Tim (00:00):

Thank you, Olivia. Welcome everyone. We're really glad to be back with you again. I know we've gone a few months without an Office Hours. And today what we wanted to do was to back up to a presentation that we did a few months ago in the late fall. And we had three presenters discussing on Increasing In-House Capture Rates. And unfortunately, things went a little long and Keith really got cut off, and he has some really good ideas and opportunities to share with us. And so I thought I'd give him a chance to go ahead and pick that up, and walk through his data with us again. Along with that, I ask him to cover Med Sync, and this is something I'm really intrigued with. We haven't done it at my pharmacy yet, but we've discussed it, and I know there's advantages to it.

Tim (00:55):

So Keith's going to walk through what they do and what they've seen as a result from it, and some pitfalls to look for along the way. One thing I do want to bring up before we move on to Keith's presentation, regulatory affairs is going to begin 340B Office Hours next month. You will receive an email letting you know about the topic and the dates and time. As you know, we are not allowed to discuss 340B on this Office Hours program. So we're doing a different one through a different department where we can discuss our 340B, so just stay tuned for that. So today again, Keith Sinay is the vice president of Pharmacy Services at HealthPoint in Washington state. And we're really glad to have him, and I'm grateful that he's willing to come back knowing that we cut out his time the last time. So sit back, enjoy his presentation, put your questions into the Q&A, some of the general ones I'll answer as we go through the presentation, but we can save the more specific ones for Keith at the end. So Keith it's all yours.

Keith Sinay (02:10):

Great. Thank you very much, Tim, and welcome everyone. As Tim mentioned back in October, I think it was, when I went through some of this. And we had to go pretty quickly, so I'm not even sure how much actually people heard because I was going so fast. So thanks again for letting me come back and go over it. Let me clip up my notes here. So the agenda basically is really two parts. We want to go to Overview of HealthPoint and who we are, what we do, just to give you a level set on that. And then just go over the four Strategic Focus Initiatives that we started from. I began here at HealthPoint in 2014 at the tail end there.

Keith Sinay (02:59):

And so between that, 2015, and on forward, these are really the main things that we've been working on here at HealthPoint. So we'll go over how we developed the ideas, what went into them, why we did them. Just go over some things on deployment, how we launched these initiatives. And then we'll study the results, what's worked, and then I'll offer some, at least next steps on what we're going to do. So if it's valuable, then that's why I wanted to do that. Next slide.

Keith Sinay (03:38):

So this is our Overview. HealthPoint is on the western region of Washington state. In case people aren't familiar with Washington, there are two sides, there's east and a west, and they're quite different. West is much more populated. Our clinic volume, our unique patients are about 111,000 in 2021, 212 medical visits, 57,000 dental visits. We have 10 main clinics, but 19 total service locations that include school-based and some other affiliated clinics that we work in partnership with, some of the community

partners. And then those are our services. On the pharmacy side, just a level set where we did about 30,000 unique patients last year.

Keith Sinay (04:32):

We have five pharmacies that are located within the main medical clinics. We have a separate central refill pharmacy. And then we have a call center that is located in the Central Fill Pharmacy. We have one specialty pharmacy. And last year we did about 274,000 in scripts, which is down. I think most of us could probably experience some down over the pandemic. We used to have around 300, so we did get a dip. We're responsible for about almost $27 million in revenue to our organization and almost $15 million in operating margin for our organization. Next slide.

Keith Sinay (05:17):

So the four Strategic Focus Initiatives are Mail and Home Delivery, Specialty Pharmacy, Patient Engagement, and Medication Synchronization. Next slide. So one of the first things we did was the Mail Deliveries, and why did we do it? And the main reason we did it is we really wanted to remove barriers to patients for using our pharmacies. Barriers including, probably we can all relate to this, location, transportation, hours of operation. And why we wanted to remove the barriers, we really feel we can better manage our patients assigned to HealthPoint if they make our pharmacies their primary pharmacy home.

Keith Sinay (06:04):

Patients that are sent away to CVS and other places don't get to take advantages of the things like sliding scale, COPI assist. Our full fee medication is actually pretty good compared to the competition. Our staff, pharmacists, we can do refill authorizations quicker. We have substitution protocols and prescribing protocols. We have easy access to our providers, could tap them on the shoulder. We have access to EMR. All the things that we all know that we have advantages over the retails, that we want to bring to our patients. And most importantly, it pulls them in, generates the revenue, and capture. Excellent.

