**North Carolina Association of Pharmacists**

**Legislative Day May 25 2022**

**Talking points**

*The following are some brief talking points for use in your meetings. It is important that you use your own experiences to personalize these points. Use short stories that illustrate the importance of the issue for patients, small businesses, and our healthcare systems. Stories, that legislators can relate to, helps them to better understand what are often complex pharmacy issues.*

*Feel free to put these talking points into your own words. Remember just be yourself and speak from the heart.*

**Keep in mind: legislators have no healthcare education or experience beyond their own personal interactions with various healthcare professionals. Educating legislators about our issues is the primary purpose of pharmacy legislative day. Therefore, use this time to respectfully speak with legislators. Think of them as laypeople and avoid using pharmacy or healthcare jargon and acronyms.**

For some of the meetings, you will be part of a group. The group may be meeting with a legislative leader or it may be a small group from your district meeting with the same legislator.

[Depending on how much time is allotted for the meeting and the number of individuals in the group. You may need to adjust some of the following talking point guidelines.]

These first three points should take no more than 5-8 minutes of the meeting.

1. First thank the member for taking time out of their busy schedule to meet with you.
2. Briefly introduce yourselves. Your name, what city/town you live, and where you work. If you’re a constituent, make sure you tell the legislator that.
3. Thank them for their support of the significant pharmacy legislation that passed last session. Senate 257 “Medication Cost Transparency Act” and H 96 “Allow Pharmacists to Administer Injectable Drugs.” These bills helped to address serious violations of state law by PBM organizations and expanded the scope of pharmacy practice in ways that will both improve public health and help improve access to health care in many parts of the state.

The next points are the focus of the meeting. These talking points are general guidelines. Please put them into your own words and provide examples from your experience to illustrate. [You may choose to briefly address each of these priority issues or depending on the interests of your group, you may opt to focus on just one or two of the issues.]

**Additional Pharmacy Benefit Managers Legislation**

North Carolina has a Pharmacy Benefit Managers (PBMs) audit protection statute, and last year you helped to pass S 257, which now requires PBMs to register to do business in NC with the DOI. Both of these laws are great first steps in holding PBM organizations accountable. But there is much more work to do.

* Pharmacy Benefit Managers are the middlemen between health plans and pharmacies and our patients. Each year, PBMs have become increasing more powerful and are the primary driver behind rising drug costs, so much so that PBMs continue to be the focus of attention in Congress, the FTC and the Supreme Court.
* PBM’s continue to try to skirt state laws and drive small independent pharmacies out of business.
* PBM’s have taken control over specialty medications preventing our health-system medical clinics from being able to provide medications in a timely and direct manner for patient care.
* PBMs steer patients to use mail order or take away their choice of what pharmacy they want to use for their care.
* Last year, some important consumer protections and other measures were left out of S257. We understand that Senator Perry is planning on bringing additional legislation this session to help address these issues, and I/we hope you will support that effort.
* You can cite current examples of these ongoing struggles you might be having with PBM’s here.
* Please tell the legislator, that the North Carolina Association of Pharmacists is available to you and your staff to further discuss PBM issues and to answer questions you may have during the legislative session. (NCAP business cards will be provided to someone in your group to leave behind.) [Also, if you, as a pharmacist, are willing to be a resource to the legislator, please share this with them, and leave your busines card.]

**Fair Reimbursement for Pharmacy Services**

Last session in H.96, we thank you and other members of the General Assembly for passing this legislation which now allows patients to access birth control, tobacco cessation products, HIV prevention medication, prescription prenatal vitamins, and glucagon which is a life-saving medication for severe low blood sugar. These new authorities greatly serve to expand access to care for all North Carolinians.

* Birth control provides a good illustration. For a patient who seeks birth control from their pharmacist, the pharmacist must like any other healthcare provider, use the CDC medical eligibility criteria for determining how and what to prescribe. This involves a detailed questionnaire and then the pharmacist has to use the patients answers to apply a series of clinical guidelines. Once the appropriate therapy is determined the pharmacist must conduct comprehensive patient education. The process is no different than how birth control would be started in a medical office. The visit would require 15-20 minutes of the pharmacist’s time. Pharmacists have been called to provide this service but are yet recognized to be paid for the service.
* Also, pharmacists have the training and education, as well as the authority to provide comprehensive medication management services, administer certain point of care tests for flu, diabetes testing, and HIV, but pharmacists are not allowed to bill to be reimbursed for the test, let alone their clinical expertise.
* **North Carolina statutes already designate pharmacists as "healthcare providers", when it comes to medical liability. We need the passage of fair reimbursement legislation will help ensure that pharmacists are compensated for the care they provide. (provide examples of this from your experience.)**
* This will NOT raise the overall cost of medical care. First, we will not be duplicating services. Second, what we are doing will actually drive down the cost of health care by addressing issues in patients before they become more serious. Example: a pharmacy visit for flu vs. the cost of unintentional pregnancy or a pharmacy visit for HIV prevention following exposure vs. the cost of care for HIV positive patient. Fair Reimbursement is one of our top legislative priorities for the 2022 session.

