Eliminating the Barriers to Providing Cost Effective, and Safe Prescription Medications While Improving the Quality of Care For Pennsylvanians

A White Paper developed by the Pennsylvania Pharmacists Association
May 1, 2007
Updated November 21, 2013

Note: It is important to note that this document is frequently reviewed for changes and updates. However, there have only been a few changes. Most of these barriers and concerns remain in place. Only one issue has actually had legislation recently passed.

Introduction

Control costs! Control costs! Controlling costs currently appears to be the largest driver of today's health care policy and particularly when it comes to pharmaceuticals. Unfortunately, much of what are the real costs, especially when it comes to pharmaceuticals, are often ignored for the selection of quick and easy fixes. Policy makers now need more than ever to also consider quality of care, safety issues, and outcomes in evaluating future actions.

The Pennsylvania Pharmacists Association believes that preventative care is a key component to controlling these health care costs. Preventative care includes personal responsibility by an individual, including healthy life style choices and regular attention to all health care needs. However, we also know that people do contract diseases, become ill, or suffer injuries, regardless of the amount of preventative care. We are fortunate enough to have a wide variety of medical treatments including prescription drug medications available to treat many illnesses and injuries. Our health care system may need improvements; but, at the same time we have seen significant advances in the many medication options and treatments available.

Prescription medications when used properly can do a world of good. They can significantly improve outcomes by treating illnesses and injuries, saving lives, and improving someone's quality of life. When used unnecessarily, incorrectly, or inappropriately, prescription medications can also cause considerable harm, including death. Therefore, it is crucial that the use of prescription medications be effectively evaluated, monitored, and managed. Prescription medications, particularly brand drugs, can be expensive. However, their effective use will reduce other costs, such as emergency room visits and hospitalizations for more serious problems.

There is only one health care provider who is educated and trained expressly for the purpose of effectively monitoring and managing drug therapy: the pharmacist. Pharmacists receive six years of education which includes, but is not limited to, the science of dosage form design, development and application (pharmaceutics, biopharmaceutics, pharmacokinetics); drug action and use (medicinal chemistry, pharmacology, biostatistics, literature evaluation, therapeutics); normal and abnormal physiologic states (anatomy, physiology, infectious disease, immunology, biochemistry, pathophysiology); law, pharmacoeconomics, drug information, patient counseling and medication therapy management. Additionally, pharmacists in Pennsylvania must maintain 30 hours of continuing education credit every two years. No other health care provider, including physicians, receives this in-depth education on medications.

The design of an efficient, health care model should encourage each, (member of the health care team), to fulfill their specific role by calling upon their specified training and expertise. Utilizing pharmacists to properly use their knowledge as medication experts maximizes their potential benefit to the entire system of quality patient care.

The system under which pharmacists and pharmacies operate is less than optimal. Almost everything in the system is designed to stop a pharmacist or make it extremely difficult for him or her to use their professional judgment and fulfill their role as medication experts.

On the following pages, the Pennsylvania Pharmacists Association details some of these issues which serve as barriers to providing better health and pharmaceutical care through appropriate use of the pharmacist's professional training and expertise.

Regulation of Pharmacy Benefit Managers (PBM)

Brief Description of the Issue: Pharmacy is currently under the control of PBMs who are dictating health policy and establishing procedures which serve to largely enrich their own pockets. Due to their inherent conflict between shareholder profit-based interest and the fair payment of pharmacy claims, the PBMs' primary interest may not necessarily be in serving the public good, providing quality patient care, or in optimizing outcomes but rather in delivering a profit. While, at a superficial glance, it appears that PBMs have controlled pharmacy costs; the questions are, at what cost and to whose benefit? The current reimbursement climate for pharmacies is such that they are being squeezed by low payments while still attempting to deliver high quality patient care. At some point, this economic pressure becomes too much and this will impact care and ultimately increase costs. The original role of a processor and administrator of pharmacy claims was a necessary one for PBMs but which PBMs have now far exceeded.

Solution: Regulation of Pharmacy Benefit Managers. Regulation would require PBMs to register with the Commonwealth, post a fidelity bond, respect the prescriber's authority to select appropriate medications, provide appropriate disclosure regarding fees, and provide fair payment and treatment to providers. The result is improved patient care.