Keith Sinay (06:53):

So we started in 2015, we wanted to study this a little further about whether a mail delivery service there would be demand for it. So in 2015, we added a question in our monthly patient satisfaction surveys. We use Crossroads. I think some of us use that same company, but the question was whether or not mail service would be something that people would like. And as the responses were coming in overwhelmingly positive, we decided that was enough of a positive response to move forward, to designing and developing the mail delivery program. So after we designed it, we deployed it in 2016, it started off just doing the regular mail, USPS, using the Stamps.com platform. And then in 2019 due to the pandemic, but also because a lot of our patients, even before the pandemic we were moving down this route. A lot of them didn't want to use the mail because of where they live.

Keith Sinay (08:02):

And a lot of places, people don't live in secure areas where people can just drop packages off. And where they received their mail, they didn't feel comfortable. And if in rural areas, having a drug stuck in their mailbox kind of thing. So we wanted to add a same day, next day delivery option, and so we did that in 2019 in response to the pandemic. And I think some of us are probably using these companies

already, but we used ScriptDrop. We began deploying FedEx as a resource, and then Nimble is another same day delivery service. Excellent.

Keith Sinay (08:52):

So these are just snapshots of the results since then, since we launched in 2016. Obvious growth, especially between 2019 and 2020. I don't think that's a big, huge surprise, and then 2021. So we anticipate even more, as people became more adapted under these circumstances, this actually helps the hesitancy for people to using mail as a medium for receiving their medications. So in a good way I think this might be hopefully something that continues on even after pandemic goes away. And then our home, but I wanted to point out the... So we started this program with the estimate of under $2 a script cost. And we were around $1.50, $1.80 when we originally began. And in 2021, we jumped up to about $2.25, which still isn't too bad, but there's some workflow issues around that, but also adding the same day FedEx and other next day services, which are as we know more expensive.

Keith Sinay (10:12):

We do about 278 a day mail delivery, and that will peak at 300, 400 on Sundays. So it can get pretty busy depending on the day. And our takeaway benefits is obviously, it's convenience to the patient. They really like having it delivered to them. We think it's adherence, a lot of our patients who are on Med Sync take advantage of this and autofill features that we provide. We feel it's a retention getter for us because it eliminates that idea that the complaints, we're not on every street corner like a Starbucks and your hours of operation aren't 24/7. And our motto is, if we can't be a Starbucks, obviously we can't be a CVS every corner, but we can be like an Amazon. And if they can't come to us, we go to them.

Keith Sinay (11:12):

So that's our thinking on how we can continue to improve this service. So next steps for us, at the beginning of our strategic planning year in October we decided we wanted to add an internal courier delivery service. So another driver, another vehicle, we already have two that go out to do the Central Fill distribution to the sites. We're rethinking that a little bit based upon assessing the information that we were gathering currently, because the vendors that we're using now are doing pretty good delivery, and it's really not that expensive. On the last slide a script drop was about $10 something a delivery. But it's usually $1.5 to $2 per script. It's not a whole gaggle of prescriptions. It's usually the ones that they forgot or acute med that needs to be delivered right away.

Keith Sinay (12:14):

So it's probably $5 to $7, a stop for that. And now that we've begun looking at that data, we're looking at our own cost per script stop, and we're thinking, geez, can we even beat that? And we don't have the infrastructure that they would have with dozens of vehicles versus just this one. Anyway, we're reassessing that, but I kept it on the slide just to know. There is some other advantages to doing that. I won't go into it though. The other thing we're going to do is Process Improvement. So we had a huge jump in using it, using our service as you saw on the slides. And we think we can do a lot more preventable expensive deliveries. There are some patients that really shouldn't be on the next day delivery, which is more expensive.

Keith Sinay (13:05):

If the planning is better and education to them, maybe put them on autofill, Med Sync. And then for our script drop clients, they get charged within a radius. So if you fill out a pharmacy that's way outside that

radius, you get double charges. So we just be smart about picking the pharmacy closer to the patient for the drug to be picked up and delivered to the patient. So things like that. And then lastly, believe it or not, we've been doing this for how many years? Some of our recent survey that we did in January shows still that 70% of the patients did not know we did this regular mail delivery service. And 80% didn't know we do same day, next day for free. Yet in the same survey, 68% showed interest in the program. So we still have a big opportunity to make the patients, providers, and even plans aware that we offer this service. Next slide.

Keith Sinay (14:16):

So Specialty Pharmacy is a second initiative. So why did we do it? The main driver for us was diversification and growth in revenue, and in retaining our own HealthPoint assigned patients to us. And the specialty market has been trending for 20 years. And over the last 10 years, about 10 years ago, it was about 15% to 20% of the total spend over traditional medications. And I believe a conference I just went to this year, speaker said it's now broached half, so 50 something percent of all spend. And it's expected to continue to grow over traditional prescriptions for the foreseeable future, so that's why we decided to get into it. Next slide.

Keith Sinay (15:17):

So we initiated the idea in around 2015, with two primers. We worked with a Medicaid managed care plan called Community Health Plan of Washington, to allow us to fill specialty medications for our assigned patients that were restricted to Accredo's pharmacy. And then in 2014, we had received a grant for a Hep-C clinic, which they stood up. And in 2015, they began seeing patients, and we recognized the opportunity here to take care of the medication side of the treatment. But the providers were very reluctant when we initially broached them about this idea of using our pharmacies.

Keith Sinay (16:12):

They didn't see us as a clinical pharmacy. They thought of us as Rite Aid, so they really didn't feel like we could do it. And so to manage that, we said, "Well, what if we were to put our clinical pharmacist in the clinic and help them with the management in the Hep-C clinic?" And they thought that was a great idea. And it really brought forth the value of the clinical pharmacy in that practice setting and really helped with their workflow. It was, I think really the only way we were going to get that business. And so we started filling both the Community Health Plan prescriptions and our Hep-C patients through our Central Fill Pharmacy. Next slide.

Keith Sinay (17:09):

So the revenue and prescriptions from both sources grew between 2015 and 2017. Hep-C alone grew from zero in 2015 to, we peaked out at $4.7 million in 2017, that was on the back of Harvoni, which was at that time that's always what we filled, but since then, obviously the other medications which are less expensive, it's driven that down to about $2.6 million a year. And why we made the decision to separate that activity from Central Fill to its own pharmacy, is that we realized the workflow of a refill center and the handling of specialty medications was just not conducive to the high touch needs that are required for specialty. The training of staff equally and consistently was a problem because Central Fill had like 15 staff members, and any one of them could touch those drugs. Authorization and the tracking was much more complex, and it felt like every drug had to have a PA, and you had to be on top of it to get it renewed.

Keith Sinay (18:27):

There were issues with mailing. If you didn't know what the product was and the intricacies to how it had to be packaged and delivered for cold chain reasons, that was getting mixed up. Issues with our pharmacy type, although it didn't happen very often, but sometimes we would get rejections because our taxonomy code for our refill center created a rejection. And then what was really hard from a business side of things was the revenue and expense that was blended together from this new business was blended into the refill center. So it was really starting to get hard to analyze, is this a good business or not? And it was really mixing up the metrics on the Central Fill because it was conflating a revenue per script and expense per script. And then during budgeting, we're going, "What? How did this jump like this?"

Keith Sinay (19:25):

And we decided the results look like it would be better, because this business was growing, it was doing well, to separate it. So since we were going to be investing in the organization, money and resources, we needed to build a business proposal or a concept. So in 2017, we developed a business proposal, which in my thinking is just, do we sell this idea? And the idea was to separate and build a separate licensed pharmacy to invest in accreditation, separate staffing, we would need to IT infrastructure resourcing, and then facility design and build. And next one. Your already there. Okay. And so we took it to leadership, and the proposal was given okay to go to the next phase, which for us is we built a business plan. And I'm not going to go over any of this. I just wanted to show you that this is what we use as a template to look at gaps in our thinking by using this template to exercise, to expose gaps, and refine the ideas and concepts. So we submitted our business plan in 2018 to senior leadership, and they approved it. And next slide.

Keith Sinay (21:05):

So in 2019, we officially launched the HealthPoint Specialty Pharmacy. We got separate NPI, NCPDP codes with taxonomy codes of specialty. We were able to co-locate in Central Fill, which really reduced our cost for a whole new structure outside of our building. And mainly, the main cost was the separate pharmacy dispensing software, at the time it was QS/1. So we had to buy another QS/1 license. And then we adopted a patient manage software platform, Asembia 1, some people may use that, or they may use Therigy, but Asembia was the platform we chose. And we had to get all insurance contracts, which was a pain as everyone knows. We developed new job descriptions. We had to hire, well, actually, we already had existing staff, but we transferred them into the pharmacy, one pharmacist and one technician to begin. Next slide.

Keith Sinay (22:19):

So first full year, we recorded about $16 million in revenue and about 854 scripts. We ended last year about almost $13 million. First two months of this year, we're projecting maybe they get to the $15 million. The takeaway from this, what I wanted to share is that you could see the script volume in patients are very small, but the revenue is very large for this category of filling. And the margins are obviously very good too. So it is very time consuming, and sometimes when I look at this, and I ask my people, "Do you really need more staff?" But we've gone into evaluating exactly the steps and what things are doing, and how, and doing time studies on all the work that they do every day, desk audits and things like that.

Keith Sinay (23:21):

And it is very time consuming from where I sit. That was always going to be the question for me. But again, the PA authorizations, none of these come from our internal providers. These are all outside providers. So there's verification, things that we have to do to make sure that they meet criteria. And there's lead time to order some of these drugs. They're not next day, they're drop ships, so you have to keep track of those, make sure they get through to you when you need them. And like all of us on this call, our population came to be very challenging. Even though it's their specialty meds, we still have the same issues with non-specialty meds around our language, population language, and literacy barriers.

Keith Sinay (24:19):

And then one of the ones that really take up a lot of time is the care plan documentation that we are required to do within our accreditation standards with our accreditation. Next slide. So our Next Steps here are to... In 2021, for 2022, we were able to negotiate for allowing our employees to be included in the specialty prescription benefit part of our plan, our employee plan. And our idea is to incentivize, if not require HealthPoint employees to use our HealthPoint specialty pharmacy. We've also been contemplating the idea of being a specialty provider pharmacy for some of the local small employers. There's 20 minutes of talk I can go over just on that, but I won't. Then continue to negotiate with our other MCO partners to allow us to fill on behalf of our patients.

Keith Sinay (25:42):

We were successful this year. We've been trying for three years to get access through one of our MCOs Coordinated Care. And our CFO, every time we would go into negotiations for the medical and dental side, she would always be pushing this and me by her side, of reasons why they should allow us to fill for our own patients. And we were successful this year. They used to have to go to a carrier, and being January 1st, we are now allowed to, we are now able to be filling for our own patients. And additionally, we'll be adding more staff and more technicians, and moving to a bigger space through a remodel of our Central Fill. Next slide. The third initiative strategy we did is I launched the Patient Engagement program, with a specialist employee. Why did we do that? It was a way for us to generate the revenue and retain patients that were assigned to us from filling outside pharmacies. Next slide.

Keith Sinay (27:00):

So shamefully, this idea I stole from the Equiscript model, when I hit the ground running in 2014 and felt like every year after that, they were constantly asking me to come let them service us. And since then, we had been contemplating doing some of this on our own. But with other priorities, we decided to bag that for now. But in 2019, we decided to go ahead and go forward with this. And we launched the pilot to help design and develop the program for a proof of concept. And we were able to do that through an opportunity to deploy a technician that needed to work from home. She had a condition where she was needing to work from home. So that's why we decided to.

Keith Sinay (27:57):

We had the resource dedicated to doing this, so that's why we did that. And so we launched the pilot in 2019 to 2020, and we were able to, the way we did the pilot and started the process of analyzing is we work with our plan partners, Medicaid manage care plan partners for the four major ones, to give us our claims data for patients that are assigned to HealthPoint, but don't use our pharmacies. And the idea is to target those patients and bring them to HealthPoint. Next slide.

Keith Sinay (28:35):

So here's an example of claims data that hopefully most people have easy access to it. I couldn't say that's for sure, but it's simple data, the date filled, NDC number, the drug, what the cost was, and what pharmacy they went to. But if you can't get claims data like this through your partners, your EMR might also be able to show you where these scripts are going. We can also get reports out of NextGen, which is our EMR that shows which drugs went to one, and we can extrapolate a cost through a formula to figure out exactly what that opportunity would've been based upon. We know what our contracted rates are with our plan partners. Next slide.

