Dispensing Pharmacy: An

A final report on ACCC's Educational Project

by Monique J. Marino

On Jan. 13, 2011, the Association of Community Cancer Centers (ACCC) held a webinar entitled *Dispensing Pharmacy: An Option for Private Practices.* The expert panel for this webinar included: Steve D'Amato, RPh, BCOP, director of Pharmacy Services at the Maine Center for Cancer Medicine in Scarborough, Maine, and member of ACCC's Board of Trustees; Diane Gerards-Benage, CMPE, director of Medical Oncology at Quincy Medical Group, the Cancer Center at Blessing Hospital in Quincy, Illinois; John Hennessy, MBA, executive director of the Kansas City Cancer Center in Overland Park, Kansas; and Carol Kovach, RN, BSN, OCN, practice administrator at Iowa Cancer Specialists, P.C., Davenport, Iowa.

The information presented at this webinar and during follow-up communications with the expert panel is presented here in a Q&A format.

Q. Can you briefly describe your practice setting, your patient volumes, and payer mix?

Hennessy. The Kansas City Cancer Center is a 34-physician multidisciplinary oncology practice with 9 offices in the greater Kansas City area. Our first pharmacy opened in 2001. Our program sees about 6,000 new cancer patients each year. In terms of visits, we have approximately 100,000 patient visits annually.

Our mix is about 60 percent commercial payers and 40 percent public or government payers. We include Medicare+ Choice with the commercial payers. Our practice has a pretty diverse commercial payer mix. BlueCross BlueShield makes up about 35 percent, and the rest is scattered among a number of national payers. The good news is our payer mix is diverse; the bad news is that it's more policies and regulations to keep up with.

Kovach. Iowa Cancer Specialists is a three-physician practice with two locations, including one at Genesis Cancer Center, an ACCC-member program. Our practice sees between 400 and 500 new patients each year.

Our payer mix is about 60 percent Medicare and 30 percent BlueCross BlueShield.

Gerards-Benage. The Quincy Medical Group is a multispecialty practice with 120-providers. We have 4 medical oncologists and 2 radiation oncologists. Our practice sees about 700 new cancer patients annually, with about 19,000 office visits per year.

The payer mix for the multispecialty group practice is about 50 percent Medicare and 50 private payers. The payer mix for our oncology practice is 65 percent Medicare and 35 percent private payers.

D'Amato. Maine Center for Cancer Medicine has 13 medical oncologists spread over 4 sites. We see over 2,400 new patients a year and have approximately 42,000 patient visits a year.

My practice sees about 55 percent Medicare, 25 percent Anthem commercial payers, a smattering of other private payers, and only 1 to 2 percent Medicaid or state-aid.

Why Open a Dispensing Pharmacy?

Q. What made your practice look into opening a dispensing pharmacy?

Hennessy. Our practice is affiliated with US Oncology, so we had the advantage of seeing what other practices were doing around the country. And many practices were going in the direction of dispensing medications. Our practice understood that its pharmacy was not going to be an economic windfall. Instead, we saw a pharmacy as a differentiator in terms of the patient experience. In other words, our patients would have access to the agents they needed without having to make multiple stops or extra trips. Bottom line: our decision to open a dispensing pharmacy was absolutely about patient convenience.

Kovach. Our practice did not consider opening a dispensing pharmacy until we were approached by our GPO (group purchasing organization) at the end of 2006. It was a new concept for our practice, and we originally thought that having a retail pharmacy would mean hiring an FTE pharmacist.

Gerards-Benage. Quincy Medical Group went back and forth on the decision to open a dispensing pharmacy. The practice initially decided to open a dispensing pharmacy in 2008, then chose to hold off, and has now moved forward with the project.

D'Amato. Our practice saw a pharmacy as another potential source of revenue. More importantly, a pharmacy will allow Maine Center for Cancer Medicine to develop a patient adherence protocol and provide convenience to its patients—if they so wish and are eligible to have their prescriptions filled in our office.

Option for Private Practices

Carol Kovach

Diane Gerards-Benage

John Hennessy

Steve D'Amato

Decision-making Process

Q. Can you describe the team you brought together and your decision-making process?

Hennessy. Once our physicians made the decision that they wanted to open a dispensing pharmacy, I worked with our staff pharmacist on the project. And because our pharmacist had retail and contracting experience, we immediately had a good sense of what business our pharmacy would and would not be able to capture. We also worked closely with our peer group. For example, we made a few site visits to practices within the US Oncology network that were doing retail pharmacy. It was particularly helpful to see how dispensing was done at the practice level and to talk to the people involved in this service line. For a small financial investment, our team was able to learn a lot of information very quickly.

