How Pharmacists Implemented a Test-and-Treat Program and Transformed Access to Care

PODCAST 48

00:00
Dr. Jane Caldwell
Hi, I'm your host, Jane Caldwell. Welcome to the *On Medical Grounds* podcast, your source for engaging, relevant, evidence-based medical information. Today, we'll discuss how pharmacy point-of-care test-and-treat programs can improve access to care, and how one pharmacy group instituted a testing and billing workflow that simplified reimbursements.

Let me introduce our first guest, Dr. Duane Jones. Dr. Jones serves multiple functions for the Pharmacy Division of Harps Food Stores. He is the regional pharmacy supervisor, community pharmacy residency director, and clinical programs director for this, the largest employee-owned company in Arkansas with 151 supermarkets in Arkansas and the surrounding states of Oklahoma, Missouri, Kansas, Mississippi, and Louisiana. Dr. Jones was a 2022 Luminary of the Year and past chairman of the Community Pharmacy Enhanced Services Network in Arkansas. He is an adjunct assistant professor at the University of Arkansas for Medical Sciences College of Pharmacy, and program director for the MTM The Future Today, which provides team-based training programs for pharmacists and pharmacy technicians. Dr. Jones was Arkansas Pharmacists Association's 2019 Pharmacist of the Year. Dr. Jones's professional experience includes community pharmacy, home infusion and compounding, hospice, nursing home consulting, and community clinical pharmacy.

Hello, Dr. Jones. Thank you for joining us today.

Duane Jones
Thank you very much for having me. It's a pleasure to be here.

01:58
Dr. Jane Caldwell
Our second guest is Dr. Jennifer Griffin. Dr. Griffin is a clinical pharmacist for Harps food stores where she specializes in medical billing, point-of-care testing, treatment workflow, and marketing clinical services. She earned her Doctor of Pharmacy degree from Harding University College of Pharmacy, Bachelor of Science in Healthcare Administration and a Master of Science in Health Promotion from the University of Central Arkansas. She has written for NCPA's *America's Pharmacists Magazine* and participates in the CPESN NextGen Luminary Program. She also serves on the CPESN USA Network Development Committee as a NextGen participant.

Dr. Griffin, welcome to *On Medical Grounds.*

Dr. Jennifer Griffin
Thank you so much. I'm thrilled to be here.

02:53
Dr. Jane Caldwell
So Dr. Jones, I'll begin with you. What do you see as the biggest gap in patient treatment and outcomes in the US medical system today?

Duane Jones
I think it's twofold. First of all, just collaborating across professional lines to provide continuity of care. One of the challenges we have in this country, and there's a couple of studies that have been written from the *Annals of Pharmacotherapy*, one was in 2018, one was in 2021, that references that over 270,000 people die every year in this country from non-optimized drug therapy. That's not a disease state. That is incorrect medication, drug-drug interactions, and adverse effects, non-adherence. That's a huge number. When I present this, I always say, let's put it in perspective. One of the longest wars we've had in recent history was the Vietnam War. Seven years, we lost 56,000 men in that war with tanks, guns, hand grenades… There's five times that many people [that] die every year in this country from non-optimized drug therapy, and that is because we don't have collaboration across all healthcare professionals on behalf of the patient. Now that results in about a $500 billion expense to this country every single year.

So you can see that there's definitely, by these statistics, a lack of collaboration across all these professional lines. And that's where I think pharmacy can help close those care gaps and improve patient care. We've proven that on several different surveys and several different grant funds that we've done to show that once pharmacists are engaged with these patients, that outcomes improve. You've got to remember statistics show that we see patients 33 times a year on average, and the primary care physician only sees them three. So we have so many more touch points with these patients and we have relationships with them that we can help them with these disease states and I think that that's one of the challenges. The second challenge is just access to care.

I mean, we see you can reference so many different things in the media today and so many reports that we are seeing a decrease in care. The American Association of Medical Colleges has stated in one of their reports that 20 percent of the providers in this country are 65 years of age or older. That tells us in the coming years, we're going to have a 20 percent reduction in just providers alone. So, there's going to be an increasing need across this country for access points. So, there are many, many healthcare deserts in this country, not just in rural, but also in inner cities, simply because there's not enough practitioners for our aging population.

05:56
Dr. Jane Caldwell
According to a 2022 study published in the *Journal of American Pharmacists Association*, approximately 89 percent of Americans live within five miles of a community pharmacy. So how does this situate pharmacies as resources to help eliminate both health disparities and accelerate public health initiatives?

