

## TRANSCRIPT OF AUDIO FILE:

### THE ROLE OF ON-SITE LABS AND PHARMACIES\_RECORDING

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#### **BEGIN TRANSCRIPT:**

JENNY CRAWFORD, JD, LCSW-C, MODERATOR: CIHS promotes the development of integrated primary and behavioral health services to better address the needs of individuals with mental health and substance use conditions, whether seen in specialty behavioral health or primary care provider settings. In addition to national webinars designed to help providers integrate care, the Center is continually posting practical tools and resources to the CIHS website, providing direct phone consultation to providers and stakeholder groups, and directly working with SAMHSA primary and behavioral healthcare integration grantees known as PBHCI grantees, and HRSA-funded health centers.

Before we get started, I have a couple of housekeeping items. To download the presentation slides, please click the drop-down menu labeled “Event Resources,” on the bottom-left of your screen. Slides are also available on the CIHS website, at [www.integration.samhsa.gov](http://www.integration.samhsa.gov), located under the heading “About Us/webinars.” [00:01:01]

During today’s presentation, your slides will be automatically synchronized with the audio, so you will not need to flip any slides to follow along. You will listen to the audio through your computer speakers, so please ensure they are on and the volume is up. You may submit questions to the speakers at any time during the presentation by typing a question into the “Ask a Question” box in the lower-left portion of your player. We’ll be taking – we’ll be *responding* to your questions at the end of the webinar, since both of our speakers today will be addressing both on-site labs and pharmacies. Finally, if you need technical assistance, please click on the question mark button in the upper-right corner of your player to see a list of frequently asked questions and contact info. for tech support, if needed.

Today’s purpose for this webinar is to create fully integrated behavioral health systems and to create better outcomes for individuals with mental illness and addictions. [00:02:02]

Some behavioral health organizations have incorporated on-site pharmacies and labs into their service array. This webinar will feature two camps of primary behavioral healthcare integration grantees, one a former grantee and one a current grantee, who have included pharmacies and labs in their organizations’ workflow for integrated primary care. We are going to present to you nuts

and bolts about issues related to the implementation of these two additional services. Today's webinar will review key questions to ask about: adding pharmacy and labs as part of your primary care integration; information about the cost-benefit analysis of having an on-site lab or pharmacy; considerations for licensing, staffing, and space.

I want to issue a disclaimer at this point, in that the National Council and CIHS are not promoting any particular company or lab, or pharmacy, or any particular modality; we just have an excellent opportunity today to look at how two organizations have chosen to have similar and different implementation process to have on-site pharmacies and labs. [00:03:11]

So, as I introduce myself, I am Jenny Crawford, your Moderator and the Deputy Director at CIHS. We're going to have two great speakers today; the first is Becky Hudzik, who is the Director of Wellness and Recovery Services at Wellspring Resources, in Illinois, and Sandy Stephenson, who is the Director of Integrated Healthcare, Southeast, in Ohio. And we're going to start our discussion today with some cold questions for all of you so that you we all, including you, have some insight about other organizations across the Country and what you are doing with on-site labs and pharmacies. We will have our first poll question [pauses], and the question is, "Do you have an on-site lab?" Yes or no. [00:04:04]

In just a second, we'll get – if you will answer that question, we are going to get our result. [Pauses] And we'll get the results in just a minute. [Pauses for six seconds] And it looks like [pauses] – [inaudible at 00:04:30] [Pauses] – that 76 of – [pauses] – I'm sorry. I'm trying to make – to look at this. Here we go – that 76 percent of you said that you do not, and that about 20 percent of you said that you do have an on-site lab.

So we'll go to the *next* poll question. [Pauses] [00:05:00]

And while our assistant is bringing that up, [pauses for five seconds] – so our next poll question is, "If you do not have an on-site lab, do you have difficulty accessing your clients' recent lab information?" And your responses are: "yes," "no," or, "I don't know." [Pauses for seven seconds] And our assistant will be – if you're answering, we'll be sending you the results in just a second. [Pauses] So it looks like about 48 percent of your answered "yes," about 23 percent of your answered "no," and about 26 – 25 percent – 28 percent of you answered, "I don't know." [00:06:03]

So we've got, currently about – over 150 people on the call, so that gives you a sense of where we are. And we have another poll question for you, if we can load that one. And this one that you'll see in just a minute, as our system loads the questions, will ask you, "If you *do* have an on-site lab, do you have difficulty accessing your clients' recent lab information?" Part of the reason for this question is, are you able to get lab information, lab results directly into an electronic health record, are you able to access it and print it, and able to print it and scan it, but we want to know your perception of, is that, even with an on-site lab, is that difficult for you – yes, no, or I don't know. And so I think most of you have answered that, and the response is that about eight percent of you have said – oh, here we go... [00:07:04]

The results – a little more than eight percent of you have said, “Yes”; 47 percent of you have said, “No”; and 44 percent of you have said, “I don’t know.” So for those who don’t know, this might be an interesting thing for you to go back and find out whether you can easily get lab results or not.

And the fourth question for the moment, before we head into our speakers – and our system is going to load that question for you – is, “If you have an on-site *pharmacy*, have you contracted with an established pharmacy to operate at your location, have you created your *own* pharmacy?” And, finally, “We don’t have an on-site pharmacy.” And so we will – as you’re responding, we’ll get those results to you in just a second. [00:08:01]

It’ll just take another minute. And here we are. And our results are that about 32 percent of you have contracted with an established pharmacy to operate at your location, three percent of you have created your own pharmacy, and – I’m sorry – 11, almost 12 percent of you have created your own pharmacy, and 61 or 62 percent of you say that you do not have an on-site pharmacy.

All right, so that gets to some baseline information for those of you on this call, and now I am going to turn this presentation over to Becky Hudzik from Wellsprings. And she is going to talk to you about both their on-site pharmacy and lab. So, Becky, here is to you.

