# LEADING THE CHARGE: NEXT STEPS ON THE PART OF CPS
## Feedback from the 2024 Annual Meeting

| Next Step | Annual Meeting Attendee Recommendations | # of dots (prioritization) |
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| CPS Support @ Future Mtgs (Workplace conditions; well-being topics/approaches) (#6) | 1. Advocate for legislation that does the following:<br>a. Ban quotas<br>b. Require lunch breaks<br>c. Mandate tech hours based on number of Rx's filled | 10 |
| | 2. Taking PBMs to task. #1 most important thing to do to help with everything else. | 4 |
| | 3. Just do something! Do not just have a report of result. We must act! | 3 |
| | 4. Make CPS membership (esp. first time) more attractive and enticing to chain/supermarket pharmacists/techs.<br>5. Help us help you in CO. | 2 |
| | 6. Officially rank safety 1st, customer service 2nd, speed last in State of Co pharmacy. | 1 |
| | 7. Do not forget about the other areas of pharmacy. Numbers might be lower or not as bad, but they have struggles too. | 1 |
| | 8. Have a "Sip & Social" event & invite retail pharmacists to attend (include/target non-CPS members- this will also be a membership drive!) Make it a townhall event and ask them what needs to be changed. | 1 |
| | 9. PBM & payer transparency in reimbursement models with flat rate dispensing fees. | 1 |
| | 10. Create a job postings board on CPS website to help any pharmacy easily see what other opportunities are available throughout the state. | 1 |
| | 11. Education/Advocacy for decrease in work distractions<br>a. Not multi-tasking<br>b. Only answering phone, etc. | 0 |
| | 12. Well-being focused initiatives that benefit those across all areas of practice (many areas have different challenges, but focus on personal strategies, too!) | 0 |
| | 13. Colorado Pharmacist Teams site for all members to share. | 0 |
| | 14. Perceptions of pharmacists and careers positive to negative. | 0 |
| | 15. Efficient optimization consultants & business management training. | 0 |
| | 16. Legislation to protect pharmacist ratio to staff (not just techs).<br>17. Do not allow for a pharmacist to oversee multiple locations. | 0 |
| | 18. Create a dashboard for visibility & transparency. | 0 |
| | 19. Pharmacists required by state board to be part of the state association. (Maybe increase dues) | 0 |
| | 20. BCPS requirements to encourage membership/involvement. | 0 |
| | 21. Create networking/resume building events to support career growth. | 0 |

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| | 22. Planning meetings on how to implement important topics. | 0 |
| | 23. These other states that are creating policies seem like bare minimum approaches. Colorado should lead with the most progressive changes to benefit pharmacists. We already do that with scope. | 0 |
| *Sharing Data with Stakeholders (#3)* | 24. In-person workshops for leadership. | 5 |
| | 25. Formation of committee with members from across key stakeholders (retail, chain, hospital) | |
| | 26. Have legislators and public spend a day with a pharmacist. | 2 |
| | 27. Avoid "commoditizing" of pharmacy services that leads to patients using the lowest cost provider and thus the lowest profit for provider. | 1 |
| | 28. Work with physician organizations to advocate on our behalf. | 1 |
| | 29. We like to hear from similar disciplines that "look like us." Have pharmacists share with pharmacists. Have techs share with techs. Have business admins share with business admins. | 0 |
| | 30. Send Emily Z. to Washington to advocate for the profession! | 0 |
| | 31. LinkedIn/Indeed | 0 |
| | 32. Have leadership work in the pharmacies for a day/week. | 0 |
| | 33. How do you "invite" your legislation for a little discussion? Share the process with CPS members. | 0 |
| *Implementation Summit (#2)* | 34. Consider a separate "Summit Conference" attended by National/State/Local stakeholders to launch initiatives, led by pharmacists more than 'other disciplined' administrators. | 11 |
| | 35. Bring all org leadership to the table to share survey results to provide perspective on how staff are feeling and suggest ways to help. | 3 |
| | 36. Education on how to advocate for your workplace safety needs professionally. | 3 |
| | 37. Virtual town hall or workshop with separate practice areas (i.e.- retail, ambulatory, hospital, other) | 1 |
| | 38. PBM accountability. Get paid for at least cost of meds. | 1 |
| | 39. Getting rid of metrics and focusing on patient care. | 0 |
| | 40. Empowering staff to tell patients that are abusing them to go elsewhere. | 0 |
| | 41. We see well-being talks that are great, but could there be education for organizations and leaders of how to implement/get buy in. | 0 |
| | 42. Have follow-up survey for retail staff. Get leadership buy in to encourage staff to complete. Ask for ideas to improve. | 0 |
| | 43. Host town hall (local) and post message boards for continued feedback. | 0 |
| | 44. CPS- create a tech training program to be an objective supplier of technicians to be able to choose or cater to where they want to work. | 0 |
| | 45. More transparency with staff regarding financials. | 0 |
| | 46. Need to involve the heads of health care orgs (Head of CVS, Head of Walgreen's) | 0 |
| *Gather Input from* | 47. Create a CPS phone app for members and non-members where any professional can include their input | 3 |

