Podcast Transcript

Drew Mihalyo On Pharmacy Deserts and More

00:01 - Melody King (Announcement)

Welcome to TCN Talks. The goal of our podcast is to provide concise and relevant information for busy hospice and palliative care leaders and staff. We understand your busy schedules and believe that brevity signals respect. And now here's our host Chris Comeaux.

00:23 - Chris Comeaux (Host)

Welcome to TCN Talks. I'm excited. Today Our guest is Drew Mihalyo. Drew is the president of pharmacy at Delta Care Rx, which is now part of StateServe. Welcome, Drew.

00:34 - Drew Mihalyo (Guest)

Thank you, Chris. It's great to be doing this with you.

00:38 - Chris Comeaux (Host)

Yeah, no, I really appreciate it. You guys have been such a great sponsor of this show and early sponsor of our show, Drew, so we really appreciate you guys. But before we jump into what we're going to talk about today, what does our audience need to know about you?

00:51 - Drew Mihalyo (Guest)

Oh boy, I'd like any listeners to know that I'm a hospice pharmacist originally from the greater Pittsburgh Pennsylvania area, and I'm someone that feels eternally blessed and grateful for being able to meet and work with so many professionals like you, Chris, on a journey that's allowed me to play a small part in really helping further the mission of end-of-life care providers throughout the country, for can't believe I'm saying it, but about 15 years now.

01:19 - Chris Comeaux (Host)

That is crazy. You're like 12 whenever you started that You're like 12 whenever you started that.

01:25 - Drew Mihalyo (Guest)

Yeah, so I've got a passion for business transparency as it relates to pharmaceutical care. Obviously, being a pharmacist and being someone who, for the first part of my life, grew up watching my parents run an independent pharmacy, there's no replacement for business transparency. Or, let me say, there's, at this point, no technology or innovation discussion that I wouldn't love to participate in, and you know, other than that, what do I want people to know? I'm a, I'm a husband and father of a growing family of five six if you count my, my golden do, teddy and, as mentioned, I'm a lucky son that's really grown up in hospice and healthcare under parents who have been focused in that space for some time. I learned what a hospice pain medication was at the age of 12 or 13.

02:20 - Chris Comeaux (Host)

Wow, Well, tell the story of Delta Care, Drew. I think that would actually be really cool to share.

02:27 - Drew Mihalyo (Guest)

Sure, and I think doing so helps us make sense of the core topic today being, you know, pharmacy deserts, or a new term that I hope we can coin together and spread the word about, which is hospice pharmacy deserts. Deserts, they're actually, I think, two different things, and you know, the story of our company is one that dates back to 2009, where, together with some really early adopting clients and partners, we started to become a movement of sorts fueled by you know, I said a few moments ago, you know, the introduction of transparent and, more importantly, most importantly, pass-through prescription purchasing options that enabled hospices to buy meds at acquisition costs, like a pharmacist would rather than you know at the time, what was, you know, artificial and inflated other mechanisms. You still see that a lot today. Actually, we did this in a really loud way for four to five years and we screamed from the mountaintops about the value of, you know, hospices bottom lines when choosing or demanding this type of option from

their pharmacy partners, and I remember this was during a time when a cost per patient day of $10 to $11 was considered acceptable for medications. You know, nowadays, I for medications, you know, nowadays, I think you know, most people are shooting to be somewhere between seven and eight, and you know there's a lot, of, a lot of hospices out there that are much lower than that and performing, uh, quite well.

03:54

So, you know, the model challenged old school pharmacy billing models that had traditionally made large profits. Um, on these, you know, per diem or average wholesale price based discount models Very rarely does an AWP or an average wholesale price represent the real cost of a drug these days. It's astounding, actually, how far different the two can be. And we're also a company that's I think, successfully, you know accomplished a level of extreme customer service and innovative technologies that we used as a way to surround those core services and attracting our partners. E-prescribing, remote patient care, that's all stuff that I think we're pretty well known for and quite proud of care. That's all stuff that I think we're pretty well known for and quite proud of. So, you know, in summary, focusing on the ability to dig in, solve problems, I'm proud of my team, I'm proud of the next chapter, which is really now state-served Delta Care Rx, as I'm sure you've heard.