Adding a pharmacy was an easy decision to make because our practice understood the downside—labor costs. As long as our pharmacy did not dispense drugs that were not going to be reimbursed, our practice would be okay. Of course the year was 2001, so our practice wasn't looking at the expensive oral oncolytics you see today. We also weren't dealing with Medicare donut holes. At that time, reimbursement to retail pharmacies was incredibly quick compared to the outpatient setting, so opening a dispensing pharmacy was even lower risk from that standpoint. But our practice did its homework by talking to our major payers about what it would mean to add dispensing services.

Kovach. As a small practice, all three physicians were involved in decision making, along with administration, two key nurses, and our billing manager, who is our reimbursement expert.

Gerards-Benage. Our situation is a little different. Quincy Medical Group had started down the road of putting in a dispensing pharmacy prior to my hire. About four days after I started, the CFO asked me if I was on board with the project, and I had a list of reasons why I couldn't say "yes."

Quincy Medical Group is a multispecialty group, and I am only responsible for medical oncology. My payer mix is very different from the rest of the practice. Bottom line: I felt the practice was basing their decision on an entirely different payer mix than what oncology generally sees.

Second, the option that was originally presented to our practice was a much less-automated system than what is available today. There were fewer oral agents. Additionally, the "package" that was offered to our practice did not allow us to select what we wanted to carry in our pharmacy.

Finally, our cancer center is located off campus from the rest of the practice, so I didn't see how it would be an advantage to the rest of the medical specialties to send their patients to the cancer center. Nor did I have the right staff at the time. I had two pharmacists in the cancer center; both were concerned about being responsible for dispensing to patients outside of the cancer center, including liability issues.

For all of these reasons, I could not support opening a dispensing pharmacy at that time.

Our practice has since reconsidered the decision. As director of Medical Oncology, I oversaw the dispensing pharmacy project that went live in February 2011.

D'Amato. After investigating the dispensing models available, I brought the issue to our Leadership Team—composed of a nurse manager, a pharmacist, our operations manager, our CEO, a lead physician, and our finance officer—and all of our physicians. It was important to have physician buy-in and to get authorization for a dedicated staff member to oversee the project.

Q. Did your practice collect data, such as payer mix, most frequent disease sites, and most prescribed treatment regimens to identify a break-even point for your pharmacy?

Hennessy. Our practice identified which payers our pharmacy would and would not be able to contract with. Using that data, we were able to back into the number of scripts per day our pharmacy would need to break even. Interestingly, our prescription numbers increased when our practice added nurse practitioners. For some reason, our nurse practitioners yield far more prescriptions for our pharmacy than our physicians do.

Kovach. Our process was more informal. As a small practice, we know our payer mix—about 60 percent Medicare—and our top disease sites. We also looked at SEER data and the data we got back from payers about the scripts our pharmacy would be able to fill.

It is important to contract with your payers to recognize your site as a provider and, if possible, maintain or increase the number of patients your pharmacy can serve over time.

Gerards-Benage. Our practice looked at its oncology payer mix versus its multispecialty group payer mix. Using data mined from our EMR, I generated reports about what we were writing in prescriptions and the kind of volume we were generating. For three months, our practice also tracked the number of times and the amount of time our pre-certification and pre-authorization staff were spending on the phone attempting to procure drugs for our cancer patients. This was staff time for which our practice could not recoup its overhead costs.

D'Amato. Our practice did analyze its patients' benefits to determine our payer mix and patient eligibility. Specifically, we collected insurance information from patients and submitted that data to ION for analysis. We found that our practice will be able to fill prescriptions for approximately 60 percent of its patients. Based on that calculation and our projected volume of prescriptions, our pharmacy should provide revenue to our practice.

It is important to contract with your payers to recognize your site as a provider and, if possible, maintain or increase the number of patients your pharmacy can serve over time.

Implementation and Costs

Q. How long did the implementation process take? What costs were involved?

Hennessy. For our practice, establishing a dispensing pharmacy was really a "process within a process." We were building a new cancer center, and the pharmacy was an element that was relatively inexpensive to design in. From sketches to opening, the process took about one year.

