to narrow the scope because it's got to score well within the CBO. On the flip side, and getting back to Rutledge, it's all on the states now, where you don't have that so much. And the states are able, especially if they're looking at Medicaid or they're state employees, they're able to look at the holistic cost of care, and pharmacists can reduce that. Let's make that happen.

WOLDT: *DIR has been referred to several times. We had a meeting with [Hy-Vee chairman] Randy Edeker this morning, and he said that he was still pretty alarmed by the latest CMS regulations, from a cost perspective. They're not really helping pharmacy.*

SHAH: I would agree.

ANDERSON: With the DIR rule?

WOLDT: *The new rule.*

ANDERSON: I think we all agree with that.

WOLDT: *It helps on transparency, but it doesn't give you any financial relief at all.*

SHAH: If anything, it's difficult now on the clinical aspects. The momentum we had on the clinical side of it was great. It would have been helpful if they had protected the clinical components to allow transparency there, while still ensuring the ability to be incentivized to help your patients stay healthy. Having that ability locked in would have been a huge benefit. Right now, it's just open hunting season. It's not exactly clear what that's going to look like. I think the transparency is a great step forward. We need transparency in the entire process, because it's very confusing. It would be great to see what's step two, three, four, so that we can make sure we're continuing to protect the patient at the end of the day. Right now, that road hasn't been clearly developed.

> ***'The American public wants, and has come to expect, pharmacy services.'***

HARDING: In 2022, year to date, DIR fees are averaging 3.5% of total sales in a pharmacy, which is huge. All of 2021 was 2.9%. So it just continues to grow. And when we talk to a lot of our clients, there are some concerns about what 2024 is really going to look like. Specifically, are they going to have the transparency to understand the difference between DIR fees at the point of sale versus reimbursement rate negotiations, and how will they be able to tell the difference? And what kind of things are they going to have to do to get the money back? So I think there's a lot that we need to think through as an industry. And certainly, Inmar is always happy to help any of our clients.

HOEY: On the pharmacy DIR front, as Rina said, it's not perfect, but it's a step forward. Our members have said pharmacy DIR is their No. 1 issue for the last four or five years, like 98%, and for the reasons that Lari is talking about. So it's not perfect, but definitely trying to make it better. I know our organizations are meeting with CMS next month. They're not going to wave a magic wand and make it the way we want, but at least beginning to make it better and get some quality measure definition that really is missing. So when I hear critics of it — and I'm careful with how I phrase it — but the old way was not working. We knew we needed to do something different, and this may not be perfect, but it is at least a step in the right direction. So, I am glad for the catalyst for change to get to something. And just on Rutledge and the states, not only have we had Rutledge, but also we've had positive movement *because* of Rutledge that has led to even more positive action in the courts in North Dakota, which is also Eighth Circuit. And so far, so good in Oklahoma, where PCMA is suing the state. And those continue to build off of the Rutledge case, to continue to further define. And pharmacy so far keeps winning and showing that states can regulate PBMs. So that's, again, more momentum in our favor.

SULLIVAN: I mean, in the last year the movement on this stuff has been amazing.

SHAH: It just shows that you have to have like 70 irons in the fire to come at this. You have the DIR piece showing some movement, and what's happening at the state level. If we would just keep at it, at some point we're going to start tipping the scales.

HARDING: Patients and consumers are getting it too, because it doesn't make sense to them that if they don't use their insurance, they can get a better price for their medicine.

NIGHTENGALE: I don't intend this to come out negative, because it's not. But it's in addition. So we've had success, right? You mentioned a num-

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Patients had to relearn the habit of taking prescriptions

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ber of laws enacted in states. And the next iron in the fire, which we have to pay attention to right now is enforcement, because we can have 150 laws passed. Once Congress and once the governors sign it, it's done, thank you, we're moving on to the next thing. It then turns to the regulators to enforce. Once the laws are in place, the industry must identify and report. If we don't do that, we didn't get anywhere. So that next iron in the fire has to be in enforcement. And we can't wait until we see things happen, and then react.

SHAH: Yes, there needs to be continual compliance.

NIGHTENGALE: Correct.

COUGHLIN: A lot of this boils down to technology, once again. Just trying to figure out what they're doing to you is difficult enough, let alone doing something about it. And it's got to be done systematically, regularly — both individually and collectively.

HARDING: Those running on a multi-state basis are now operating with six, eight, 10, 15, 50 different models.

COUGHLIN: Yeah, that's important.

ANDERSON: You have the FTC investigation. It's going to be data, data, data, and that's what's going to fuel the decision.