Duane Jones
Well, I mean, that's true. And that's why as we move into collaboration across all health care specialties, that pharmacies have that opportunity to close that care gap because they're accessible. So, as we look

at—our topic here is test-and-treat—as we look at pharmacies becoming more involved as access points for testing and treating patients, we also have that opportunity to do chronic care management. We have that opportunity to do medication reconciliation and help them understand their medications, why they're taking them, why it's important to take them, and even help educate them with their disease states. So I think that it's an excellent opportunity for us to fill that gap. We did a grant study and taught 19 pharmacies in the Delta region of Arkansas, the most impoverished, underprivileged area in Arkansas. And we taught them how to manage their disease state. The results were fantastic.

These are people that are unfortunate and not well-educated and we still were able to one-on-one help them understand how to manage their disease states and I think that that's a tribute to the fact that people have access to care. We just need to make that feasible for them.

07:38

Dr. Jane Caldwell

Dr. Jones, Duane, you've been a pharmacist since 1977. You've owned your own independent pharmacies and you've worked as a pharmacy director for the grocery chain Harps Foods stores. As boots on the ground, what is the biggest challenge facing pharmacists today?

Duane Jones

Well, biggest challenge initially is just reimbursement. We're fighting this battle nationally at our state level. Reimbursement from the pharmacy benefit management companies has dropped drastically in the last five years. We have more pharmacies going out of business simply because they can't sustain themselves just on dispensing. One of the things that we're trying to—on the heels of that—is we're trying to also make them aware of how to workflow clinical programs within their pharmacy to take care of patients to meet this need that we just talked about, and it will also help to improve their revenue sources to make them sustainable. So the biggest challenge, first of all, is just fixing the reimbursement problem. And I think that we are certainly on the fighting front of that. Arkansas just passed a law that prevents anti-competitive practices from some of these entities that own pharmacies that are steering patients to themselves. And that will allow patients more access to their local independent pharmacy. So that's first and foremost. then secondly, we have to get them more involved in test-and-treat programs.

09:09

Dr. Jane Caldwell

What is test-and-treat and could you describe how test-and-treat works outside the primary care clinic?

Duane Jones

Sure. So test-and-treat in pharmacy is protocol driven and patients have access to come into their pharmacy, get tested for strep, flu and receive prescriptions for it. Now, not all states have passed this yet, but the states that allow the pharmacist to test-and-treat, it's protocol driven. And by being protocol driven means that we also don't prescribe unnecessary medications if they test negative. So, and I'll talk about that a little bit later, but that's really important, is that we need to be accessible. We can actually have an impact on patient outcomes and some of the studies that we've seen are really, they exceeded my expectations actually, because we have a reduction in hospital visits up to 30 % or more in most cases, and a reduction in emergency room visits. You have to remember that a lot of these patients that they're looking for access to care, if they can't find a primary care, they wind up in the emergency room. And that costs our country a lot of money, and our states a lot of money every single year.

10:30

Dr. Jane Caldwell

There are lots of point-of-care platforms and they all have different implementations. What platform are you running your testing on and did the manufacturer do anything to get you set up?

Duane Jones

So when we started test-and-treat, and we started our test-and-treat program back years ago, the test and the law was silent on whether or not pharmacists could do point-of-care testing and so since it was silent we wanted to expand our scope of practice into communities to provide these services to our residents and the communities we serve and so wanted to make sure that we had the best system and so did some research to find out what the clinics were using as far as analyzers, what hospitals were using as far as analyzers, emergency rooms using as analyzers, and that's when we made our decision. We went with Quidel. And Quidel is the largest manufacturer of testing equipment in the United States. And we've been very pleased with the success we've had; with the support we've had. And yes, they have helped us many ways, creating some marketing literature for us, training our staff. They actually came to our location and we had a training session with all of our clinical staff. And then we replicated that throughout all of our other pharmacies. And we took our clinical team to all the pharmacies and taught them the technique that they taught us so that we're providing the same exact technique and same service, same analyzers as you would get if you go to your primary care, urgent care, or your hospital. So they've been great for us and we've had a great relationship with them for a good eight years now.

12:04

Dr. Jane Caldwell

The American Medical Association released a statement in June of last year coming out against expanding test-and-treat policies beyond medical doctors. And here is a direct quote.