Prior Authorizations

Brief Description of the Issue: Each PBM has its own formulary and thus its own requirements for prior authorizations for medications outside of its approved formulary. Typically, this is because certain pharmaceutical manufacturers offer the PBM a better rebate. Unfortunately, when physicians are writing prescriptions based on the prescription medication they feel is best for the patient's situation; they do not take into consideration coverage and cost issues with the patient's insurance. When a patient brings a prescription to the pharmacy which is then rejected, it becomes the pharmacist's problem to work with the physician to resolve the issue. Many times when faced with the daunting task of obtaining a prior authorization, the physician will simply, for convenience sake but still reluctantly, change the ordered medication. Most prior authorizations exceed the 24 to 48 hours that PBMs purport.

Solution: 1) Allow pharmacists, when they have the necessary information, to provide the information needed for the prior authorization. This would allow the patient to obtain their medications in a timely manner;

2) Require PBMs to provide, in their return message requiring a prior authorization to the pharmacy, the formulary alternatives rather than have the physician and pharmacy play a guessing game;

3) Require plan sponsors and PBMs to establish and follow a standard temporary day supply for patients, (which is at least a minimum of one week), while a prior authorization is being obtained; and,
4) Require PBMs to establish and follow a reasonable time-frame for notice on the outcome of a prior authorization, which matches the allowance for a temporary supply to the patient, and which is provided directly to the pharmacy.

Uniform Drug Cards

Brief Description of the Issue: Currently every PBM and insurer has a different format for its prescription drug coverage card. The cards are often difficult to decipher for the correct billing entity, family member coverage, and other critical issues. Often the only way to get this information is to call the PBM. Unfortunately, this is not always feasible on weekends and evenings, potentially creating a delay in providing a patient with desperately needed medication. Complicating this further, are the patients who come into the pharmacy with only an ID# written on a piece of paper and then expect the pharmacists to figure out the billing immediately so they can receive their prescription.

Solution*:* Require Uniform Drug Cards, following the National Council of Prescription Drug Plans (NCPDP) guidelines, which contain all of the correct and necessary information to process a claim for the patient, be used by all PBMs operating in Pennsylvania. Cards also must contain a statement that clearly delineates if they are discount cards rather than insurance coverage and no co-branding or commercial relationship shall be allowed to be displayed on the card. Currently at least 29 states already mandate this.

Audits

Brief Description of the Issue: Audits should serve to deter and eliminate fraud, waste, and abuse rather than penalize providers who have acted in good faith when providing services. However, some audit techniques are unfairly established with the sole purpose of collecting as much money back from pharmacies as possible. Many audits do not provide for sufficient notice to collect records, go too far back in time, take too long to present results, are not clear on appeal procedures or simply don't even have any appeal process, and give no window of opportunity for corrections. Some of the errors that are identified in audits are ones caused by no fault of the pharmacist or due to incomplete information provided by the prescriber. The authorization number received by the pharmacy when adjudicating the claim should be the final result indicating acceptance by the insurer/PBM, except if fraud is proven.

Solution: 1) Require fair and uniform audit and appeal procedures and prohibit extrapolation audits;

2) Restrict routine audits to only one year prior period; and,

3) Provide that the adjudicated claim is a final payment except in the incidence of proven and intentional fraud.

Prompt Payments

Brief Description of the Issue: Some payers, both PBMs and programs such as Pennsylvania Medical Assistance, delay payments for 30 to 45 days for pharmacies causing serious problems with cash flow. With greatly reduced margins, cash flow has become increasingly important to the community pharmacy. Pharmacies must purchase the drugs daily and pay for them within the week. They then provide the medications to patients but must then wait for payment from the PBMs. This delay enriches the PBMs at the expense of the pharmacies.

Solution: 1) Require all PBMs to provide financial remuneration to pharmacies within 7 to 15 days; and,

2) Require the acceptance of online adjudication of the claim as the final record and use electronic fund transfer (EFT) for payments to pharmacies rather than paper checks.

