Can pharmacists help fill the growing primary care gap?

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By 2020 157 million people in the US will be living with at least one chronic health condition. As the number of Americans managing diseases such as diabetes, hypertension and high cholesterol increases, the ranks of primary care providers (PCPs) who currently perform the majority of chronic disease management are dwindling.

Within the next 10 years, there is estimated to be a 27% shortage of PCPs in the US – about 90,000 fewer PCPs than the US health care system requires.

But there are approximately 300,000 pharmacists in the US, and the number of pharmacists is going up. Between 2003 and 2013, the number of pharmacists in the US increased by approximately 19%.

Pharmacists are trained to do much more than dispense medication, and they could help plug the growing gaps in chronic care management in the United States.

The trouble is that state pharmacy practice statutes were written in a different era, and haven't caught up with the training pharmacists receive today. There's a chasm between what pharmacists are trained to do and what they are allowed to do by law.

What does your pharmacist know how to do?

Your local pharmacist is a highly trained medical professional. Before pharmacy students even start school, they have to take and pass the standardized Pharmacy College Admissions Test (PCAT), which covers topics like chemistry and biology and mathematics. Before entering pharmacy school (which is a four-year program), most students will have completed a bachelor's degree or a rigorous two-year program of prerequisites. That means graduates of pharmacy schools have doctoral level training.

Would this work? Before they can practice, students have to pass a licensure exam (North American Pharmacist Licensure Examination, NAPLEX). Some will go on to receive board certification in cardiology, pediatrics or infectious disease or other specialties, by the Board of Pharmaceutical Sciences (BPS).

Of course, pharmacists receive extensive training in drug therapy management – medical care provided by pharmacists whose aim is to optimize drug therapy and improve therapeutic outcomes for patients, and the subtle differences between medications.

But pharmacists are also well versed in preventative care, patient counseling and health and wellness. They know how to manage chronic diseases, including high blood pressure, diabetes and high cholesterol. A pharmacist can manage a treatment plan initiated by physician, order basic laboratory tests, and adjust medication dosages, adding or subtracting medications as needed. These are things that many patients with chronic disease need to schedule an appointment with their PCP to do.

Pharmacists are often more accessible to patients than PCPs. No appointments are needed and in general pharmacists are available for consultation at hours during the day and night that most physician offices are closed.

But in most states, pharmacists stick with drug therapy management and don't get to use the rest of the skills that they learn throughout their pharmacy education.

In some states, pharmacists are allowed to participate in administration of certain immunizations or are allowed to participate in preventative care or wellness. But it is the minority of states that have progressive pharmacy statutes allowing pharmacists to interact with patients, take medical histories, and order appropriate laboratory tests under certain conditions.

Why aren't pharmacists doing more?

Outdated pharmacy statues aren't the only thing blocking pharmacists from doing more than dispensing medication.

Pharmacists are often assisted by pharmacy technicians who preform routine tasks, like counting pills and labeling bottles, so they can devote more time to patients. Despite that division of labor, almost 70% of a pharmacist's time is still spent on tasks that can be performed by technicians.

Pharmacists are paid based on the number of prescriptions filled. Even though they can do a lot more than dispense medication, that's what they get paid to do, with a few exceptions.

For instance, Medicare reimburses pharmacists for medication therapy management – where a pharmacist manages and adjusts a the medication to suit an individual patient's needs.

Because pharmacists don't get paid for other services they provide, the end result is that patients receive less care than they could and should when visiting the pharmacy.

Letting pharmacists play a bigger role in care is a boon for patients

Even if there were enough PCPs to take care of the explosion in chronic diseases, there is evidence that PCPs aren't doing a good job at managing their patients' chronic diseases.

Fifty percent of patients walk out of appointments not understanding what they were told by their physician. Patients actively participate in their own clinical decision-making less than 10% of the time. Just one-third of US patients with diabetes, hypertension, and elevated cholesterol have their conditions under good control.

And patients are taking more medication than ever. The number of prescriptions written in the US has increased from 700 million in 1989 to 4 billion in 2014. Since 2002 there has been a 15% increase in the number of 55-64-year-olds taking five or more medications. Ninety percent of adults over the age of 65 years take at least one prescription drug.

Taking more medication makes it more likely that a person won't take them as directed. This can lead to medical complications, higher costs and even death. And more medication means a greater the likelihood of harmful interactions.

But research shows that when pharmacists are part of patient care teams they can help avoid these problems and result in better patient care. This is called a collaborative care model.

For example, the physician in charge of the care team would assign activities to a pharmacist, like monitoring blood pressure, ordering lab tests, evaluating and changing medication or doses. This lets the

pharmacist act more independently while still working closely with the physician who is leading the care.

Collaborative care models have been shown to improve outcomes in patients with hypertension, diabetes, clotting disorders and high cholesterol. Putting a pharmacist on the care team can reduce adverse drug reactions and lower costs. If patients can go to a pharmacists for day-to-day management of their condition, physicians can spend more time seeing the patients that really need their expertise.

Change is happening…slowly

There are bills in both the House and Senate proposing an amendment to the Social Security Act authorizing the Secretary of Health and Human Services to develop pharmacist-specific codes for insurance reimbursement.

These efforts are necessary and long overdue, but even if these bills are passed and signed into law, what pharmacists can do is still restricted by antiquated state statutes that have little connection to how pharmacists are trained today.

Once laws catch up to what pharmacists are really trained to do, it will be the patients who benefit the most.

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