The Pharmacist Activist
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Editorial

Chain Pharmacists of America (CPOA): PART 2

I have received many comments and recommendations regarding my editorial in the May issue of *The Pharmacist Activist*. Every respondent strongly agrees that there is an important need to establish an organization/process that will provide strong and effective representation for chain pharmacists. To maintain the momentum for considering this concept, I am providing below observations and ideas I have received (some of which I have excerpted and/or paraphrased) that are typical of most of the responses. Although I would like to identify and give credit to the individual pharmacists who provided these responses, I consider it best that I not do so.

Responses

"I like the CPOA idea. Don't need conventions. Just need a good CEO and a competent staff. And the $100 dues should be easy to get."

"I'm 100% behind the CPOA plan."

"I've shared the May issue with hundreds. Wherever I can be helpful, count me in!!!"

"I read your May editorial with great enthusiasm. For a number of years I have been fighting what is wrong with our profession and how our state and national organizations seem out of touch with what we as professionals really need and want for our beloved profession. I have been trying to come up with ways to help, even postulating that I should start my own organization. My problem has always been getting stuck on the 'how to' part of the plan. How do I start an organization? How do I get it recognized? I have seen other startup groups peter out before gaining any substantial following. I believe if the energy is put into a plan from the beginning with a clear goal in mind, success can be realized."

"I agree completely with your editorial. The one issue I would add is that of practice autonomy. An organization of employed pharmacists would be a great force for ensuring the professional autonomy of practitioners."

"I'm writing for two reasons. First, to ask how I can be of help in this endeavor. I am a pharmacist-in-charge at a grocery store pharmacy. I came here to escape large chain pharmacy but many of the patient safety problems still exist in both settings. Secondly, I'd like to suggest one change to the proposed organization. Rather than rallying as 'Chain Pharmacists of America,' we could add valuable members to the ranks by a small change to 'Community Pharmacists of America.' Independent community pharmacists face similar challenges in fighting against PBMs concerning unfair reimbursements that force them to attempt to survive at lower staffing levels as well, or risk being absorbed by PBM affiliates like CVS. It's unsustainable, unsafe, and unethical to allow chains and PBMs to continue to push their power upon both us and our patients in this way."

"I would recommend that the word 'Chain' be dropped from the organization title and use the term 'Pharmacists of America.' I also would endorse that 'Pharmacists of America' be able to do a work stoppage/walk out if working conditions are not met. I

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realize this sounds like a 'union' but what is really going to make employers do the right thing? It all comes down to money. If pharmacists aren't available, then there's no money. Pharmacy managers/directors must also be able to 'walk out.' Yes, patients may be inconvenienced but with bad working conditions patients are inconvenienced but they just don't know it – until something bad happens to them. Having been a pharmacy director, I know that pharmacy directors/managers are squeezed in the middle. Often powerless because senior management will fire them if they don't do what they're told. These people need the right/protection to 'walk out.'"

"Having been in manager/chief/director positions over the years, it is important to include those of us who are often caught in the middle between staff that we work with and try to support, and senior management with questionable metrics and expectations. Concerns raised are met with disregard at the least. I agree with the rationale regarding unions, but the organization must be able to wield power to create needed change. I am not sure about the legalities, but staff and managers need the ability to stage a 'walk out' or other action if needed. Some pharmacies do not fit in the common categories and, perhaps, 'Chain' should be dropped from the name resulting in 'Pharmacists of America.' The focus could still be chain pharmacists, but it would be inclusive of other ambulatory settings."

"Contact the Teamsters and see what it takes to unionize. Big retail pharmacies will fight you but now is the time!"

(A California pharmacist shared the following experiences.) "We had a coalition to improve working conditions of Employed Pharmacists. We worked out a set of 'rules to live by' which were very reasonable. All the major chains except one refused to sign off on them or even discuss them. A few years later, a pharmacist advocate was designated to work with corporate officers who make decisions on working conditions in the pharmacies. They would not meet with him or provide information, and the program quickly ended. The California Nurses Association only focuses on working conditions and patient care, not wages and benefits. Every time reporters talk to a nurse on camera, with a sign, he/she talks about patient care, breaks, etc."