Regular and Timely Price Updates

Brief Description of the Issue: This issue is more common in government programs than private ones. Here in Pennsylvania, state programs only update their pharmacy pricing files once a month. Unfortunately, pharmaceutical manufacturers are submitting price updates all the time and quite frequently. These prices are immediately passed on to pharmacies that must purchase the prescription drugs at the higher price; but who will not receive those prices from the program until the file is next updated. If the file was just submitted for that month, this could mean up to 45 days. This means pharmacies are suffering outright losses and underwriting the state programs.

Solution: 1) Require payers to obtain at least daily updates from pricing sources; and,

2) No payer should use pricing sources which take longer than three business days to input price updates received from manufacturers.

Quantity Limits and Appropriateness

Brief Description of the Issue*:* Sometimes the required or allowed quantity of the PBM does not match the prescribed medication. Dispensing 90 day supply can be wasteful particularly on a first fill for a patient on a new drug therapy, who may or may not tolerate or be able to remain on the medication. Also there are many drugs for which a 90 day supply is not appropriate. An example of this would be Percocet or Oxycontin – 90 days supplies of these are simply too dangerous and are unnecessary. Dispensing Schedule II drugs in large quantities is simply encouraging a black market for these drugs.

Solution: 1) Schedule II drugs must be restricted to 30 day supply limits from any pharmacy provider, including mail order; and,

2) Do not allow quantities to be dictated by PBMs. Assuming that 90 day supply is saving money is incorrect. (See the following issue.)

Mail Order

Brief Description of the Issue: In recent years, many PBMs have forced patients to utilize mail order for obtaining their medications under the guise of cost savings. The supposed cost savings is a manipulated issue and in fact, mail order dispensing at 90 days is sometimes inappropriate (see above) and often wasteful. Mail order can and should be an acceptable option for convenience purposes just as it is for many other products. Unfortunately, it should not be mandated. Patients should have the freedom of choice and the option to speak to and discuss their medication questions with the medication expert – the pharmacist. There are individuals who quite frankly can't afford the two combined co-payments at one time.

Solution: *1)* Prohibit PBMs from requiring mandatory mail order or providing misleading incentives to drive patients to mail order; and,

2) Require mail order pharmacies to comply with appropriate storage requirements when delivering drugs.

Pill Splitting

Brief Description of the Issue: It is becoming increasingly common for PBMs to require certain medications to be split. This is often because the manufacturer's price for the 40 mg dose is less than the 20 mg dose, when divided by two. Therefore splitting the 40 mg dose tablets can save the patient, the plan, and the employer some money. We do not believe that the overall concept of splitting pills is necessarily a good one; however, we understand and support the economic reasons for doing so. There should be certain restrictions on when this should be done. Some pills are absolutely not suitable for splitting for a variety of reasons including efficacy, size, and coating. If pill splitting must be done, it should be done by pharmacy personnel and not by individual patients. It is important to note that some waste can and will be incurred in pill splitting and that should be considered in the evaluation of any economic value.

Solution: Discourage this practice except where absolutely necessary and then require PBMs to have sound pharmacological reasons for employing pill splitting while adequately compensating the pharmacist for performing this task and for any waste generated. PBMs must also carefully provide public awareness materials so people do not assume it is always safe to split medications as a cost-saving measure.

Telephoning Prescriptions Into the Pharmacy

Brief Description of the Issue: Under the respective Practice Acts, licensed prescribers may delegate to anyone the responsibility of calling in the prescription to the pharmacy. We appreciate the expedience of calling in a prescription, but sometimes the person doing this has limited knowledge of prescription medications and cannot answer the questions the pharmacist might have. This is further compounded when the information is simply left as a voice mail. Now the pharmacist must call back and try and obtain crucial missing information. This takes

considerable time and creates a huge opportunity for medical errors, which add cost to the health care system.

Solution: Unfortunately, we do not really have a good solution to suggest in this situation. Requiring the licensed prescriber to call in the prescription is probably physically impossible; yet, pharmacists currently have to bear the same restrictions on their time. While the licensed prescriber is responsible for whomever he/she delegates this task to, the burden still falls on the pharmacist to figure out every aspect. One solution might be to establish a minimal qualification level and a certain amount of ongoing education or training for those individuals who will call in a prescription. In addition, as more prescribers embrace eprescribing this should help with some of these issues.