05:01 - Chris Comeaux (Host)

Yeah, so we'll go there in a second. I'm just reflecting, drew. Yeah, so we'll go there in a second. I'm just reflecting, drew, you'll fall out of your chair. The PPD at my very first hospice job and I was 25 years old was $16 a patient day and I'm just sitting there and thinking about, like you know, that's half, but what those dollars meant of reinvesting back into the mission of the organization. That just feels weighty. I'm just reflecting now, thinking the trajectory. I remember when your mom and Phyllis, before there was a DeltaCare, was trying to use them as this great resource of pharmacotherapy. But then, seeing how it all came together in DeltaCare and thinking the trajectory of your company and how you've seen those cost-per-patient days get to where they're at now, just have not reflected on what we did with those, that Delta has reinvested it back into the mission of our organization, which is pretty incredible when you think about it.

05:55 - Drew Mihalyo (Guest)

Well, I really appreciate you acknowledging that. I mean, look, like I said at the beginning, we've played a small part in what's become a movement of a lot of hard work and believe in folks. Um, you know, are we the only company out there that can do this? No, but I, I think that what's in our DNA, and, uh, you know mine specifically, is to try and lead with that and have that the only be the only way we do business, um, and I think that alone, you know, says something. So, uh, I appreciate it, chris.

06:28 - Chris Comeaux (Host)

Well, so you just alluded to some pretty big news. So you recently combined Delta Care with StateServe. Why did you and your family go that route?

06:47 - Drew Mihalyo (Guest)

that we were going to have to make a decision about if we wanted to continue to operate the company at the size we were, through most of COVID, into some pretty rapid growth that actually happened thereafter, and continue to go up against some of the largest companies in the world, payers in the world, competitively, and that they also have hospice pharmacy operations of their own, hospice pharmacy operations of their own and you know some of them, even at time zone hospices, long-term care pharmacies. You know I'll probably mention it later there's a lot of vertical integration going on, but you know that's a different discussion for another day. You know, staying on course was an option, obviously, but we could also look to find a way to grow into the future and scale the product we believed in by gaining access to more growth funds. But from the start of that conversation we also knew that if we took that step or ultimately did go that route, we were committed to making sure that any decision we made would bring additional options and innovation for our partners, our clients nationally, really the entire sector. We wanted to affect positively and also raise the ceiling of opportunities for our Delta family and team members.

08:07

If anything was going to happen, we were fixed on ensuring that decision was really a paradigm shift for the space, and I think we did that in doing what we did with StateServe.

08:19

So you know the next thing you know I reached out to some folks at StateServe. The next thing you know, I reached out to some folks at StateServeS and then what they thought about creating the first national large scale combined pharmacy and DME benefit management solution. One thing leads to another, and regular conversation are happening with people like Paul DeCosma, who's the CEO of StateServe, and over the course of 20 years now, since he was one of the founders of the company, he's built a really large team and a great service, a great program as well. In the fall of 2023, we completed a process that combined our companies through the acquisition of Delta by StateServe state serve and that's going to allow for our team's spirit and original mission to move well into the future at high speeds with a very I think you'll agree differentiated value prop. So you know it's really exciting and again just just feel real, real blessed to be on this journey and and work with so many great folks that's awesome, awesome, drew.

09:24 - Chris Comeaux (Host)

Well, drew, again, I'm kind of reflecting back and we had a show that we called to look back, to look forward, and so maybe that's kind of the interesting, kind of pivot point. But it feels like we're really interesting stage right now for the current state of pharmaceutical care in the Hospice and Palliative Care field. Can you just summarize, like where you think we're at?