WOLDT: *Doug, do you want to talk at all about the FTC investigation?*

HOEY: I'd love to. Steve teed it up. As he's mentioned, the FTC is doing a 6(b) study, which gives them subpoena power to look at PBMs. It's sort of had a soap opera backstory where they voted on it in February and the results were a tie. And so they scrapped it. But then it came back and they voted again, and it was unanimous for it in June. There was a forum the FTC had, I think, on either Thursday or Friday, where they're talking to community and regional, maybe chain as well ... for sure regional chains and community pharmacy, and consumers, about what are the problems with PBMs. I completely agree that the responses have to be very data driven. But the things they're looking for are things like impact on rebates and formularies on Rx costs, patient steering towards PBM-owned pharmacies, and unfair audits of independents. Here's one that pharmacies can relate to: complicated and opaque reimbursement methods. So they're hitting at the heart of the things that are of interest to us. They've said, "Look, this is going to take a while." But [FTC Chair] Lina Khan has also said that we'll get things out in phases. And I hope that's what happens; that it's not a three- or four-year wait, because the results of this I think will help to further drive federal policy agendas and state policy agendas to get us back to transparency. One thing that's important with this, Debbie said earlier, is we've got to convert. So we're able to show whose hand is in the cookie jar, what they're taking out. But that still doesn't mean that pharmacies are going to be paid fairly, necessarily. So we still have to execute on the services that pharmacists provide and get paid fairly, to make the world a better place for our members. But the FTC study is a piece of the puzzle, and we were pretty excited in June when the FTC voted 5-0.

Todd Huseby

Sean Spears

Selena Reyes

ANDERSON: You'll find all that stuff in the FTC press release. I encourage you to pull it up online. But there are a lot of factors that can impact the investigation. For example, elections matter. NACDS is a very bipartisan organization and PBM reform has strong bipartisan support. Yet there is a potential that political shifts or newly elected individuals in Congress could change who controls the FTC purse strings. There was a unanimous vote to open the investigation of PBM practices. But there is now a commissioner vacancy. President Biden has to replace this Republican commissioner. And that will be a long process. The Republicans will pay really close attention to see who the president appoints to that position. These dynamics could play a big role in how all of this plays out.

HOEY: All the more reason for the need for speed with this investigation.

WOLDT: *These investigations generally take many months.*

ANDERSON: I'm told that the FTC may well be going to subpoena so much information that it may take a long time for the PBMs to submit it. And then what happens, it goes to the FTC attorneys. So all the work gets done by the staff attorneys and economists from this point forward. There's going to be a lot that's got to be done by all of us. And we just can't sit there and monitor it and wait to see what's going to happen. We have to take a more active role.

WOLDT: *We've been talking a lot about current issues. I'd like to shift the focus back to a topic that was hot a little while ago – adherence. We, as an industry, seem to have, at least in our discussions, lost track of it.*

STANIFORTH: I think we haven't lost track of it. We got a bit off track during COVID because we had to respond to the task at hand. But at the end of the day, most of us were able to really maintain the population that we had and provide continued care — because we played an important role during COVID for maintenance medications. I do think some people, some customers, patients got off track, but I would say that we never lost focus. And, if anything, we just have a renewed effort on adherence in every aspect of what we're doing because of the importance of it going forward and the clinical work of which adherence is just one piece of everything we're doing clinically. It's an important piece, but it's the base for everything that we have to do and the value that we provide. So I would say we have not gotten off track.

ROTSART: At our company, adherence has always been a core focus. We work with 30,000 pharmacies, independents and chains. We work with the top national pharmacy chains to drive adherence.. We did a lot of work. We monitored patients during COVID. We saw the folks that dropped off. We worked with different departments to do the outreach afterwards to say, "Hey, COVID is over. It's time to come back in." And we saw people coming back into pharmacy. And in some ways, we had to treat them like they were new to therapy because they had to relearn a healthy habit of taking prescriptions. But we never lost focus. But there was a dip. There was a dip in the number of scripts being written as well. But everybody is back, re-focusing on it again, because it is a really important subject. We've changed obviously the technology. It's a lot less paper based. It's a lot more digital-based technology addressing it, which is having a great impact, especially on younger folks.