Because of our relationship with the US Oncology network, our pharmacy was able to carry a heavier inventory on the front end.

Probably the aspect that took the most time was finding the pharmacist to staff our pharmacy. We were looking for the "right fit." Our pharmacy is not a volume shop. And because our pharmacist is not filling that many scripts per day, we needed someone with the appropriate personality, as well as an understanding of the challenges facing oncology patients. Also, we found ourselves doing a lot of compounding right out of the gate so that was an important skill for us to have in our pharmacist.

Kovach. The entire process took between 9 and 12 months. And it was an expensive investment, requiring much discussion and planning.

Our practice first looked at our state's regulations. Iowa does allow practices to open a dispensing unit under the physician's license and NPI (National Provider Identifier). Then we brought in legal counsel to answer questions such as: "*What were the ramifications of opening a dispensing pharmacy*?" and "*How would our pharmacy fit in with our state laws?*"

Next we had to see if our facility even had room to add a pharmacy. Our main office is located in Genesis Cancer Center. The cancer center was expanding, but radiation oncology was taking much of the new space.

We also researched what it would cost our practice. To do so we had to answer questions such as: *What were the security issues? Who would staff the pharmacy*? *Should we use existing staff or hire new staff?*

Finally, we looked at the list of oral agents that our pharmacy would have to carry. Our practice came into this project in 2008 when drugs were very expensive. We quickly realized, however, that not having an expensive drug available when our doctor first prescribed it—especially the first regimen—was no different than if our patients filled the script at a retail pharmacy. In other words, most patients on oral oncolytics were waiting at least 24 hours to get their medication because hospitals and retail pharmacies were not stocking them either.

As far as implementation costs, we needed a dedicated computer, a dedicated printer, and miscellaneous supplies, such as medication labels. The initial inventory our pharmacy stocked required an investment of about $20,000 to $25,000. The higher-priced drugs were stocked as our practice saw the patients and wrote the scripts.

Gerards-Benage. While we've only been dispensing for a few months, our practice had staff in place. Our financial counselors and our pharmacy technicians work in conjunction. I did have to purchase a dedicated printer for the pharmacy.

D'Amato. Our process took about 12 months. Some of the delay was due to budget approval of a dedicated staff. The practice also had to carve out space to accommodate the pharmacy. Expansion started in 2011 to provide dedicated space for the pharmacy.

The pharmacy costs included the hardware, software, and inventory discussed previously.

With dedicated staff and equipment in place, our pharmacy started dispensing in April 2011. ION helped us establish payer contracts prior to this date.

We are still in the process of developing an adherence program and finalizing our formulary.

Challenges

Q. What challenges have you faced that are a direct or indirect result of adding a dispensing pharmacy?

Hennessy. The original challenge our practice faced was that some of our physicians were not using their own pharmacy. From my perspective, our pharmacy numbers have been driven by our nurse practitioners. For example, it is not uncommon to see a nurse practitioner walking a patient over to the pharmacy.

The biggest challenge we face in controlling pharmacy costs is making sure that when something is going wrong that the patient calls us. We find that patients are reluctant to say anything is wrong for fear of not getting the next chemotherapy dose. So our pharmacy offers another opportunity to have a conversation with patients and say, "*When you're not feeling well, call us at noon.*" If patients call us early enough, we can bring them in. We can hydrate them. We can get them in to see a nurse practitioner. If they call us at the end of the day, we're kind of stuck.

Kovach. Looking back, staffing was our biggest challenge. Using existing staff did not work for our practice. Once we hired the right staff person, a FTE pharmacy technician, the process became much more effective—for both patients and staff. Keep in mind, if you choose not to hire a pharmacist, as our practice did, you must make sure that whatever staff is filling medications is following your state regulations.

With the right staff person in place, we were then able to look at the schedule and answer questions such as: *What patients were coming in that week? What treatment regimens were they on? Were patients continuing on the regimen so that we could order drugs ahead of time? Were there patients that we wanted to see a physician before we ordered their medications?*

Staffing Models

Q. What staffing model do you use for your in-house pharmacy?

Hennessy. Our state requires that an RPh or PharmD be present during all opening hours. If not, the pharmacy needs to be locked. So your practice needs to have infusion drugs in an area outside the "lockable zone."

Kovach. Our practice has an FTE certified pharmacy technician. We have also cross-trained three other staff so that they are able to carry out pharmacy-related functions when the technician is out, for example during vacation or illnesses.