09:46 - Drew Mihalyo (Guest)

the care field. Can you just summarize, like where you think we're at? Yeah, great question, you know. I'll start by saying that in general, you know pharmacists are accepting responsibility for patient outcomes nationally. It's a wonderful thing, and that's in collaboration with other healthcare professionals. The hospice environment of care, fostered by strong hospice leadership, has historically very thoroughly embraced pharmaceutical care. I don't think anybody would doubt that Today I would rate pharmaceutical care and hospice a six out of 10,. Despite the intense efforts of so many and other organizations ASHP, ascp, apha come to mind you know these organizations are still attempting to get the American Medical Association to embrace pharmaceutical provided care so that CMS will recognize pharmacists as providers, just like physicians, nurse practitioners, pas and others.

10:55

We think the American public and I'm biased desires and deserves this. Give you a little more information that I think are top of mind for a lot of folks. National drug shortages are at record-setting levels. This does affect medications used in end-of-life care and palliative care more than you might think. There was news that came out not too long ago and for those interested than you might think there was news that came out not too long ago and for those interested, you know I'm going to ask that you and your partner, jeff, be able to put up a QR code that leads to some interesting downloadable information. Post-podcast.

11:36 - Chris Comeaux (Host)

We'll definitely do that. Yeah, we'll definitely do that Drew.

11:39 - Drew Mihalyo (Guest)

Yeah, thank you if you're open to it. But as it relates to these, you know, cited shortages, most significant for hospice is, you know, ongoing shortage of injectable opioids and lorazepam. One of the things I'll put in the QR code bucket is an example of Pfizer letter that addresses that, you know. Next thing I want to mention is that infusion pharmacy accessibility and their on-hand products are a problem nationally. These types of pharmacies are unable to, you know, purchase hydromorphone and morphine injectable package sizes. These are used to prepare sterile opioid infusions. In the past, you know, opioid shortages typically occurred late in the year. These days we're facing the issue in first quarter of 2024, supposedly due to new DEA regs, so Drug Enforcement Agency regulations that are really putting a lot of stress on pharmaceutical manufacturers. You know, the chain drugstore industry that has been on the news every night right continues to experience significant labor-related issues that hinder patient care. Chris, you've seen this stuff, right? It's all over the news.

13:00 - Chris Comeaux (Host)

Yeah, like recently actually, like within the last two weeks actually.

13:04 - Drew Mihalyo (Guest)

Yeah, in your face and you know, as a result, hours of operation continue to be compressed and 24 hour pharmacist availability is going well over the country. Mail order pharmacy

services can't be the sole answer for that right. We, we, we work in an environment of care where where now means now, and 20 to 30% of the time or more, hospice patients need same-day stat needs. Believe it or not, most hospices I know using traditional mail order. Well, it's become a nice-to-have option rather than a primary means of procurement. So the closures are very concerning. They interrupt patient-primary-, interrupt patient primary care pharmacist relationship.

13:50

There's these, you know, once again, national shortage of drugs coupled with actually a national shortage of actual pharmacists or pharmacy technicians, and you know this is it's compromising care at many, many levels. So you know I don't want to be too long-winded, but I'm passionate about this. You know, hand-in-hand with all these shortages. You know we've got to mention that. I should say everything I'm mentioning serves as an example why hospices need a really comprehensive approach and partner in renting pharmaceutical care. Okay, I'm not being salesy.

14:25

It's not my intent here. I'm here to talk about pharmacy deserts, but we've got to put the context around it and you know there's a lot of options out there. For that, they need to be able to rely on a partner with experience and wisdom, uh and, and have operations led by pharmacists. You know, pharmacists understand pharmacy, pharmacists understand pharmacists, and that's the way to make the headaches go away. So, you know, better pivots, better planning. I would call for strong camaraderie across the sector. Mm-hmm, you know, given the variable forecast so it feels like drew.

15:05 - Chris Comeaux (Host)

So I'd never heard of the term until our mutual friend, Mark Cohen, doing our top news stories of the month, and it's catchy the term of a pharmacy desert. And then I think the complete context Mark was talking about really being concerned in rural areas because you already have health care deserts and then pharmacy is one of the last bastions of healthcare left in some of these communities, but it's way beyond rural communities now it seems like nationwide. And so I reached out to you and said, hey, man, can you kind of help me understand a little bit more what's going on here? And so maybe can you define because it feels like your age has kind of set the table Is that the pharmacy desert? Or

could you define a little bit more? And why do hospice, impaired care people need to worry about this burgeoning issue that's being referred to as a pharmacy desert.

15:52 - Drew Mihalyo (Guest)

Well, everything we've talked about thus far is not the pharmacy desert concept. I mean, it exacerbates it, no doubt. But yeah, hot topic across the country, you know. It gets a lot of attention even through the lens of regulators nowadays, which is a good thing. But there's a lot of good information out there about pharmacy deserts, a large piece of which is available and has been a product of some really hard work and interesting studies through University of Southern California School of Pharmacy. So kudos to them. But when you define pharmacy deserts, it's important to keep in mind and I really should say this over and over again the landscape you're speaking about.

16:37

For instance, a suburb or somewhere fairly close to a city, compared to some rural geography could have definitionally differences as it relates to pharmacy deserts Statements have also been made that we need to consider things like whether or not the population in the area you're talking about has access to transportation, or if the status quo way of getting around is walking or public transportation, again affecting whether or not you designated a pharmacy desert. At a high level, though, the most recognizable work out there again USC and other groups identifies pharmacy deserts existing in suburbs when most people live more than two miles away from the nearest pharmacy, or a half mile if most residents in that suburb tend to not own a car. And a pharmacy desert in a rural area is indicated when people there are residing more than 10 miles from the nearest pharmacy. Other things worth noting black and Latino neighborhoods in the 30 most populated cities nationally had fewer pharmacies than white or diverse neighborhoods. Again, that's a stat from some competent research that looked at large data sets over the span of consecutive years. This is obviously concerning and needs to be addressed, and I'll say it again, pharmacy deserts disproportionately affect Black and Latino residents in the largest US cities.

18:19

As a close to home, you know, chris, mechanism for proper management of this specific topic. You know one of the organizations in the National Partnership for Healthcare and

Hospice Innovation is Hospice Acadiana, and I'm sure you know Keith Everett, who's the CEO there. He also is.

18:42 - Chris Comeaux (Host)

That's my home, turf man. That's where all my family lives.

18:45 - Drew Mihalyo (Guest)

Right on. How am I forgetting that right? You know he's also fostering a program called True Hue. They're currently working with a number of entities to evaluate and assess diversity, equity, inclusion and belonging. So DEIB efforts internally and externally. I know there's a lot of other organizations like his that are interested in the discussion. Externally, I know there's a lot of other organizations like his that are interested in the discussion. But, as it relates to pharmacy deserts, they too are assessing how organizations build effective relationships. That require identifying key programs, competent programs and initiatives to battle this.

19:25

So, without going much further and if I'm giving you too long answers, just let me know but without going much further with definitions, the listeners here to the podcast can quickly start to put two and two together and ask the right questions. And here we go, let's create it and coin a new term. Well, if this is a problem for non-hospice, non-serious illness patients nationally, how big of a problem? Or what kind of problems exist as it relates to pharmacy deserts for providers, clinicians, patients, caregivers in end-of-life care or palliative care populations? I can tell you it's a big one. Not only that, but one that could get worse.

20:12

So here's a prime example that I think most will agree with. You know, the standard pharmacy that does actually exist in an area where there's not too much access or where a pharmacy map is beginning or a pharmacy desert is beginning to form on the map, I should say, is not always a pharmacy that stocks medications commonly used for symptom management and end-of-life care. So having a pharmacy to access period is one thing and it's a problem, as we've talked about. Having a pharmacy to access period is one thing and

it's a problem, as we've talked about. Having a pharmacy to access that has the products and hospice competency know-how needed is what I mean by the potential for these pharmacy desert-like conditions to be exponentially worse in end-of-life care of the patients that we treat. Now, areas where you may not have a pharmacy deferred by desert, by standard definition, doesn't mean you don't have a pharmacy desert there. You know it again. There's different definitions based on the areas you're dealing with and, uh, you know, I'm actually surprised that this hasn't been a bigger discussion.

21:31 - Chris Comeaux (Host)

That's exactly what's occurring to me. I'm sitting here listening to you and painting the picture, Drew. Where my mind goes to is what are you and your team doing about this? I've got to imagine you seeing this. It's almost like I feel like we're standing on the shore. I know you spend some time in Florida and you're seeing that big thunderstorm build. It's like what are you guys doing to anticipate how to navigate that?

22:12 - Drew Mihalyo (Guest)

which are fantastic and I've participated in at least three times now is powerful, albeit basic, mantra of needing to truly understand a problem before you attempt to fix it.

22:20

And then when you do, you need to make sure you've got the right tools in hand to get the job done in an efficient manner, so you're not wasting your time, because there's lots to do. That said, you know fixing the problems associated with hospice and palliative care. You know pharmacy deserts takes a variety of tools, methodologies and customizations that can be different for each type of provider. In no particular order. I'll give you some. You know what I think are best practices as part of the toolkit. Number one would be having turnkey access to multiple pharmacy options or locations, because if you are an organization that serves patients in either pharmacy deserts or potential pharmacy deserts, you know, even if it's only a certain zip code, that you serve as part of your program which is the case for many hospices where only a portion of their ADC they serve is in a pharmacy desert. You need these options, and this is most commonly simplified by a relationship with a pharmacy benefit manager or said type of organization right when you can sign one contract and then have access to a bunch of different pharmacies or really any pharmacy in the country. But it's not that simple the relationship with those pharmacies that you do

have at your fingertips within a reasonable distance for your patients leads us to the next point that someone needs to own the management of the local pharmacy relationship so that they have the medications on hand and their understanding of what's needed for hospice patients and typically at any level of scale. You need to be able to count on, again, some sort of very robust network partner or PBM to do this. You know different size PBMs have different purchasing power as would be the case in other spaces. So you know to a certain extent size and you know robustness of technologies around it. Do matter Are the dispensing services provided at. You know, fair rates to both the pharmacy who's in that community, because if they're not, that can worsen the desert. You know they may not stay open. You know one of the causes for these pharmacy deserts is no doubt you know, questionable reimbursements from payers all over the country that have gotten worse and worse over the years. I've read and heard many stories about independent pharmacies who are the only pharmacy in a desert that ultimately close up shop because, say, a larger chain drugstore comes in town and can do things better and cheaper for customers. Well, a year or two passes and that larger chain isn't making enough money off their decision. So either they scale their pharmacy way down and close up, or even close up and now there's no pharmacies because they closed the independent shop by coming into town in the first place, you know.

25:33

The other thing I'll mention is, you know, a lot of times these pharmacies are more than prescription drug access. Chris, I mean, you need a loaf of bread, or you need some juice for your children, or you need some over-the-counter products? I don't know you need some toothpaste. I mean, let's be real, it's not all about prescriptions that are favorable, about having a pharmacy nearby. Number three would be, you know, making sure that you've got a plan B because, like I said earlier, I know that 20, 30% or more prescriptions are needed same day or stat in hospice or serious illness. But you know, if, if you do run into a situation where you can't get something locally, can it be mailed to you? Because in most cases, you know most zip codes, you can get something next day and that's better than nothing. So I would always surround, you know, a local procurement uh option with comparable mail order be a major delivery mechanism.

26:33 - Chris Comeaux (Host)

That's all good, Drew, thank you. I'm sorry, go ahead, keep going.

26:37 - Drew Mihalyo (Guest)

I got a couple more, you sure.

26:40 - Chris Comeaux (Host)

Oh, yeah, yeah, absolutely.

26:42 - Drew Mihalyo (Guest)

Okay, All right. So number four and just let me know if we're running up on time but would be keeping some kind of local quarry or access intact so that meds can be delivered or brought in from, maybe, a pharmacy that's a little more distant away, but you can still accomplish those same day or stat needs. And then number five would be to leverage comfort care kits, Chris. So I know, you know what those are. CCKs, you know be able to keep medications in the home of a patient for an emergency. I'd like to say, as a pharmacist or clinician, that you know, I believe, that comfort kits are there for the unforeseen or the unknown and you know a lot of times you can get out in front of, you know, bad situations that occur for patients, for their families, by having one of those on hand, especially in an area that you know is a pharmacy desert.