Prescription Legibility and Provision of Complete Information

Brief Description of the Issue*:* It is not uncommon for a pharmacy to receive a prescription which is difficult to read or the format in which it is written is confusing. There are hundreds of examples where a drug could easily be misread or even where the instructions are confusing. Problems include poor prescriber handwriting and prescriptions incorrectly written by prescriber – such as no strength or incorrect dosage. An example might be Celebrex and Celexa, which are written typically for 200mg and 20 mg respectively and both for one/day. It is easy to see how one of these poorly written could easily be misinterpreted. On weekends and evenings, receiving clarification is challenging. This could lead to a medication error or delay of treatment for the patient.

The second piece of this is that physicians are to print their name and license number on the prescription. However, many large physician practices may have a list of all their physicians on the prescription pad and may have their license numbers printed, but fail to check or otherwise identify which one is specifically writing a specific prescription. It is often challenging to decipher the handwriting and determine which physician wrote the prescription and even the patient when asked may not know who they saw at that time. This is a particular problem on prescriptions from hospitals which do not include the preprinted information and it is even more difficult to try and track down prescribers through the hospital. Pharmacies MUST use the correct one or later face recoupment of the reimbursement they received. It is after – hours, what do they do – delay dispensing the needed drug? Provide the wrong information and face recoupment thus losing money? Suggesting they go back later and correct is impractical given the number of times this occurs.

Solution: 1) Enforcement of the current requirements by physicians to print name and license numbers including instituting a simplified method for registering complaints when this is not followed;

2) More responsibility placed on non-complying prescribers. They pay no penalty for non-compliance yet pharmacies will have their money taken from them if physician information is inadequate;

3) Include diagnostic information on the prescription (see next issue);

4) Widespread implementation of eprescribing. (See issue on eprescribing on challenges for pharmacists.); and,

5) Additional dialogue and discussion is needed with the Pennsylvania Medical Society and also between medical and pharmacy schools on this issue.

ICD Codes

Brief Description of the Issue: In trying to dispense the correct medication, the pharmacist is often operating in a vacuum, without all the necessary information. When questions arise concerning either deciphering handwriting or other prescription instructions or even in researching interactions with health conditions and other medications, it would be very helpful for pharmacists to have the diagnostic code related to the treatment on the face of the prescriptions. When hand written Celebrex and Celexa might look very similar but Celebrex is used for arthritis and Celexa for depression. If the pharmacist had this information, deciphering the handwriting for the correct medication becomes a much easier task.

Solution: Encourage physicians to provide ICD codes or diagnosis on prescriptions.

Eprescribing

Brief Description of the Issue: We fully support the implementation of eprescribing as a way to reduce medication errors and ensure quality of care. Physician practices have been offered financial benefits including incentive payments and other grants to implement systems Yet pharmacies, which have had to maintain adequate computer systems for years because of claims processing, are expected to bear all their own costs relative to implementation. Not only is there a fee to register with a eprescribing provider, pharmacies pay a transmittal fee for each eprescription which is in addition to and separate from their transmission fees for adjudication of claims.

Solution: 1) Eliminate extra charges to pharmacies for implementation;

2) Have PBMs and government programs provide some financial incentives to pharmacies for implementation; and,

3) Offer grants to pharmacies to assist in implementing eprescribing.

Access to EMR/EHR

Brief Description of the Issue: Along with eprescribing much is being discussed about total electronic medical records (EMR) or sometimes referred to as electronic health records (EHR). The impact these will have on overall patient care is significant. We are concerned though that pharmacy is largely being viewed as a source of patient information and not as a key component in information sharing. A system which allows the pharmacy access would provide the pharmacist with so much additional helpful information such as diagnosis information, lab test results, patient history, and medication and health interactions, all of which should provide for further checks and balances and protection from medication errors.

Solution: Support efforts which encourage the pharmacy role in EMR/EHR.

