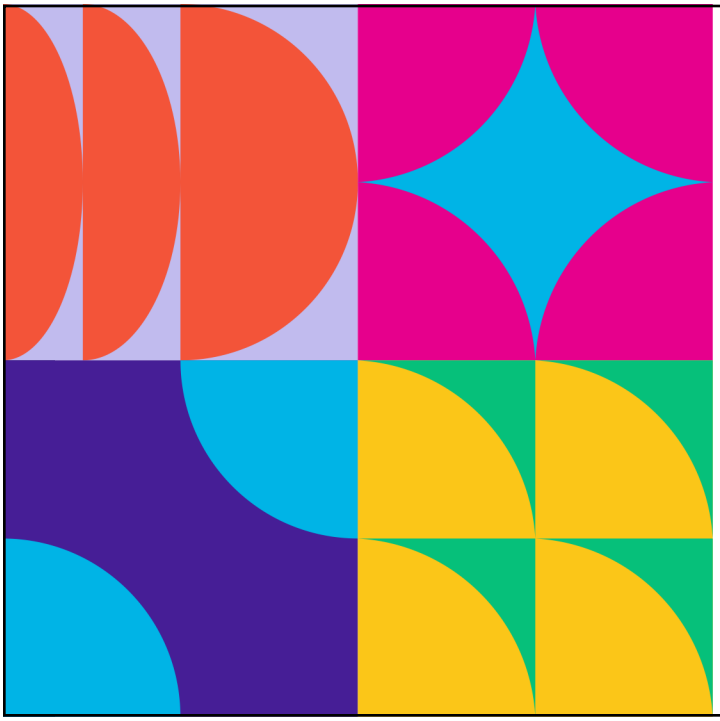

Closed-Door LTC Pharmacy: Serving Facility-Based Care

Paul Shelton, BA

Description

Closed-door LTC pharmacy models offer a novel way to support facility-based care beyond traditional retail dispensing. Examine how these models operate, including facility partnerships, medication coordination, packaging systems, and regulatory considerations. Evaluate whether closed-door LTC services align with your pharmacy's capacity, partnerships, and long-term strategy.

Meet the Faculty

Paul Shelton, BA

President
PharmaComplete Consulting Services, LLC

Paul Shelton

Paul Shelton is a seasoned professional in the pharmacy industry. At PharmaComplete, Paul leads efforts to assist pharmacies in growing their businesses, enhancing efficiency, and delivering differentiated solutions to patients and provider partners. With expertise in pharmacy organizational structure, workflow, and design, Paul specializes in operational evaluations, wholesaler RFPs, pharmacy startups, and transitions. Driven by a passion for improving patient outcomes, Paul is committed to keeping patients in their homes longer, reducing hospitalizations, and enhancing their quality of life. He collaborates with comprehensive care teams to introduce new and innovative concepts in pharmacy services delivery.

Disclosures

- Paul Shelton has no relevant financial relationships with ineligible companies to disclose.
- Paul Shelton discloses that AI tools were not utilized for this presentation.

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Learning Objectives

Upon completion of this activity, learners should be able to:

- Explain how closed-door LTC pharmacy operations differ from traditional community pharmacy models.
- Recognize workflow processes required to support medication administration, packaging, and facility coordination.
- Compare pharmacy-facility partnership models used to deliver closed-door LTC services.
- Assess operational and regulatory considerations that influence the feasibility of closed-door LTC pharmacy services.
- Outline practical steps to evaluate or prepare to enter the closed-door LTC market.

Our goal is to answer one question:
Is closed-door LTC (or combo shop) a good fit for your pharmacy?

- ✓ Which facility type are you best positioned to serve?
- ✓ What packaging model can you support consistently?
- ✓ What integrations or workflow changes are required?
- ✓ What staffing, delivery, and after-hours coverage are needed?
- ✓ What regulatory or contracting risks need review?
- ✓ What is one next step you should take before pursuing this market?

