Creighton University School of Pharmacy and Health Professions

Proposed Resolution Title/Topic:
Education on Prevention of Accidental Opioid Exposure (APhA-ASP Resolution 2023.1)

Proposed wording *(desired action(s)):*

1. *APhA-ASP encourages all schools and colleges of pharmacy to incorporate education about protecting family members and pets from accidental exposure to opioids.*

Background Statement (list reasons for the action(s) / pros and cons / references or resources):
Opioids claim tens of thousands of lives every year from overdoses of medication. Most of our counseling that we learn from school or school-mediated experiences focuses our efforts onto the patients themselves. This is a very great step in prevention and awareness of opioids and the risks that are involved; however, patients' family members and even pets could also be at risk of an opioid overdose, especially if they are opioid-naïve with high doses of opioids around which could lead to life-threatening situations. It is also important to note that children could mistake opioid medications as candy, along with pets for pet food. Education to student pharmacists, and therefore to patients in the future, about preventative measures such as: storage recommendations, use of locking devices, and proper disposal of medications could create stronger preventative measures on the opioid epidemic and save more lives as a result. This emphasizes the critical role that future pharmacists can play in ensuring the well-being of their patient and their families and the emphasis can start within the experiences that the schools and college of pharmacy provide.

Are there any adopted resolutions currently on the books related to this Proposed Resolution?
Yes

If yes, please provide the number and title of the adopted resolution(s) as well as your rationale for the addition of this Proposed Resolution:

2019.2 – Increased Access to Opioid Reversal Agents

This resolution encourages all schools and colleges of pharmacy to incorporate opioid reversal agent training as a requirement for completion of the pharmacy program; however, I do believe that it is also important to educate on the preventative measures before usage of reversal agents as this could prevent life-threatening situations for occurring in the first place, especially if ingested accidentally from others who are not the patient, such as family members or pets.

Drake University College of Pharmacy and Health Sciences

Proposed Resolution Title/Topic: *DIR Fees*

Proposed wording *(desired action(s)):*
- APhA-ASP supports legislation prohibiting “gag-clauses” pertaining to DIR fees that restrict the pharmacist’s ability to be transparent with patients involving medication costs.

Background Statement (list reasons for the action(s) / pros and cons / references or resources):

One of the foremost concerns for patients when they visit their community pharmacy is inquiring about the cost of their prescribed medication. The pricing of medications is subject to a complex interplay of factors, with a significant proportion of a patient's copayment determined by decisions made by Pharmacy Benefit Managers (PBMs). PBMs, acting as intermediaries between insurance providers, pharmaceutical manufacturers, and pharmacies, hold substantial influence over the co-payments borne by patients. This influence extends to the imposition of Direct and Indirect Remuneration (DIR) fees, which often results in patients encountering what is commonly referred to as the 'donut hole' or the 'coverage gap.' During this phase, patients face heightened co-payments until they reach their second deductible. PBMs contend that DIR fees are intended to reduce co-payments by offering savings or discounts to Medicare beneficiaries. However, the review process for DIRs is often protracted and lacking in efficiency. It is imperative to acknowledge that PBMs continue to receive compensation when DIR fees are applied, ultimately leading to an increase in patients' co-payment costs. This inflation has the undesirable consequence of expediting the occurrence of the coverage gap for patients, engendering an inverse relationship between the cost borne by patients and their adherence to prescribed medications. Patients in the coverage gap may become less inclined to adhere to their drug therapies to evade higher co-payments, thereby elevating the likelihood of the emergence of other health issues.