JHAVERI: Jim, I guess I have a little bit of a different approach on this, which is while we haven't taken our eyes off of it, I think it's become more difficult for pharmacists to maintain adherence levels for their patients. And I'll tell you what I mean by that. More and more programs are starting to get introduced into the trade, whether it's a discount card or a discount app. Great for the patient. But it can also fragment that data. It starts to bring patients into different pharmacies. And pharmacists are no longer able to have a holistic view of that patient's profile. We have to be cognizant of that. And so as we're talking about adherence, which is the core of what pharmacists do, that is our job, that we don't take our eye off that ball because that's the value that we then start to lose, right? You can't go after prescriptive authority and test-and-treat, and then give away the core of what we are and who we are, right? Because that's the value that got us there. I think we just have to be very cognizant that it's getting more difficult. While there are new things coming out into the market for patient care and for affordability, it may also have an unintended consequence, which is fragmentation of the data.

> ***PBM reform is strongly backed by both parties.***

NIGHTENGALE: I agree with you. At least with our stores, the stores that hadn't embraced technology and/or different practice patterns, like Med Sync, struggled through COVID, all of the vaccinations and keeping up with the pace of everything. Those that, thank goodness, embraced Med Sync and appointment-based approaches and all of that, actually, I think, thrived through adherence because they could set up the vaccination while they're having their Med Sync visit and their appointment. They already had modified their practice patterns to be able to be as efficient as possible, built around adherence, so that there wasn't as much disruption when it came time to setting up vaccine clinics and other appointments. So that efficiency and that patient-centric adherence model really was beneficial to those that had adopted it. Those that hadn't, I agree with you, probably struggled a lot more than they would have otherwise. And you've probably got a lot more to say on that than I do, but that's what we've seen.

HOEY: You summed it up well.

WEITZMAN: I would add that there was a bit of a cycle prior to the vaccine being released, where we saw record numbers of pharmacists using our Outcomes platform to look for engagements, to find ways to connect with patients, and to take advantage of the revenue that was available through that platform. When the vaccine was released, we saw a bit of a dip, due to the staffing levels and the number of hours in a day. We've seen it come back, as you just talked about, Brian, now that they realize they can do both.

SHAH: I do think the socioeconomic status of the American population impacts adherence. To the point earlier in which Nim was saying costs for medications have gone up tremendously — the need for lower-cost solutions is not only on the pharmacist or a technician, but patients also have been very focused on finding lower-cost alternatives or making decisions that can lead to nonadherence. That goes back to the FTC conversation we were having earlier. We need to remain focused on that to help drive adherence, because right now what

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‘Our stores are in communities everyone else has left’

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they see is a sticker shock of, “It costs $500. How is that possible? Let me split my medication in half. Let me become nonadherent or let me go to multiple pharmacies or go online to figure out what pharmacy I can use.” We may not understand the holistic picture of what’s happening with that patient. It just doubles down on the need for us to continue the conversation we had earlier so we can have transparency. Overall, the best outcome would be that the patient doesn’t have to pay as much, and we actually remove some of the issue that’s happening much earlier.

STANIFORTH: It means we all are still very focused on adherence. And there’s still a lot of investment in how we can do all the things all of us just talked about.

SPEARS: We will look at adherence programs across all of our products, because it’s critical for patient outcomes. Adherence has allways been top of mind.

ROTSART: That may be an aside, because I’m working with dozens of manufacturers who have no issues with legal and regulatory that say, “Hey, we need to support the pharmacists in their role and we need to help them with the content.” And it’s not just about educating patients. It’s not a one-size-fits-all. It’s a pretty complex process of getting people compliant. It’s based on patient behavior, meaningful content, frequency of communications, timing of communications, and so most manufacturers have come to understand that this really is an important issue to be considered, because they need to support the pharmacists that do it.

HOEY: There used to be enough margin in the prescription to pay for that. But there’s not anymore.

STANIFORTH: Great point.

SHAH: The view is that our job is literally just to dispense the medication and talk about that one medication at that one time, and that is it. I think that’s where there is confusion. It goes back to transparency. The dispensing cost has shrunk so much that, unfortunately, there isn’t any sort of room to perform these additional services. Hence the resuts of MTM and these other programs that are through outcomes. It demonstrates that you do need to have longer conversations with patients, but we can also pay our pharmacist to do that. Right now, in the current reimbursement structure, it’s not actually included. That is a mind shift for everyone that supports us, legal and compliance. They need to be educated on how that has transformed in the last five to 10 years, how it’s quickly dwindled, where that isn’t valued in the reimbursement.

WEITZMAN: Think about how unique our industry is. For example - if you take your car to a mechanic and pay them to fix the air conditioner, and they notice a fuel leak, will they fix it for you anyway? No, the mechanic is going to tell you about the problem and charge you to fix it.