Gerards-Benage. Our practice staffs its pharmacy with a financial counselor and a pharmacy technician. It is considered a physician dispensing model, but the physician's nurse will actually make the drug handoff to the patient.

D'Amato. In Maine, we do not need a pharmacist to dispense medications, so we also plan on using a registered nurse and a pharmacy technician to fill our prescriptions.

Q. How many days a week is your pharmacy open?

Hennessy. Our pharmacy is open 9 am to 5 pm, five days a week—the same as our office hours.

Kovach. Our pharmacy is open five days a week.

Gerards-Benage. We are open Monday through Friday.

D'Amato. Our pharmacy is open Monday through Friday from 8 am to 5 pm.

Drug Inventory

Q. How does your pharmacy handle drug inventory? Do you dispense only oncology drugs or do you also dispense non-oncology drugs?

Hennessy. Our pharmacy is unlikely to carry aromatase inhibitors (AIs) and drugs like Xeloda unless we have a patient with very good performance status who is coming in monthly to get a refill. Among all of our practice sites, only two have retail pharmacies, so we may send those prescriptions from other sites if they fit that category.

Maybe a year and a half into the project, our practice started getting tight on its pharmacy inventory. We wanted to make sure the pharmacy was carrying what we were going to use and not just carrying product because we can. And those decisions are mostly related to cost-to-capital factors.

Our practice figured out fairly quickly what medications we were going to use in volume. We have a pretty good sense—particularly when someone is on maintenance medication—of what drugs we're going to need and when we're going to need them. We identify what patients are coming into the office in the next two or three days and then stock medications accordingly.

Our pharmacy dispenses both oncology and non-oncology drugs. We have a fairly broad inventory—less high-dollar medications and more everyday medications patients need so that they don't have to go somewhere else. We are also flexible about shifting our inventory mix as our physician prescription patterns change.

In terms of volume, our pharmacy moves more non-oncology drugs. Most of our patients in treatment see us more than a dozen times a year. Fresh out of treatment, our patients still come in three to four times a year. We dispense a vast amount of chronic medications, for example, beta-blockers and medications that treat hypertension.

We do not stock the high-cost oncolytics. And we do not carry medications for colds or flu. We like to send patients back to their primary care providers for those types of medications. Overall, our physicians are managing a lot of chronic and long-term issues. So we try and make sure that our pharmacy is a one-stop shop for those types of patients.

Kovach. Our practice tracks which patients are coming into our office in the next few days; our nurses order for the infusion center and our pharmacy technician orders for the dispensing pharmacy. Incidentally, we do not stock narcotics.

Our practice stocks the following: oral oncolytics, antibiotics, antifungals, AIs, diuretics, steroids, antiemetics, warfarin, Arixtra, and supplements, such as iron and MagOx.

Gerards-Benage. Our pharmacy uses a similar process to manage drug inventory.

We dispense oncology and oncology support drugs only at this time. We are getting many requests for white-bagging, for example, the ESAs, Neulasta, and Neupogen. Our pharmacy does stock those medications, and we would like to be able to keep that revenue. We also chose not to carry narcotics in our dispensing pharmacy.

D'Amato. Our plan is to dispense all agents related to oncology care, not just oral oncolytics. We are not likely to stock high-priced medications with low turnover. We plan to carry all products that our physicians routinely order. Our nurses have compiled a list of the most common agents prescribed by physicians.

Q. For what percentage of patients treated at your practice is your pharmacy able to fill prescriptions?

Hennessy. As of today, our practice can fill 100 percent of our patient prescriptions. We had difficulty getting BlueCross and BlueShield on board right out of the gate, but now four years into the process, they have rolled over. We average between 20-25 prescriptions a day.

Kovach. Our practice is only able to fill about 78 percent of our patients' scripts, which are about 10 to 15 prescriptions daily.

Gerards-Benage. We are hopeful that our practice will be able to fill about 90 percent of the orals agents we are now sending out. Depending on inventory, our practice anticipates filling 10-20 prescriptions per week.

D'Amato. Our practice anticipates filling about 60 percent of our patient prescriptions, maybe more.

Q. Do you have to give your patients the option to go elsewhere to fill a prescription before you drive them to your pharmacy?