"While pharmacists and physicians each play important roles in healthcare delivery, the length, breadth, and focus of their education and training are vastly different and prepare them for separate and distinct roles in patient care. Pharmacists are medication experts, but their clinical training does not prepare them to perform physical or mental examinations, diagnose patients, interpret test results, or provide primary care services, the independent practice of medicine by pharmacists put patient health and safety at risk."

Could you please address AMA's position?

Duane Jones

Sure, so we really don't get involved in polarizing conversations or emotionally charged opinions on the state of affairs. What we focus on is how we can collaborate with healthcare professionals across this country. Like I said before, the states that allow test-and-treat for pharmacists are protocol driven. Protocol driven means that if they test negative, we don't treat them. We have a protocol to follow when they do test positive and that ensures that the patient receives the proper care that they need. We actually become a great referral source for physicians because if we identify something that in that time that we're doing the test-and-treat and they're negative, but they still have some severe symptoms, we'll refer them on to their physician for care. So we actually become a conduit for these physicians. The other thing is we're seeing a lot of physicians, especially during cough cold season when patients cannot get in to see their primary care physician because they're so busy, they refer them to us. And then we create that relationship.

And like I said, in the very first question you asked, we focus on collaborating across all professional lines and practicing at the top of our license on behalf of the patient. There has been a consideration for, let's call them turf wars in the past, and seriously, there is not a turf here other than the patient. You know, we have to get beyond thinking about self-preservation and we have to think about putting patients back at the center of patient care. And when we do that, we're reaching out to all health care professionals to ask them to practice at the top of their license. I will tell you that one of the largest payers, the largest payer actually in the state of Arkansas, I worked with them to develop test-and-treat for them to pay us for our services in the test-and-treat program. Their chief medical officer said, Duane, I am so excited about this program because you all follow protocols. It's about antimicrobial stewardship, okay? Because statistics show that about 52 percent, over 50 percent of the patients that are treated for flu, for example, actually weren't tested. They were empirically treated with antiviral medication. Twenty-five percent of those only tested positive. So only 25 percent of them actually had disease states. So we're overprescribing antibiotics and antimicrobials. And what that leads to is resistant strains that can potentially become life-threatening.

So if you look at the protocols that we follow and the outcomes that we have, they're evidence-based. And we look at evidence-based facts. We have worked in the past with physician groups in medication therapy management trying to make sure that they have the proper therapies for their disease state. This group that we worked with was so excited about the progress that we made that they actually replaced some of their physicians with other physicians that understood how to collaborate.

Because once we can impact that—like I say if we impact patient care and teach them how to manage their disease state, we affect the quality of care across the entire country and it's not about taking away from any one area. It's about providing care now. One of the studies that I've read recently is that for everyone in this country to have the equal amount of access to care you would have to have an additional 200,000 practitioners or physicians. And that came actually from a physician report from the College of Medicine. And that it's not feasible if we're looking at 20 percent of the practitioners retiring in the next several years. So we have an access point that we can provide with protocols. And I have other physicians that have said, "we love the fact that you're involved in this space because it is protocol driven." And so you're not operating outside of any boundaries. And that's our focus in the future. And that's what we're trying to get other pharmacies to do, is to provide that level of access to patients and then be a resource back in to physicians and refer them back to patients. One of the things we're doing in the state right now is oral contraceptive prescribing.

So we have protocols in this state, not just for oral contraceptive prescribing, but also for test-and-treat. You got to remember that all of the states that have test-and-treat have protocols in place. Well, those protocols have been approved by the state medical board and by the pharmacy board. So all of our protocols have been approved by both the Arkansas board, medical board, and also the pharmacy board for the whole purpose of taking care of the patients. Like I said, we have to put patients back at the center of patient care. So the oral contraceptive prescribing program had approximately a thousand females last year that gave birth that had never seen a provider. So what happens is they come in to us, we're able to see them, actually talk to them, assess them, and refer them back to a physician for care. So like I say, we go back to evidence-based medicine, facts that we can actually be a touch point for patients, refer them back to care whenever they need care. So we don't see that there's any division here. We just see that there's a great opportunity for all of us to join arms and put this patient back at the center of patient care and help solve the big issue that we have in this country.

18:36
Dr. Jane Caldwell
Tell me about MTM The Future Today.

Duane Jones
So that was, you mentioned that I'm the site coordinator for our residency program. So our second resident at the time that Part D Medicare programs were requiring medication therapy, I said, you know, we need to develop a program for all of our pharmacies and develop a medication therapy program. It turned out that it was more than just a medication therapy program. It was a workflow program. It was a clinical workflow program that set the foundation for everything else that we do.