Inclusion of Required Information (NPI and DEA)

Brief Description of the Issue: Prescribers often neglect to provide full information on prescriptions, even as currently required, such as their medical license number and their DEA number if a controlled substance. Pharmacies are the ones which must spend the time to research and obtain these numbers prior to submitting the claim and dispensing the prescription. This means trying to track down the prescriber, which after hours does not work or finding the correct number in some other manner. The DEA number is required on a controlled substance prescription yet when the physician does not provide this; the pharmacy must pay the price and take the time to find this information. Despite the implementation of the NPI, Prescribers still do not include their NPI or DEA on the prescription This is particularly true with prescribers other than physicians It is important to note that if pharmacies do not include this information or don't include the correct information, they are found in violation on an audit and will have the entire payment for that claim recouped. Yet there is no penalty for the prescriber.

Solution: Require physicians to include their NPI and DEA number on prescriptions.

Third Class of Drugs

Brief Description of the Issue: Many drugs which are sold over-the-counter (OTC) are medications which should use the consultation of the pharmacist. A pharmacist's intervention and counseling in some of these situations is crucial. For example, Prilosec, cough and cold products, antacids, vitamins, herbals, H2 blockers like Zantac, and even aspirin products. All of these products have significant drug interactions with other medications.

The FDA has suggested that it may be time for establishing a behind-the-counter class of drugs. Proposed products would be 'medications that can be available without the need for a prescription by a health care professional, but are delivered in the context of being able to have patients guided and directed and instructed about their appropriate use." Because of rapid developments in the Rx-to-OTC reclassification arena, and in light of the fact that the pharmacist is a primary guardian of the public health, it may be time to reexamine a "pharmacist legend" class of drugs.

Solution: It is time to reevaluate this entire issue and to consider establishing a third class of drugs or even restrictions for some strictly OTC products, as has already been done with pseudoephedrine. There should be more emphasis on involving the consultation of a pharmacist when using these products, especially those with abuse potential or where safeguards for patient safety are important. Most individuals are not aware of some of the serious ramifications or how to properly utilize these OTC products. These ramifications can cause serious harm resulting in emergency room visits and hospitalizations, all which cost money.

Open Access to State Board of Pharmacy

Brief Description of the Issue: Sometimes it is very difficult for pharmacists to get in touch with the State Board of Pharmacy. When contact is made, some of the very questions and issues for which a licensed pharmacist needs guidance, in the public's best interest, they are unable to

receive as it would be deemed providing an advisory opinion. Some of these questions arise through pharmacy inspections, where inspectors seem to vary significantly in their knowledge, expertise, and interpretations of the law and regulations. There are also times when the backlog of applications for pharmacists and pharmacies is dreadfully behind and the process desperately needs modernizing.

Solution: 1) Encourage the state board to provide more statements of policy or guidance on issues in some appropriate format such a joint determination by the board;

2) Modify the regulatory process so that it does not take so long to implement needed changes to keep up with changes in today's marketplace;

3) Encourage communication between the Board and inspectors, as well as some uniform requirements regarding aspects of enforcement; and,
4) Update the application process for timely acknowledgement and delivery of issuances or denials.

Continuing Education Requirement

***Brief Description of the Issue**:* In Pennsylvania, pharmacists must obtain 30 hours of continuing education every two years. We believe that while this is a sufficient requirement, many pharmacists could use a regular review of applicable laws. With so much happening on the legal front, we believe such regular review would be beneficial for all pharmacists and ultimately for patient safety.

Solution: In each renewal cycle, require two hours be dedicated to pharmacy law. However, this topic area should be broad enough to encompass all related federal and state laws and regulations, case law, and other applicable standards.

Expansion of Scope of Practice

***Brief Description of the Issue**:* In many states, pharmacists are able to more effectively manage drug therapy and in some states pharmacists may even initiate some drug therapies. Under the current law, working under a collaborative agreement to manage drug therapy is only allowed in an institutional setting. Pennsylvania pharmacists may now get involved in medication therapy management and disease state management but they can not change medications, the dosage or other instructions without the physician's approval. If collaborative practice agreements were allowed in the community setting, pharmacists could, under an advance agreement with a physician, completely manage a patient's drug therapy regimen, making appropriate changes as authorized in the practice agreement.

Solution: 1) Remove the words "in an institutional setting" from several places in the Pharmacy Practice Act.