Closed-Door Pharmacy Requirements, Operations Models, and Workflow

CMS Criteria for Long-Term Care Pharmacy

- Comprehensive Inventory and Inventory Capacity
- Pharmacy Operations and Prescription Orders
- Specialized Packaging
- IV Medications
- Compounding and Alternative Forms of Drug Composition
- Pharmacy On Call (24/7/365)
- Delivery
- Miscellaneous Reports, Forms, and Prescription Ordering Supplies
- Emergency Boxes
- Emergency Log Books

CMS Long Term Care Guidance, 16 March 2005
www.cms.gov/medicare/prescription-drug-coverage/prescriptiondrugcovcontra/downloads/ltcguidance.pdf

Traditional Community Pharmacy Model – *Reactive*

- Patient initiates workflow
- Data received and entered
- Prescription filled
- Pharmacist reviews
- Patient picks up medication

Options:

- Medication synchronization
- 30-day vs. 90-day fill

LTC Pharmacy at Home Model – *Proactive*

After initial onboarding, pharmacy initiates workflow:

- Data entry staff contacts patient, confirms batch, delivery date, that there have been no changes since last fill, and initiates fill process (Day -10)
- Refills requested as needed, prior authorizations worked as needed (Day -10)
- Orders adjudicated (Day -10/-9)
- Prescription filled (Day -5)
- Pharmacist verification (Day -4)
- Order (group of prescriptions) is prepared for delivery (Day -4/-3)
- Pharmacy delivers medication to the patient's home (Day -2/-1)

Closed-Door LTC Pharmacy Model – *Hybrid Reactive-Proactive*

New Order

- Facility initiates workflow
- Pharmacy integrated with facility for data
- Data entry
- Pharmacist verification (PV1)
- Adjudication – prescription is cycled
- Prescription filled
- Pharmacist verification (PV2)
- Pharmacy delivers medication to facility

Refill Order

- Pharmacy initiates workflow
- Data entry confirms batch and initiates fill
- Bulk adjudication
- Hard stops are resolved or removed
- Prescription filled
- Pharmacist verification (PV2)
- Pharmacy delivers medication to facility

Major Differences in Models

Community Pharmacy

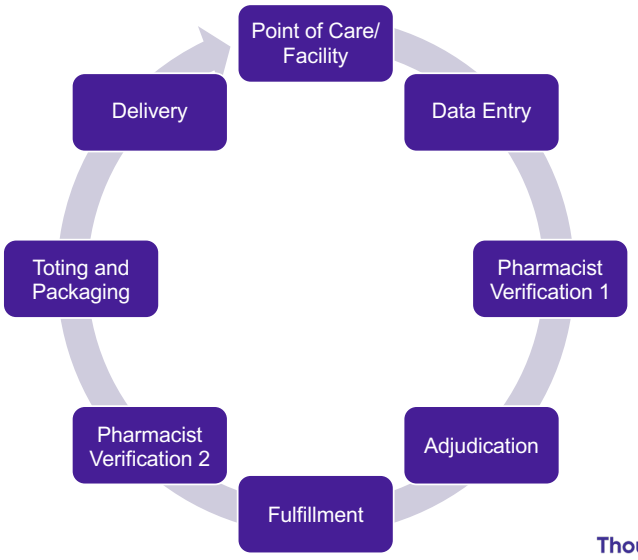
- Banker's hours (or close)
- Completely reactive model, little to no scheduled work
- 19-20% Gross operating margin*
- 1-2% Net operating margin*
- Patient is primary customer
- Delivery is a convenience and "nice to have"

Long-Term Care Pharmacy

- 24/7 availability, usually open and active later
- Mostly scheduled work, some reaction for new admits, changes from medical staff
- 30-36% Gross operating margin*
- 4-6% Net operating margin*
- Facility is primary customer
- Delivery is a CMS requirement (can be outsourced)

*PharmaComplete Pharmacy Assessment data aggregation

LTC Workflow Simplified



Facility Types and Impacts

Group Homes

Basic Information

- Patient Residence Code: 04*
- Average number of medications: 8
- Common packaging types:
  - Unit-dose card
  - Multi-dose card
  - 14-28 days multi-dose strip
- Inventory cost per patient month: $200