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| *Pharmacy Professionals (the how) (#10)* | and comments. | |
| | 48. Focus groups with different practice area representatives to discuss challenges and solutions | 3 |
| | 49. Drive to show big box chain PharmD why/how CPS can help them. | 2 |
| | 50. Create an online messaging system/forum across all systems/offices for messages/concerns. Especially for errors, transfers, etc. | 2 |
| | 51. Email/mail letters - pick a few pharmacies to just stop by to physically talk to individuals. | 2 |
| | 52. Show face and have personal interactions with pharmacy professionals | 1 |
| | 53. Continued use of surveys. | 1 |
| | 54. Surveys and forums / Work place meetings | 1 |
| | 55. Open forums | 0 |
| | 56. We tend to want what we can't have. Frame communication on what patients stand to lose (not to gain). | 0 |
| | 57. Membership - how have other states orgs successfully engaged with chain/supermarket pharmacists and techs and encouraged their membership and input? | 0 |
| | 58. CPS sponsorships of community pharmacists to come to summit or conferences (PTO days?) | 0 |
| | 59. Anonymous message boards. | 0 |
| | 60. A text to speech free form E-script system to type in called-in scripts instead of having to read bad handwriting (direct from voicemail) | 0 |
| | 61. Start with students, they likely have concerns with things they have seen/experienced | 0 |
| | 62. Offer ways for tech/staff that are able to speak more than 1 language. | 0 |
| *Positive workplace practices (#9)* | 63. Pharmacist and tech FTE should be established based on # RXs filled at pharmacy (no performance metrics on the #/RXs filled) | 5 |
| | 64. Pharmacists with business expertise leading chains instead of strict business leading HC with no HC background | 2 |
| | 65. Undercover boss for upper management to step in and work to see the needs, stress and workflow to adjust staffing | 2 |
| | 66. Central fill location to help work flow for certain medications (i.e.- maintenance meds) | 2 |
| | 67. Management actually going into retail pharmacies to <u>experience</u> what a real day feels like with everything they are requiring them to do with minimal staffing and help. | 1 |
| | 68. Upper management should step in to cover sick days/vacations. | 1 |
| | 69. At first glance, it appears that <u>upper</u> <u>management</u> rates the situation more positive than the actual worker bees. Leadership (AKA upper management) must be more involved with day-to-day operations. | 1 |