(A friend who is not a pharmacist but has extensive experience/expertise regarding health care and the pharmaceutical industry shared the following comments.) "I suspect it will be very difficult to organize pharmacists for the positions you advocate. Strong, disruptive action to correct a situation is out of character for pharmacists. Of course, skillful organizing can take even less likely prospects and turn them into an effective group. Good labor organizers can take reactionary individuals and turn them into effective opposition to management exploitation. The kind of enlightened , professional society you advocate seems highly improbable to me. It reminds me of individuals with whom I used to argue – they were highly principled and wonderfully well intentioned, but they presumed a similar level of rationality, good intentions, and initiative among those for whom they were advocating. Sorry, but the mass of men and women are not that way. Health care in this country would be better and more affordable if it moved closer to a socialist or a more truly capitalist system. But that can't happen as a result of well intentioned appeals to professional integrity. The effort to make such an appeal to pharmacists and, as a result, arouse their initiative, consists of trying to dance with a dead woman. Despite my disagreement with your strategy and tactics, I believe we share the same objectives and I applaud you for bringing important issues to your readers."

(Although I do not agree with this individual's general characterization of pharmacists, I consider it important to be aware of how we are viewed by some who are not in our profession. Indeed, such comments can contribute to our motivation to be proactive in pursuing progressive change.)

Next steps

If it was currently possible to take a vote of employee pharmacists, I anticipate that there would be an overwhelming mandate for actions that would improve working conditions for employed pharmacists that would also result in fewer errors and improved patient safety. The responses I have received strongly support such advocacy, but also identify important questions, such as the following:

Should the organization being considered include only chain pharmacists or have an extended membership of all community pharmacists or all employed pharmacists?

Should a "work stoppage" in the interest of patient safety and improved working conditions for employed pharmacists be an option for the membership of the proposed organization?

Should a pilot project (e.g., in a particular state or a particular chain pharmacy) be conducted?

I welcome your additional recommendations and perspectives, as well as suggestions of pharmacists to be involved in the leadership and planning in this initiative.

Daniel A. Hussar

New Drug Review

Delafloxacin meglumine

(Baxdela – Melinta) *Antibacterial Agent*

New Drug Comparison Rating (NDCR) = 4
(significant advantages)
in a scale of 1 to 5 with 5 being the highest rating

Indication:

Administered orally or intravenously for the treatment of adults with acute bacterial skin and skin structure infections (ABSSSI) caused by susceptible isolates of the Gram-positive bacteria *Staphylococcus aureus* (including methicillin-resistant [MRSA] and methicillin-susceptible [MSSA] isolates), *Staphylococcus haemolyticus, Staphylococcus lugdunensis, Streptococcus agalactiae, Streptococcus anginosus* Group (including *Streptococcus anginosus, Streptococcus intermedius, and Streptococcus constellatus*), *Streptococcus pyogenes*, and *Enterococcus faecalis*, and the Gram-negative bacteria *Escherichia coli, Enterobacter cloacae, Klebsiella pneumoniae*, and *Pseudomonas aeruginosa*.

Comparable drugs:

Levofloxacin, moxifloxacin.

Advantages:

- Has been demonstrated to be effective in ABSSSI caused by MRSA;
- Spectrum of antibacterial action includes a larger number of Gram-positive and Gram-negative bacteria;
- May be less likely to cause QT interval prolongation and phototoxicity;
- May be less likely to interact with other medications.

Disadvantages:

- Labeled indications are more limited (whereas comparable drugs are also indicated for respiratory and certain other infections);
- Is administered every 12 hours (whereas comparable drugs are administered every 24 hours).

Most important risks/adverse events:

Risk of tendinitis, tendon rupture, peripheral neuropathy, central nervous system effects (e.g., dizziness, confusion, tremors), and exacerbation of myasthenia gravis (boxed warnings; should be avoided in patients with a history of tendon disorders, peripheral neuropathy, or with a history of myasthenia gravis; treatment should be immediately discontinued in patients in whom such adverse events occur; patients should be advised to not drive or engage in other activities that require mental alertness and coordination until they know how the drug affects them); risk of *Clostridium difficile*-associated diarrhea; use in children is not recommended; dosage for intravenous administration should be reduced in patients with severe renal impairment (serum creatinine concentrations should be monitored); may form chelates with multivalent metal cations (should be administered at least 2 hours before or 6 hours after products such as antacids and vitamin/mineral supplements that contain multivalent cations).

Most common adverse events:

Nausea (8%), diarrhea (8%), headache (3%), transaminase elevations (3%).

Usual dosage:

Bioavailability of a single oral dose of 450 mg is comparable to that of a single intravenous dose of 300 mg: 300 mg every 12 hours over 60 minutes by intravenous infusion, or 450 mg every 12 hours orally; treatment may be initiated intravenously and then switched to oral administration as appropriate; duration of treatment is 5 to 14 days; in patients with severe renal impairment, the dosage for intravenous administration should be reduced to 200 mg every 12 hours because of the potential accumulation of the intravenous vehicle.