WOLDT: *Let’s switch to another topic, which is on everyone’s mind, and that’s health equity. How are your companies approaching the challenge?*

SHAH: We’re doing a lot in this space. COVID has really shifted our approach in how we look at all of our programs. I know many organizations have spent a lot of time and effort on what health equity means to them. For us, especially when COVID hit, we saw such a huge disparity in what was happening in the communities we serve. Then we started looking at our data a bit differently, and we realized that every single program we do has a health equity component to it. We just weren’t highlighting it, and we were still creating our programs with a one-size-fits-all approach. It required us to go back and redesign what our programs look like, based on the data we had behind the scenes. We looked across the 9,000 locations, asking what we would determine as high-equity or high-SVI locations. That sparked not only when the social unrest situation had really gotten to its peak but also with vaccine equity and testing equity. We were seeing hospitalizations and deaths happening in communities that we were already in, so we needed to shift our approach on vaccine distribution, access to testing, access to medication, even delivery — offering free delivery if we saw a need for it. We were seeing patients coming via bus to the pharmacy, and if their medication wasn’t in stock, then they were out of medication. So we started rethinking, “OK, well, if that’s the case, let’s just deliver the medication to them. Let’s flip what we’re offering.” So we set up an incubator in Chicago where we have about 15 to 20 locations, where we tested out different concepts. What’s working? What’s not working? It’s a grassroots effort. It’s not just us and a whiteboard, mapping everything out. We had the data on the whiteboard, but we also had our pharmacists and technicians and leadership come and say, “This is what we think would work. This is what we think we need to do,” realizing that that’s the Walgreens view. We would then bring in community partners and faith-based organizations, to make sure the message really resonates. That’s where we’ve seen a lot of traction on being able to drive equity, or at least access to care. So with lots happening within our infrastructure and shifting our infrastructure, we were able to make much more of an impact on day-to-day programs that we were offering.

> ***‘COVID has shifted our approach in how we look at all of our programs.’***

It’s been great to see. The next level up is what additional partners can we have? What additional investments do we need to make? But even just the redesign of what we’ve done thus far has been really great to see.

WOLDT: *How about the drug makers? Are you guys involved?*

BELKNAP: We are. The biggest area that we’re seeing is in our specialty area, in lack of funding for programs and patients not being able to get access to the meds. And it’s a different world out there, in regard to the funding for different disease states. And one week they’ll have it. The next week, they won’t. And it’s been a big challenge, but affordability is a huge issue.

SHAH: We have a division within Walgreens — Walgreens Health — where we have a chief clinical trials officer. The intent of that is to partner with manufacturers so that we can have the ability to complete clinical trials in underserved communities. This will allow us to really increase the population of individuals that are being tested and are able to have access to medication. We can gather that data to understand, really, what are the demographics we can implement. We come at this much more comprehensively as our stores are great access points. They’re in communities that everyone else has left. It’s an opportunity for us to really drive different services in our locations.

BELKNAP: We have trouble getting people from the U.S. to be in a clinical studies. So that might be an area that really has some opportunity.

STANIFORTH: And some of the things that we’re doing, outside of everything that Rina described, with delivery and all those things, what we realized is that equity means different things in different communities, right? You might think your store is in an area that has a high SVI. You think people have access to your store. But the truth is, there are some people who won’t come in your store. And how do you really reach those communities? And we’ve been doing some work recently with some of our health plan partners, on identifying where those communities are, and what can we do differently in a community where maybe we have five or six stores in an area, and then we’re able to actually leverage the total, all those stores to help a specific community or town that our health plan partners, in some cases, help us identify. Some communities may need more than a retail pharmacy or a pharmacist. And we’ve done some recent partnerships with Wellspan and Homeward and some others. That’s how we’re really thinking about equity and how we start to expand access to services, deliver on those services, and not just access to the pharmacy.

HOEY: Through CPESN is one way pharmacy teams are helping underserved areas. So independent pharmacies are often in rural and underserved areas. Not always in rural areas, but often in underserved areas. I think our latest numbers are showing about 70%, 80% are in populations of 50,000 or fewer. One of the things, through CPESN, that some payers are interested in is social determinants of health, where the pharmacist or his or her pharmacy team can connect with that patient because they have a relationship and often know some helpful details, like do they have a phone? Do they have an address? Are they coming in for their medications on time, especially for mental health medications? And again, for the independents, they’re the last mile in many communities for that underserved patient. From a policy standpoint, we’re working with the University of Southern California to map out pharmacy deserts. And so not just looking at the definition of a pharmacy desert, using CMS data, but actually looking at accessibility, so instead of miles, looking at minutes. How difficult is it for that patient, from a minutes to access standpoint, even though they may be three miles away. If they’re three miles away without accessibility or there’s no bus line, there’s no transportation — what’s the barrier for them? We hope the USC research will be helpful to changing the accessibility conversation.