Pharmacy Impact

- Heavily cycle dependent
- Multi-dose can present challenges due to unskilled medication administration
- 36-40% Gross operating margin
- Patient has the right to choose
- Very stable medication regimen

*NCPDP Patient Residence Code (Field 384-4X)

Assisted Living

Basic Information

- Patient Residence Code: 04
- Average number of medications: 12-13
- Common packaging types:
  - Unit-dose card
  - Multi-dose card
  - 7-14 days multi-dose strip
- Inventory cost per patient month: $250

Pharmacy Impact

- Heavily cycle dependent
- Large volume of OTC and generic use
- 36-40% Gross operating margin
- Patient has the right to choose
- Marginally stable medication regimen
- Integration with EHR/eMAR common
  - Pharmacy push is becoming standard

EHR: Electronic Health Record; eMAR: Electronic Medication Administration Report

Skilled Nursing – Transitional Fill

Basic Information

- Patient Residence Code: 03
- Average number of medications: 12-13
- Common packaging types:
  - 14-day multi-dose strip
  - 14-day multi-dose card
- Inventory cost per patient cycle: $250-$275

Pharmacy Impact

- Must be delivered to the patient at the facility
- 32-36% Gross operating margin
- Transition fill billed to insurance, not facility
- 14-day short cycle fill required for brand
- Opportunity to follow patient into the community for care if appropriate for LTC pharmacy at home
- Automatically qualifies for LTC pharmacy at home services for 6 months

Skilled Nursing – Rehab

Basic Information

- Patient Residence Code: Facility bill
- Average number of medications: 12
- Common packaging types:
  - Unit-dose card
  - 3/4 or 7 days multi-dose strip
  - 7-day unit-dose strip
- Inventory cost per patient month: $450-$500

Pharmacy Impact

- Can be individually cycled, more commonly on demand
- Large volume of OTC and generic use, strict formulary use
- 28-32% Gross operating margin (contract dependent)
- Contract pharmacy use only
- Unstable medication regimen, frequent changes
- Integration with EHR/eMAR standard
  - Facility push is standard

Skilled Nursing – Custodial Care

Basic Information

- Patient Residence Code: 03
- Average number of medications: 12-13
- Common packaging types:
  - Unit-dose card
  - 3/4 or 7 days multi-dose strip
  - 7-day unit-dose strip
- Inventory cost per patient month: $450-$500

Pharmacy Impact

- Can be individually cycled, more commonly on demand
- Large volume of OTC and generic use, strict formulary use
- 32-36% Gross operating margin
- Contract pharmacy use only, no patient right to choose any willing provider
- Unstable medication regimen, frequent changes
- Integration with EHR/eMAR standard
  - Facility push is standard
- Average length of stay is 2-3 years

Other Types of Care Locations

Adult Day Programs

Patient Residence Code: 04

Patient still resides in their own home but attends program

Patient must be at program 30 hours per week

Care must be provided while at the program location

Very common for both senior adult daycare and for IDD day “Shop”

Correctional

No Patient Residence Code – direct bill

Heavy generic use

Usually limited drug formulary

Average of 1.5-2 Rx per patient

Substance Abuse Rehab Centers

Patient Residence Code: 04

Usually commercial or Medicaid

Rarely increased reimbursement

Heavy controlled substance use

Compliance challenges in some states depending on licensure

IDD: Intellectual and Developmental Disabilities

Regulatory and Operational Considerations

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- IV Medications*
- Compounding and Alternative Forms of Drug Composition*
- Pharmacy On Call (24/7/365)*
- Delivery*
- Miscellaneous Reports, Forms, and Prescription Ordering Supplies
- Emergency Boxes
- Emergency Log Books

*Can be easily outsourced depending on service level needs

CMS Long Term Care Guidance, 16 March 2005
www.cms.gov/medicare/prescription-drug-coverage/prescriptiondrugcovcontra/downloads/ltcguidance.pdf

Additional Service Requirements and Recommendations

- Pharmacist Consulting – care-level-dependent frequency requirement
- Behavior and Quality Meeting Attendance
- Nurse and Aide Education
- Vaccine Clinic Services
- Family and Responsible Party Education and Engagement
- OTC Provision

What can and can't I provide in my homes?