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| | 70. Over the years, it seems like there have been massive increases in middle management - all while the expectations of the actual pharmacists have increased. This leads to resentment and disparity. | 1 |
| | 71. Increased pharmacist overlap | 1 |
| | 72. Workplace hours max for pharms, interns, techs. | 1 |
| | 73. Work to support pharmacy professionals being able to attend meetings during work, attend conferences (front line has no flexibility) | 1 |
| | 74. Filling Rxs as the primary function of a pharmacist is an underutilization of the profession. We HAVE TO CHANGE THE MODEL. | 1 |
| | 75. If you have so many clinical programs, you have to have pharmacist overlap | 1 |
| | 76. Pharmacists must be in charge of setting performance goals in practice setting- especially retail. | 1 |
| | 77. Remove RPh:Tech ratio of 1:6- it doesn't exist. Go back to 3:1 via legislation | 1 |
| | 78. Proper amount of training. Don't just throw to the wolves (patients) for safety | 1 |
| | 79. Pharmacy technician longevity. Many leave in less than a year of employment | 1 |
| | 80. Recruitment/retention strategies for certified techs | 1 |
| | 81. Collaboration matters. Pharmacists and techs should not be staffed to only cover the workload and have no time to interact and collaborate. Interactions lead to new ideas and happier people. We are not machines. | 0 |
| | 82. Get rid of drive through pharmacies. We are a profession, not fast food. | 0 |
| | 83. Patient care type calls (POQ type calls) limit cold calls from pharmacy in-store staff. | 0 |
| | 84. Minimum number of tech/# of Rx filled (including BTS #s) | 0 |
| | 85. Stores that do not close for lunch, must have PharmD overlap. | 0 |
| | 86. Leadership MUST be pharmacists with medical background. | 0 |
| | 87. Maximize top of practice scope for pharmacists and techs. | 0 |
| | 88. Organize a meeting with Corporate leadership around re-establishing pharmacy as doctoral medical professionals and not retail employees. Pharmacy counter should not be a checkout for lipstick & groceries unless also picking up meds. | 0 |
| | 89. Organize a meeting with corporate leadership around making community pharmacy more like ambulatory care where pharmacists are reimbursed for clinical services. | 0 |
| | 90. Organize a meeting with corporate leadership (Walgreen's, Safeway, etc.) around adequate staffing since they are the decision makers. | |
| | 91. Minimum- tech hours per X prescriptions filled (FILLED not SOLD) | 0 |
| | 92. Prohibit pharmacy chains from guaranteed wait times (do not allow pharmacies to advertise that they'll fill your prescription in "30 min or less") | 0 |
| | 93. Minimum 1 tech for 2 pharmacists if volume > XX/day or pharmacy gets fined! (recommendation for | 0 |

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| | board of pharmacy to implement a rule) | |
| | 94. Impose partitions on corporations that do not incorporate well-being (breaks, etc.) | 0 |
| | 95. Require free therapy for pharmacy staff | 0 |
| | 96. Always having a tech working with a pharmacist. The pharmacies should not have to be responsible for all duties for safety reasons. | 0 |
| | 97. Break down stratification between "Pharmacist v. tech" in the behind-the-counter culture.<br>98. Grow respect & unified team within the pharmacy. | 0 |
| | 99. Music playing, hangouts outside of work, feeling like friends/family (not a forced concept) | 0 |
| | 100. Support from leadership | 0 |
| | 101. Hire more pharmacists for overlap | 0 |
| | 102. 800 scripts per day for one pharmacist doing a 12-hour shift = lower patient safety | 0 |
| | 103. 10hrs for techs per 100 Rxs | 0 |
| | 104. Pharmacists overlap during work hour | 0 |
| | 105. 1-hour lunch | 0 |
| | 106. Limiting clinical management calls per day in retail setting | 0 |
| | 107. Standardization of pharmacist workplace guidelines | 0 |
| | 108. Need a way to mitigate # of hours worked off the clock for RPhs. (I.e.- payment for completing tasks outside of open pharmacy hours) | 0 |
| | 109. Provide staff with complimentary membership to a Rx organization: increased morale, interest, networking | 0 |
| | 110. Change the tech to pharmacist ratio back to 3 to 1.<br>111. For a 10-hour day or longer, the pharmacy must close for lunch for 1 hour | 0 |
| | 112. During flu shot season, pharmacies are required to have overlapping coverage for a minimum of 2 hours (1 pharmacist giving vaccines, 1 pharmacist verifying and filling prescriptions) | 0 |
| | 113.<br>a. Having designated clinical practitioners and technicians outside prescription filling<br>b. If a technician is designated for assisting with immunization, that technician should only help with filling if there's a down time | 0 |
| | 114. Require pharmacies that fill 100 or more scripts per day to have a cashier dedicated to checking out patients (this will free up technician's time) | 0 |
| | 115. Positive workplace practices: regular staff meetings to air concerns | 0 |
| | 116.<br>a. Workplace training<br>b. Mandatory break | 0 |