BECKY HUDZIK, DIRECTOR, WELLSRING RESOURCES: All right. Good afternoon, everybody. I am speaking from Wellspring Resources in Alton, Illinois; we’re just north of St. Louis, Missouri. [00:09:02]

And we serve individuals with mental health conditions and substance abuse disorders in four southern Illinois counties. Our vision for integrated health services began as part of a leadership retreat. Leaders of the Organization were trying to think, “What are the ways that we’re able to best serve the consumers in our area?” and they decided, “We want to create a one-stop shop.” Our CEO – she started with researching pharmacy service options. The most urgent need, though, for our consumers was access to medications, and we recognized that we needed to partner. Starting our own pharmacy was beyond our skill set and our resources. So, after resourcing [ph] Genoa, our CEO brought to the table the idea of Genoa. She thought that Genoa presented the best partner for us. [00:10:02]

Genoa’s vision for a mental health and addictions community is to act as a partner and advocate to improve consumer outcomes, and to provide enhanced quality of care through integration and support services. Their vision fit perfectly with our key objectives in wanting a pharmacy on-site and being able to provide further integrated care for the consumers that we serve.

The logistics involved – because Wellspring decided on a pharmacy service rather than an on-site *full*-service pharmacy, the only space needed was one office, so approximately 144 square feet, an Internet connection and a telephone, and they were ready to set up shop. Our partner *did* state that they needed approximately 5,000 customers in order to contract with us, and part of that is that we have five residential group homes, and that was part of the deciding factor that helped Genoa to feel that they could sustain having a pharmacy tech here. [00:11:01]

They provide pharmacy services on-site, via a pharmacy technician. They offer something that really spoke to us, which is that Genoa offers this bill packaging, which means that, for folks that take multiple medications at one time or maybe have difficulty opening pill bottles, they will place the entire med pack in a bubble pack. And the bubble packs are clearly labeled. They are in a sheet for a week at a time, so if somebody takes medication at eight, four, nine o'clock, all of the medications are in one little package for that timeframe. And it lists the name, dose – all of that is clear, and that has really shown to increase med compliance, specifically for those with serious mental illness. They will also deliver medications to our residential sites. They offer prescription assistance through patient assistance plans, to help low-income consumers to get their needed meds. They also offer payment plans, so if a customer does not have all of the money one month, they will allow them to make payments, which is really nice. [00:12:08]

We have the pharmacy tech available on-site Monday through Friday, from 8:30 to four. [Pauses] I apologize for not moving my slide. So our vision for integrated health also included having a lab service on-site. We needed to supplement the pharmacy service and the primary care services that we already had here. We learned a lesson. Our first lab partner was not the best site. Their rates were not competitive, and the consumers chose to get their labs done elsewhere. What this also meant is that the funds that we have available to assist those without insurance and no income – we were also choosing to pay for those somewhere else, because it was more – we could serve more people with using another provider. So we didn't end up having the numbers to sustain the lab, and the volume of the Medicaid and uninsured consumers was not acceptable for the initial lab partner. [00:13:07]

Our *second* lab partner is the number one lab provider in *our* area. We are a collection site, so LabCorp uses two rooms; they have a draw room and they have a room for urine collection. Wellspring leases space to this partner, and we did not need to obtain any new licenses. And they are here three days a week – Tuesday through Thursday – from 8 a.m. to 5 p.m. They provide lab tests, blood draws, and other lab services. They provide discounts on lab work for consumers with no income, if our agency pays. So what they did was, when we partnered with them, they sat down with our revenue cycle folks and they set up. If we are willing to be the guarantor between our consumers and the lab provider, we can give them lab work at a much – a very deeply discounted price, so consumers pay us and we pay LabCorp. [00:14:07]

And we also have medication-assisted recovery services for those with opiate addiction. And those consumers were paying over \$1,000 at local lab services, whether it was at the hospital or other places in the community. They are now able to get all of that lab work completed with LabCorp here in our building for \$150, a *major* price difference.

So what is the impact? Having a pharmacy and lab service on-site has really helped to encourage our integrated health efforts. The lab tech and the phlebotomist have become integral key members in providing integrated health to our consumers. The follow-through on filling prescriptions and completing lab work is higher for our consumers, as the barriers to obtaining both have been eliminated. [00:14:55]

The grant project for service participants has a high rate of reassessment for labs. We are currently at 97.2 percent, which is pretty phenomenal, and this is, in large part, due to having the lab services being located on-site.

More benefits for the consumers or our services are that we do have a one-stop shop. We have a lab, the pharmacy services; we have a primary health clinic and then also the behavioral health services such as counseling and case management all available in one place. Pharmacy delivery services are available, and this eliminates barriers for the consumers without transportation. We also have a prescription assistance program so that low-income consumers can get needed medication at minimal or no cost, and there is increased collaboration between health providers - nurses, pharmacy techs, physicians, clinicians - all co-located and working together. And there are conveniences for staff, as well. LabCorp is the preferred lab provider of the health insurance provided by the agency, for staff, and staff can also have their prescriptions filled with Genoa and have them delivered to the office. [00:16:07]

It is also a time-saver. The Genoa pharmacy technician is the person who fills out and submits patient assistance plan paperwork on behalf of our consumers. It is a really nice added bonus having her off the lobby.

Benefits for the agency as a whole are that we're spending less on staff mileage reimbursement for transporting consumers to and from the pharmacy or lab appointments, and we're able to serve more people in a shorter amount of time because these services are so easily accessible. Also, the agency gets exposure to potential consumers of our services when they're visiting Genoa or LabCorp in our building. And we collect rent from LabCorp and Genoa for space, so we actually make some money off of them being located in our building. [00:16:56]

Some logistics and start-up considerations – Wellspring Resources does not own or operate the lab or the pharmacy that is co-located in our building. This arrangement means that the agency had minimal start-up costs. Wellspring Resources provides space for a drop room and a draw room for the lab, and a pharmacy tech office. We collect rent from both LabCorp and Genoa, and we do not employ the lab or pharmacy workers, which saves the agency money.

And, lastly, the role of the pharmacist – our staff speaks to an on-site pharmacist technician directly, as do the consumers who utilize them. The actual pharmacist is about 30 miles away, at their main office; however, they are available for consult, for staff and customers, as well.

JENNY CRAWFORD, JD, LCSW-C, MODERATOR: [Muffled, feedback] Thanks, Becky. We'll have Becky and our next presenter's contact information at the end of the presentation. [00:17:59]

We're going to release our final poll question right now – poll question Number Five – if our assistant can bring it up [ph]. We know that some of you are sending in questions, and we're going to get to those, too, after our next presenter.

So this final poll question – we'd like you to check all that apply. Someone asked us how many people we have on the call today, and the percentage is that, currently, we have 172 people in the audience for this call.

