2018.1 - Education on Lesbian, Gay, Bisexual, Transgender, and Other Identities

APhA-ASP encourages the advancement of optimal patient care for Lesbian, Gay, Bisexual, Transgender, and Other (LGBT+) patients through the implementation of the following measures:

a. Development of continuing education programs with a focus on unique health disparities, specialized pharmacotherapeutic considerations, and advancement of cultural competencies, and;

b. Inclusion of education on topics related to diverse gender and sexual identities in the curriculum of schools and colleges of pharmacy.

Background Statement:

A 2016 Gallup Poll estimates that 10 million American adults identify as LGBT+, an increase from 8.3 million adults in 2012. Section 1557 of the 2010 Patient Protection and Affordable Care Act explicitly states that discrimination based on gender identity in health programs, activities, and insurances is prohibited, yet LGBT+ patients may still face difficulties in accessing care. Barriers may exist due to discrimination or the limited exposure health care professionals, including pharmacists, receive in regard to the specialized care that members of this community may require.

The National Institutes of Health identifies sexual and gender minorities, also known as LGBT+, as a health disparity population. Disparities in LGBT+ communities occur due to a multitude of reasons, including decreased access to health resources and a lack of research into this community’s specific needs. The Healthy People 2020 initiative has set a goal to improve the health, safety, and well-being of LGBT individuals, and identified the need to reduce disease transmission and improve mental and physical health.

As a result of health disparities the LGBT+ community faces, there are unique health care needs and pharmacists must be familiar with them in order to provide their patients the best care possible. This community is at a higher risk for a variety of health concerns, such as depression, STDs, and cancer. LGBT+ patients are 3 times more likely than others to experience a mental health condition. In 2016, 67% of those diagnosed with HIV were gay and bisexual men. Lesbians and bisexual women have an increased risk of breast, ovarian, and endometrial cancers due to fewer full-term pregnancies, fewer mammograms, and obesity. Transgender patients face a variety of disproportionate comorbidities: 44% have been diagnosed with depression and 33% with anxiety; at 30%, the reported smoking rate among transgender individuals is 1.5 times that of the general population; transgender women are disproportionately burdened with HIV, with a prevalence of 20% worldwide; and most alarmingly, the attempted suicide rate in the transgender community is 26 times the rate of the general population, with 41% having attempted suicide at least once. The transgender community has additional concerns, including hormone replacement therapy and the gender confirmation process in which pharmacists can play a role. In order to fulfill this role, pharmacists need more education specific to the needs of this community.
While ACPE does not directly address LGBT+ issues, Standard 3 of the Accreditation Standards calls for cultural sensitivity, which would be met by more education regarding this community. Incorporating the care of LGBT+ patients in schools and colleges of pharmacy develops more prepared graduates, allowing higher quality health care for this community. Recommendations for the treatment of patients in the LGBT+ community are constantly changing. Pharmacists must remain informed on topics related to this community through development of continuing education.

A commitment to improved health care for LGBT+ patients will align the views of APhA-ASP with those of many other professional health care organizations.

References:
2018.2 - Direct and Indirect Remuneration (DIR) Fee Practices

APhA-ASP opposes retroactive Direct and Indirect Remuneration (DIR) fees imposed by Pharmacy Benefit Managers (PBMs) on pharmacy claims.

Background Statement:
A Pharmacy Benefit Manager (PBM) manages a patient’s drug benefits on behalf of their health insurance company. The PBM’s primary tasks include processing real-time pharmacy claims, determining plan-specific formularies, and reimbursing for pharmacy services.

According to Lisa Dofka, PharmD, a managed care clinical PBM pharmacist, direct and indirect remuneration (DIR) fees were designed to recoup unforeseen costs at point-of-sale. The original intent of DIR fees was to track all costs associated with a medication, mainly including manufacturer rebates that impact the total cost of Medicare Part D medications. Over time, these fees became a blanket term incorporating all charges in the supply chain primarily focusing on retroactive fees charged to community pharmacies. Without a clear definition or parameter, PBMs have redefined DIR fees to the action of dispensing prescriptions.³

The concern for many community pharmacists and CMS is the unintended impact of DIR fees. DIR fees are charges that have been transformed and served by PBMs to a pharmacy after the point of sale. An average of 6 months after the patient receives a medication, a pharmacy may be charged a DIR fee based off of a percentage of the dispensed product or a flat rate. Lack of transparency is the key problem with DIR fees. These fees are charged retroactively and unexpectedly. Steve Giroux, former National Community Pharmacists Association (NCPA) president and an independent pharmacist from Middleport, NY, commented, “When [DIR’s] are not done in real time, we often don’t know for months or almost a year that we are unprofitable on a particular transaction.”² Some pharmacies operate not knowing that they are in debt because of these retroactive fees. Independent pharmacy owners in Nashville, TN, have noted that they are not able to gauge their pharmacy’s finances because of these charges and are forced to work with insufficient funds. In a survey conducted by NCPA, approximately 67% of respondents stated that PBMs did not provide information as to how much or when DIR fees would be collected or assessed. Additionally, 87% of pharmacists said DIR fees “significantly affected” their pharmacy’s ability to provide patient care and remain in business.³ After hearing the concerns of many, NCPA proceeded to construct legislative policy.