Keith Sinay (29:32):

So in order to join this product or to manage her workflow, it was just a very simple, rudimentary tracking form. It didn't need to be fancy. We just needed something to start with and something that she can help organize her work of tracking the patients, which ones she transferred, which drugs were they, which ones say, I don't want to. And since there were thousands and thousands, and thousands of claims, we were able to organize it by highest claim spend in descending order. And that's how she did her work. And then this tracking form was so that we can quantify the work to see if the work she was doing resulted in any positive returns. So next slide.

Keith Sinay (30:26):

So the results of the pilot were positive. And we did as best as we could to put the work she did into actual claims revenue generated through prescription filling that we could. And this was enough for us, even if it wasn't 100% guaranteed that these people would retain with us forever and ever, and ever. I'll talk about that in a minute. But we thought it was very positive. Now what you're looking at is these numbers, where they generated from. They're a grand total calculation of an annualized value of the prescription that was transferred. So example is if you transferred a Humira or something for $2,500 bucks a month, then the annualized value of that transfer was recorded as $30,000. So that's what you're seeing. Good or bad, that's how we did it. Next slide.

Keith Sinay (31:32):

So we now launched into a proposal mode because it wasn't really going to be a huge lift like we did with specialty. It mainly was a position, so we just did a light proposal with an SBAR designing what we wanted, the skillset, and everything to be. And so we developed that job description, and we got approval for that. Next slide. Here's the job description. Next slide. And then before launching, we took that Excel tracking spreadsheet, developed our own program database that would be better and easier for her given the thousands and thousands of claims that she was having to deal with. To help track better on the progress of each claim or each account that she's managing, whether or not they said yes, if they said no, they'll contact me again.

Keith Sinay (32:44):

Each month we don't want to keep going after that same person. So she's able to designate them, don't call or forget it. And then it also automatically tracked the claims data and generated reports automatically. So we ditched the Excel spreadsheet, and we were able to do this much better. Next slide. So results. We officially started her position in 2021, but it wasn't a full year because of the pandemic and things that were happening with people calling out. So she had to sometimes fill in. And another good, but irritating thing was we had to make a pause on it several times because it got too busy, when she was pulling in.

Keith Sinay (33:41):

And one of the odd effects was she would pull in a really expensive specialty med, but then they would have seven or eight regular meds, which is great. We want the whole account, we just don't want the one specialty med. So the specialty med would go over to the pharmacy, which at the time could handle it. But then the transferring and the management of hundreds of new prescriptions for the Central Fill mail order side of things was what ended up causing that pause. But we ended in $1.2 million in 2021, and we are projecting $1.6 million annually in this effort to pull again, HealthPoint assigned patients to HealthPoint.

Keith Sinay (34:34):

Next steps are to continuous improvement on refining and improving our data collection and really understanding the longevity that patients when we pull them in, to how long do they stay with us? And we're hoping forever, but we know that's not always the case as they transfer care to other outside organizations, and they change plans. So it's inevitable that's going to happen, but we don't want service related issues to be that source of reason. So we're going to spend the year refining our database, collecting reports.

Keith Sinay (35:16):

And also, we looked at expanding this position scope to not just include working that list, but also we all, everyone in this call has transferred outs. And we want to try to understand that a little bit better, and this position could be a perfect type of position to help do outreach to those groups of patients. And so that's something we're contemplating, and we'd obviously have to add some resources for her to do that.

Keith Sinay (35:54):

And maybe down the road, we thought about testing this service to provide to some of our locals, Washington state CHCs that maybe don't want to pay the amount that Echo scripts and other vendors do. We could probably do it for a third of the cost. And we're also contemplating the role to be more around an account manager or a concierge service, where they own these accounts, these high dollar accounts, and they manage them. And they're their direct source for handling problems and concerns like that. Okay. Next. Lastly, this is Med Sync. Why did we do it? Well, to be honest with you, the providers were the real drivers, at least here at HealthPoint, before I got here and then also patients. So next slide.

Keith Sinay (37:03):

So the journey began when I just got here. The providers were requesting the service. And when I'd started noticing is based on the fact that we had a lot of patients with that need. And some sites were doing it, and some were not. By and large, the providers were sending them out, so we were losing an opportunity. It is one of those things that because we were already doing it, we felt like we had one foot in one canoe already. So we thought, "Okay, let's examine this. What will we need to do to make this work?" So we did a patient's needs assessment and looked at again, you can get your data from however, EMR, we just are fond of claims data, because we can get it pretty easily.

