

Considerations for Pharmaceutical Dispensing in Urgent Care

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Point-of-care dispensing has gained traction as a way for urgent care operators to increase revenues and differentiate their centers through added patient convenience. Buying medications at the urgent care center not only saves patients a trip to the pharmacy, but they can begin their course of treatment immediately. According to the 2008 UCAOA Benchmarking Study, approximately 49 percent of urgent care centers dispense pre-packaged pharmaceuticals. The following considerations can help the urgent care operator determine whether in-office dispensing is an appropriate fit and assure a dispensing program meets its objectives and avoids potential pitfalls.

1.) Control Your Inventory

One of the biggest operational challenges of in-office dispensing is managing inventory. Although many pre-packaged pharmaceutical vendors provide software to facilitate dispensing, such does not prevent “shrinkage” due to expiration, theft, and administrative error. Unsold inventory dilutes margins and can make a program altogether unprofitable. Some suggestions on controlling inventory to reduce shrink include:

- **Limiting the Formulary:** Because pharmaceuticals for in-office dispensing are wholesaled in minimum quantities of 20 packs or more, slow-moving drugs often expire in inventory. To reduce shrink due to expiration, limit the formulary to the most frequently prescribed drugs. Choices should be sufficient to cover the majority of patients but also limited to “essentials” that turn on a frequent basis. Developing an appropriate formulary requires buy-in and compromise from all providers. Although a provider may make a good clinical case for carrying a particular drug, if volume doesn’t support it, odds are it will expire before use. Evaluating the historic frequency of ICD-9 diagnostic codes can provide a business case for stocking one pharmaceutical over another.
- **Counting and Logging Inventory:** To prevent shrink due to theft, inventory should be counted by two staff members when the center opens, closes, and when shifts change. To speed counting, some centers shrink-wrap or rubber-band inventory into “sleeves” of 5 or 10 packages. Inventory should be recorded in a log and reconciled against sales and disposals since the last inventory. Inventory should never be removed from the shelf without first logging it or checking it out using the dispensing system. Most dispensing systems provide real-time inventory reports—any discrepancies between actual and expected inventory should be investigated immediately.
- **Limiting Access:** When inventory discrepancies occur, an investigation begins by identifying who has had access to inventory since the last count. Access to pharmaceuticals should be restricted to those trained and authorized to assist the provider in dispensing. Pharmaceuticals should be kept in an appropriate cabinet that’s locked at all times, with steel reinforcement and dual locks for narcotics. Keys should be restricted to one or two staff members and stored in a separate locked cabinet from which they are signed in and out at the beginning and end of each shift. Staff should never share keys. Likewise, access to systems used to track dispensing and inventory should be restricted by unique password and users should be required to logout of the system after each use.
- **Knowing Your People:** Control also involves knowing the people who will have access to pharmaceuticals. One urgent care center hired—without conducting a thorough background check—a medical assistant had been terminated from a previous job for prescription fraud. After several patients complained of prescription painkillers “not working,” it was discovered someone was tampering with bottle seals and replacing the narcotic hydrocodone with over-the-counter acetaminophen (a white tablet similar in appearance). An investigation yielded a confession

and resignation but not only did the private investigator's fees wipe out the center's entire profit from dispensing that year, there was undue risk posed to patients and the center's reputation.

2.) Assure a Smooth Workflow

The in-office dispensing value proposition of patient convenience is undermined when patients are required to wait for their scripts. It's not uncommon for patients to complain of 25-minute waits at discharge because the doctor needs to sign-off on bottles accumulating at the medical station while he's examining other patients. The value of providers' time treating patients exceeds incremental margin from drug sales so providers might complain about the extra process steps and in busy times, forego dispensing altogether. Consider the following to assure dispensing does not reduce the provider's efficiency:

- **Systems Integration w/EMR:** Numerous electronic medical records (EMR) systems send prescribing information electronically to in-office dispensing systems. Without integration, manual re-entry of patient demographics and prescribing information into the dispensing system can be a time consuming task. Integration reduces time, steps, and the possibility of errors in data entry and dispensing.
- **Physician Workflow:** Urgent care profits are driven by volume—the more efficiently physicians can treat patients, the more profitable the practice will be. Although it may be easy for a physician to order dispensing using the EMR, if the physician's workflow is later interrupted by inspecting and signing off on pharmaceuticals (as required by most state's laws), then the provider's value perceptions of dispensing may start to diminish. If a provider feels that dispensing is not "worth" his or her time, or that it causes unnecessary hassle or slow-down, then he will be unlikely to support the program no matter the benefits to the center or patients. Impact on the physician's workflow should therefore be a primary consideration for any dispensing program. Develop processes that require minimal distraction of the provider.
- **Clinical Implications:** Providing the first dose at time of service can increase patient compliance with physician orders. However, retail pharmacies often act as an information repository of all drugs that a patient is taking and the pharmacist's systems can identify potential drug interactions. Because in-office dispensing takes the pharmacist out of the loop, it's important that a provider inquire what other drugs the patient is taking and investigate potential risks. The urgent care center should also provide counseling and educational materials on each medication at the time it's dispensed.