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| | c. Proper staffing<br>d. Limited hours<br>e. Managerial support | |
| | 117. Change staffing minimums<br>118. Reduce tech to pharmacist ratio | 0 |
| | 119. Pharmacist management is a must. Non-pharmacy leadership teams cannot make good pharmacy decisions. | 0 |
| | 120. Have a pharmacist scheduled for clinical activities/immunizations and pharmacist for filling. Swap duties throughout the day and have pharmacist help filling pharmacist at busy times when they don't have pts scheduled. This will change up activities through the day for brain ease (?) and provide coverage when needed. | 0 |
| | 121. Adopting ergonomic tools to make the job physically easier. The pharmacy flooring could be softer. If a padded mat is placed, it's hard to put a stool on it. A compromise on this is necessary. | 0 |
| *Partnering with National Rx Organizations (#4)* | 122.<br>a. PBM return of above all else<br>b. PBM legislation needs more teeth. More action & accountability | 13 |
| | 123. APhA (Alex VarKey (pres) & Michael Houge (CEO)) are meeting with community pharmacy corporations- can we work with them directly to communicate national work to CPS members | 3 |
| | 124. Increase tech pay to match criticality of work they do | 3 |
| | 125. Driving Provider status to increase new lines of revenue | 3 |
| | 126. CPS/Organization rep at retail/corporate yearly meetings (manager/staff) | 1 |
| | 127. Evaluate "metrics" for hospitals with recommendations for productivity minimums | 1 |
| | 128. Allowing national organizations to visit pharmacy schools to educate us on important concepts. | 1 |
| | 129. Shift national & state/local semantics to refer to "Pharmacist services" rather "pharmacy" services to increase professional image and standing of RPhs | 0 |
| | 130. Work with safety organizations ARHQ | 0 |
| | 131. Combating DIR and claw backs for dispensing efforts | 0 |
| | 132. Infiltrate the state board to start understanding their responsibility to support and improve conditions | 0 |
| | 133. Require SBOP/DORA to include CPS membership with license | 0 |
| | 134. There's a huge disconnect - Host a summit to bring together managers and frontline pharmacy teams from multiple systems and corporations to exchange honest info about their work situations day-to-day | 0 |
| | 135. Promote how benefiting us benefits them! | 0 |
| | 136. Continue to partner with organizations like CDPHE who are well funded to support advocacy and coalitions that can move the profession forward. NP, PA, Medical Associations | 0 |

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| | 137. Disseminate findings to national orgs and other states - do other states need similar report? Or can extrapolate from our data? | 0 |
| *CPS Academies (#6)* | 138. CPS cannot do this alone. We must connect with leadership organizations to get them to participate in the change. | 5 |
| | 139. Community Academy: should especially focus on this & deep dive into the results<br>140. Get engagement from multiple big box chains to compare best practices & share ways to improve & barriers that need focus | 2 |
| | 141. Create counsel that requires heads of each pharmacy company in CO to be on board (Walgreens, hospitals, retail) to work together to address the issue | 1 |
| | 142. Bringing up these topics at meetings (annual for example) and brainstorming and surveys and showing data representation | 1 |
| | 143. We can begin addressing rec. From students in school who were techs or interns. See what works! | 1 |
| | 144. CPS Academies- Focused charges about well-being | 1 |
| | 145.<br>a. Continue to focus on PBM Reform<br>b. Medicaid model AAC & DF<br>c. Minimum claim value | 1 |
| | 146. Provide training/education around cash-model- helps patients and helps economics of pharmacy | 0 |
| | 147. Think outside the box! | 0 |
| | 148. Outreach to non-members regarding workplace issues and well-being (AND encourage membership) | 0 |
| | 149. More information about what the academies are. Scope, Etc. So, more people can be engaged. | 0 |
| | 150. Topic: Diabetes and meds hard to get and affects | 0 |
| | 151. Ways to spread info from the board to membership in real time. Keeping ALL members informed. | 0 |
| | 152. Each academy should divide up and dig deeper into data to identify root cause and areas for impact | 0 |
| | 153. Schedule regular workplace well-being meetings through CPS | 0 |