The rising challenges that come with direct and indirect remuneration fees have become more visible in recent years. In the last decade (2010-2020), DIR fees have increased by 107,400% (2023). To combat this issue of DIR fees, multiple states have passed legislation that allow pharmacies to display more transparency of patients’ copayments. These legislative measures predominantly aim to counteract 'gag clauses' that PBMs may impose on pharmacies. Gag clauses serve as restrictive provisions that inhibit the sharing of information pertaining to the cost and quality of healthcare with relevant stakeholders. Consequently, pharmacists frequently find themselves constraining from conveying essential information to patients, thus disrupting the crucial patient-pharmacist connection. In efforts to ameliorate the adverse consequences of DIR fees, Georgia, for instance, passed a state bill in 2017, which curtailed some of the excessive power exercised by PBMs. The legislation prohibited PBMs from constraining pharmacies from openly discussing the details of their patients' medication claims. Prior to this enactment, PBMs were able to penalize pharmacies, subjecting patients to unwarranted co-payment increases, and prohibiting rights from pharmacists. In the past, DIR fees have been incredibly active and relatively easy for PBMs to utilize. However, with more awareness of the impact that they have on patients, pharmacists, and insurance companies, DIR fees may need to be more regulated.

The increased awareness of the detrimental impact of DIR fees on patients and pharmacists necessitates a call for more comprehensive regulation. Formulating legislation that disapproves of DIR fees will foster

a better understanding of co-payment structures among patients, build a better connection between patients and their pharmacists, and lower unnecessary fees. Patients will feel more secure knowing that their medication expenses are more transparent. As pharmacists are able to provide clarity to their patients regarding how their copays are determined, patients will be more satisfied. Ultimately, the pharmacist's primary concern is the patient's well-being and when patients are content and are compliant with their medications, the pharmacist has fulfilled their professional duty.

Are there any adopted resolutions currently on the books related to this Proposed Resolution?

Yes

If yes, please provide the number and title of the adopted resolution(s) as well as your rationale for the addition of this Proposed Resolution:
2018.2 - Direct and Indirect Remuneration (DIR) Fee Practices

This addition and discussion of DIR fees serve to raise awareness of the significant influence wielded by PBMs in determining patient co-payments and to address the resulting impact of this manipulation. The proposed policy aims to empower pharmacists to provide transparent information to patients regarding their medication and drug costs, irrespective of co-pay requirements.

North Dakota State University College of Health Professions School of Pharmacy
South Dakota State University College of Pharmacy and Allied Health Professions

The University of Iowa College of Pharmacy

Proposed Resolution Title/Topic: Sustainable Compensation for Dispensing Services

Proposed wording:

1. APhA-ASP calls for prompt and transparent payments from third-party payors to reimburse pharmacies at a fair, sustainable, and predictable rate that exceeds the cost of drug acquisition plus a reasonable cost of dispensing.

2. APhA-ASP urges that during instances of extended drug shortages, third-party payors cover an attainable alternative at the rate of the preferred NDC, ensuring medication accessibility for patients and financial sustainability of the pharmacy.

Background Statement (list reasons for the action(s) / pros and cons / references or resources):

Pharmacy reimbursement for medication dispensing services continues to fall, which is putting extreme financial strain on pharmacies.[1-4] This issue is particularly detrimental for independent community pharmacies that support themselves primarily though pharmacy revenue as opposed to merchandise or grocery sales. The issue of under compensation for dispensing has gotten so severe that pharmacies are often forced to refuse to fill certain prescriptions because they would lose too much money to be financially viable.

Independent pharmacies and regional franchises represent a majority of the community pharmacies in rural areas where they serve as critical access points for healthcare. The survival of independent pharmacies is paramount to the health of populations with limited healthcare access.[5-7]

The issue of insufficient reimbursement is exacerbated by the many ongoing drug shortages. When a non-preferred NDC is the only option for patients to fill, pharmacies cannot afford to bear a significant financial loss due to inadequate reimbursement, and patients should not have to be denied service for the pharmacy to protect its financial situation.

The proposed policy is inspired by the successful payment model used by Iowa Medicaid, in which payment to pharmacies per prescription is the average acquisition cost of the drug plus the average cost of dispensing.[8] We believe the Iowa Medicaid model of reimbursement serves as an outstanding model because it is fair, sustainable, and predictable, which is imperative for pharmacies.

Are there any adopted resolutions currently on the books related to this Proposed Resolution?

No

References:

1. Lazaro, Edmer, Fred Ullrich, and Keith Mueller. "Update on Rural Independently Owned Pharmacy Closures in the United States, 2003-2021." Policy File 2022 (2022).
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3. Lazaro, Edmer, Ullrich, Fred, Mueller, Keith J. Update on Rural Independently Owned Pharmacy Closures in the United States, 2003-2021. RUPRI Center for Rural Health Policy Analysis: Rural Policy Brief. 2022 Aug; 2022-3.
4. Draisey, Brooklyn. Iowa has lost more than 10% of pharmacies since 2008, Drake professor finds. Iowa Capitol Dispatch. 2023 Oct 17. https://iowacapitaldispatch.com/2023/10/17/iowa-has-lost-more-than-10-of-pharmacies-since-2008-drake-professor-finds/
5. Constantin, Ullrich, Mueller, "Rural and Urban Pharmacy Presence – Pharmacy Deserts" RUPRI Center for Rural Health Policy Analysis. Rural Policy Brief, Brief No. 2022-1(2022).
6. Yurukoglu, A., Liebman, E. and Ridley, D.B. (2017) The Role of Government Reimbursement in Drug Shortages, American Economic Association: Economic Policy . Available at: https://www.aeaweb.org/articles?id=10.1257/pol.20160035 (Accessed: October 2023).
7. Shaban, H., Maurer, C. and Willborn, R.J. (2018) Impact of drug shortages on patient safety and Pharmacy Operation Costs, Federal practitioner : for the health care professionals of the VA, DoD, and PHS. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6248141/ (Accessed: October 2023).
8. Iowa Department of Health and Human Services. Prescribed Drugs Provider Manual. Des Moines, IA: Iowa Department of Health and Human Services; Last revised Oct 21, 2022.

University of Minnesota College of Pharmacy
University of Nebraska Medical Center College of Pharmacy

Proposed Resolution Title/Topic: Use Of Diagnoses For Clinical Care In Pharmacies

Proposed wording *(desired action(s)):*
1. APhA-ASP encourages pharmacists to require diagnosis codes on all new prescription orders to allow pharmacists to better use their clinical expertise in evaluating medications.
2. APhA-ASP calls on pharmacies to develop sustainable and financially viable compensation models to apply to all stakeholders, including but not limited to, patients, employers, and third-party payers, recognizing the value and cost of additional medication evaluation by pharmacists with the implementation of diagnoses codes on prescription orders.
3. APhA-ASP supports the development of educational programs and other resources to aid pharmacists and pharmacy students in incorporating the evaluation of diagnoses and implementing diagnosis programming into their practice.

Background Statement (list reasons for the action(s) / pros and cons / references or resources):

A common goal for pharmacists and pharmacy students is to be able to "practice at the top of their license" by providing clinical care across practice settings.[1] In the past few years, pharmacies large and small have been closing their doors due to financial constraints and reducing access to in-person healthcare services.[2] This is especially evident in medically underserved areas where these closures have already shown a decrease in medication adherence.[3,4] Even with the expansion of clinical care services in pharmacies such as point-of-care testing and test-to-treat protocols, dispensing is still a major source of a pharmacy's income. Profit margins on dispensing continue to slim, with competition for dispensing driving insurance reimbursement down to an unsustainable level.[5] Recently, an opportunity has presented itself to add a clinical care component to the dispensing process, which pharmacies may be able to monetize.

With the recent popularity of off-label weight loss medications causing third-party payers to require ICD- 10 diagnosis codes for payment, pharmacies have started to be able to receive diagnoses from the prescriber on the prescription order.[6] Reviewing a patient's diagnosis allows the pharmacist to provide a more complete review of a medication's suitability in the patient's regimen as that can contribute to drug interactions, dosages, and treatment duration.[7] By incorporating this requirement across all pharmacy practice settings, the value of pharmacy services would naturally increase.