Generally OK to provide:

- Access to an integrated Electronic Health Record
- Medication carts
- Fax machines
- Team member education for medication handling
- Emergency drug kits (electronic preferred)

<u>Never</u> OK to provide:

- Services that have value for no/low charge
  - Consulting pharmacist time
  - Data entry for other pharmacy's patients
- Other inducements, such as cash or valuable instruments

HHS Office of Inspector General. Fraud and Abuse Laws/Anti-Kickback Statute guidance.

Other Pharmacy Data Entry Risk

The Ask: Pharmacy is to data enter off of orders being filled at another pharmacy so that the pharmacy push Electronic Health Record (EHR) or Electronic Medication Administration Report (eMAR) updates correctly, even though there is no intent to fill the prescriptions.

Other Pharmacy Data Entry Risk

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The Risks:

1. Liability – no ability to determine if the orders were filled elsewhere
2. Loss of productivity – by data entering for other pharmacies with no intent to fill, there is no prescription revenue to offset the cost
3. Kickback – by providing a service to the facility for no fair market compensation it appears to Office of Inspector General (OIG) as a kickback or inducement

The Answer: JUST SAY NO…if you absolutely have to do the data entry, charge fair market value for it and have a very robust hold harmless in the contract with the facility that protects you from liability.

Entering the Market

Perform a Market Analysis

Start with Open-Source Intelligence (OSINT) search for facilities

- State-level licensure registrations
- Medicare.gov for skilled and home health
- Use a basic AI (e.g., ChatGPT, Gemini, Claude) to data mine and then confirm accuracy
- Look at common ownership, single decision-makers, and local decision-makers

Learn what other pharmacies in your market are already doing using OSINT

- Pull state licensure or NPI info for pharmacies in your area
- Review their websites, marketing materials (if available), LinkedIn and Facebook pages
- Evaluate for packaging type, integrations, service levels and customer satisfaction

Determine Your Path

- What packaging style will your pharmacy offer?
  - Usually pick 1-2 “core” options and deviate as little as possible from these
- What integrations do you need for your market?
  - Does your prescription management system support these?
  - Are you willing/able to pay for the integration and service for facilities (check state laws)?
- What type of emergency drug kits in care levels that allow it (state dependent) are you going to use?
  - Automated, partially automated, tackle box
  - If allowed, will you provide to all facilities regardless of use case, or will there be criteria?
- Are you insourcing or outsourcing IVs?
- How will you deliver?

Execute on the Plan

- Start with saturation sales plan
  - Pull every door
  - Learn contact name of decision-maker
  - Gather expiration date of contract
  - Determine who currently services the facility
- Vaccination marketing
  - Offer to do small clinics for assisted living facilities (ALF), group home, adult day care, etc.
- Transitional care marketing
  - Build a transition plan with local Skilled Nursing Facility (SNF) buildings if they can't make a change for their main business
  - Grow your LTC pharmacy at home through these patients while you wait for the SNF to be ready to convert to your pharmacy

Cash Flow Considerations

- Facility start-up costs:*
  - Carts – assume $3,000 per cart on average
  - Emergency drug kits range from $100 to $30K, depending on type
  - Initial inventory – assume $250 for ALF and $500 for SNF (per patient month)
  - Integration costs with EHR/eMAR – varies from $1,000-$3,500+ per facility
  - Data conversion – integration reduces this cost, but assume 20 minutes per patient
  - Onboarding costs – personnel to be at the facility for in-services, go live, post go-live support, along with meals and other travel costs
- Expect:
  - 21-day prompt payment for Medicare
  - 60- to 90-day terms for facility payment

*PharmaComplete Pro Forma and Pharmacy build planning documentation, 2019-2026

Is closed-door LTC (or combo shop) a good fit for your pharmacy?

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Questions?