Currently, there are two federal bills being proposed (S.413/H.R. 1038) that would prohibit retroactive DIR fees on pharmacies. Additionally, this ban on DIR fees would reduce the cost-sharing imposed on patients at the point of sale. Since the implementation of DIR fees in recent years, there has been a gradual decline in the number of independent pharmacies in the United States. This bill would preserve access to community pharmacies by removing the retroactive DIR fees and stabilizing their finances. As a benefit to taxpayers, a financial analysis by Wakely Consulting Group hypothesized that the exclusion of retroactive DIR fees would save the federal government $3.4 billion dollars over the next 10 years.⁴ The savings come from exposing the transparency of a patient’s cost-sharing at the point of sale. In addition, this legislation would give CMS a predictable perspective of the actual spending on Part D prescriptions. In light of this information, retroactive DIR fees should be eliminated in the interest of preserving the quality and profession of community pharmacy.
2018.3 - Emergency Prescription Refill Protocol

APhA-ASP encourages state boards of pharmacy to develop a standardized protocol allowing pharmacists to provide refills, not-pursuant to a prescription, during a declared state of emergency, natural disaster, or man-made disaster.

Background Statement:
In 2017, over 275,000 Americans were displaced due to natural disasters.\(^1,2\) As a result, patients were forced to leave their homes without medications or prescriptions and may not have had access to adequate health care resources. Therefore, as the most accessible health care professionals, it is crucial to give pharmacists the ability to use their clinical judgment to provide patients with a sufficient supply of medications to ensure continued care throughout the duration of the emergency.

Currently, there are no standardized protocols in the United States to provide medication refills for patients who have been displaced due to natural or man-made disasters. Fifteen out of 50 states do not have an established protocol; however, protocols that do exist vary in time and quantity of medication that may be refilled.\(^3\) In Utah, only a 72-hour supply is allowed, but across the border in Arizona, over a 30 day supply is allowed.\(^3,4\) Of states that do have protocols, those protocols are often expanded during disasters or after declared states of emergency, which can lead to inconsistency in the continuity of care.

For instance, Tennessee Governor Bill Haslam enacted an executive order in light of Hurricane Irma, expanding the state medication refill protocol from a 72-hour supply to allow for emergency refills up to a 14-day supply.\(^5\) Due to the variability between state protocols, a standardized approach to maintain continuity of care could improve the utilization of community pharmacy services and expand the roles of pharmacists during times of emergency.

The Emergency Prescription Assistance Program (EPAP) helps patients to obtain medications during a natural disaster; however, this service is only available “for eligible individuals in a federally-identified disaster area.”\(^6,7\) After Hurricane Harvey, the CEO of the Alliance of Independent Pharmacists of Texas said that the governor’s quick declaration of a state of emergency allowed for preparation, making the effects of the hurricane not as extensive as anticipated.\(^7\) Although this service is tremendously helpful, problems
may arise for patients who are victims of natural or man-made disasters that are not declared as states of emergency. Additionally, those patients that are displaced to neighboring states not included in the state of emergency are unable to utilize EPAP without legal repercussions from the state the patient may be displaced to, or the state in which, the patient permanently resides. Thus, it is imperative for each state to have an emergency prescription refill protocol in place that allows pharmacists to provide medication access to underserved patients without legal repercussions, even if the patient must cross state lines to receive care.

Currently, many states, such as Missouri and Ohio, have protocols in place, but these do not allow refills at a pharmacy that has never filled the prescription in question before.\textsuperscript{8,9} Stipulations such as these make it difficult for patients to access medications when the pharmacy they typically visit is inaccessible. Due to Hurricane Maria, many patients were displaced to Florida from Puerto Rico.\textsuperscript{2} Under the current system, Florida pharmacists were unable to serve this patient population because they had moved out of the area under the declared state of emergency. Without the burden of legal scrutiny, pharmacists may provide the best possible patient care to this underserved population during emergent times. With the vastly differing state laws, ideally the creation of a nationally standardized emergency prescription refill protocol should be discussed further to avoid discrepancies of care patients may face.

Barriers to medication access can result in increased health care costs, especially for patients with chronic disease states, leading to more emergency department visits and hospitalizations.\textsuperscript{10} The additional burden caused by natural and man-made disasters strains emergency departments, which are already overcrowded.\textsuperscript{10,11} In the aftermath of Hurricane Katrina, patients presented to emergency departments, instead of pharmacies, in search of maintenance medication refills. Increasing medication availability through pharmacies that are easily accessible allows patients to avoid costly, time-consuming, and unnecessary trips to institutions designated for emergencies.

Challenges that may hinder pharmacists from delivering optimal patient care, specifically medication access, during natural or man-made disasters include the ability to validate a prescription and inability to communicate with a patient’s home pharmacy or provider.\textsuperscript{12} These communication barriers present a unique problem: patients who are unaffected by the natural or man-made disaster may try to use the situation to their advantage to access medications without an active prescription or necessity for the service. In these instances, pharmacists are required to use their clinical judgment to decide if the patient’s prescription refill request is valid or if the remaining refills can be utilized.

During Hurricane Harvey, Texas pharmacists were allotted temporary dispensing powers to refill a non-controlled prescription for up to a 30-day supply, even if the prescriber could not be reached based upon professional discretion.\textsuperscript{13} This emergency refill procedure seen in Texas and many other states offers pharmacists the flexibility to use professional judgment to allow partial refills, refuse refills, and the discretion to determine when refusing a refill, regardless of prescription status, could cause a patient harm. When creating a standardized protocol, similar policies would need to be in place to reinforce the ability for pharmacists to use their professional discretion when refilling emergency prescriptions.

Expanding and standardizing refill protocols during natural and man-made disasters will improve patients’ access to care. By utilizing the accessibility of pharmacists in the community, patient care, health outcomes, and overall health care costs will be improved.
References:


