Expanding Access: The Role of Pharmacists in Prescription Renewals

Nathan Wende, PharmD, Director of Clinical and Consulting Services
Medication Review

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Introduction & Context

- Provider shortages & rising demand

- Chronic disease management requires timely refills

- Delays harm adherence & outcomes

- Objectives: Scope, benefits, strategies

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Regulatory & Legal Framework

- State variations in pharmacist authority

- Collaborative Practice Agreements (CPAs)

- Standing orders & independent renewals

- Liability, documentation, patient consent
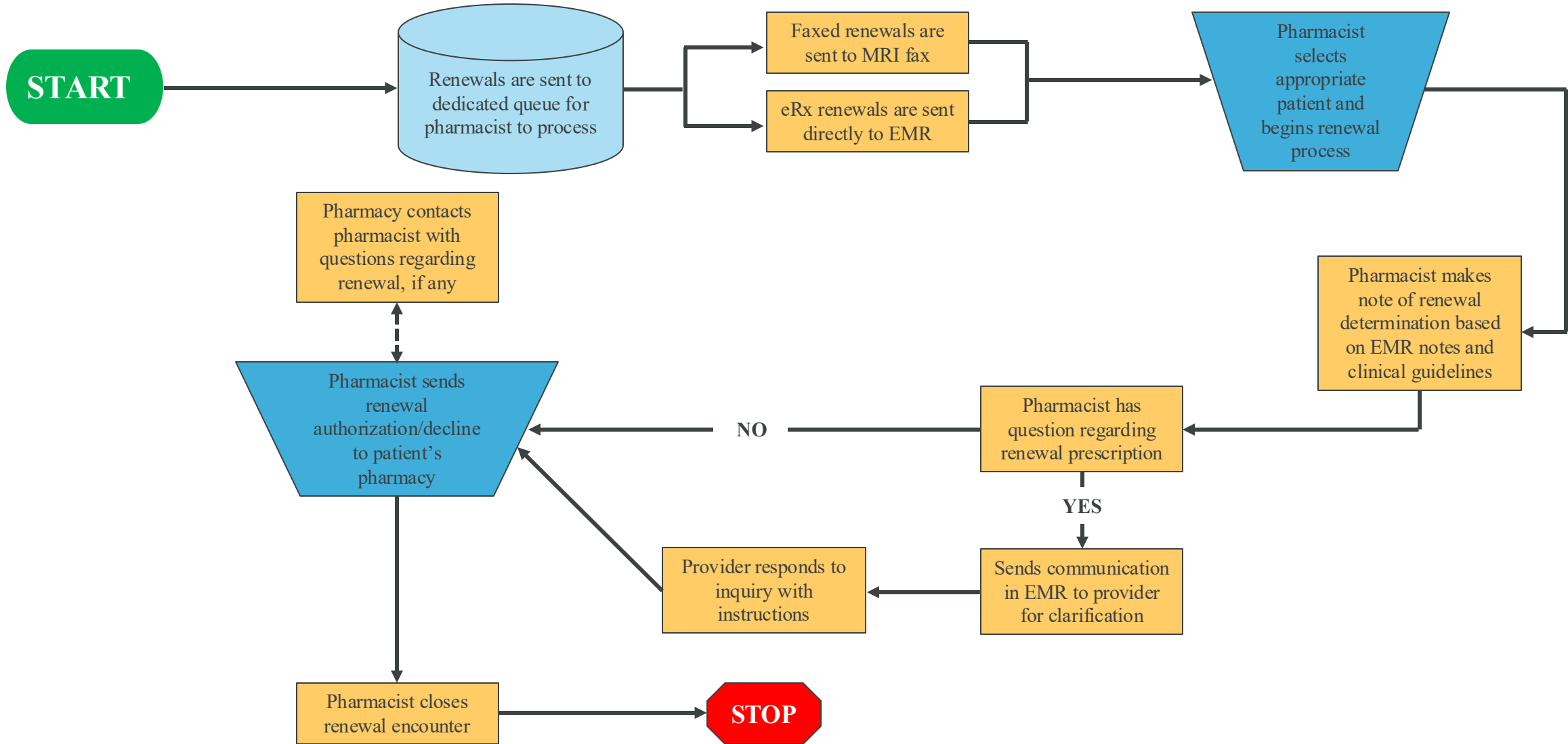
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Clinical & Operational Benefits

- Patients: Improved adherence & access

- Providers: Reduced administrative burden

- Health systems: Cost savings & better-quality metrics

Workflow Model

- Community pharmacy renewals

- Clinic-embedded pharmacists

- Telehealth & digital pharmacy models

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Renewal Workflow

START → Renewals are sent to dedicated queue for pharmacist to process

- Faxed renewals are sent to MRI fax
- eRx renewals are sent directly to EMR

→ Pharmacist selects appropriate patient and begins renewal process

→ Pharmacist makes note of renewal determination based on EMR notes and clinical guidelines

→ Pharmacist has question regarding renewal prescription

NO → Pharmacist sends renewal authorization/decline to patient's pharmacy

YES → Sends communication in EMR to provider for clarification → Provider responds to inquiry with instructions → Pharmacist sends renewal authorization/decline to patient's pharmacy

Pharmacy contacts pharmacist with questions regarding renewal, if any

Pharmacist closes renewal encounter → **STOP**

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Case Study

- Study Overview
- Design: Retrospective cohort, pre-post comparison.
- Setting: UC San Diego Health, Family Medicine & Internal Medicine clinics.
- Duration: Jan 2017–Dec 2018 (12 months pre vs 12 months post).
- Staffing: 1 pharmacist + 2 technicians, serving ~20% of primary care sites.
- Scope (under collaborative practice agreement):
  - Renew select chronic meds.
  - Initiate prior authorizations for noncontrolled meds.
  - Order labs (BMP, lipid, thyroid, A1C, etc.) and request follow-up visits.

Bhakta K, Lee KC, Luke T, Bouw J. *Impact of a pharmacist-run refill and prior authorization program on physician workload.* JAPhA. 2022;62(6):727–733

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Case Study

Table 1 Physician efficiency scores

EHR metric	Clinic 1 (n = 15)				Clinic 2 (n = 7)			
	Baseline (CY 2017) (mean ± SD)	RPAPP (CY 2018) (mean ± SD)	Change from baseline	P value	Baseline (CY 2017) (mean ± SD)	RPAPP (CY 2018) (mean ± SD)	Change from baseline (mean ± SD)	P value
% of EHR messages not completed within 24 h	26.9 ± 2.56	22.9 ± 2.25	−4.0	0.001	19.4 ± 3.72	17.7 ± 3.78	−1.7	0.300
% of EHR results not viewed or addressed within 72 h	36.7 ± 3.66	36.5 ± 4.77	−0.2	0.918	33.7 ± 2.37	34.3 ± 5.56	+9.6	0.733
% of EHR office visit encounters not completed on the same day as visit	68.1 ± 3.81	61.2 ± 4.82	−6.9	0.001	24.3 ± 4.13	29.0 ± 6.68	+4.7	0.059
% of EHR patient telephone call encounters not completed within 24 h	38.8 ± 2.26	33.3 ± 3.29	−5.5	< 0.001	29.2 ± 3.78	37.9 ± 5.15	+8.7	< 0.001
% of EHR patient prescription (Rx) renewal requests not completed within 24 h	15.9 ± 2.24	16.2 ± 2.64	−0.2	0.782	6.5 ± 2.51	10.7 ± 3.13	+14.2	0.002
Average efficiency score	39.1 ± 1.15	35.9 ± 2.90	−3.22	0.003	23.6 ± 2.07	28.1 ± 3.67	+4.45	0.002

Abbreviations used: EHR, electronic health record; CY, current year; RPAPP, refill and prior authorization pilot program.

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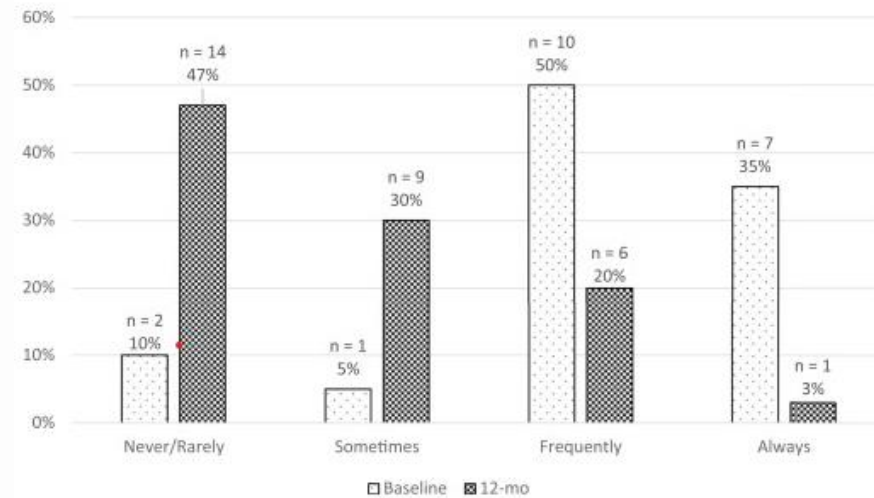
Case Study

- Shows sharp reductions in physicians working outside of hours on refill tasks:

- "Frequently/Always" dropped from ~70% to ~10%.

- "Never/Rarely" rose from ~15% to ~47%.

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Figure viewer

Figure 1 Physician frequency of time spent outside of normal work hours. Abbreviation used: RPAPP, refill an 0.001, N = 20 at baseline, n = 30 at 12 months.

Case Study

- **Overworked feelings:**
  - Baseline: 70% "Frequently/Always."
  - After 12 mo: 10%.

