

Telepharmacy Opportunities and Obstacles



Telehealth is a popular issue during the COVID-19 era. According to data released by [IQVIA](#) telehealth claims increased by 2400 percent during the first week of April while billing for services provided at medical facilities and physician offices have plummeted.

[Google Trends](#) analysis on search data reveal monthly searches for telehealth have spiked on March 29 and continue to remain high, while [Ubersuggest](#) shows searches for telehealth at more than 22,000 per month.

The icing on the cake is consumer satisfaction with telehealth. [J.D. Power](#) reports a consumer satisfaction score of 851 (out of 1000) for consumers, a score only exceeded by consumer satisfaction with direct banking. It seems that once they try it, healthcare consumers love telehealth.

Telepharmacy, however, has not kept pace with the rise of telemedicine. Search data are difficult to uncover, simply because the numbers are so low.

Why the difference in popularity between two search terms that are within the same broad category? Some insight into the dynamics of telehealth and telepharmacy may be appropriate to begin.

What is Telepharmacy?

Telepharmacy is broadly defined as a method by which pharmaceutical products and services are delivered through telecommunication. Examples of telepharmacy include remote dispensing and online pharmacy counseling.

Many pharmacists in the long-term care pharmacy community may be familiar with remote dispensing by which a pharmacist authorizes the release of a prescription drug located in a remote dispensing machine in a nursing home. This is helpful when admissions arrive at the facility late in the day or when a resident requires a stat dose of a new drug in response to a prescriber's order.

According to the [TelePharm website](#) (TelePharm is a telepharmacy company owned by Cardinal Health) there are four different types of telepharmacy:

Inpatient Remote Order Entry Review: A remote pharmacist performs a video-assisted verification of an inpatient resident of a hospital or other facility prior to administration of the drug.

Remote Dispensing: As described in the example above, a remote pharmacist authorizes dispensing prescription drugs to patients arriving at a pharmacy without an on-site pharmacist.

IV Admixture: Pharmacists can remotely review the preparation of intravenous fluids for administration without having to physically enter the clean room.

Remote Counseling: Pharmacists can engage with patients via a live interactive video session to answer medication-related questions or receive a medication review.

These seem to be valuable services that any reasonable person would be happy to accommodate. However, there are a few barriers to adoption that seem to have restrained the growth of this practice.

Why Telemedicine but not so much Telepharmacy?

In a word, regulation. Every healthcare provider professional classification (e.g., physicians, nurses, occupational therapists, dentists) is regulated by state regulatory agencies. Pharmacy is no exception. In order to practice telehealth it must be an approved practice by the state board that regulates the profession. State medical associations have been effective advocates in obtaining scope of practice regulatory approval that includes telehealth. The regulatory barriers vary somewhat, such as whether the physician is authorized to have consultations with out-of-state patients, but virtually every state allows its licensed physicians to engage in some version of telehealth. Reimbursement by public insurance programs may vary (e.g., Medicaid) but we can assume that physicians wishing to engage in telehealth do not need to change their domicile in order to do so.

Pharmacy, on the other hand, has not been as successful in obtain scope of practice legislation in the states that includes telepharmacy operations. University of Iowa researchers performed a [50-state survey](#) of telepharmacy regulation in 2016, revealing that only half of all US states explicitly authorized pharmacists to engage in the practice of telepharmacy.

Having a comprehensive regulatory framework in place appears to be the most important prerequisite for a robust telepharmacy culture. Federal regulatory authorities are not likely to create reimbursement mechanisms for telepharmacy if half the states do not allow the practice or limit its scope.

During the COVID-19 crisis CMS officials removed reimbursement barriers to reimbursement under Medicare and Medicaid for telemedicine. For example, federal survey guidelines for nursing homes require that a resident must be seen by a physician at least once every thirty days during the first 90 days of residence and at least once every 60 days after that. During the COVID-19 period CMS allowed these visits to be conducted by telemedicine rather than face-to-face.

Nursing facilities are required to hire or contract with a pharmacist to review resident medication regimens and medical records and provide recommendations to attending physicians, medical directors and directors of nursing. These reviews are typically performed by a pharmacist who visits the facility and performs the review in person. Interaction with the resident is not required by the regulation.

To perform this function pharmacists must have access to the residents medication record and medical record. Current guidelines do not require the facility to make an electronic health record accessible to the pharmacist so that reviews could be performed remotely. Even if they did, it is not clear that state pharmacy regulations would allow pharmacists to perform this function via electronic devices even if the practice were authorized by survey guidelines and encourage by CMS.

Community-Based Settings

Many LTC pharmacies have begun offering drug therapy management services to community-based residents. Many of these are enrolled in Medicaid Home and Community-Based Services (HCBS) programs or are served by Medicare Advantage programs. Increasing numbers of Medicaid HCBS enrollees are also enrolled in Managed Medicaid plans and could, under agreements with the MCOs perform remote drug regimen reviews remotely through telepharmacy programs. However, if there is no enabling regulation that allows pharmacists to perform this function we can't be certain that the practice is authorized.

Reimbursement Issues

As we are all aware, pharmacists are not considered healthcare providers under Medicare statute and regulation. Pharmacy organizations have fought for years, through trade and professional associations, to achieve provider status. Even though majorities of members of the US House of Representatives and Senate have supported giving provider status to pharmacists the legislation has yet to receive a floor vote by either body.

To be sure, there are budgetary implications with creating provider status for pharmacists, but an equally important issue for telepharmacy is the lack of a near universal acceptance of the practice by state pharmacy professional regulatory agencies.

Making Way for Telepharmacy and Reimbursement

One of the many long-term effects of the COVID-19 outbreak will be the advancement of telehealth in the US healthcare environment. Patients who have had experience with telemedicine consultations tend to have a good experience and many will continue to access care via telehealth once the crisis is past.

As providers, payers and healthcare consumers become more comfortable with telehealth and begin to see the quality and financial advantages of this method of providing service, access to expansive programs will become a reality.

Where will pharmacy be once the dust settles? If telepharmacy continues to be confined to a plurality of states with inconsistent scope of practice we will not see the full potential that this innovation has to offer.

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