Hennessy. Yes. In fact, our practice has had to do that for imaging and for radiation services for some time. It seems like every year CMS comes up with new regulations to make it more challenging. We found that the physicians were a little upset the first time they had to tell a patient this information, but that the vast majority of patients do not care. Patients are looking for convenience. They do not particularly care whether or not the physicians own the pharmacy; they want to know whether or not our pharmacy stocks their medications.

Gerards-Benage. Our practice has posted the choice of pharmacies in sign form. We also provide that information when our counselors discuss cost and pre-certification issues with the patient, allowing patients the choice of obtaining the medications at our pharmacy, at the pharmacy of their choice, or through the mail if that option is available. We do, however, explain that it has been our experience that local pharmacies do not often stock these medications.

D'Amato. Our practice informs patients of their pharmacy options and allows them to decide where they want to have their prescriptions filled.

Billing and e-Prescribing

Q. What type of billing system are you using to post charges and payments for your retail pharmacy? Also, what EMRs are your practices using?

Hennessy. We use the Rx3000 Pharmacy Management System (*http://www.newtechsys.com*).

Our program does not yet have an EMR. We have a lot of electronic connectivity, but we do not yet have that "middle" piece.

Kovach. We are using QS1 (*http://www.qs1.com*) to bill. Our practice built an in-house EMR.

Gerards-Benage. We use QS1 to bill. Our practice is multispecialty, so our EMR is not oncology specific. Our practice uses McKesson (*http://www.mckesson.com*).

D'Amato. We are also using QS1, with a beta interface with our Nucleus Solution product. My practice uses Altos Solutions for its EMR (*http://www.altossolutions.com*).

With physician dispensing in place, we can now verify our patient's medication lists to ensure accuracy.

Q. *How does your practice deal with e-prescribing?*

Hennessy. Our retail pharmacy opened before e-prescribing became widely adopted. The technology has simplified our process and made it almost easier to get prescriptions into our pharmacy because we can put some form of tiering into the e-prescribing. Our practice uses Relay Health (*www.relayhealth.com*).

Kovach. E-prescribing is effective because the information goes straight into our EMR system where our pharmacy and nurses can see it. Overall, e-prescribing has made it much easier to track scripts—much more efficient than when the physicians used to handwrite the scripts and place a copy in the patient chart.

Gerards-Benage. Our practice does have an EMR in place for e-prescribing so our prescriptions come directly into our pharmacy.

D'Amato. My practice switched to a new EMR (Altos/OncoEMR) in April 2011. Today, all prescriptions, excluding narcotics, which we have elected not to fill internally at this time, are generated electronically. It has made tracking medications easier and gives us an accurate medication profile for our patients. With physician dispensing in place, we can now verify our patient's medication lists to ensure accuracy.

Patient Compliance

Q. *Does your pharmacy have a compliance program for patients who are on oral chemotherapy?*

Hennessy. Not in any formal sense. From the payer perspective, this lack of a formal compliance program makes us less competitive than big specialty pharmacies. Our pharmacy can identify if a 30-day supply of medication is lasting 35 days, but some of the better specialty pharmacies do outbound calls in the first week, particularly for medications with a side-effect profile that might discourage patients from compliance.

Kovach. Our compliance program is generated from our EMR. Patients on oral chemotherapy have monthly CBCs (complete blood counts), and a "no-show" will be flagged. The nurse then e-scribes our pharmacy technician to refill the medication. Also the QS1 tickler system lets the pharmacy technician know to check if the patient is to continue on the medication or if there has been a change.

Gerards-Benage. The specialty pharmacies notify our financial counselors when the product ships. The financial counselors let our nurses know the drugs have shipped, and our nurses follow up with our patients.

D'Amato. We developed a compliance program prior to the opening of our dispensing pharmacy.

A Specialty Pharmacy?

Q. *Has your practice applied to be a specialty pharmacy?*

Hennessy. No. Our practice is not in the emergency medicine business. We have about a 72-hour waiting period for patients who need an infused drug—unless there's an emergency. And if it is an emergency situation, most of those patients need to be in the hospital. Our system gives the practice time to order the drug, allows the patient and family time to prepare for chemotherapy, and lets us conduct chemotherapy evaluation on the patient. So the need to have drugs immediately—other than routine refilling of prescriptions—is not an issue for our pharmacy.

