American Pharmacists Association
For Every Pharmacist. For All of Pharmacy.

American Pharmacists Association
House of Delegates – March 24-27, 2023

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NEW BUSINESS

(To be submitted and introduced by Delegates only)

Introduced by: Cory Holland
(Name)

January 23, 2023 **(Date)**

APhA-APPM Public Health SIG **(Organization)**

Subject: Pharmacy Shortage Areas

Motion: To adopt the following policy statement as listed below:

1. APhA recognizes geographic proximity and transportation to pharmacies as key determinants in equitable access to medications, vaccines, and patient care services.
2. APhA calls for laws, regulations, and policies that reduce pharmacy shortage areas and ensure equitable access to essential services.
3. APhA supports the development of financial incentives to establish physical pharmacy locations in pharmacy shortage areas and to prevent the closure of pharmacies in underserved areas.

Background:

Community pharmacies are a key access point for timely preventative care, acute and chronic disease management. They offer essential public health services such as immunizations, contraception, and naloxone, and treat common illnesses such as strep throat, influenza, and COVID-19. The COVID-19 pandemic demonstrated the significant, direct impact pharmacists have in life-saving care. Pharmacists are estimated to have administered >50% of COVID-19 vaccinations in the United States by providing >270 million vaccinations (Grabenstein). Pharmacists also tested >42 million patients for COVID-19 and provided >100,000 COVID-19 monoclonal antibody treatments (Grabenstein). Pharmacies also offer services to manage a variety of chronic conditions like diabetes and hypertension.

Despite their importance, there are significant disparities in access to pharmacies in the U.S. We commonly hear that 90% of Americans live within 5 miles of a pharmacy. In fact, 48.1% of people lived within one mile of any pharmacy, 73.1% within 2 miles, 88.9% within 5 miles, and 96.5% within 10 miles (Berenbrok). However, distance alone does not adequately determine access to a pharmacy. Access is also impacted by the ability to spend money and time traveling to a pharmacy. Areas where access to pharmacies is especially difficult are referred to as pharmacy shortage areas or pharmacy deserts. While definitions for these designations vary, one study found that over 40% of counties are pharmacy deserts, where most people have to drive more than 15 minutes to reach nearby pharmacies (Nguyen). Using the Pharmacy Access Initiative-led standards, 1 in 4 neighborhoods in the United States are pharmacy deserts or pharmacy shortage areas (NCPA). In a study that considered travel time in four major cities, half a million people lived in pharmacy deserts (Ying).

Moreover, narrow networks determined by pharmacy benefit managers (PBMs) significantly impact patients' ability to access pharmacy services. In 2022, TRICARE beneficiaries faced unforeseen challenges when more than 15,000 independent pharmacies were no longer in the TRICARE retail pharmacy network (TRICARE Communications). Affected patients may have lived near a pharmacy but were forced to travel farther distances to a pharmacy that accepted their insurance. In these cases, independent pharmacies lost loyal patients negatively impacting business sustainability and, in turn, patients lost trusted pharmacies. It is important to note that not all pharmacies offer the same types and levels of patient care services. Access to clinical services such as immunizations and disease management, as well as operational services such as home delivery, interpreter services, and multilingual staff, vary between pharmacies. In a 2017 study, chain pharmacies were significantly less likely than independent pharmacies to report offering home-delivery (6.2% vs. 64.2%) or multilingual staff (1.8% vs. 30.6%) (Qato, 2017). While many pharmacies offer essential public health services, narrow networks and other PBM practices impact the variety and quality of services that patients receive.

Pharmacy shortage areas, which are exacerbated by pharmacy closures, disproportionately affect low-income communities, communities of color, and those without access to a vehicle (Guadamuz, 2021). Between 2009 and 2015, one in eight pharmacies in the U.S. shut down. Most closures occurred at independently owned pharmacies located in low-income urban areas (Guadamuz, 2019). In urban areas, pharmacy closures were more common in Black and Latino neighborhoods (Guadamuz, 2021). Pharmacy closures have real

impacts on clinical outcomes; for example, one study found declines in adherence to cardiovascular medications (Qato, 2019). Pharmacy closures are expected to worsen due to increasing competition, preferred pharmacy networks, and declining reimbursement rates (Schulman).

Policy measures are needed to mitigate pharmacy shortage areas. Such policies could include financial incentives to establish pharmacies in shortage areas and prevent the closure of pharmacies. Examples include providing higher reimbursement to pharmacies that are considered critical access pharmacies, establishing payment mechanisms for pharmacist-provided care, and increasing reimbursement for Medicaid and Medicare prescriptions. Consideration should also be given to the role that PBMs play in declining reimbursement and restrictive pharmacy networks. Additionally, access standards that identify pharmacy shortage areas are needed at the federal level. Currently there is no federal designation for pharmacy shortage areas and policy decisions are made based on medically underserved areas and health professional shortage areas. Pharmacy shortage area designations would improve our ability to target pharmacy desert communities.

Although pharmacies are an important access point for vulnerable communities to receive a wide range of health services by a trusted health professional, disparities in pharmacy access exist. Pharmacy closures are disproportionately impacting vulnerable communities, thereby lessening our ability to care for populations who fall through the cracks of our healthcare system. Access is further restricted by lack of recognition of pharmacists as providers and PBM practices such as narrow networks. Efforts to improve access to healthcare services must consider the impact of pharmacy shortage areas. Policy change is needed to ensure equitable access to essential services.