Products:

Tablets – 450 mg; vials for injection – 300 mg as a lyophilized powder (should be reconstituted and diluted with 5% Dextrose Injection or 0.9% Sodium Chloride Injection).

Comments:

Delafloxacin is a fluoroquinolone antibacterial agent with a broad spectrum of action, and is the first fluoroquinolone to be demonstrated to be effective in the treatment of infections caused by MRSA. Its effectiveness was evaluated in two studies in which it was compared with and demonstrated to be noninferior to the use of vancomycin and aztreonam in combination. An objective clinical response (a 20% or greater decrease in lesion size) at 48 to 72 hours was achieved in approximately 80% of the patients with both treatment regimens in both studies. The success of treatment as assessed on follow-up at about 14 days exceeded 95% for both treatment regimens. Its effectiveness as a single agent that may be administered orally provides an advantage over the concurrent intravenous use of vancomycin and aztreonam.

Daniel A. Hussar

Why CVS Loves ObamaCare*

***This is the title of an Opinion column in the May 30, 2018 edition (page A14) of *The Wall Street Journal*. The information and implications for the profession of pharmacy are so important that all pharmacists should read the entire column and forward it to our legislators and others with responsibilities for prescription benefit programs. Excerpts from this column are quoted below:**

"Big business feasts on big government, and ObamaCare has been a bonanza for companies that have figured out how to exploit it. Witness how CVS Health is dining out on Ohio's Medicaid expansion.

In addition to retail pharmacies, CVS operates a pharmaceutical benefit manager (PBM) that acts as a middleman between insurers, pharmacies and drug manufacturers. PBMs decide which drugs are listed on a formulary, how much pharmacies are reimbursed and how much insurers pay.

Ohio contracts with five managed-care organizations (MCOs) to administer Medicaid benefits, four of which outsource their drug benefits management to CVS Caremark, the CVS PBM. The state uses drug claims data to set its annual drug budget. So if claims increase, the state will allocate more Medicaid funds for drugs the following year.

Yet CVS appears to be billing the state for far more than what it is paying pharmacies, driving up taxpayer costs. CVS's actual drug payments aren't transparent to the state or MCOs.

CVS is also attempting to drive independent pharmacies out of business and expand its retail market share. We spoke with eight current or former independent pharmacists in Ohio who complained that CVS has slashed payment rates below the pharmacists' wholesale costs. They say CVS is pocketing the increased 'spread pricing' – that is, the difference between what the PBM pays pharmacies and charges the state."

"Independent pharmacists say they first noticed a decline in Medicaid payment rates three years ago. CVS slashed them further last fall." (Several specific situations are described in which independent pharmacists closed or sold their pharmacies to CVS.)

"Most pharmacists don't want to be publicly identified because their CVS contract bars them from disclosing payment rates. But one said he was getting paid 18 cents per capsule of the generic antidepressant duloxetine while his wholesale cost is about 23 cents. According to Centers for Medicare and Medicaid Services data, PBMs in Ohio last fall were charging Medicaid $1.53 per duloxetine pill. The spread pricing for a 60 mg dosage of duloxetine during the first nine months of 2017 totaled $6.3 million."

"Ohio state senator Dave Burke, who runs an independent pharmacy and serves on the state Joint Medicaid Oversight Committee, says two-thirds of the Medicaid drug claims he processes are below his drug acquisition cost. He's fortunate that Medicaid patients make up less than a quarter of his customers.

CVS payment rates, he says, are 'take it or leave it.' If pharmacists refuse to accept Medicaid prescriptions, they risk losing CVS contracts for Medicare Part D and commercial plans that typically pay more.

Some pharmacists said that after the Medicaid payment reductions they received solicitations from CVS Pharmacy Regional Director of Acquisitions Shane Stockton saying: 'I'm a pharmacist myself. I know what independents are experiencing right now; declining reimbursements; increasing costs, a more complex regulatory environments. Mounting challenges like these make selling your store to CVS Pharmacy an attractive and practical option."

"In the last three years, Ohio has lost 164 independent pharmacies while CVS has added 68."

"But as neighborhood pharmacies close, health-care access for low-income patients diminishes. That at the very least should concern politicians."

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Author/Editor - Daniel A. Hussar, Ph.D.
Philadelphia College of Pharmacy, University of the Sciences in Philadelphia
Publisher - G. Patrick Polli II
Publications Director - Jeff Zajac

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The Pharmacist Activist, 515 Shoemaker Rd., King of Prussia, PA 19406
610-337-1050 • Fax: 610-337-1049
E-mail: pharmacistactivist@news-line.com
NEWS-Line PUBLISHING