Keith Sinay (37:58):

And there's value attached to the claims data that we could use to help with our ROI, where if you do EMR, you have to extrapolate that. But the patients of five or more meds that are assigned to HealthPoint was pretty large, was well over 1000. And then also we started to do some research on what are other pharmacies doing? And looking at the data, some theoretical, some empirical data showing the value of improved workflow, increased revenue capture, improving adherence, reducing inventory, all those kinds of things were things that we've talked about.

Keith Sinay (38:43):

And finally, we looked at, do we decentralize it? Or centralize it? But the fact that we had a Central Fill Pharmacy already, and it wasn't being really utilized as much as if it needed to be at the time, we decided to move this over to Central Fill. And it allowed us to develop a more standardized approach because the sites were all doing it a little bit differently. And it allowed us to use, we had a robot at the time, so it allowed utilization of our robot to reduce the burden of filling. Next slide.

Keith Sinay (39:22):

So when we started it, it had a rough beginning, and I'll share why. But we then proceeded to have year-over-year, some decent growth. Next slide. And so the challenges, and there were quite a few of them. But first one was developing an efficient workflow process. So we started with a spreadsheet, and obviously that's not an efficient way to do it. We only had a couple dozen patients. That's what they started with. Then eventually we switched to a company called Prescribed Wellness, which I personally thought was way better.

Keith Sinay (40:08):

And so I pushed that, but the staff felt there was too many glitches between the interface, between at the time QS/1 and this platform. So they kept using the spreadsheet to double check with Prescribed Wellness, and then it just became double work. So then we said, "Okay, why don't we go to..." The QS/1 solution at the time was a Health-Minder. So we switched to that as our source of truth, and now we have Liberty. So the change management challenges, the staff really struggled at first. They felt it was more work. The why we were doing it, just why it was important, and for buy-in, just wasn't quite there yet. They really struggled trusting the process. They would perform workarounds and double checks, and triple checks with a theory that it happened that one time out of 1000.

Keith Sinay (41:11):

So they felt like they had to check all thousand every time to find the one, and it just became unmanageable. But that's from my perspective. The staff's opinions were that, that were doing at the time, that the workarounds and the process checks was just patient care. And my position is that it's just not sustainable. And if we want this to be a permanent thing, we really need to figure this out or we're going to have to cancel the program. So what really helped is that under new leadership with a different perspective, a different buy-in, a different tolerance for what is acceptable and not acceptable in the real world.

Keith Sinay (41:56):

And the fact that she dedicated a certain one staff member to be a primary overseer with cross training of other staff, it really helped to improve the efficiency and standardization in the workflow. So that was a huge takeaway from this, from where I sit, and then why I think things turned around. Next slide. So the advantages were from again, where I sit and what I see, and how would I feel is, if done efficiently, it

works well. I've seen it done inefficiently, and I like where we're at today. It can improve the workflow because it's very predictive. You know what your day tomorrow for this group anyway, is going to be. It's no mystery that somebody's just walking up to a counter and doing on-demand prescriptions, you know what's going on. So you know how many you need to fill, you can manage your volumes and spacing, doing what's called level loading on your days so that you don't do a 201 day and then three on Wednesday, something ridiculous like that.

Keith Sinay (43:16):

Yeah. And to be honest with you too, I really felt this, and this is why we started it, was that we are retaining these patients that would've been taken out. And I believe that in my heart, that would've happened if we didn't do this. So that is a whole revenue generating opportunity by itself. And then all the other quality measures opportunities, increasing your star ratings. We noticed our Central Fill is slightly higher or better than some of the other sites, but it's hard to make that correlation because they do other filling that's not specifically to this. So I can't make that statement. And real quickly, lessons learned, anticipate pushback, create an efficient process from the beginning, have rules of eligibility. That's something we got to go back to.

Keith Sinay (44:15):

I see several times when there's people with two or less, and I'm wondering why, but there's also 12 or more, so that's something we're going to study. Cross trained staff, and think about creating a [inaudible 00:44:32]. That's their job, and that's what they do. And then have metrics to determine what does success look like. So you know if you need a course correct, or you're doing well. And then next slide. Real quickly. So we're going to try to optimize our new Liberty system. We've only been on it since August. Like I said, review eligible criteria. We have never marketed to providers, patients, or plans, and we plan on doing that. And then adding a pouch packaging opportunity. Next slide.