WOLDT: *Brian, you’re shaking your head. Are you guys trying to use data to help retailers pinpoint the places where help is needed?*

SULLIVAN: I’m mostly nodding my head in agreement. Our KiSoft analytics provides data on all kinds of different aspects of the prescriptions that are being dispensed through our system. So could that data be utilized to help this program? I think so.

WOLDT: *Lari, what are you seeing in this whole area of health equity?*

HARDING: A lot of our clients are struggling with how to measure it. And having all of the right pieces of data, because you can’t manage what you can’t measure. And so, Inmar is headquartered in North Carolina, and UNC has a center for business of health, where they have brought together their med school and their pharmacy school and their business school and their school of government. And they’re really doing some interesting things and research there. So we’ve been talking to them about doing some research on this, on how can we get really creative about the way that we measure it so that we can help our clients be more successful creating health equity.

HUSEBY: I love that health equity collaboration model that Lari just described bringing together so many academic disciplines. It’s similar to a model of what we will need to do to address health equity. What do I mean? A few miles from my home on the West Side of Chicago are some neighborhoods with life expectancies 20 to 30 years less than in my neighborhood. There’s more needed to solve that than I can articulate here. But one thing for certain is that it’ll take lots of disciplines to improve outcomes in areas with structural challenges. We’ll need grocers, churches, clinics, transporta-

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‘We want to get paid for dispensing and added services’

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tion providers, nonprofit groups and employers, even business incubators and, yes, especially pharmacies. If we’re going to make a difference in health equity then we’re going to need to recognize the importance of collaboration and partnerships.

WOLDT: *We’ve touched on reimbursement in various forms. Rina, I know you’re exploring alternative payment models that don’t rely solely on payment for products dispensed. Where are we on that journey?*

SHAH: We want to get paid for dispensing, and we want to get paid for these additional services. It kind of goes into the DIR conversation, too, that the concept of DIR was that if we had a pot of money that we were able to save, we could help patients stay more adherent to therapy, and then it would be a pay-for-performance type of environment. Conceptually, that sounds fantastic, and that is something that we need to continue to build on.

ROTSART: To feed off that, we’ve started to do a couple of tests with some payers, where we’re taking the content that they were sending to their members that was going on from the medical director. We’ve taken the same information, and we’re sending it from the pharmacist and the scores for the star ratings, and for re-enrollment into programs are much better when it comes from the pharmacist. So they recognize if the message comes from someone patients know and trust, they respond to the information. They say I’m going to act on it. We’ve got more payers that are looking at this, so hopefully that will help with what you’re trying to do as well.

HUSEBY: That’s a great example. That alone could be a quick win for many pharmacies and payers to work together. What I heard was that the content was the same, but who sent it made a difference and led to better health results. Makes total sense! Now imagine if we played with that a bit. How can technology help us to choreograph the messages a patient hears so that they’re delivered in the pharmacy’s app in a moment of need, and in-person from the pharmacist when she has the patient’s attention, and on social media amidst all the patient’s family and friends’ comments? If all the pharmacies in this room were part of integrated payer-provider-pharmacy networks, then this idea would sound like something that would obviously happen rather than being such a point of contention.

WOLDT: *Selena, are the retailers that you deal with wrestling with these issues?*

REYES: Absolutely. Great point. And I don’t know how we’re going to get there. Most of them are independent. We want them to be independent. At the same time, we need some uniformity in order for this to expand, in order for reimbursement to happen, and so forth. So great point. How do we get there? It seems like it’s a heavy lift, but I can tell you that when certain pharmacy owners that we speak to in the different pharmacies that we interact with, some of them are challenged just with staffing because they’re trying to care of the patient, as well as the dispensing side. So you see them struggling, even within themselves, because they still have those financial burdens. All those challenges are still very real for them on the day to day. And now they want to add care so they can come out of their situation. So great point. I don’t know how that bridge is ever going to happen, but maybe there are some guidelines that need to be published. Because what I also understand is that when you speak to an independent pharmacy owner, they’re looking for that guidance. They don’t know it. They know how to take care of their community. They know how to take care of their business. But give me some guidance, and they always rise to the occasion.

HOEY: Pay pharmacies fairly, and good things happen. I need to amend that a little bit because pay pharmacies fairly and good things happen *when there’s scale*.