27:37 - Chris Comeaux (Host)

Do those? Normally the Comfort Kits usually come out of the Plan B, or do you ever have circumstances where it's coming out of the local pharmacy?

27:45 - Drew Mihalyo (Guest)

Well, I would say it's probably about a 60-40 split In most cases. For our customers, if they want to use Comfort Care Kits, we supply them via mail order and again, they may sit unused for a period of time. Other times, local pharmacies that we partner with will supply the care kits. But you know, again it's. It's. It's looking at each hospice uniquely, for their situation, their geography, digging in and customizing a solution that fits so drew.

28:22 - Chris Comeaux (Host)

This is great, by the way. I'm just just listening to you. I'm just getting this is such a good education. So what's your hope and vision for formic therapy, of hospice in the future? I mean just thinking about all these challenges, thinking about what your family has journeyed and the great solution that you provided, and I can even see how the solution you provided kind of build off of some of the earlier models. So what's kind of your hope and vision for the future?

28:48 - Drew Mihalyo (Guest)

I get to put it all on the table, huh. So I'll give you at least my primary wish list. I hope that you know the hard work and drive of so many professionals continues. That's evident and essential, whether it be on the hospice provider side or the the vendor support side. There's I've met the most compassionate and smart people in my career and without that, in a challenging climate, I don't like to think about where we'd be next. I'd say that you know there's some really vital topics that we need more discussion around. Chris, You've got such a wonderful microphone through these podcasts and people respect you so much. I would certainly encourage you to have conversations with the right people about topics you continue to find interesting that maybe we we talked about today or we identify here. But you know, with our, our core topic of pharmacy deserts, we need to take the conversation to people who can, you know, stop the leak.

30:06

Stop and really my mind goes to very quickly regulators, you know, like we just mentioned you know, as a hospice or as a partner to a hospice, you can be reactive and you can plan and you can be creative. You can customize, of course, and will have to ongoing. But I also challenge hospice leaders and, you know, collaboratives of hospices, to be very loud and push for regulators to better protect pharmacies. On the last line of defense of a pharmacy desert forming, you know, reimbursement, reshaping or enhancement mandates from these regulators for payers I I think is very, very important. You know there could be a different style of reimbursement or different level of reimbursement for someone who serves a pharmacy desert, like population, as compared to a pharmacy that operates where there's 50 other pharmacies in a very urban area or city like condition, where you have one on every corner. But you know I probably shouldn't use the word urban because, again, we have pharmacy deserts in urban areas, but you know what I mean. I mean there's parts of the country where you can't walk, you know, a block or two without seeing three pharmacies and maybe those entities receive a different reimbursement than others.

31:38

Next, hospice leaders need to demand business transparency ongoing from pharmacies, pbms, anyone involved in the prescription procurement process. Take a step further. This includes demanding transparency from I've seen a lot of pb brokers or PBM broker middlemen operating now finding a niche. Those folks, too, in their contracts I think it's important that they spell out who they're being paid by. Is it just the hospice? Is it possibly one of the PBMs that ultimately gets selected through an RFP process that they're running? Not comfortable stuff to talk about. But, chris, I've seen it go on. Simple, blanket statements in every contract that assure that the vendor is identifying all routes by which they can get revenue or make profit is a good best practice way to protect yourself.

32:44

And you know I hold myself accountable to that or any businesses I'm associated with. Number three a focus on resolve, again through sector camaraderie, root problem causes of national drug shortages. Let's have a conversation about this in a big way. The economic consequences to the hospice industry. I'm not going to say hospice industry, that's not right.

33:13 - Chris Comeaux (Host)

The field, the movement.