While requiring diagnoses on scripts would add more to a pharmacist's workload, it is important to consider the implications of third-party payers already requiring diagnosis codes to determine whether they will cover a medication. It isn't much of a jump to imagine they may start to implement that requirement more often to avoid covering additional medications. Once the pharmacies receive patient health information to satisfy third-party payers, pharmacists will be expected, and even legally required, to use that in their evaluation process with or without additional compensation. Pharmacies must develop compensation models to account for this imminent change in practice so the added value to patient care does not come at the expense of the availability of in-person pharmacy services. Without third-party payer coverage for the increased value of pharmacy services, compensation may need to come directly from the patient. Third-party payers may not see the value in the additional time spent evaluating the patient's medications immediately, but that does not mean it should be free of charge to the patient while that data is collected. As patients begin to see the benefit of the service, in all likelihood, so will the third-party payer. Pharmacies need to receive compensation that reflects their value to continue operating in a capacity that best serves the patient's interests.

While the incorporation of diagnoses into medication management in pharmacy settings would enhance patient care and could be used to reevaluate pharmacist compensation for that management, it is not without barriers. It would be an extensive and time-consuming shift in workflow for many pharmacies. The development of educational and financial resources for installing diagnosis code programming and implementing it into the dispensing workflow and billing practices could help ease the transition and reduce the burden on pharmacies.[8]

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2. Danziger, Pamela N. "Drugstore Downsizing: CVS, Walgreens and Rite Aid to Close Nearly 1,500 Stores." Forbes, Forbes Magazine, 29 Sept. 2023, www.forbes.com/sites/pamdanziger/2023/09/27/drugstore-downsizing-cvs- walgreens-and-rite-aid-to-close-nearly-1500-stores/?sh=47f3196ce560.

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8. McGivney, Melissa. "Expert Discusses Pathways of Pharmacist Payment for Patient Services." Pharmacy Times, 18 Mar. 2022, www.pharmacytimes.com/view/expert-discusses-pathways-of-pharmacist-payment-for-patient- services.

Are there any adopted resolutions currently on the books related to this Proposed Resolution? Yes_X__ No___

If yes, please provide the number and title of the adopted resolution(s) as well as your rationale for the addition of this Proposed Resolution:
1993.4 - Provision of Diagnosis and Other Information to Pharmacists

The proposed resolution focuses on making the requirement of diagnosis codes on prescriptions a pharmacy based initiative to advance their value in the healthcare system as opposed to a legal requirement and further expounds on that particular subset, in light of current events. We believe the urgency to address the role of diagnosis codes in the pharmacy today didn't fit as an amendment to the more general patient care initiative set forth in 1993.4 as it may confuse the objective of both resolutions to do so.

1994.9 - Payment for Cognitive Services
The proposed resolution includes a call for compensation for a pharmacist's cognitive services, however, it is primarily concerned with specific services that extend beyond the scope of 1994.9 and would not qualify as an amendment.

University of Wyoming School of Pharmacy

Education on the administration of life-threatening medication.

1. APhA-ASP urges all schools and colleges of pharmacy to incorporate education on administering life-threatening medication throughout the curriculum.
2. APhA-ASP urges the development of continuing education and training programs to support existing practitioner administration of life-threatening medication.

The first reason to add education on administrating life-threatening medication is that in 2022, the Wyoming legislature amended the emergency administration of opiate antagonist act to include an epinephrine auto-injector. The change is where a practitioner or a pharmacist can prescribe with a prescriber-patient relationship and administer an epinephrine auto-injector in good faith in life-threatening situations with immunity from criminal or civil liability.1 (Wyoming SF0101, 2022) Almost all states and the District of Columbia allow pharmacists to prescribe/administer epinephrine auto-injectors. Since the states allow the pharmacist to prescribe/administer epinephrine auto-injectors in life-threatening situations, adding administration of epinephrine auto-injectors education to the curriculum will allow the future pharmacist to act more quickly and accurately on administration of the epinephrine auto-injectors in life-threatening situations.

The second reason would be that at least one person or more would carry an epinephrine auto-injector at work or school. I carry an epinephrine auto-injector with me, and I would let a co-worker/classmate know where I would have my epinephrine auto-injector. In my pharmacy class, one other person also carries an epinephrine auto-injector with them. With the increase of patients at risk of anaphylaxis, there are more patients with epinephrine auto-injectors.

With more patients having epinephrine auto-injectors, the University of California did a study to see if there could be an improvement in auto-injector usability and carriage frequency with at-risk anaphylaxis patients.