So this question is that we would like you to check all that apply. And the questions are: "Please describe your organization's use of an electronic health record: where all integrated care staff and primary care and behavioral health can use our EHR to see lab results; all integrated care staff, primary care, and behavioral health can view the same behavioral health/primary care medication reconciliations, and behavioral health and primary care prescribed medications; they can see the electronic lab results directly into our EHR, in the lab; or we do not yet have an EHR into [ph] capacity and cannot access both behavioral health and primary care medication information in our EHR." [00:19:22]

So if you're answering all of those that apply to you, I'm going to [inaudible at 00:19:30] log them into here and be able to show you the results. Wow, you all are a wonderful, fast audience, so thank you. So it looks like 20 – almost 27 percent of you – 17 people said all of the integrated care staff, primary care, and behavioral health staff can use your EHR to see lab results. A little more than 26 percent of you said that all integrated care staff can view the same behavioral health/primary care medication reconciliations and prescribed medications. A little – 24 percent of you said that you can see the electronic lab results directly into our EHR. And 55, almost 56 percent of you said that you do not yet have an EHR with these capacities or cannot access this information [outside noise] both for behavioral health and primary care in our EHR. [00:20:26]

All right, so thank you for that information. It kind of [inaudible at 00:20:29] nationally on where you folks are. And now I'm going to turn this over to Sandy Stephenson. Sandy, again, is the Director of Integrated Healthcare from Southeast, Inc., in Ohio, and is one of the graduated camps [ph] of primary and behavioral healthcare integration grantees. So, Sandy, this is to you.

SANDRA STEPHENSON, DIRECTOR, INTEGRATED HEALTHCARE, SOUTHEAST, INC.: Thank you. I want to give you just a little bit of context so that what I say drops into that context.

Southeast is based in Columbus, Ohio. We serve six Ohio counties and, as noted, we were a SAMHSA Cohort 1 grantee. [00:21:05]

I like to think we *are* rather than were a [chuckles] Cohort 1 grantee. At the end of our grant, we had over 1,200 clients participating. This is important – Southeast is a solo provider within the PBHCI Model. Solo is significant. It is a contributor for this presentation. For us, solo simply equals more control.

Our target population for the work we do is quadrant 4, so high needs with regard to behavioral healthcare and very high needs with regard to primary healthcare. Southeast became a federally qualified health center at the end of 2011, which also contributed to our capacities for sustainability in the future. And, this past year, we had almost 3,000 patients using our federally qualified health center for primary care in an integrated manner. [00:22:05]

We're continuing our integrated healthcare expansion as we talk. We do have Joint Commission accreditation. We had it for years with behavioral healthcare, and we were surprised when, when we became an FQHC, we discovered that the Joint Commission insisted that we go under Ambulatory Healthcare accreditation. The next year, we did and, at the same time, we also achieved certification as a Joint Commission primary care medical home.

So, our pharmacy – we're going to start there. Southeast owns its own pharmacy; it is called Apothecare, and you may note that that is the play on the word "apothecary." It is a closed-door pharmacy, non-retail specialty owned and operated by Southeast. And since it is closed-door, non-retail, we are allowed to have no external signage. [00:23:01]

The status, however, allows us into buying clubs, so you can't compete with the large pharmacies of the world without being part of a larger whole; that is very important from a business perspective. Because we are part of these buying clubs, we have fairly deep discounts when we purchase medications. Our specialty status means that our primary targets are people and clients who deal with mental health issues or cognitive disorders on a short-term or chronic basis. In 2013, Southeast served 3,345 clients. In addition, we have external customers, and we've filled almost 75,000 prescriptions. Because we are a solo model and we own the pharmacy, we control our staffing, so Southeast employs three full-time pharmacists, one full-time clinical pharmacist, and three pharmacy technicians. It is a large operation. [00:24:00]

Our current cost of goods is over \$5 million, and this is over a 10-month period with a sale of over \$6 million. Our hours of operation are Monday through Friday, eight to five, and Tuesday evenings. And I will note that that is a competitive *disadvantage*, as most pharmacies are accessible seven days a week and well into the evenings.

As far as history and start-up, I would say this is not for the faint of heart. It was a very complex, difficult decision we made, and it has been very challenging but a good experience. And we had a different sort of situation. In the beginning, we did lease space to a closed-door pharmacy, almost a precursor of the Genos that exist now. That particular company went out of business. It was involved in too many different activities and could not sustain the pharmacy business, so they sold the pharmacy to CVS, and CVS also does have specialty pharmacies. [00:25:03]

That was not a good relationship for us, as CVS did not understand the population we were serving. Southeast purchased that pharmacy in 2002, and we purchased it for the cost of goods on the shelf, so we got a great deal [and], suddenly, overnight, we were in the pharmacy operation business. So I would say, in terms of making a decision to own your own pharmacy and to operate your own pharmacy, it has to be a fit with your organization and business plan. You have to have a specific skill set that we *did not* have in the beginning – many management challenges. You have to have adequate space. If you own your pharmacy, you're going to have all of your pharmacy stock on-site. Staffing is expensive. The pharmacy software is complicated. We had to develop rapid purchasing agreements through these buying clubs and otherwise, and set up agreements with wholesalers that deliver our drugs. [00:26:02]

We had to pay close attention to State pharmacy law - that was also very new territory for us – and learn how to manage the inventory. When you're managing inventory of pharmacy goods,

you have turns. And, as example, currently, the value of the inventory sitting on our shelves is over \$200,000, and if you don't turn it rapidly, pharmacy items will expire, and then you've lost a lot of money. We had to look at various packaging options. We had to look at competition and then, of course, we had to look at the margin that we felt we needed to sustain this operation. Today, we also have to deal with assuring that our pharmacy is an option with the managed care plans and the insurance companies, so that is a very new intrusion into our business, as well. We have expanded our pharmacy since the inception and, under the Federally Qualified Health Center, we also have a 340B separate pharmacy within that pharmacy. [00:27:03]

I want to show you a picture, because pictures really help people perceive what I'm talking about. On the left, you will see the part of the pharmacy. It is in a lot of space, and this was a bookstore in the building we're in. On the right of the picture, you see packaging occurring, or you see one pharmacist and a pharmacy student who is packaging drugs. These are our packaging options; we have three, and they go from really expensive to moderately expensive, to not expensive. On the left, you see a strip. We purchased a machine that costs \$300,000, that packages quickly. And these plastic bags that are really cool because it tells you the drug that is in it. [00:28:00]

And these are combined, so you get your doses in there like with the blister packs, but it describes the shape, the color of each medication, what it is called, and why you're taking it. In the middle of the picture is the blister pack that is probably similar to the one that Becky mentioned. It is set up by days of the week and the dosing times. And, of course, at the right in that picture is the typical, traditional bottle, which is the least labor-intensive. On the right of the screen is our 340B pharmacy, where you see that we are absolutely separating inventory in stock. As is required, it has to be virtual or actual, and we didn't trust ourselves at this point in time for virtual separation.