References:

1. Berenbrok, L. A., Tang, S., Gabriel, N., Guo, J., Sharareh, N., Patel, N., Dickson, S., & Hernandez, I. (2022). Access to Community Pharmacies: A nationwide geographic information systems cross-sectional analysis. Journal of the American Pharmacists Association. https://doi.org/10.1016/j.japh.2022.07.003.
2. Grabenstein JD. Essential services: Quantifying the contributions of America's pharmacists in COVID-19 clinical interventions. Journal of the American Pharmacists Association 2022;62(Nov-Dec): in press. doi.org/10.1016/j.japh.2022.08.010.
3. Guadamuz JS, Alexander GC, Zenk SN, Qato DM. Assessment of Pharmacy Closures in the United States From 2009 Through 2015. JAMA Intern Med. 2020;180(1):157–160. doi:10.1001/jamainternmed.2019.4588.

4. Guadamuz JS, Wilder JR, Mouslim MC, Zenk SN, Alexander GC, Qato DM. Fewer pharmacies in Black and Hispanic/Latino neighborhoods compared with white or diverse neighborhoods, 2007–15. Health Aff (Millwood). 2021;40(5).
5. NCPA collaborates with USC on Groundbreaking Pharmacy Mapping Project. National Community Pharmacists Association. https://ncpa.org/newsroom/news-releases/2022/10/24/ncpa-collaborates-usc-groundbreaking-pharmacy-mapping-project. Published October 24, 2022. Accessed January 13, 2023.
6. Nguyen A. Mapping healthcare deserts: 80% of the country lacks adequate access to healthcare. GoodRx. https://www.goodrx.com/healthcare-access/research/healthcare-deserts-80-percent-of-country-lacks-adequate-healthcare-access. Published September 9, 2021. Accessed January 13, 2023.
7. Qato DM, Alexander GC, Chakraborty A, Guadamuz JS, Jackson JW. Association between pharmacy closures and adherence to cardiovascular medications among older US adults. JAMA Netw Open. 2019;2(4):e192606.
8. Qato DM, Zenk S, Wilder J, Harrington R, Gaskin D, Alexander GC. The availability of pharmacies in the United States: 2007–2015. van Wouwe JP, ed. PLoS ONE. 2017;12(8):e0183172.
9. Schulman KA, Richman BD. The evolving pharmaceutical benefits market. JAMA. 2018;319(22): 2269–70.
10. TRICARE Communications. Tricare pharmacy network changes may affect independent pharmacy customers. TRICARE Newsroom. https://newsroom.tricare.mil/Articles/Article/3186908/tricare-pharmacy-network-changes-may-affect-independent-pharmacy-customers#:~:text=%E2%80%93%20Starting%20Oct.,to%20more%20than%2040%2C000%20pharmacies. Published October 13, 2022. Accessed January 27, 2023.
11. Ying X, Kahn P, Mathis WS. Pharmacy deserts: More than where pharmacies are. Journal of the American Pharmacists Association. 2022;62(6):1875-1879.

Current APhA Policy & Bylaws:

2020 Community-Based Pharmacists as Providers of Care

1. APhA advocates for the identification of medical conditions that may be safely and effectively treated by community-based pharmacists.
2. APhA encourages the training and education of pharmacists and student pharmacists regarding identification, treatment, monitoring, documentation, follow-up, and referral for medical conditions treated by community-based pharmacists
3. APhA advocates for laws and regulations that allow pharmacists to identify and manage medical conditions treated by community-based pharmacists.
4. APhA advocates for appropriate remuneration for the assessment and treatment of medical conditions treated by community based pharmacists from government and private payers to ensure sustainability and access for patients.
5. APhA supports research to examine the outcomes of services that focus on medical conditions treated by community-based pharmacists.

2017 Patient Access to Pharmacist-Prescribed Medications

1. APhA asserts that pharmacists' patient care services and related prescribing by pharmacists help improve patient access to care, patient outcomes, and community health, and they align with coordinated, team-based care.
2. APhA supports increased patient access to care through pharmacist prescriptive authority models.
3. APhA opposes requirements and restrictions that impede patient access to pharmacist-prescribed medications and related services.
4. APhA urges prescribing pharmacists to coordinate care with patients' other health care providers through appropriate documentation, communication, and referral.
5. APhA advocates that medications and services associated with prescribing by pharmacists must be covered and compensated in the same manner as for other prescribers.
6. APhA supports the right of patients to receive pharmacist-prescribed medications at the pharmacy of their choice.

2013 Ensuring Access to Pharmacists' Services

1. Pharmacists are health care providers who must be recognized and compensated by payers for their professional services.
2. APhA actively supports the adoption of standardized processes for the provision, documentation, and claims submission of pharmacists' services.
3. APhA supports pharmacists' ability to bill payers and be compensated for their services consistent with the processes of other health care providers.
4. APhA supports recognition by payers that compensable pharmacist services range from generalized to focused activities intended to improve health outcomes based on individual patient needs.
5. APhA advocates for the development and implementation of a standardized process for verification of pharmacists' credentials as a means to foster compensation for pharmacist services and reduce administrative redundancy.
6. APhA advocates for pharmacists' access and contribution to clinical and claims data to support treatment, payment, and health care operations.
7. APhA actively supports the integration of pharmacists' service level and outcome data with other health care providers and claims data.

****Phone numbers will only be used by the New Business Review Committee in case there are questions for the delegate who submitted the New Business Item content.**

New Business Items are due to the Speaker of the House by **January 23, 2023** (60 days prior to the start of the first House session). Consideration of urgent items can be presented with a suspension of the House Rules at the session where New Business will be acted upon. Please submit New Business Items to the Speaker of the House via email at hod@aphanet.org.