Keith Sinay (45:08):

So some of you may already have this, it's called pouch packaging. It's something that's becoming more of a craze. Amazon bought PillPack, and they are aggressively going after this market. And we're starting to see other pharmacies around us beginning to offer this. We had purchased this for this year. We think it's a good compliment to Med Sync for improving adherence and safety. For us, it's a pretty simple ROI. We looked at that group of patients recently on five or more meds patients assigned to HealthPoint.

Keith Sinay (45:52):

And even if we were just to grab this 10% of those patients and pull them in that don't feel for us now, again, assigned to us, but don't feel for us, you could see the ROI is pretty good. Especially with the fact that the whole unit with training and everything came about $240,000. So we'll make that up lickety-split. That's it for me. And I hand it back over to Brandon.

Brandon (46:29):

All right. Thank you so much, Keith. We've gotten tons of questions in there, so I'm pretty sure we're not going to get through all of them. But what I will do is thank you all for submitting your questions in the Q&A, it makes it much easier for us to moderate and manage those. And I saw there are some questions earlier on in the chat, and I plucked them, move those over to a doc. And we'll get to those, but I'm prioritizing the Q&A questions. Just so you know, any questions we don't get too live, I'll be sure to send

these over to Keith and certainly Tim, and they can work together and provide some responses that we can resend back out to the cohort today.

Brandon (47:08):

All right. And I saw there was one question or comment about the link that I shared with the recording. Remember, today is our first 2022 Office Hours session. We did not have one since December 2021 due to some conferences and things happening earlier this year. All right. So Keith, we've got tons of questions. And as a reminder, I'm going to skip over ones that are addressing 340B, as you remember Tim's comment earlier during Office Hours. So I'm just going to fire away Keith, starting from the top. Any tips for meal delivery for a transient population?

Keith Sinay (47:47):

No. Actually. It is a problem. We just encourage them to use a place like a friend or a family member, or someplace that is obviously more secure than their current condition. But it's a problem.

Brandon (48:12):

Great. Thanks Keith. Before we get to the next question, I did want to, I think Irene has her hand up. Irene, if you'd like to voice your question, feel free.

Irene (48:27):

I'm sorry. That was an error. I'm sorry.

Brandon (48:29):

Oh, no worries. I want to make sure you got an opportunity. Thanks, Irene. Okay. The next question on our list was Keith, can your pharmacist approve refills?

Keith Sinay (48:40):

Yeah, actually, in the state of Washington like other states, we have CDTAs through our pharmacy commission and our providers. And that's what's really unique. All of us have this opportunity because we are part of the same system. Our providers love it, and that's one of the carrots that we give them, to use our pharmacies and not send them out is that we do refill authorizations for patients that go to our pharmacy. We've contemplated opening it up to all, but we've had this discussion over and over, but we feel this is the carrot that is being effective in them referring them to our own pharmacies.

Brandon (49:28):

Great. Couple other questions here. How are you paying for mail fees? And that's one question. And are you charging patients?

Keith Sinay (49:37):

No. With the margins that we're getting, and I know we're not supposed to say the word 340B, but the intent is to improve access to patients, remove barriers. We really feel that this is one of those things that were the intent of what our mission is supposed to be doing is. And so the margin on an average drug release for us is $40, $50. So the $2 is really nothing.

Brandon (50:16):

Great. Thanks, Keith. What percentage of your prescriptions are mailed out?

Keith Sinay (50:23):

That's a really good one. We did. So out of 200, whatever the math is, I can't do it that fast. So we did, the slide was 67,000 out of 275. So sorry, whatever that math is.

Brandon (50:42):

All right. I'll let folks figure that math out. Thanks Keith. Another one was, do you have any PBM issues with delivering prescriptions by mail? [inaudible 00:50:52] [crosstalk 00:50:52].

Keith Sinay (50:51):

Not yet. Not yet. We're aware of the risk. We do look at our contracts. We do look at that percentage. If we need to be a true mail order, that's on our radar, if that's where we need to go. One of our main plans, Community Health Plan in Washington is one of our best partners and our biggest plan, and the one we do the most. We don't feel that they're going to come after us for anything like that. And so we do talk to our counsel on it about risk, and we feel we can mitigate the risk. But if we need to pivot and change, we're willing to do that.