We have since taught that program across the United States to several other pharmacies to help to workflow clinical programs into our system. MTM The Future Today was actually the basis for our CDC grant study that I mentioned earlier that we did. We trained 19 pharmacies in the Delta and taught them on this program how to workflow clinical, how to work one-on-one with their patients and teach them how to manage their disease state. [When] we started there were only 31 percent of the people that were actually taking their blood glucose and their blood pressure that knew what their target was. So if they were taking it, they didn't know if their blood pressure was high or low or if their blood sugar was high or low. You fast forward that four years, 75 percent of the people knew what their target was and knew if it was high or low.

The last year we went into legislative review, we were chastised because three of the individuals fell out of this program. I said, well, the reason they fell out of this program is because we taught them how to manage their disease state. They're no longer on medication, and you have to be on medication to be in this program. So it's a testimony to the fact that you put pharmacists in this equation, teach them how to delegate. Jennifer will talk about this in workflow a little bit later. But then have an impact on patients. Now you've got to remember also that two years of this four-year study was in [the] pandemic, was in COVID. So some of these pharmacies had to close their lobby just simply because of COVID. These patients were still making notes, had their folder, taking their blood pressure, and they were still involved in their own disease state management. I gave a presentation to some physicians not too long ago and practitioners. I said, you, I think we've been guilty somewhat of keeping patients ignorant so that they have to depend upon us and come back to us. And that's kind of sad because once we teach them how, the managers say, what hypoglycemic episode is, what hyperglycemia is, what the effects it has on your body and teach them how to manage it, they become owners. We know that knowledge is power. And once we give them that knowledge, they have the power to take care of their own disease state. And if we can do it in the Delta area where people are impoverished, we can do it anywhere in the United States. And there are white papers that have been written in the last two years that show evidence to that. And that's what excites me about working with patients and working with pharmacies to improve their workflows.

21:44
Dr. Jane Caldwell
So Dr. Griffin, I'd like you to chime in on this next question. Tell me about your workflow processes.

Dr. Jennifer Griffin
Absolutely. So in our pharmacy, one of our biggest points is that we delegate in our pharmacy. So it's essential to delegate these non-clinical tasks to technician staff. So our technicians are involved in data

entry, product dispensing, and managing the adjudication queue. So these are tasks that are handled by technicians and should be.

And so we're talking about test-and-treat and all these enhanced clinical services. So this is what's going to be key to freeing up the pharmacist to perform clinical tasks like testing and treating a patient for strep or flu. Another part of our workflow that is key is we use medication synchronization or med sync. So that allows us to transition a majority of our prescription workload from being acute to being on more of a predictable schedule so that our pharmacists have the flexibility to step away from the verification queue whenever they need to administer a vaccine or teach a patient how to use a blood glucose meter or provide a test-and-treat service and they're not feeling rushed.

So those are just a few points that we've implemented in our pharmacy and have been using for years and years now to just really enhance our pharmacy workflow at Harps.

23:25

Dr. Jane Caldwell

Well, let's continue down that path. I understand that each state has different regulations for pharmacists and their reimbursement. If a pharmacist or a pharmacy system administrator wants to start the process of implementing a workflow for reimbursement, what resources are available to help them figure out their first steps?

Duane Jones

Sure. So there are a lot of great resources for pharmacists today. NCPA has a great test-and-treat program. CPSN, which is Community Pharmacy Enhanced Services Network, is a clinically integrated network across the United States, has 3,500 pharmacies that are part of that network. They provide a great resource for everything from workflow, helping with workflow, with medical billing, with test-and-treat. We actually have a boots on the ground program called "Flip the Pharmacy." We will go into a pharmacy and every state has, practically every state now has a network. And we go into the pharmacy and help them with what Jennifer was just saying. How do you workflow things? How do you delegate non-clinical tasks to your staff and allow them to become part of your team? That's the value that MTM, the future today brought to everyone is that now it's a team approach. (We) have to remember technicians typically want to help more than they can, but legally they're constrained as to what they can do. If we can teach them how to help us then it becomes a team effort. Whenever we develop our workflow, I said we're going to be providers, we have to act like providers. And so if you go into [a] provider's office, the nurse comes in, they do vital signs, they do the assessment, they turn the chart over to the physician, physician comes in and does his clinical duties and then turns the chart back over to the nurse to file it and to bill it. That's the model we have in our pharmacies. We utilize our technicians, it's that ancillary staff to do all of the assessment, they can do the vital signs, we come in and do our professional counseling, we come back and give it back over to them and they help us and so that creates a more seamless flow throughout our workflow. We treat every patient, every test, every prescription, every immunization as [if] it is a prescription. So it workflows through our system and it's not foreign to our pharmacists at that point. So it's really key to get your entire team together and you have a provider program.

