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Pharmacists can help solve ou overmedication problem — if v them

BY DONALD DOWNING AND JUDITH GARBER, OPINION CONTRIBUTORS — 01/28/20 03:00 PM EST
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Imagine that your local grocery store announced they would start employing several nutritionists, each of whom had years of training to help people improve their diets and health. Excited, you go to the store to get your personalized diet plan. But when you get there, you discover that the nutritionists are all busy filling customers' carts with food. When you ask if you can talk with a nutritionist to get advice on your diet, one of them says, "We would love to talk to you, but we're only paid to fill carts with food, not to advise customers on what to eat."

This scenario seems absurd, but it mirrors the reality of certain health care professionals in America—pharmacists. Pharmacists have many years of graduate training specifically around medication use and safety, and are perfectly positioned to help older patients and their medical providers manage medications. Yet most patients in America don't realize their pharmacist has this expertise—and if, by chance, they do ask for their pharmacists for help, patients discover the pharmacist is too busy filling prescriptions to take the time for a longer conversation.

This is largely because insurers, including Medicare, the primary payer for medical care for seniors, do not recognize pharmacists as health care providers or allow them to bill for helping patients sort out their complex medication regimes. Barring pharmacists from providing this type of clinical service seriously limits patient access to the nation's best trained medication experts. (Medicare Part D does pay pharmacies for a once-a-

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year medication review to reduce drug costs, but this is not a substitute for on-going clinical pharmacy care.)

If pharmacists can earn money only from filling prescriptions, that is what they will do. That's why it is important that pharmacist clinical services be compensated separately from filling prescriptions—through Medicare Part B's medical services plan (not Part D's pharmacy benefits). Under this arrangement, a pharmacist would be paid for managing complex medication therapy as part of a clinical care team–working not just in community pharmacies but also in a health care provider's office, seeing patients in exam rooms and consulting directly with patients' multiple providers.

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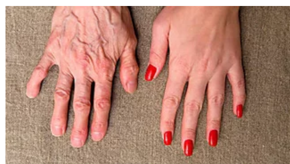

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Pharmacists' clinical skills are needed now more than ever. Americans, especially older adults, are increasingly taking more medications to treat chronic conditions like heart disease, diabetes, and high blood pressure. More than 40 percent of Americans age 65 and over take five or more prescription medications, triple the rate of the mid-1990s.

Without help to manage this increasing pill burden, millions of older Americans are at risk of a serious side effect. An estimated 1 in 5 older Americans experienced a serious drug side effect in 2018, and 280,000 of these events resulted in hospitalizations. If the pattern of unchecked growth of medications continues, there will be 4.6 million hospitalizations of older Americans for adverse drug events in next decade and 150,000 premature deaths.

As is recommended in Eliminating Medication Overload: A National Action Plan, released this week from the Lown Institute, patients taking multiple medications need opportunities to discuss all of their medications with a clinician and deprescribe (discontinue) those that are unnecessary or potentially harmful. Primary care clinicians and specialists usually do not have time (and rarely have the training) to manage complex medication regimens and, importantly, to coordinate prescribing between providers.

Pharmacists do have this training, but the lack of reimbursement for this work is a significant disincentive. In fact, if pharmacists take the time to help patients with complex medication issues and coordinate care with patient's medical providers to deprescribe inappropriate medications, they lose prescription revenue while at the same time, not being paid for the services that are known to save lives and health care dollars. This negative incentive to provide appropriate medication therapy drives up prescription costs and overuse of medication, putting patients at increased risk for harm.

But what would happen if pharmacists were given the opportunity to practice at the top of their training, and were reimbursed for this work? Washington state, where legislation was passed in 2015 requiring commercial insurers to recognize pharmacists as health care providers, provides an example. After the law went into effect, overburdened primary care medical clinics all over the state started hiring pharmacists on their medical teams – not to fill prescriptions but to help manage them. By being able to bill for pharmacist clinical services these clinics are generating added revenue, helping to take a burden off of primary care doctors, and helping to prevent adverse drug events for countless patients. Increasingly, community pharmacies in Washington state are being paid by commercial insurers to use pharmacists to provide this same critical expertise.

While Washington's legislation has increased access to pharmacists for commercially insured patients, Medicare still does not reimburse pharmacists for ongoing clinical management of medication issues, leaving the population at the highest risk for medication harm without access to these important services. Recently, both Tennessee and Texas legislators, recognizing the value that pharmacist care services can provide their communities, have followed Washington state's lead and passed similar legislation.

It's time that Congress removes this unnecessary bureaucratic barrier to clinical pharmacy care. There is proposed legislation that would expand patient access to pharmacist medication management services in medically underserved (mostly rural) areas. This legislation would be a good start, but does not help the other 77 percent of elderly people in the U.S. who live in suburban and urban communities. We need a policy change that helps people *everywhere* get access to needed pharmacist clinical care services, by removing barriers to putting pharmacists on the care team.

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