Applying to become a specialty pharmacy would have meant getting access from both a payer and a distributor standpoint. US Oncology offers a large specialty pharmacy that our practices use as much as possible. One of the main reasons we do this is the network's patient assistance programs. When we have a patient assistance issue, our practice can "outsource" it to US Oncology's reimbursement specialists. For many of my peers, dealing with patient assistance on the expensive oral oncolytics has been one of the biggest challenges in the last few years. And now it's not just the oral agents. For our practice and pharmacy, it was a question of: "*Do we really want to be in the specialty pharmacy business*?" In the end, we decided that we did not.

Kovach. Our practice came to the same conclusion when we looked into becoming a specialty pharmacy. In addition, it would negate so many of our pharmacy contracts that it would be detrimental for our practice. We have good contracting relationships, so we did not see any real advantages to being a specialty pharmacy.

Gerards-Benage. Our practice did apply to be a specialty pharmacy, as we believe that specialty pharmacy is where payers are sending their business. We are also working with our contract renewals to negotiate being the primary pharmacy for oncolytics.

D'Amato. My practice has not investigated the specialty pharmacy option at this time.

Oral agents have been rapidly moving to the fourth tier; co-insurance rates have been going up.

Improvements and Effectiveness

Q. What programmatic improvements have you seen that are a direct or indirect result of adding a dispensing pharmacy?

Hennessy. The best benefit for our practice has been happy patients—pure and simple. Having a dispensing pharmacy has been a differentiator. Our pharmacy is not making a huge bump in the bottom line of our practice, but that was never our intention. And now we have the opportunity to talk to patients about what they can expect from their medications. We have a good sense—although it is hard to measure—that we are creating conversations about side effects and what the patient can expect.

Kovach. Our patients are much happier. Our practice treats a fairly high number of elderly patients, so the onsite pharmacy has been a great help to them. Our pharmacy receives as many patient letters as our nurses do, thanking them for all of their help and support. Patients are just very appreciative of the convenience.

Q. What metrics does your practice use to measure the effectiveness and success of its dispensing pharmacy?

Hennessy. Our pharmacy looks at the bottom line every month. Some months the numbers are good; other months the numbers are rather alarming. If the pharmacy bottom line was the only metric that our practice looked at, we would be particularly challenged. However, we also look at patient and provider satisfaction. For example, some of our employees get their medicine at our pharmacy, so there is a staff convenience factor.

Our practice does a lot of surveying, and we've found that there are a number of patients who do *not* access our pharmacy. But for the patients that *do* access our pharmacy, we are almost always doing a better job of service than anyone else. Quite frankly, one of the challenges of conducting subjective surveys is that our patients almost always say good things about our practice. It's challenging to weed through all the "good" and find some opportunities for improvement.

Kovach. Our practice looks at the pharmacy's bottom line too—every month. We also look at patient satisfaction. We did a patient satisfaction survey a year or so ago, and it came back with glowing responses. But we are also looking at ways to improve our services, as there is always room to improve. Simply put: as long as our pharmacy remains financially sound and it helps our patients, then our practice will continue to dispense medications.

Gerards-Benage. While our practice has only been dispensing medications for a short time, we are also looking at our bottom line. We also intend to assess patient satisfaction and the timelines for initiation of treatment. At this point, some of our patients are waiting two weeks for drugs to ship from their pharmacies.

D'Amato. As our pharmacy only went live a month or so ago, we are in the process of getting some experience under our belt. We are looking at expenses and revenue, and examining patient adherence rates. In the future, we will likely conduct a survey to get patient and staff feedback.

Q. Looking to the future, how do you see oncology drug management trends, such as increasing the number of drug tiers, white bagging, and REMS, affecting your dispensing pharmacy?

Hennessy. If our pharmacy was heavily invested in the high-price or high-margin drugs, it would be more challenging for our practice. Oral agents have been rapidly moving to the fourth tier; co-insurance rates have been going up. Patients who fall into the Medicare donut hole have been particularly challenging for us. The other challenging piece is the "mini-med" policies with $5,000 and $10,000 limits—enough for patients to be diagnosed, but not enough for them to afford treatment. At some point I think the saving grace for our practice will be a "maximum out-of-pocket" benefit. While our practice has been very successful in getting patient assistance and making it possible for patients to get access to expensive drugs, we worry that those types of resources are going to run out.

Kovach. We're all very worried about the future of healthcare—the cost of drugs, declining reimbursement, and how much of the costs are being passed on to the patients. But our practice takes it one day at a time and one patient at a time. If you look too far out into the future, you start questioning whether the practice can last. As you all know, as a country we are asking ourselves: "Are we going to be able to afford healthcare?"

