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Incorporating Pharmacists into the Primary Care Team

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We want to thank Dellogono et al for their insightful study demonstrating the value of a pharmacist in the primary care setting.[1] The authors' focused on the number of medication-related problems identified by the pharmacist during an interprofessional hospital discharge follow-up appointment. Their study was conducted at a federally qualified health center (FQHC), which implies these pharmacists were providing care to an underserved population.[2] Underserved populations experience social determinants of health that trend toward more complex care. Dellogono et al demonstrate the ability of a pharmacist to identify upwards of 450 medication errors within 4 months. They tracked medication related problems, the different types, and potential adverse drug events. As the authors note, this does not mean much clinically and their study does not contain any patient-oriented outcomes.

As an adjunct to the above described benefits, Synder et al have recently shown that a pharmacist-initiated transitions of care program decreased the odds of 30-day all-cause readmissions compared to usual care.[3] Of additional note, a 2018 study demonstrated an ambulatory care pharmacy-based transitions-of-care program yielded an estimated cost saving of nearly $1.8 million for the managed care plan.[4] This information clearly shows the added value of pharmacists in this area of patient care.

However, incorporating pharmacists into primary care practices can be a challenge, especially in limited resource settings (such as an FQHC). Billing mechanisms for patient care services are restrictive. To illustrate, the American Pharmacists Association surveyed over 200 pharmacists and found only 34% are receiving payment for three-fourths of their patient care services.[5] Lack of concrete payment models for pharmacists in primary care is a barrier to vast implementation. Primary care clinics have noted that although the addition of a pharmacist has decreased physician workload, increased patient access to providers, and improved quality measures, justification for more pharmacists remains challenging due to issues of reimbursement from insurers.[6] This is not a new problem, but as healthcare professionals in the primary care setting, we owe it to our patients to continue to create innovative solutions to offer quality care.

We applaud Dellogono et al for their work in advocating for pharmacists to provide services to the underserved community in the primary care setting. The question becomes how we can begin to replicate this model so that all patients have access to the benefits of a pharmacist on their primary care team. We would benefit from further information about the authors' successful implementation in a limited resource setting, including the number of full-time equivalent pharmacists and the justification for their salary. For example, at El Rio Community Health Center in Tucson, Arizona, they use bonuses received from meeting quality metrics through the Medicare Shared Savings Program to justify the cost of their pharmacists' services.[5] Additional advice on how to replicate the clinic model would be of great benefit to the primary care community.

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