So why own a pharmacy? Some of it is kind of apparent. It is seamless for everybody. We have real-time consultation with a number of pharmacists, and they go beyond consultation; they get actively involved with our practitioners and prescribers. [00:29:00]

And if they detect a problem, they will leave the pharmacy and track down the practitioner to talk through a drug interaction or a problem with the prescription. So there is real-time intervention. We also control the electronic health record we have, so we control electronic prescribing. Our pharmacy accepts electronic prescribing, and the way we've set it up absolutely meets meaningful use. We have real-time shared information between behavioral health and primary care, and *anyone* can go in and look at the medications that people are taking. A number of people are working on medication reconciliation and patient education. It is *convenient* for our patients. It is right in the building where they're getting their other services. We can determine the rate of medication possession: did they pick up their prescriptions; are they picking them up in a timely manner; when do they come back? And we can intervene if medications that have been ordered sit on the shelves. [00:30:00]

It is affordable for our patients. We have various options that create very affordable pricing for our patients, even those who are homeless, who have no money. We can engage our pharmacists in prior authorization assistance. And we were *very* happy when we were able to hire a clinical

pharmacist, a very different role from your traditional pharmacist. They're very well trained in – my slides are jumping around here. I apologize – they're very well trained in terms of dealing with medications and prescribers, and talking through less expensive options, dosing schedules, what might not be indicated or counter-indicated.

And then, of course, last but not least are financial considerations with regards to owning your own pharmacy. I was asked to note the margin, and the margin changes every year. [00:30:58]

We have never *not* had a profit with this pharmacy but, in the early years, we had significant profit. It is *truly* being squeezed due to pricing in Ohio with our Medicaid Department and also because of the squeeze that the managed care companies have put on some pharmaceuticals.

I am going to switch gears now and move to lab services. As Becky's organization does, Southeast contracts with LabCorp. It is a contracted partner model and, as a solo integrated healthcare provider, we didn't have to worry about our partner and what lab *they* wanted to use because we *are* a partner, so we are all using LabCorp. LabCorp provides a phlebotomist five days a week, from eight to 2:30. They provide all equipment. They meet CLIA standards, which are not easy to meet. They provide schedule specimen pick-up, because we do draw from different sites. [00:32:01]

They provide requested lab reports, which has been very nice. And they contact our practitioners, real-time, 24 hours a day with critical lab results. We, today, have lab on-site and off-site capacity. We're going integrated healthcare at more than one site, and we're very fortunate that our LPNs all can draw blood. So we draw blood at other sites, we bring it to our downtown site in Columbus, and LabCorp picks it up. Our pharmacy is embedded within the primary care space, and *all* of our staff members know the phlebotomists, know the lab, and get involved with the operations.

With regard to business considerations, we negotiated lab services and fees based on volume. We don't have to pay for the cost of lab equipment or the upkeep. We don't have to deal with the CLIA certification. However, I'll get back to CLIA because we have to deal with CLIA for the waived labs. [00:33:09]

If we had done this as a solo model, we would have needed far more space than what LabCorp is in, because we would have had all of the lab equipment. Southeast determined, too, that we needed to have ability to eat costs. We have many, many patients who had no health insurance; with Medicaid expansion, that is improving, but it is an ethical consideration. If labs are needed, your psychiatrist or family practice docs are ordering the labs. In some centers, those docs know that those clients are never going to get the labs because they have no ability to pay. That is not OK for us, in an integrated healthcare setting so, last year or this year – ten months – we've spent \$85,000 of our own funds to pay for labs, for people that are uninsured. [00:34:00]

This is a picture of the lab, and it is actually the size of two closets; that is the amount of space it takes. There is a restroom right next door, so it is easy for the urines to be passed into the lab. With LabCorp and NextGen, our electronic health record, we did have an interface built. I believe that integrated healthcare providers *must* have an interface to support integrated

healthcare. And, in fact, integrated healthcare truly does require an effective electronic health record. The lab interface that we have meets meaningful use; in other words, NextGen receives electronically lab results, and the lab results dump into the appropriate element within the electronic health record. [00:35:00]

We also, now that we have support for data reports and population health management reports; examples would include your hemoglobin A1c reports. All practitioners and staff involved with patient care can see all lab results and know what supports our patients need. So if I'm a case manager and I know that somebody's hemoglobin A1c is high, when I go out to the house, my thinking should be focused on, "What is the person eating? How are they spending their time? Where can they shop? Do they have access to fresh produce?" and etcetera.

With our electronic health record, we also have an electronic portal for patients, so our clients and patients are able to see their lab results within a specified number of hours by going into their own protected portal. [00:35:57]

The interface we built cost \$7,500, and one interface works with one lab; that is the downside of all of this. So if our patients use other labs, those lab results *cannot* come back into our electronic health record. When the lab results come in, they draw up into a provider approval queue called their "PAQ," or their P-A-Q. And there are certainly challenges with interfaces. It took an *inordinate* length of time to establish this interface. Even though NextGen and LabCorp were working together to get it done, there was some back and forth stuff about who was causing the problems when it wasn't operable for months and months and months. And, as I noted, the interface supports only one lab company, and our practitioners – and I'll bet none of you have physicians who would ever do this, but our physicians were used to going directly to LabCorp through a bridge to see lab results, and they didn't really want to use the PAQ [chuckles] within NextGen. [00:37:06]

So we cut off access to the labs direct reports, because if they don't go in and look at the lab in the PAQ, they aren't authorizing it as having been viewed and approved; they haven't signed off on it, and that is essential for liability.