33:15 - Drew Mihalyo (Guest)

The hospice sector. The hospice movement industry is not the right word. Sector, the hospice movement industry is not the right word. The consequences of these shortages and short supplies is terrifying. Think about it. What if the cost of oral concentrated morphine doubled as a result? Or what if the cost of furosemide became equal to bumetanide? I mean, I know I'm using these drug names, but so, comparatively, $0.05 a tablet versus $0.40 a tablet as a central loop diuretic therapy for so many different diseases we experience in end-of-life care. I mentioned, you know, this camaraderieaderie. It's just, it's urgent. Let's get together and have these conversations. If this was a baseball game, chris, unfortunately, as it relates to drug shortages, I'd say we're, we're watching on unfold

well before the seventh inning st retch. Another topic electronic medical record or EMR interfaces have become a money-making venture.

34:26 - Melody King (Announcement)

(Drew Mihalyo) And here's the problem with that.

34:28 - Drew Mihalyo (Guest)

Interfacing is absolutely essential in order for positive steps forward in provider and clinician workflow to occur. It's hard enough and I can tell you this from deep, deep experience and getting in the weeds and making interfaces integrations happen. It's hard enough to have effective and impressible interface work when there's no cost barrier. It's a whole other challenge to do so when dollars and cents become a hurdle for hospices to absorb. I think in most cases you know if standard asks from an interface perspective are occurring, it should be an assumed responsibility of vendors, you know, operating in our space to commingle and pass data. The government needs to standardize this approach nationally, not just in hospice, and there's you know there's meaningful use criteria.

35:25

Efforts that have taken shape, but you know they're slow moving and early stage.

35:31 - Chris Comeaux (Host)

Th at's really good, Drew. That's all of that man. There's so many pearls in that. Well, your opportunity. Final thoughts you got the ear of hospice and palliative care leaders throughout the country. What final thoughts? You got the ear of hospice and palliative care leaders throughout the country.

35:42 - Drew Mihalyo (Guest)

(Chris Comeaux) What final thoughts would you like to share with them? (Drew Mihalyo) So some final thoughts I would share, or maybe a request I'd have for for everyone, might be to you know, if you find the time, reach out to me on the side and share your thoughts about the unique needs of rural hospices in this country. Put the pharmacy desert topic aside I

mean, obviously that's in the conversation, but it's important to me as a professional, especially going forward, to contribute what I can to making sure we're tending to those unique needs. I think there needs to be a bigger discussion about that and a focus on it. So, you know, I would just call on everyone to think about that and if you're a rural hospice, please, please, please, reach out to me and give me your feedback. We've already talked to a good handful of those folks and, you know, garnered some of that information. We're forming a, a playbook. That makes sense, but that's what comes to mind and, uh, appreciate it in advance no, that's, that's awesome, drew.

36:50 - Chris Comeaux (Host)

I just want to thank you and your team for the work that you've done. Um, I know, um, imagine Mary's a little bit in the latter half of what she's doing and has done and I just I got to watch her, watch her in action recently, and I don't think I've ever had been sitting in like a pharmacy review meeting with her before. Just masterful, I mean. I just feel like I was sitting in a master class and watching her interact with clinicians and so just thank you for what you and your team have done. I've just kind of sitting here more in a reflective mood and thinking about the trajectory. Thank you for what you and your team have done. I'm just kind of sitting here more in a reflective mood and thinking about the trajectory we were one of those early clients with DeltaCare and thinking about what we've learned over the years and the good work that we've done.

37:28 - Drew Mihalyo (Guest)

So I just want to say thanks. Well, thank you for you know, the business relationships, Chris, the friendship. I've learned a lot from you. You've been one of the biggest mentors in my life and I probably don't tell you that enough, but it means a lot.

37:48 - Chris Comeaux (Host)

No, I appreciate that, man. Well, we always end with a quote. Drew picked this one. This is really good. I think it's actually the first time we've ever had a Jeff Bezos quote, and so the reason why we pick a quote, listeners, is we just want you to something to be provocative, kind of maybe a thread that kind of encapsulates everything we've talked about today, and this feels like a really good one. It says "if you're going to do anything new or innovative, you have to be willing to be misunderstood, and if you can't tolerate that, then don't do anything

new or innovative. And again, that's by Jeff Bezos. Drew, thank you, and to our listeners, thanks for listening to TCN Talks.