Panic or Panacea, Changing the Pharmacist's Role in Pandemic COVID-19

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Clinical pharmacy has evolved over the last 40 years, especially in the hospitals and ambulatory clinics where clinical pharmacists round out the interprofessional care team with physicians, nurses, social work, case managers and other vital members of the health care team. Since the 1970s, pharmacists' training has become more clinical, meaning that our training emphasizes use of drug knowledge applied to specific patient care issues, linking laboratory and physical findings to make best medication choices, managing drug interactions, mitigating adverse drug reactions, and bridging patient care provider gaps. Our expertise, everything and anything about drugs, includes how they behave in the body and how drugs can be best utilized to treat illness and maintain health.

The public's most familiar view of the pharmacist, usually in the community retail pharmacy setting, places the pharmacist 'behind the counter' in a role that dispenses the medications pursuant to a prescription from a prescriber. The pharmacist is touted as being the most accessible of health professionals. This traditional function of the profession stems from a strong foundation built as chemists and purveyors of apothecaries. However, with recent challenges that include a triad of declining insurance reimbursements for the medication dispensing function; juxtaposed against skyrocketing drug costs and drug shortages; and rapidly evolving technology where prescriptions are automatically filled and then mailed to the patient, this traditional function of the community pharmacist leaves at least this part of the profession in a panic. No doubt, pharmacists' partner with prescribers to address the multitude of insurance issues that accompany a supposedly simple writing of a prescription such as gaining prior authorizations, and ensure all drug interactions are handled appropriately. Legislation has helped the state's progress with more advanced pharmacist practice acts. The community pharmacist has increased their clinical roles for direct patient care through collaborative agreements with physicians and nurse practitioners. Their role as immunizers, advocates for women's health, and point of care testing have helped to transition the pharmacist to in front of the counter.

Enter the COVID-19 pandemic. To spur business but to also assure that patients continue to take, especially, their chronic medications, pharmacies have stepped up by providing mail and home delivery services of refill prescriptions. A service that our profession has fought against because without the patient picking up the prescription, then with it, also goes the pharmacist's opportunity to interact with patients and offer any needed counseling and education. Pharmacies and pharmacists are listed as essential in this crisis. From the public's view, the question may arise, besides providing the medications themselves, what is it then that makes the pharmacist essential? When the COVID-19 pandemic resolves, will patients return to the pharmacy to pick up their medications that were conveniently delivered during the pandemic?

Many businesses from takeout food service to educational programs are probably asking these same questions. Health care in general, will be recalibrating the necessity for face to face interactions that take travel time, missed work hours, physical space and costly human resources. Due to the limitation of access to clinics and hospitals during this pandemic, an exponential number of primary care providers have moved to distance technology or telemedicine in order to provide care. Unlike physicians or nurse practitioners, professions with strengths in diagnosis and procedures, the pharmacist's expertise in medication management therapy does not necessarily need to be physically face to face. Since many clinical pharmacists in the ambulatory care clinics partner with primary care providers to help manage patients with medication centric chronic diseases such as diabetes and hypertension, this function could be performed more than adequately via telemedicine. In fact, there are many activities that a pharmacist can move to in the telemedicine world in order to help with health issues.

Even prior to COVID-19, a number of pharmacist services have used telehealth as a means to provide various clinical pharmacy services. Some examples include CPESN, which stands for Community Pharmacy Enhanced Services Network.[1] CPESN

provides an opportunity to patients to access a pharmacy network that supports the enhanced pharmacy service needs of patients. Some services are offered via phone, distance or in person. Patients who benefit might be on a long list of medications that need to be whittled down, or have a drug expert make recommendations to providers on medication selections. RX Live® is a telehealth service that links pharmacists to patients to help them with safe and effective medication regimens.[2] Arine® is a company that provides medication management services through data driven information in order to achieve better patient health.[3] More and more, pharmacists are being sourced as translators of using managed care big data in providing cost effective medication management services.

The Daniel K. Inouye College of Pharmacy has a successful model of embedding a faculty clinical pharmacist in family medicine physician practices. This model, known throughout many academic medicine patient clinics, the Kaiser HMO system, and the Veterans Administration, is known to decrease overall cost of patient care by reducing drug complications, adverse reactions, improve patient's medication adherence, and improve disease management outcomes. Pharmacists provide valuable and cost saving interventions especially in medication centric diseases.

However, there remains one problem. Pharmacists are not approved as providers in the Centers for Medicare and Medicaid Services (CMS).[4] The simplest way to explain the issue is with this comparison. A physician who spends 15 minutes treating a patient will bill the insurance company, Medicare or Medicaid, for that time and expertise and receive reimbursement. If a pharmacist spends 60 minutes with a patient teaching the patient about how to best take their heart medication, how to best manage side effects, and check on any interactions with other drugs or disease states, the pharmacist is not allowed to bill CMS or insurance companies for that time and expertise. In order for clinical pharmacists to directly bill and receive 3rd party insurance reimbursement for their services, they would need to be recognized by CMS as providers.

Pharmacist salaries are expensive and coupled without a mechanism to bill insurance, this then leaves the profession trying to make the case of their value. Numerous studies show that although a pharmacist caring for a patient with chronic diseases may utilize a higher cost medication, the pharmacist demonstrates better adherence, a safer side effect profile, avoid readmission or costly disease progression.[5-7] This then leads to a lower cost of a patient's overall care from a team-based model where not only one intervention but rather a team of interprofessional interventions provides value. This is the model utilized by the Kaiser HMO and VA systems, where the pharmacists' salaries are incurred in the operational cost of the clinic with overall outcome value based on the total care of the patient.

The transformation of the health care payment model from fee for service to value based care, is based upon providers achieving quality measures specific to disease states. Whether in a model of CMS and 3rd party insurance billing reimbursement or pharmacist salary integration into operations overhead, the point is that utilizing a dedicated pharmacist's skill, may help the provider with a means to add value and efficiency and allow them to concentrate on more complex patient cases, procedures and diagnostics.

Conclusion

The COVID-19 outbreak has forced the move to telemedicine to expand accessibility of providers to patients. This detour has been especially helpful for a state facing a massive shortage of primary care providers. For the pharmacy profession though, the move towards home delivery medication services, implies a tremendous loss for a pharmacist's face to face interactions with patients. Here is the silver lining for pharmacists in this pandemic. Telemedicine could provide the panacea for the profession's loss of physical patient contact and link their expertise either before or after a telemedicine visit. How about when the provider is finished with a patient on the telemedicine line, now says, "Here's the clinical pharmacist to go over your medications"? This interprofessional partnership would help providers to achieve their quality measures, assist insurance companies meet their star ratings, and offer comprehensive team services for our beloved patients.

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