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Pharmacy: An Evolving Profession without the Status

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The profession of pharmacy has evolved from preparing graduates to be focused on compounding and dispensing to one that is more focused on clinical practice and the preparation of a practitioner who is an integral part of the healthcare team. This has been made evident in recent decades with the mandate for the Doctor of Pharmacy degree, the discussion to require pharmacists directly involved in patient care to complete a residency by 2020, and the growing credentialing and certification opportunities available for pharmacists to present themselves as experts in a specified disease state or area of practice [1-3]. Now on the brink of another major milestone, the profession is advocating for provider status which will allow pharmacists to directly bill and receive reimbursement for outpatient services. With the passage of the Medicare Modernization Act in 2003 and the Patient Protection and Affordable Care Act in 2010 (PPACA), pharmacists have been identified as practitioners positioned to manage medication therapy. Under the PPACA, Medicare Part D plan sponsors were required to offer medication therapy management services (MTM) to targeted beneficiaries that include at minimum strategies to improve adherence to prescription medication. Pharmacist's were identified as health care professionals qualified to provide such services [4].

The Accreditation Council for Pharmacy Education (ACPE) is requiring academicians to make curricular improvements to move with the changing profession. There is an increasing emphasis on interprofessional education (IPE) to ensure pharmacists are prepared to practice with other healthcare practitioners and have a clear understanding of their role on the team. The 2016 ACPE draft standards introduce a stand-alone standard which focuses on IPE, and makes it clear that this education must include interactions with prescribers [5]. Current standards require pharmacy practice experiences include direct interaction with diverse patient populations in a variety of practice settings and involve collaboration with other health care professionals [6]. Additionally, the recently updated Center for the Advancement of Pharmacy Education 2013 Educational Outcomes included the addition of two affective domains in the areas of Approach to Practice and Care and Personal and Professional Development. These are aligned with other healthcare practitioner outcomes and have subdomains which include interprofessional education and innovation and entrepreneurship to ensure graduates are forward-thinking and prepared to work collaboratively [7].

Integrated team practice models are emerging to include pharmacists in recognition of the benefits of having them involved on the team to improve clinical outcomes. The Patient Centered Primary Care Collaborative suggests that there is a need for integrating comprehensive medication management within the Patient-Centered Medical Home (PCMH) [8]. The PCMH encompasses five functions and attributes including comprehensive, patient-centered, coordinated care with accessible services that are safe and quality. Coordinated care requires communication among the patients and members of the broader care team, which can include pharmacists [9]. Accountable Care Organizations (ACOs) are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to their patients. ACOs that are able demonstrate the delivery of cost-effective, high-quality care receive incentives based on savings it achieves for the Medicare program [10]. In these models, pharmacists generally work under collaborative practice agreements with physicians to make decisions about medication therapy, and there has been evidence of the pharmacists having an impact on patient outcomes [11].

Despite legislation identifying a role for pharmacists in MTM and evidence that MTM involving pharmacists results in improvement when compared with usual care for some measures of medication adherence and appropriateness, medication dosing, and health plan expenditures on medication costs, the profession of pharmacy has yet to achieve the elusive provider status it seeks to gain [12]. Although physicians, physician's assistants, certified nurse practitioners, qualified psychologists, clinical social workers, certified nurse midwives, and certified registered nurse anesthetists are listed as providers in Medicare Part B of the Social Security Act, pharmacists remain to be unnamed. The omission of pharmacists as listed providers limits Medicare beneficiaries' access to pharmacists' services in the outpatient setting and serves as the reason state and private health plans cite for a lack of coverage for beneficiaries or lack of compensation of pharmacists for providing comprehensive, patient-centered care [13].

In March 2014, a coalition of 14 organizations referred to as the Patient Access to Pharmacists' Care Coalition (PAPCC) succeeded in having H.R. 4190 introduced in the House of Representatives to amend Title XVIII of the Social Security Act to enable patient access to, and coverage for, Medicare Part B services by state-licensed pharmacists in medically underserved communities [13]. The American College of Clinical Pharmacy established the Part B Medication Management Coverage initiative to pursue legislative and regulatory changes to the Medicare program and relevant sections of the Social Security Act (SSA) to recognize the direct patient care services of qualified clinical pharmacists as a covered benefit. Intrinsically, ACCPs initiative differs from the PAPCC house bill in that ACCP states that, "a legislative proposal that would add pharmacists to the list of eligible providers under section 1861 of the Social Security Act would do little to expand opportunities for delivering care to patients unless it were to include coverage for a defined process of care that pharmacists could bill for, whether under the existing fee-for-service structure or through evolving payment and delivery models" [14]. However, there are currently no mandates in either regard.

Amidst the debates and advocacy for change for pharmacists to

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receive coverage for services or be recognized as providers via the SSA, California became the first state to pass legislation recognizing pharmacists as health care providers in January 2014. S.B. 493 expands opportunities for pharmacists to deliver medication management services in formal collaboration with other members of the health care team and established a designation for Advanced Pharmacists Practitioners for pharmacists with advanced credentials. Although, this recognition is indicative of progress, S.B. 493 neglects to establish coverage for services under the state Medicaid program and does not include a mandate for private payers to cover pharmacist services [14].

Therefore, it remains that the profession must continue to work to gain the acknowledgment it seeks. However, in an era of providing services out of mandates or providing services that directly show an opportunity for revenue-generation rather than cost savings, the profession must continue to provide evidence of the value pharmacists bring to the team and demonstrate why coverage for services is warranted. If the profession is unable to be recognized as providers or receive coverage for its services, it remains difficult to justify pharmacist services as revenue-generating for organizations driven by a bottom line. Therefore, the profession must continue to challenge its current status and demonstrate the clinical and financial benefits of pharmacist services, while ensuring graduates and current practitioners are adequately prepared to work collaboratively and contribute to the healthcare team while advocating for legislative changes.

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