Gerards-Benage. The biggest challenges that my practice and pharmacy face are payer-related. Insurance companies keep making it more and more difficult to get the patients the medications and treatment they need. My staff new hires have been financial counselors. And these staff members are spending a lot of the time on the phone—with payers, with specialty pharmacies, with patient assistance programs. I'm waiting for payers to start telling providers what we can or cannot dispense. In the meantime, I work with our payers and try to stay ahead of the trends.

Audience Q&A

At the conclusion of ACCC's webinar, audience members had the opportunity to ask questions of the panelists. Here's what our panelists had to say.

Q. What level of profitability did your pharmacy see last year?

Hennessy. Simply put, if your practice can manage three components—drug margin, labor costs, and bad debt, your pharmacy will be in good shape. We do see a positive margin on the drugs we dispense. Our biggest cost is the labor cost for our pharmacist and pharmacy technician, followed by bad debt.

Kovach. One of the positive aspects of dispensing medications is that your practice knows immediately whether or not a drug is covered. We knew that if we put processes in place and followed those processes on a daily basis that our pharmacy would eventually pay off and be a win-win for both our patients *and* our practice. And that's what happened. It took our practice about two and a half years. The first year our pharmacy broke even. In 2009—our first full year of dispensing medications because we did not have a dedicated staffer in 2008—our pharmacy realized about a $90,000 profit. In 2010 we doubled that amount and saw an 18 percent margin.

Gerards-Benage. We anticipate a margin of about $100,000.

D'Amato. Our practice developed a *pro forma* based on what we have seen in other practices. After putting in our data—our 14 physicians, our patient mix, and the number of prescriptions we generate—a conservative estimate is that our practice will see about $100,000 in profit the first year. But what we've heard here today is that if a dispensing pharmacy is managed correctly and with adequate staffing, break-even should be the worst that you do, while providing a great patient service.

Q. Do you have patients that frequently come back each month for medications like aromatase inhibitors (AIs), even though they might only see the provider yearly?

Hennessy. We rarely have patients come in just to use our pharmacy. And for a lot of patients who are going to be on a long-term agent, we would probably have the prescription run through a specialty pharmacy because they will get reduced co-pays if they receive it quarterly versus monthly at our practice. The challenge there—as we all know—is ensuring that our patients are staying on their meds. We've known a long time about the challenges related to AIs. But it's been interesting to hear about the compliance issues related to chemotherapy agents or biologics. However, some of the specialty pharmacies are coming up with their own outbound calling programs to meet that need.

Kovach. Our practice does fill monthly AIs. The QS1 system has a tickler file as a reminder, so we are able to track patient compliance and any issues that come up.

Gerards-Benage. We leave that decision up to our patients. Some of our patients are local; others travel quite a distance for treatment. As a specialty pharmacy, we can offer the same reduced co-pay, so the patient's cost would be the same.

D'Amato. We obviously want those patients to use our pharmacy on a regular basis—not just to have their prescriptions filled, but also to be able to assess patients and act as a resource for patients on a regular basis.

Q. What if a physician decides to switch therapy and the drug was ordered ahead of time?

D'Amato. Our practice generally waits for payer approval for the expensive oncolytics. Once the medication is approved, we order it for next-day delivery. I would work with my wholesaler if it was a medication that I was never going to use again. In other words, if the patient was unable to receive the medication and as long as the medication had not been opened, we would try to return it to the wholesaler and get compensation.

Kovach. If our physicians change the therapy when the patient comes in and we have the medication on our shelf, I would try and return it to the wholesaler. We also take a look at our schedule and see if another patient who is on the same medication is coming in.

Gerards-Benage. Our practice will restock medications for future use if the medication is not used and has not been opened.

Hennessy. It is rare for our practice to run into this situation. Our pharmacy does not stock the high-cost oncolytics. We run through our inventory fairly quickly, so we will have a pretty good chance of getting it off the shelf in a month or so.

D'Amato. I am most concerned about payers demanding the use of their own specialty pharmacies, which is why I think it is important for practices to get payer contracts in place to allow them to dispense to patients. In our market, we do not allow "brown- or white-bagging." REMS (risk evaluation and mitigation strategies) are a reality that my practice is already dealing with—although I expect that administrative burden to increase.

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