25:57

Dr. Jane Caldwell

So I might want to add to our listeners that we're going to have links to some of these certificate programs

and training programs in our show notes. And you mentioned this before, where you talked about the importance not only of patient education, but let's talk about follow-up. Why do you believe that treatment doesn't end with diagnosis, Dr. Jones?

Duane Jones
Well, I think that's one of the biggest challenges in the country today is that I did see a study where most physicians really felt like their obligation was done at the point of diagnosis, which that leaves the patient kind of out there wondering, what do I do with this insulin? What do I do with this inhaler? And I think that at the point that we get involved, that's where we help them. And we do that. They come in unannounced to us and they'll say, hey, how do I use this insulin pen?

I had one gentleman come in and say, "you know, my mother thinks that this lasts for a lifetime. How long, when does she need to renew it?" Another one said "my mother doesn't really know how to use this. She just sticks it in, pulls it out. She never presses the plunger." So those type of things we leave the patient out there just wondering what to do that leads to like I said earlier the statistic that 270,000 people die is because they don't understand how to use that medication. Then here again if we collaborate across all professional lines and we become that cohesive force that pulls all of this information together and really results in a better, healthier patient.

27:32
Dr. Jane Caldwell
Dr. Griffin let's talk about the patient now. How do you market this program to the patient?

Dr. Jennifer Griffin
So marketing directly to patients—it's a process that we're still learning and it's evolving. So we're trying to change these longstanding behaviors. And a big part of our effort is educating patients that they can come to their pharmacy to be tested and treated. And if necessary, yeah, receive an antibiotic or an antiviral for strep and flu. Patients aren't used to thinking, hey, I can go to my local pharmacy to have my A1C checked. This is a new concept for many people. So since starting our test-and-treat program, we've created bag stuffers, added eye catching signage inside the pharmacy, and we actively promote our services on Facebook and Instagram where our audience continues to grow. But honestly, our most effective marketing is word-of-mouth. So once patients experience how convenient and simple the process is, they tend to tell other people.

And like Duane talked about, we have local physicians refer to us when they've been overwhelmed during cough and cold season. So this has been rewarding because we really are providing a necessary service.

28:53
Dr. Jane Caldwell
I know for many, billing and obtaining insurance reimbursement is very time consuming and frankly onerous. People don't want to get involved with that. Can you explain in greater detail your system for pharmacy reimbursement?

Dr. Jennifer Griffin
Absolutely. So to be honest, it can be time consuming on the front end when you're developing your process. But once your system is in place and your team is trained, it becomes a smooth and sustainable

workflow. So at our pharmacy, we bill medical claims through our pharmacy management system. It took some trial and error, but we found it doable. So when a patient enters the pharmacy for a test-and-treat service, our technician is the one who takes their insurance card and they will verify eligibility and benefits. So they make sure the patient's insurance is active on the date of service and they verify what kind of copay, deductible, or co-insurance the patient may have. So then they collect that amount, the patient receives the service, and then they're on their way to feeling better. Then the technician will bill the appropriate CPT code in the pharmacy management system.

So for example, if a new patient comes in for a strep test, we will bill the CPT code 99202, which is the evaluation and management code for a new patient. And then we'll also bill CPT 87430, which is a strep test code. What's great is that our technicians handle the entire process. They create and submit the claims. And in many cases, on my end, I just see a paid claim come through a few weeks later. Also, a part of this revenue cycle management process, I review any kind of payer rejected claims on a weekly basis. And these are typically straightforward fixes like a typo in the member ID or a formatting issue with a hyphenated last name. So I simply make these corrections and then I get a paid claim.

Every once in a while, we do get a complex rejection where we need to reach out to our third party vendor or payer to resolve, but these situations are really rare. And something that Duane and I really like to share with other pharmacies is we just want to encourage them to let them know that they can do this. Because once they've built their process and they've really empowered their staff, it becomes entirely manageable.