3.) Set Pricing to Give a Marketing Advantage

The ability of a patient to leave with "medication in hand" underscores urgent care's convenience and patient focus. To differentiate their offering, two large urgent care networks recently announced they would be offering pharmaceuticals on-site at low prices. NextCare, which operates 56 urgent care centers in six states, announced in March, 2010 it was offering 50 different medications in its centers for only \$1. Excluded are participants in government health plans. Similarly, in February 2010, Florida-based Solantic announced its 30 centers would offer 50 common medications for \$5 each. Both programs require cash payment at time of service and neither bill insurance for the price or balance of the prescriptions. In order to set pricing appropriately, an urgent care operator should consider:

- **Competitive Pressures:** Many drug, grocery and discount chains offer price promotions (such as \$4 per 30-day supply) on common generic drugs to drive sales of other merchandise in their stores. To achieve pricing parity, an urgent care center may have to approach dispensing as a break-even or loss-leading traffic generator. Dispensing thus transforms from a revenue driver to a marketing expense. Otherwise, the patient base must be willing to "pony up" for the added convenience of not stopping at the pharmacy after their urgent care visit.

- **Insurance Issues:** Some consumers are hesitant to forego their health insurance benefits to pay for any medical care out-of-pocket. Because it's generally not possible to bill pharmaceuticals on the same group health claim as a physician's office visit, the dispensing practice must decide whether to be a "cash and carry" model or contract separately with pharmacy benefit managers. Many prescription plans come with \$10 pharmacy co-pays, which is price-comparable to in-office dispensing. The advantage of cash pay is less paperwork and immediate cash receipts. However, some pre-packaged vendors offer insurance billing solutions that require minimal additional work to process pharmacy claims. To determine the best model, the urgent care operator should evaluate average reimbursement against administrative costs. The solution may be to bill some payers—such as Workers Compensation—directly, while charging cash to consumers.

4.) Market the Program Internally and Externally

Marketing involves identifying and communicating the value products and services bring to consumers. The value proposition of urgent care is clear—accessibility through extended hours, walk-in service, and neighborhood locations; and affordability through lower out-of-pocket costs than hospital emergency rooms. In-office dispensing extends urgent care's value proposition. Key is to effectively communicate the availability and benefit to patients:

- **Promote On-Site Dispensing as a Patient Benefit:** Urgent care centers that successfully implement a dispensing program take extra steps to raise awareness of it as a patient benefit. This is done through marketing collateral, in advertising, on the Internet, and through point-of-sale materials displayed in exam rooms and elsewhere in the center. Centers also utilize public relations—publicity in news stories—to announce and detail the value of pharmaceuticals on site. Public relations works particularly well if pricing is a competitive differentiator.
- **Incentivize Staff:** Staff members should tell all patients they have the option of filling their scripts on-site. In addition, medical assistants should remind providers which medications are available in the program, steering providers to utilize existing inventory. Although incentivizing doctors for prescribing pharmaceuticals raises ethical questions, generally it's okay to incentivize support staff like medical assistants for behaviors that drive top line revenue. Medical assistants are critical to the success of a dispensing program because they interact with both the public and providers. At one center, medical assistants compete with each another as to how many scripts they can "sell" in a week and track their daily results on a poster in the break room—weekly "winners" receive a "prize" (nominal value gift card) and the center benefits from increased revenue and patient satisfaction.
- **Engage in Suggestive Selling:** Rather than merely inform patients they can get their scripts filled at the center, "suggestive selling" entails a direct recommendation to the patient—"the doctor has prescribed amoxicillin, we have that here for \$10, would you like to pay by cash or credit card?" Suggestive selling can be trained through role playing exercises focused on attaining a specific consumer behavior.

Note: Federal DEA registration is required to dispense controlled substances in a doctor's office. In-office dispensing is regulated by states. Most states limit dispensing to the practice's current patients. Some states, including New York and Texas, limit or control a physician's ability to dispense. Please contact your state board of pharmacy for detailed regulations in your state. There are also civil implications involved in physician in-office dispensing to be considered—UCAOA advises engaging competent legal counsel before acting.