**Test and Treat:**

According to the National Alliance of State Pharmacy Associations, more than 25% of states in our nation have expanded what pharmacists can do to include testing and treating people for illnesses such as strep throat, flu, and urinary tract infections and preventing HIV. The ability to test and treat in the pharmacy increases the public’s access to care, and helps to prevent unnecessary delays in seeking care, that can lead to a worsening of symptoms that then requires patients to use more costly healthcare options, such as urgent care or an emergency department.

* Point-of-care tests, which offer near immediate results, could and should be available in the pharmacy setting to help promote prevention, early detection, and disease management. We are working with Rep. Sasser and Sen. Burgin on legislation to allow pharmacists to provide test and treat care in NC.

Here are two examples you might use to illustrate this point:

* Example 1: Patient comes into a community pharmacy with fever, body aches, cough and congestion, for which the patient is looking to purchase an over-the-counter medication for their symptoms. The pharmacist asks the patient a series of questions and indicates that the patient may have the flu. Today, a NC pharmacist can perform a rapid flu test, but he/she cannot provide prescription treatment for the flu in the event that the test is positive. Instead, the pharmacist’s only recourse is to say you have the flu. These over-the-counter products will help manage symptoms, but there is a prescription medication that can reduce the course of flu and help you feel better faster. However, you would need to see your physician to get a prescription. The patient would then go to the physician have the same test repeated only to have to return to the pharmacy to get the prescribed medication. Patients often cannot get into see their physician and they just go home and hours to days later their symptoms may worsen leading them to go to urgent care of the emergency department.
* Example 2. A patient presenting to a pharmacy who has potentially been exposed to HIV and they need to start post-exposure prophylactic therapy within 72 hours of exposure. Pharmacists can now start PEP and ideally the patient should be tested for HIV, first, because if the patient were already positive for HIV, he/she should be on other treatment and starting PEP would not hurt but it would not be the full regimen that they need. The problem is that pharmacist cannot bill for the rapid HIV test. We need pharmacist to be able to utilize testing and to be able to billing for reimbursement.

According to the CDC, in 2017, the flu was the number 8 leading cause of death in North Carolina. The most recent finalized CDC report on flu statistics, is 2019-2020 and NC flu mortality rate was 14/100,000 people with a total of 1804 deaths during that flu season.

**“Collaborative Practice”**

All 50 states have some form of collaborative practice authority, in which physicians can delegate certain patient care services to pharmacists. This is done via a written agreement or protocol. Examples of some of the things that can be delegated is the authority to order and interpret certain laboratory tests, or initiate, modify, or discontinue certain medications.

North Carolina was one of the first states in the nation to enact collaborative practice authority (CPA) for pharmacists. However, our state’s CPA now ranks as one of the most restrictive, imposing extensive and outdated limitations and barriers to collaborative practice and patient care.

Last year, NCAP, worked with Rep. Wayne Sasser to introduced legislation designed to modernize our existing collaborative practice statutes governing Collaborative Practice between Physicians and Pharmacists. [House Bill 862 "Improving Access to Patient Care."]

* NC’s Collaborative Practice Authority was first enacted in 1998. Our statute only allows pharmacists to collaborate with physicians. Since 1998, the numbers of nurse practitioners and physician assistants have increased significantly. Just in the last decade the number of PAs, in the United States, has increased from 70,000 to 148,500, according to the National Commission on Certification of Physician Assistants. Nurse Practitioners have grown more so from 106,000 to 355,000, nationally, according to the American Association of Nurse Practitioners.
* North Carolina residents who have a NP or a PA as their provider should be allowed to receive medication management and other delegated care services via collaboration with a pharmacist. Why does our state only allow collaborative care between a pharmacist and a physician, when the majority of other states in the nation do allow for pharmacists to collaborate with NPs and PAs?
* NC hospitals and health systems have hired pharmacists to provide collaborative care, but our health systems need these pharmacists to assist with population health. Our state should allow these pharmacists to practice under an institution-wide collaborative agreement protocol to address medication-related needs for an entire patient population. For example: all patients with diabetes for a clinic or a group of clinics, a pharmacist could through telehealth or in-person care, work to make sure that these patients are on guideline-recommended treatments. As long as the patient has a diagnosis and there is an institution protocol in place, the pharmacist should be allowed to provide care without the patient having to also see a specific physician.
* It would be helpful for patients being transitioned from hospital to outpatient setting to be able to be seen by the pharmacist for medication-related care without the patient having to first see the supervising physician. It takes longer to get an appointment for follow-up with the physician than it does to have a medication-related care visit with the pharmacist. Often the delay, waiting for that physician appointment, can lead to a readmission or emergency department visit, when had the patient been able to be seen by the pharmacist, in the clinic, some of these more costly healthcare related events could have been avoided.

We need all of our healthcare professionals practicing to the height of their education and training. Our existing collaborative practice statute is out dated, and you can help fix this. North Carolinians deserve better.