31:30
Dr. Jane Caldwell
So Dr. Griffin, according to a study published in the *Journal of the American Medical Association*, approximately one out of eight pharmacies closed between 2009 and 2015. Do you feel that this reimbursement system that you've developed will make community pharmacies more sustainable?

Dr. Jennifer Griffin
I do agree with that. But right now it's really getting more payers on board. So the more payers that we can get on board to recognize and reimburse us for the value of these services offered in the pharmacy setting, the more successful and sustainable we will be. And as we shared today, like these pharmacy-based services, they benefit everyone. The patients receive fast, convenient access to care, it supports pharmacy viability, and it's reducing that burden on an already stretched healthcare system.

32:35
Dr. Jane Caldwell
So in closing, I'd like to ask you both the same question. What were you hoping that I would ask you today?

Duane Jones
I think that why I'm so passionate about this program, about test-and-treat, about pharmacists being involved in patient care. That was what I was hoping that you would ask me.

I've been in on the clinical side of pharmacy for years and years and years. I've seen the benefits to the patient of collaborating with physicians. I've seen so many positive outcomes. We worked with one physician group and he said, "I love the fact that this is evidence-based therapy. And he said, this is what we've been

needing for a long time. If you have any problems with any of my providers, you let me know." And we were very successful in turning around that operation. At one point we had identified as many as 100 patients that were on diabetes medication did not have a diagnosis for diabetes.

But the one thing that keeps me so passionate and so driven is a story that I have of a lady who is a nurse and her husband's a physician. She came to see me several years ago and she had a prescription for an antibiotic for her child. He's about seven years old. And it was amoxicillin. And I was asking her, what's going on just in general counseling of the patient? She goes, he has these little bumps all over him. I said, what do they look like? She goes, well, they're really, really small and they've got little pus pockets on top of them and they're all over his body. And I said, well, how fast has this occurred? She goes, they just started in the last 24 hours. I said, well, you need to get to [an] infectious disease specialist and now, because this is a heroic infection that's over this child's body and this antibiotic is not going to be helpful. And she said, "well, my husband's a doctor." I said, no, you need to contact the doctor, this physician now. And I've got his number. I can call him, I talk to him, but you need to call him now. She goes, "well, my husband…" I said, before you leave here, here's his number, I want you to call. So I saw her out there, she was calling. And this was on a weekend, it was on a Friday. On a Monday, she called me back and she said, thank you. She said, "we had to life-flight him to Children's Hospital because it was an overwhelming viral infection that if he would have gone for two more days, he wouldn't have survived."

So every day I think about that, and I think about what if you replicated that opportunity? Pharmacies need to be compensated for their service today so they can viably have the staffing to be able to do that every single day. And if you can do that to one patient, how many times is that opportunity that would arise for you in a test-and-treat environment, in a counseling environment, a medication therapy environment, in a chronic care management environment? How many people could we actually impact to improve their healthcare for them and teach them about their medication and teach them about their own therapies? And we've been involved in so many studies and every single study has been a positive outcome.

We worked with a company called Elevance within CPSN. They've got some papers right now published that we save 35 percent in hospital visits, 15 percent in emergency visits. And the thing that excites me about that is I have a healthier patient. Now, what we're working with is with Quidel and some other individuals to take that data and put it into a health economist data and show to the plans how much money that actually saves them. Once we do that, that's a huge win because now the plans will get on board with compensating for these services because they see how much money they're going to save. For us, our win is we have a healthy patient. And our focus is putting patients back at the center of patient care instead of exploiting patients to make money. And we will transform the healthcare industry. We will transform the expenses of this country. If we do that and we believe 100 percent we are on the right track to make that happen, that we partner with the right people that understand that, that are making an impact. That's why I get out of bed every morning and that's why I'm so passionate about what we're doing.

36:55
Dr. Jane Caldwell
Thank you, Dr. Jones. Dr. Griffin, do you have anything to add to that?

Dr. Jennifer Griffin
Well, something I want to touch on is, so whenever we provide services like this, it really helps advance our profession. And so as pharmacists, we spend four years studying medications, and new programs like this

truly allow us to operate at the top of our license by delivering this direct patient care and like Duane said, making a big impact.

So these enhanced services really help us strengthen our role as a trusted healthcare provider in the community.

37:33
Dr. Jane Caldwell
Well, I'd like to thank you both for taking time from your busy schedules to speak with us and share your experiences and systems. Thank you so much.

Duane Jones
Absolutely. Thank you for inviting us.

Dr. Jennifer Griffin
Thank you.

Dr. Jane Caldwell
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