Reimbursement to Pharmacies

Brief Description of the Issue: Many years ago, before third parties and PBMs, a pharmacy marked up their drug product cost with a percentage factor to include the professional services

the pharmacist provided and the patient paid cash. Today's methodology consists of third parties and PBMs paying pharmacies a certain price for the drug product and a low to modest amount for a dispensing or professional service fee. In the past, the drug product markup covered the related professional expenses and then that payment balanced out the equation. Unfortunately, payers have lowered the drug product reimbursement to sometimes below the pharmacies acquisition cost. The low dispensing or professional service fee is now the only portion expected to cover all the overhead costs to dispense a product. These overhead costs include salaries, inventory, the vial, label, and packaging for the prescription, equipment, building, heating, lighting, insurance, etc. This dispensing or professional fee does not adequately cover the basic costs let alone the aspect of professional services provided or allow for a reasonable profit. And as time goes on pharmacists are being asked to do more under the realm of professional services. This pressure on the bottom line forces pharmacies to look to volume as the solution which ultimately compromises patient safety and leads to more errors.

Solution: Pay pharmacies a realistic professional fee to cover the costs involved in dispensing the prescription and also look at the additional professional services provided, as outlined below.

Valuation of Professional Service

Brief Description of the Issue: In all the discussion regarding appropriate reimbursement for the drug product, consideration of the valuable professional expertise involved in dispensing a prescription has long been forgotten. Above we mentioned much of the physical costs that are incurred in dispensing a prescription, but there are also the cognitive costs as well. In addition to reviewing the prescription for validity, checking for interactions, providing counseling services, etc., the pharmacist is often expected to perform formulary management and act as the "policeman" or gatekeeper for insurance companies and the government. For example, pharmacies must now watch for methamphetamine abuse by maintaining records, logbooks, and limiting sales on pseudoephedrine products. Pharmacists are also expected to know and provide all the correct information on a claim to an insurance company, with the insurer assuming no responsibility. Pharmacists must also struggle with incorrect prescription information, handle prior authorization impediments, and more. These ancillary requirements demand time and recordkeeping. Yet at the same time the professional services of providing consultation, promoting proper medication use and adherence are the very component of quality care.

Solution: In addition to paying a fair and reasonable professional service fee, provide additional payments and incentives for additional services.

Payment for Provision of Medication Therapy Management (MTM)

Brief Description of the Issue: While many pharmacists are starting to provide medication therapy management services, even under the limited parameters of the current practice agreement, many insurers are not providing for payment for these valuable services. Projects underway in Lancaster County and Pittsburgh are specifically demonstrating the valuable role pharmacists can have in managing diabetes care. Encouraging expansion into these areas could help reduce hospitalization costs and emergency room visits, large ticket expenses in healthcare. Better management of diseases such as diabetes but also asthma, smoking cessation/tobacco

addiction, heart disease and many others, will see a higher quality of life for many. Additionally from the employment side, you also see healthier employees and less sick days.

Solution: Implement pharmacist involved disease management programs in state programs as a first step, perhaps through several small pilot programs as a beginning. PPA is happy to work on credentials, program development, and the establishment of a pharmacist network.

Clinical Laboratory Improvement Amendments (CLIA) Waiver

Brief Description of the Issue: In order for pharmacists to properly participate in caring and managing many disease states, pharmacists need to be able to perform several simple finger stick blood tests that are used to monitor and manage patient care. The health and wellness programs and screenings that are offered in pharmacy setting generally focus on preventive care. If more pharmacists were able to provide basic health screenings that involved blood samples, patients that are at an increased risk for developing health conditions could be identified and referred to their physician.

Solution: Change Pennsylvania law to recognize the federal standards which would allow pharmacists to perform certain CLIA waived tests. Forty-eight states allow this.