This is a slide of workflow for our lab processes and electronic interface. And I want to draw your attention to the green or the kind of bluish on this screen, the third one down. When the provider orders the desired labs and the electronic health record, they close the encounter, and when they close the encounter, that triggers the electronic interface with LabCorp; that immediately sends to a designated printer that is in that small lab office, the order, and that order has – it is like sticky paper, so the labels for the patient's specimens are right there, real-time. [00:38:06]

The patient, of course, goes to have the blood drawn and, as soon as the specimen is read and the lab results are approved, they come back to the interface within 24 hours and drop in the electronic health record into that PAQ and also into the component where they need to be, and then, again, the critical lab results are called directly, either to a practitioner or to our call service.

Lab results may trigger scheduling and prescribing activity, and this is kind of the interface between your lab and your pharmacy. If a lab comes back that is high for, let's say, hemoglobin A1c, then a physician might look at that, and that would trigger an e-prescription to the pharmacy for medication, and it would also trigger, of course, bringing the client back in to talk about the lab result and to make recommendations, possibly about lifestyle issues. [00:39:07]

Providers use e-prescribing in the electronic health record always at this point in time; we have very little variance from that. Now, I want to show you a report we use in the mornings because this, again, is integration that cuts across our clients and our staff so that we are patient-centered. We have huddle every morning, and our primary care staff and our behavioral healthcare staff get together. This is just a very small component of this huddle sheet. We produce them a week at a time as every provider, every patient is scheduled who in behavioral healthcare is also working with that patient. And, over on the right side of the form, you begin to see the clinical indicators that are so very important. [00:39:58]

So diabetes - any client that has diabetes will show up here with a lab value, or you can see the red alert, "No lab." So, real-time that day, when that patient is expected, you've already had a team of people looking at this report, designing who is going to do what that day for that patient's experience. Preventive labs are also on here, including paps and colon cancer screening using fecal occult, which we will do directly in the office - so direct relationship between human beings looking at data and making clinical decisions in an integrated fashion, about what we're going to do real-time with the patient that day.

This is a report that is kind of interesting. We got this report - and we get this report from LabCorp - and we're looking at integrated lab data. [00:40:58]

The question is, "To what degree are behavioral health staff" - in this case, psychiatrists - "and our primary care staff, primary care physicians and, of course, nurse practitioners in both of those areas ordering labs?" This is just a small group of labs that are ordered, that are very important to us, including hemoglobin A1c, lipid panels, metabolic panel. And you all know why metabolic panel is important with the prescribing of atypical antipsychotics and so forth. So this gives us a way to monitor our practitioners to determine if an appropriate number of labs are being ordered, based on diagnostic categories we're seeing. And you notice a hepatic function; that is, of course, your liver function work. We have an opioid treatment program, so we expect to even see *more* labs taking place in that area as we always have to do labs in advance of starting any treatment for heroin addiction or other opioid addiction. [00:42:04]

This is another lab report, and this one has to do with order adherence. When people order labs, when practitioners order labs, a patient may or may not follow through. We've probably all been guilty of this from time to time, and because we have a lab embedded in primary care, we expect adherence to that lab order to be higher. So down the left side of the form, you see our practitioners who order labs, and then you see whether or not the patient was drawn the same day. If you look at the second person - Amy Becker, a nurse practitioner; you've got Eric Frickso [ph], family practice doc; Teresa Hom, family practice doc - look at their numbers, seven and seven, a 36 and a 29, a 45 and 40. [00:43:00]

So that tells us, in general, when those primary care practitioners are ordering labs. The patient is adhering and getting the lab the same day. If you look, however, at some of our psychiatrists – Dr. Ahmed, Dr. Blay [ph], Dr. Hassan – it all falls apart, and they are located no more than two floors away from the lab. So, from a quality improvement perspective, this report tells us that the proximity is correlated with whether or not people adhere to getting a lab the day it was ordered, and this gives us information that *we* can use, then, for quality improvement processes. I consider this an *extremely* important report or, actually, chart. Southeast takes the monitoring of metabolic syndrome very, very seriously, and this is part of a three-page document that offers protocol and guideline about how we work with our practitioners and work with our patients who are being prescribed first-time and ongoing atypical antipsychotics. [00:44:15]

This is one table that shows the relationship between that required monitoring and what we expect. So you note the typical things that are part of metabolic syndrome: the blood pressure, BMI, waist circumference, hemoglobin A1c, and fasting lipid panel. Baseline required – and then you see what is required – one to two months, three months. Moving in again, required – you see an asterisk. We continue to require the hemoglobin A1c and the cholesterol work depending on what previous lab work has shown us and how the patient is doing with those medications. This is a problem across the Country. This issue is related to the years of lost life, the people we serve, and we believe we *all* need to be doing much better in this area. [00:45:07]

So what I would say to you is to pay attention to metabolic syndrome, integrate the efforts, and assure that you're following guidelines and have a way to monitor whether or not your practitioners are actually following those guidelines by assuring appropriate labs are being done.

I want to talk a little bit about CLIA; I mentioned it earlier. And a lot of behavioral healthcare folks kind of miss this; we did. We take it very seriously now. A lot of providers who think they don't have lab really do. They're doing urine tests for pregnancy, the screen before medications are started; they may be doing saliva swabs for people that are coming in for drug/alcohol treatment. There are just a lot of labs that we do and these are actually known as CLIA waived labs. [00:46:02]

CLIA is very serious that you do following procedures when you're doing waived labs, so CLIA waived labs are regulated. The waiver simple means that you are relieved of responsibility around the other CLIA standards for running a lab. A lot of people don't understand that these are regulated because they're often over the counter in terms of being available. So examples, as I noted, are: urine pregnancy tests, glucose finger tests, urine drug screens, rapid HIV, rapid strep and so forth. If you're doing these, you have to have a certificate from CLIA. You have to apply for a lab waiver, and then Joint Commission and others require that you demonstrate staff competency. [00:46:56]

So you have to demonstrate that your staff understand the test, that they understand the kit they're using, that they *clearly* understand the instructions that go with that particular lab, and that they're evaluated by someone who is designated and who has already been trained to do them. That evaluation material has to be documented and has to be in their human resources or personnel file, or someplace on record. And staff also need to be competent in quality controls. All of these tests can have errors, and the all have quality control information. So, as an example,

with the rapid HIV, you're using reagents with that, and you have to take your first batch through a test process to assure accuracy; then you're fine until you maybe order again and get a new batch that has a different control number, so then you have to do the process again to assure that you've done the quality controls. [00:47:58]

If you have questions about that, simply go online and look at CLIA waived labs, because all of the information is there about what you have to do as a provider. So, in general, we are all already involved in doing lab work even if we're contracting with an outside vendor for the other labs.