Brandon (51:46):

Great. I remember during your presentation, you have a conversation around cost per script. So one question is, can you unpack the expected cost per script? Meaning explain a little more. And the other part to that was just FedEx, others really drop pricing that low for one day delivery, $2.25 a prescription?

Keith Sinay (52:10):

The bulk majority of the prescriptions is regular mail, which is actually pretty cheap. And the key to driving your costs down is you don't want a onesie-twosie. Onesie-twosie will really blow you up. So the way to get your cost per script down is obviously, if you have four or five scripts, you want them all in there, so that's how we calculate it. If the staff isn't really organized and thoughtful, I've seen, well, they filled these two today, and then they filled that one a week later, and then you filled that one, and then all of a sudden your costs per script go up quite a bit. Now, FedEx, introducing the FedEx, the amount of FedEx is actually pretty small in comparison to the regular mail. So that's the other control piece is who and why are they using the FedEx? For us it's mainly for specialty to get it there quicker, but we do offer it to regular patients who maybe forgot to order or too late, and can't go onsite and pick it up. So I hope that answered the question.

Brandon (53:23):

Great. I'm going to hop down a little bit. I'm seeing specialty pharmacy coming up a few times here. I'll combine a couple says four, and we'll probably make this our last one so we can wrap up our slide deck there. But the question is, for specialty pharmacy, what is the end result payer mix? Seems like every PBM requires their own in-house specialty pharmacy. And the other question, another question was, how did you get the specialty pharmacy off the ground? Did you use a consultant? And if yes, who?

Keith Sinay (53:58):

No, we didn't. This was part of the business planning process. I went over a little bit in the slide deck. We looked at data, we looked at developing proposal plan, looked at market trends, things like that. We did

our own analysis. And then the question about payer mix, we're heavy Medicaid managed care here, and with a little bit of Medicare part D, but Medicare part D is something you should really think about because it's any willing pharmacy provider. They can't restrict, so it's free to go after that group.

Keith Sinay (54:40):

And it's actually pretty easy to grab them. But absolutely right, all four MCOs have their own restricted pharmacy that they are required to send. But you can negotiate with them, and that's what we did. We were able to get CHPW to let us fill for our patients. And then Coordinated Care allowed us this year, and you just got to keep bugging them. And the key was our CFO really pushing it during negotiation with contracting.

Brandon (55:13):

Okay, great. I am going to make that our last question. Actually, I see my friend here, [Chris Jablonsky 00:55:19], put in the chat there. Hopefully that's a question you can ask really quickly. How many square feet is your facility to provide the mail order specialty pharmacy business?

Keith Sinay (55:30):

I'll have to get you back on that, because we have a brand new facility that we're moving into. That might be more pertinent, but I'll give you both. I'll give you both of those.

Brandon (55:40):

Great. All right, guys, we're going to wrap up the questions there. We have a couple more slides to close out our session, but any of those additional questions that we didn't get to, Keith, I'll send them to you, and we'll try to get some responses back to our colleagues here on the call today. All right. So just a couple upcoming events. You'll see I posted earlier in the chat there, a link to our Cultivating Health Center Operations Trainings, virtual registration is open. Go to that link. You can certainly register. I'm not sure there's going to be anything specific to pharmacy, but it certainly does encompass health center operations approaches and techniques, data strategy. So be sure to register for that if you're interested. Next week, it's coming up. I was going to attach the link, but it was so long.

Brandon (56:25):

I'll try to make sure that's forwarded out in a follow-up email, but next week's the next COVID-19 Vaccine Mandate Office Hours, is probably number three I think we've done. From two to three, it's co-led by myself as well as my colleague, Vacheria Tutson [Keys 00:56:44], whose director for regulatory affairs. So it'd be lots of questions and opportunity for questions relative to the Vaccine Mandate and prepping for onsite surveys for that. So more to come with that. Again, additional questions, we'll get those answers for you from our speaker today. Keith, thank you so much again for our recap, a really resourceful, relevant recap of your presentation from a few months ago. Again, I did place in the chat a link to all the archived recordings, so be sure to check those out as well. All right. Thank you so much for joining us today guys. Take care.