Hospital Pharmacies

Brief Description of the Issue: Hospital pharmacies are currently inspected by the Pennsylvania Department of Health rather than the State Board of Pharmacy, which licenses the pharmacies and pharmacists who work in the hospital pharmacies. The inspectors are not completely knowledgeable with the State Board requirements. For example, DOH was not aware of the Act 102 updates to the Pharmacy Practice Act, specifically the collaborative practice piece allowing pharmacists in a hospital setting under the auspices of the Pharmacy and Therapeutics Committee to have the authority to make decisions about patient care. For instance, in some hospitals, pharmacists are given the right to adjust a patient's antibiotic dose for renal function without first making a phone call to the physician. Pharmacists also reserve the right to order certain lab tests to monitor a patient's renal function. There are physicians who specifically write for an antibiotic "per pharmacy" so that pharmacists will evaluate the patient, order the appropriate dose and continue to monitor the patient during the entire visit. Yet while this is permitted, DOH inspectors have cited hospitals on this. There is also some inconsistency in the inspections. This leaves the hospital pharmacy in a compliance quandary. Additionally, many of the DOH regulations are out-of-date with current practices. An example of this would be the requirement that only pharmacists check for expired medications on nursing floors. Pharmacy technicians are adequately trained and supervised to perform this clerical function which frees up the pharmacist's time to perform the more clinical services as appropriate.

Solution: 1) Require the Department of Health to work closely with the State Board of Pharmacy to ensure inspections of hospital pharmacies follow state practice laws; and

2) Require the PA Department of Health to work with stakeholder organizations, such as PPA, to update and modify their regulations and particularly in the case of pharmacy to ensure their regulations are not in conflict with the State Board of Pharmacy.

Drug Importation and Internet Pharmacies

Brief Description of the Issue: The current U.S. drug distribution system was designed to keep unapproved and potentially unsafe medications from entering the U.S. drug supply. Consumers have no assurances of the source of their medications when purchased online through unapproved websites. Medications that have not been approved for sale in the U.S. may have been manufactured without any quality assurance procedures which are designed to produce safe and effective products. Some imported medications or those obtained via the internet, even those which bear the name of a U.S. approved product, may be counterfeit versions that could be ineffective or dangerous. Some medications and their ingredients, although legal in foreign countries, may not have been evaluated for safety and effectiveness in the U.S. These products could be addictive or contain harmful substances. Many medications are unsafe when taken without adequate medical supervision, which internet pharmacies often circumvent. Individuals should always have a personal medical evaluation and often need medical checkups to ensure the medication is appropriate for their condition, is working properly, and does not cause any harmful side-effects. Medications from foreign or unknown sources may not contain a label or include instructions for use and warnings of possible side effects or if there is a label, the information may be in a different language and make medical claims or suggest uses which have not been adequately evaluated for safety and effectiveness.

Solution: 1) Legislators and regulators should not be seeking ways to allow importation as a solution. Patients must be able to receive the affordable prescription medications that they need while benefiting from the safeguards that are in place in this country and enjoying the trusted relationship they desire with their pharmacist; and,

2) While regulation of internet pharmacies is difficult there should be ongoing public efforts to warn consumers of the distinct dangers involved in purchasing unreliable medications via the internet.

Pharmacist' Ability to Practice

Brief Description of the Issue: Pennsylvania currently has seven schools of pharmacy which graduate hundreds of pharmacists each year. Many of these pharmacists leave the state to practice in other parts of the country, leaving many parts of the state to experience a short-fall of pharmacists. Some of this exodus is motivated by various socio-economic factors but some of it is due to the fact that Pennsylvania has failed to create an environment that embraces new and innovative pharmacy practices. New pharmacy graduates want to come out and practice in a way that benefits their patient's lives, where they are making a difference. Current needs dictate an almost robotic approach to dispensing prescription drugs which short-change patient safety and lead to medication errors.

Solution: Address the issues outlined in this paper. All of the solutions would contribute to a better environment for the practice of pharmacy in Pennsylvania allowing pharmacists to practice at the top of their license and lead to better healthcare. These would be significant in recruiting and retaining pharmacists in the Commonwealth.

In Conclusion

Many of these issues and potential solutions when taken separately may alleviate or remove certain barriers. When combined and reviewed as the big picture, essentially all of the issues are opportunities to provide better patient care through the informed involvement of the pharmacist, as the medication expert. The Pennsylvania Pharmacists Association believes that patients will ultimately be better served when the system is designed to truly utilize the pharmacists' knowledge. Many of these proposed solutions would place the appropriate care and management of prescription drugs with the pharmacist working in a better partnership with prescribers and other providers without unnecessary barriers creating obstacles to patient care.