So those are our pharmacy and lab services in a nutshell. At Southeast, we believe that pharmacy and lab programs and services are significant contributors to integrated healthcare in patient-centered care. Thank you.

JENNY CRAWFORD, JD, LCSW-C, MODERATOR: Thank you, Sandy. That was *very* helpful. So we're going to go through questions that have come in and, while we do that, we would encourage you to type in any questions that you have for either one of our presenters – Becky or Sandy – into the question box, and we'll capture those as we go along.

I'm going to start by referring to a question that came in, about, "What is PBHCI?" I probably went through that too quickly. [00:49:00]

Primary behavioral healthcare integration – PBHCI – is a SAMHSA grant program for behavioral health organizations that are integrating primary care into their behavioral health settings. SAMHSA is the federal agency known as the Substance Abuse and Mental Health Services Administration. And so the key presenters today currently have – have or *did* have grants from the SAMHSA funding called PBHCI.

So, Becky, we're going to start with you, if you could unmute yourself. There was a question that came in on the "Pharmacy Partner Logistics" slide. And the member of the audience asked, "The 5,000 scripts that you require for a Genoa - what timeframe does that cover?"

BECKY HUDZIK, DIRECTOR, WELLSRING RESOURCES: Yeah, and that was something that I had to clarify with the pharmacy partner yesterday. [00:50:01]

He actually – it is not 5,000 scripts; it is 5,000 customers. He felt that, based on what he believed we could produce for them in scripts, for 5,000 customers, including our five residential locations, was enough to sustain her to be here. So it wasn't actually the number of scripts; it was customers.

JENNY CRAWFORD, JD, LCSW-C, MODERATOR: Thank you. And another question is, "How do you deal with med changes for your residential clients who have medication changes?" Do... [inaudible at 00:50:30]

[Crosstalk]

BECKY HUDZIK, DIRECTOR, WELLSPRING RESOURCES: That situation is – is a – [pauses] is frustrating because you have – what you do is you – the med change – they have to send just a couple of days because we have to send with the driver the entire whatever is left over back. As far as how it goes with insurance, I’m not really *sure* how they handle that; we don’t have an issue on our end. The medication – the new medication is paid for, and I’m not sure how they deal with the other end as far as taking the medication back. But that is part – a frustrating part of it, is you have to send medication back when that does happen. [00:51:05]

JENNY CRAWFORD, JD, LCSW-C, MODERATOR: OK. Another question was, “What is medicated-assisted recovery services?” And we might call that medication-assisted treatment. Can you speak to that, please?

BECKY HUDZIK, DIRECTOR, WELLSPRING RESOURCES: Sure! That is for people who have an opiate addiction. So if it is heroin, something of that nature, and they are treated with – here at *our* facility, our doctor only prescribes methadone. But there are other forms like Suboxone that also are part of medication-assisted recovery for opiate addiction.

JENNY CRAWFORD, JD, LCSW-C, and MODERATOR: Thank you. “And, regarding lessons learned, what would you have done differently to ensure the selection of the *right* lab partner, from the beginning? If you do something differently in the selection of the lab partner versus the selection of your *pharmacy* partner, which seemed to go better from the beginning?”

BECKY HUDZIK, DIRECTOR, WELLSPRING RESOURCES: Yeah. Well, interestingly enough, they were the same person, [chuckles] so I think that maybe shopping around, considering other options. [00:52:04]

I don’t think anybody considered that somebody from LabCorp or the lab Quest [ph] would have partnered with us, so I think that having – I think going to different places like the National Council and talking to other people, other grantees – I think we realized there were other opportunities, and I think that we would have considered other options and shopped around before starting the lab with Genoa.

JENNY CRAWFORD, JD, LCSW-C, MODERATOR: But did you have – did you have criteria of things you *wanted* from that partner? I think that is what the person is asking.

BECKY HUDZIK, DIRECTOR, WELLSPRING RESOURCES: I see. [Pauses] Not per se. I mean, truly, the main issue with them is that their price is more competitive and there was no comparison; we didn’t compare to anybody else before we built that partnership. So that was – I mean, their customer service is great. [00:53:00]

They’re an excellent company to partner with. And, like I said in our presentation, they have similar vision and mission that *we* do. It was just simply cost. And, in talking with our – the fellow over our partnership, he said that they are leaving that business; they have found that it is not working for them. They’re pulling out of that business.

JENNY CRAWFORD, JD, LCSW-C, MODERATOR: OK, thank you. And, Sandy, if I can turn to you and ask you to unmute yourself, one of our people in the audience has asked, “Are your buying clubs group purchasing organizations?” Could you explain that a little bit better?

SANDRA STEPHENSON, DIRECTOR, INTEGRATED HEALTHCARE, SOUTHEAST, INC.: Yes. Again, you as a single provider – and this is probably why there has been such a demise of the small neighborhood pharmacies in so many communities as the large chains have moved in – those large chains have buying power, and they not only have that but, when you go into Kroger or Walmart, or CVS, *you* buy a whole bunch of other stuff besides your drugs. Right? [00:54:06]

So, in order to compete with those chains and what they can do in terms of competition, you *have* to be able to access drugs at discounted prices. And because we’re non-retail – and that is *so* important – we’re able to join these other buying clubs of entities that serve specialty populations, and we have, then, that mass purchasing power. In addition, with the 340B pharmacy we have under the FQHC, we are able to purchase drugs that are even more heavily discounted, and that is new for us. We opened that pharmacy just a year ago. But, without that, we would not have any margin, we’d be losing money, and we would not be [chuckles] doing pharmacy.

JENNY CRAWFORD, JD, LCSW-C, MODERATOR: And, Sandy, can you just explain for a minute the role of the 340B and why that is unique to you as a federally qualified health center? [00:55:05]

SANDRA STEPHENSON, DIRECTOR, INTEGRATED HEALTHCARE, SOUTHEAST, INC.: Federally qualified health centers are eligible to have 340B pharmacies, as are some other entities. Locally, one of our hospitals has a 340B. I’m not sure what their mechanism is, but they have been mostly used by federally qualified health centers. Federally qualified health centers, then, either have their own pharmacy or they negotiate the 340B with an entity like a CVS pharmacy or a Kroger pharmacy.

The drugs are available at deeply discounted rates, and it is due to, of course, government’s being involved. HRSA is the oversight entity for federally qualified health centers, so we’re able to purchase drugs, sometimes, just slightly over wholesale costs. We then offer those drugs to our patients who often have no income, at \$2 per prescription, and the amount they pay goes up as their income goes up. [00:56:09]

With more and more of them moving to Medicaid, it is going to be a much healthier pharmacy environment for us, even though the Medicaid payments for pharmacy are continuing to be reduced. One of the issues with 340B is that we can select the drugs we carry, but not everything is on the formulary, but with our other pharmacy – with the umbrella pharmacy Apothecare, we can pretty much carry what we want.

JENNY CRAWFORD, JD, LCSW-C, MODERATOR: Thank you. And one of the listeners wants to know, “How many labs do you conduct per week?”

SANDRA STEPHENSON, DIRECTOR, INTEGRATED HEALTHCARE, SOUTHEAST, INC.: Oh, gee – per week. That is – that is an interesting question.

JENNY CRAWFORD, JD, LCSW-C, MODERATOR: Or, if you don't know, could we maybe use a different timeframe that you could...?

SANDRA STEPHENSON, DIRECTOR, INTEGRATED HEALTHCARE, SOUTHEAST, INC.: Yeah, my *guess* is – [chuckles] and this is – it is going to be hundreds and hundreds, because we have psychiatrists, nurse practitioners, family practice folks ordering. [00:57:07]

JENNY CRAWFORD, JD, LCSW-C, MODERATOR: OK. And do you have insurance billing for labs, and is it difficult?

SANDRA STEPHENSON, DIRECTOR, INTEGRATED HEALTHCARE, SOUTHEAST, INC.: We – *we* don't because we don't own the lab. We can't use insurance, so when we send the request to LabCorp, electronically, we do include on that lab order the person's insurance or Medicaid, or Medicare. LabCorp, then, directly bills that insurance company, or, if there is no payer, they directly invoice us. Then, when we get those invoices, we go through, line by line, and recheck to see if the person has another payer.

JENNY CRAWFORD, JD, LCSW-C, MODERATOR: And then you're able to resubmit it? Is there...?

[Crosstalk]

SANDRA STEPHENSON, DIRECTOR, INTEGRATED HEALTHCARE, SOUTHEAST, INC.: No, we pay. Yeah, it will – well, if they have insurance, then we let LabCorp know that they need to resubmit for payment. [00:58:05]

JENNY CRAWFORD, JD, LCSW-C, MODERATOR: OK, thank you. Did Southeast ever consider having their own lab with staff employed by Southeast instead of a partnership with LabCorp?

SANDRA STEPHENSON, DIRECTOR, INTEGRATED HEALTHCARE, SOUTHEAST, INC.: We did. Years ago, we visited a lab that was operating in a drug addiction services center in Akron, Ohio. This was *years* ago. It was a good operation. The person who owned the – or who operated the center – it was a not-for-profit – made a lot of money from that operation. However, over time, lab work, too, has been squeezed, and it requires a lot of space; it requires expensive equipment, and many labs are sent out anyway to a reference lab. Even lab companies sometimes end up sending the labs elsewhere for specialty labs. And it was complex. [00:59:00]

Pharmacy has been complex *enough* for us. It would never rule it out completely. I would never rule it out as far as doing it in partnership with somebody, but, at this point in time, we would even have space constraints to own our own lab.

JENNY CRAWFORD, JD, LCSW-C, MODERATOR: And, Becky, let me ask you that same question. Did Wellspring ever consider having their own staff run a lab?

BECKY HUDZIK, DIRECTOR, WELLSPRING RESOURCES: What *we* did is – we have a – the CLIA license, so what we did when we were struggling with lab work, is we bought some equipment and we did not charge the grantee participants a fee for collecting those labs. And that is the gist of what we considered for ourselves, and that was just in between trying to figure out what we were going to do as far as bringing someone else in. So, no, we never wanted our own lab and to employ that person.

JENNY CRAWFORD, JD, LCSW-C, MODERATOR: OK, thank you. Here is another question for both of you... [01:00:00]

The listener asks, “We are considering opening a moderate-complexity lab at our main site, and have 30-plus clinics that we would – pick up, run labs, etcetera. Any experience on reimbursement, etcetera of this type?”

BECKY HUDZIK, DIRECTOR, WELLSPRING RESOURCES: No, [pauses] not for lab.

JENNY CRAWFORD, JD, LCSW-C, MODERATOR: Is that you, Becky?

SANDRA STEPHENSON, DIRECTOR, INTEGRATED HEALTHCARE, SOUTHEAST, INC.: Will you repeat the question?

JENNY CRAWFORD, JD, LCSW-C, MODERATOR: “We’re considering opening a moderate-complexity lab at our main site, and have 30-plus clinics. We would pick up, run the labs, etcetera. Any experience on reimbursement with this type?”

SANDRA STEPHENSON, DIRECTOR, INTEGRATED HEALTHCARE, SOUTHEAST, INC.: No, mm-mm.

JENNY CRAWFORD, JD, LCSW-C, MODERATOR: OK. The next question is...

[Crosstalk]

SANDRA STEPHENSON, DIRECTOR, INTEGRATED HEALTHCARE, SOUTHEAST, INC.: In terms of reimbursement, the way I would *get* at that is: I would determine what labs we were going to run, and I would find out what the insurance companies were paying and the managed care companies were paying and how many required prior authorization. And then I would go to the sheets and sheets, and the reams of papers we have, where we can determine how much LabCorp is charging [pauses] or how much Quest is charging, and determine, then, if we could be a viable competitor. [01:01:14]

JENNY CRAWFORD, JD, LCSW-C, MODERATOR: OK, thank you. And, for the pharmacy – “Do any services for – do you do any services for clients at alternative sites? And how do clients get their scripts that day if there is only a pharmacy tech?”

BECKY HUDZIK, DIRECTOR, WELLSRING RESOURCES: I can speak to that for our partnership with Genoa. The meds do have to be ordered before 2 p.m. in order for the meds to be received that day. So if we have somebody at, say, one of our residential sites, who needs to start a medication that day, and it is prescribed after two, we will have them transfer the script, temporarily, to, say, Walgreen's or one of our local pharmacies, other pharmacies for that first, initial script, and *then* they'll transfer it back for maintenance. [01:02:02]

SANDRA STEPHENSON, DIRECTOR, INTEGRATED HEALTHCARE, SOUTHEAST, INC.: Yeah, with *our* pharmacy...

JENNY CRAWFORD, JD, LCSW-C, MODERATOR: OK. How about you, Sandy?

SANDRA STEPHENSON, DIRECTOR, INTEGRATED HEALTHCARE, SOUTHEAST, INC.: Yeah, with our pharmacy, because we're *filling* – I mean, we have a full-service pharmacy. We fill real-time. The prescriber electronically sends the prescription to the pharmacy. The client or patient walks over to the window and shows two identifiers. And we've already been able, with our software – pharmacy software to determine whether or not there *is* a payer: is the Medicaid active, or is the insurance active, is prior authorization required, or is there a problem with the way the person prescribed? So, real-time, we've already gone through a number of layers of determination about that particular script. And it is packaged as it is prescribed, either the blister packing or those – they come out like in a clamshell or in a bottle, and it is ready for the patient to pick up. [01:03:03]

*Off-site*, if it is, say, a pharmacy renewal, like if the script was written for three months, and CPST staff or our case managers might take it out, because it has already been prescribed. So if it is due and they're going to go out and visit the client, they might just take it out. The same thing with our residential facilities – we'll deliver to them, basically, on a delivery schedule. But, otherwise, it is real-time.

JENNY CRAWFORD, JD, LCSW-C, MODERATOR: And someone else is asking, “What is a break-even script volume for pharmacy? How many scripts does the pharmacy have to fill in order to serve this clinic?”

BECKY HUDZIK, DIRECTOR, WELLSRING RESOURCES: I wish that question could be answered. It depends on whether – it depends on the proportion of generics relative to the non-generic drugs. It depends on the payment rate in your state. In Ohio, Medicaid used to pay a nice packaging fee for the cost of actually packaging the medication. [01:04:03]

They've decreased that payment so radically that you can't plug that amount into your formula anymore, about how many scripts do you have to fill. And then the managed care companies are paying different amounts per prescription. So a lot of it is more a – like a month-to-month and quarterly *monitoring* to determine if you're – if the value of your inventory, which is expensive to have sitting on your shelves, plus the cost of your drugs and your sale price. And minus from that, because you're going to have some gross there, some excess there – minus the cost of all of your pharmacists [ph] and so forth, if you still have a margin. But there is no magic number.

It was interesting to me that Genoa wanted 5,000 people. We have, as far as our patients, close to 4,000. [01:04:59]

We do some outside work, too, but *one* person might have one script a month [while] another person might have six. So I don't look – we don't look at patients; we look more at number of scripts. But there is no magic number, and it has been a moving target for us over the years.

JENNY CRAWFORD, JD, LCSW-C, MODERATOR: I was – this is Jenny. I was at the Mental Health Service Center of Denver on Monday, and they were – I don't know what their break-even point is, but they are writing 300 scripts a day and have their own independent pharmacy. I think that is helpful to define [ph].

Someone else is asking, “What is the difference between pharmacy services and – versus full pharmacy?” Did you want to speak to that?

SANDRA STEPHENSON, DIRECTOR, INTEGRATED HEALTHCARE, SOUTHEAST, INC.: OK, that is – [pauses] pharmacy services extend for beyond filling prescriptions. [01:05:52]

Pharmacy services also include: that patient education; the interaction with behavioral healthcare and primary healthcare staff; having a clinical pharmacist who can sit *in* a primary care office or go in with a psychiatrist as they're talking to the patient, the client, or family members about medications and dosing schedules. So one is, to me, more operational [while] the other is more service.

JENNY CRAWFORD, JD, LCSW-C, MODERATOR: OK, thank you. For both of you, what are the greatest challenges in getting consumers/communities at large onboard in an integrated healthcare service or program?

BECKY HUDZIK, DIRECTOR, WELLSPRING RESOURCES: For us – for the collaboration with outside physicians and being able to collaborate and share information, they're [pauses] very busy. We operate on fee-for-service, and medical doctors operate on people in front of them, the number of people in front of them. And collaborating with us isn't always their top priority, so *that* has been *our* greatest challenge.

SANDRA STEPHENSON, DIRECTOR, INTEGRATED HEALTHCARE, SOUTHEAST, INC.: That is a good question. For me, it is an ongoing cultural shift. Becky is absolutely correct. The culture of how we bill really does drive relationships. Whether or not you have any burden time where you have time to call and talk, where your primary care doc is seeing people based on number of required contacts, and they're carrying the load of a lot of other expense of the people who work with them or, in behavioral healthcare, a lot of those people are also billing independently even though they're not licensed in Ohio. So it is a matter of who has time to talk to whom and when.

We – with NextGen, there is a delightful little function that we haven't fully brought up yet, but there is tasking internal to NextGen where - from behavioral healthcare to primary care, back and forth, different levels – you can task each other. [01:08:03]

So you can say, “This is an issue. Would you look in it?” or, “You need to know this,” or, “This person just came in, and their hemoglobin A1c hasn't moved. It has gone up. When you see them, you need to do this,” or, “So-and-so didn't show for their appointment again. Can you try to bring them in – reschedule and bring them in next time?” So the tasking allows us immediate communication that doesn't require as much time or trying to track somebody down. But being solo means that our [chuckles] providers, our staff can track each other down, even at the end of the day, if they have a question or need to talk about something that has to happen.

JENNY CRAWFORD, JD, LCSW-C, MODERATOR: Well, thank you to both of you. That was our final question. For those who are participating, you can see the contact information now on the screen if you have any questions for us, at the Center of Integrated Health Solutions, or for Becky or Sandy. And I want to thank both Becky and Sandy for offering us their lessons learned and expertise today. [01:09:05]

We also would encourage you to go to our website for ongoing information, which is in the next slide. And the recording of this presentation will be available in 48 hours, on our website.

And, finally, at the close of this, you will receive a survey. We would very much appreciate your completing that and letting us know if we've met your needs for today, and what your other ideas are for other webinars in the future.

So I want to conclude and wish everyone a good afternoon. Thank you again to our presenters. Bye-bye.

**END TRANSCRIPT**