- **Satisfaction with refill workload:**
  - Baseline: only 10% satisfied.
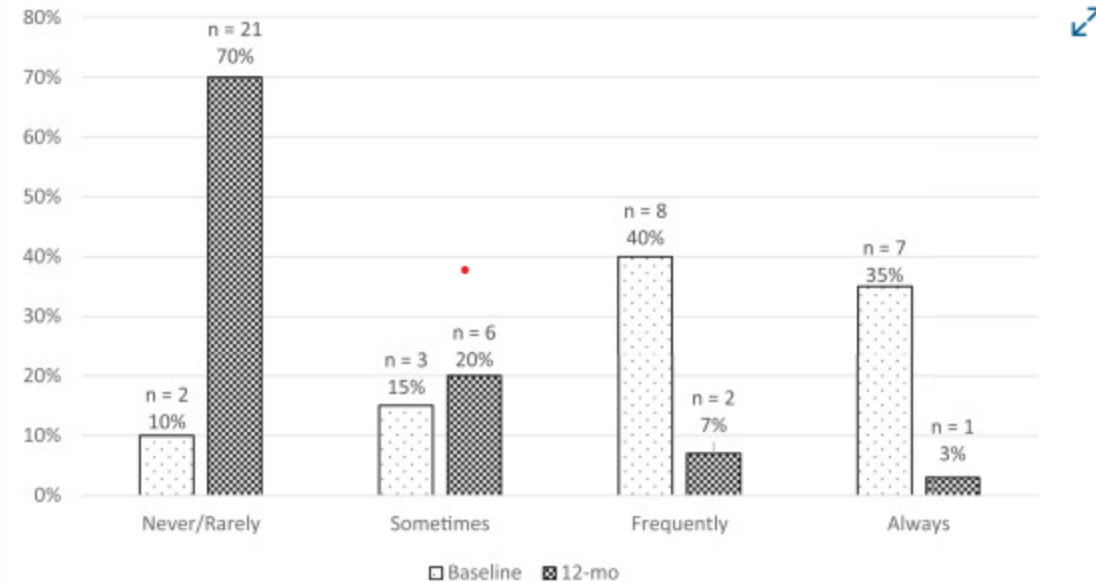 - After 12 mo: 6% satisfied/extremely satisfied.

Figure viewer

Figure 2 Physician refill workload contributing to feeling overworked. $P < 0.001$, N = 20 at baseline, N = 30 at 12 months.

Case Study

Measure	Clinic	Results			
		Baseline %	RPAPP %	Change %	P value
Two hemoglobin A1Cs	Clinic 1	54.4	62.5	+8.12	0.009
	Clinic 2	61.9	61.7	−0.26	0.93
ACEi/ARB, diuretic monitoring	Clinic 1	77.8	81.0	+3.22	0.006
	Clinic 2	82.6	83.9	+0.84	0.47
Medical attention for nephropathy	Clinic 1	91.7	91.4	−0.25	0.88
	Clinic 2	91.2	92.2	+0.97	0.55

Table 2
CMS star measures results

Abbreviations: ACEi, angiotensin converting enzyme inhibitor; ARB, angiotensin receptor blocker; RPAPP, refill and prior authorization pilot; A1C, glycosylated hemoglobin.

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Case Study

Productivity
- **21,175 refills** processed (90% independently by pharmacist).
→ ~700 physician hours saved (assuming 2 min/request).

- **1,550 PAs** processed (70% approval).
→ ~770 staff hours saved (30 min/PA).

- **357 PAs** avoided via pharmacist substitutions.

- **3,000+ lab orders** and **3,300 follow-up appointments** initiated

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Case Study

Key Implications

•RPAPP reduced after-hours physician work and overwork perception.

•Physician/staff satisfaction increased substantially.

•Positive movement on CMS Star quality measures.

•Freed hundreds of hours of physician and staff time.

•Limitations: Uneven clinic results; potential survey bias; not revenue-generating but demonstrates strong value in quality-based care models.

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Case Study 2

- **Setting:** Multi-site FQHC in Los Angeles, serving >22,000 patients annually (>70% racial/ethnic minorities; majority low income, Medicaid-covered).

- **PCPs:** ~12.5 full-time equivalents.

- **Duration:** Sept 2020 – Aug 2021.

- **Staffing:** Pharmacists and supervised trainees working under a collaborative practice agreement.

- **Workflow:** Pharmacists reviewed refill requests, checked EHR med list, monitored need for labs or visits, and recommended interventions

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Case Study 2

Service Volume & Efficiency

•**Refill requests addressed:** 1,683 (1255 encounters).

•**Proportion of total clinic volume:** 9.2%.

•**Productivity:** 10.1 requests / 7.5 encounters per hour.

•**Time commitment:** ~3.2 hrs/week per pharmacist.

•**Turnaround time:** 87.8% completed within 48 hrs

Table I. Selected Patient Characteristics For Encounters That Included One or More Intervention(s) [N=407].

Mean age	55.5 years (range 18-89 years)
Female	53.1% (n=241)
Residency clinic patients	47.9% (n=229)

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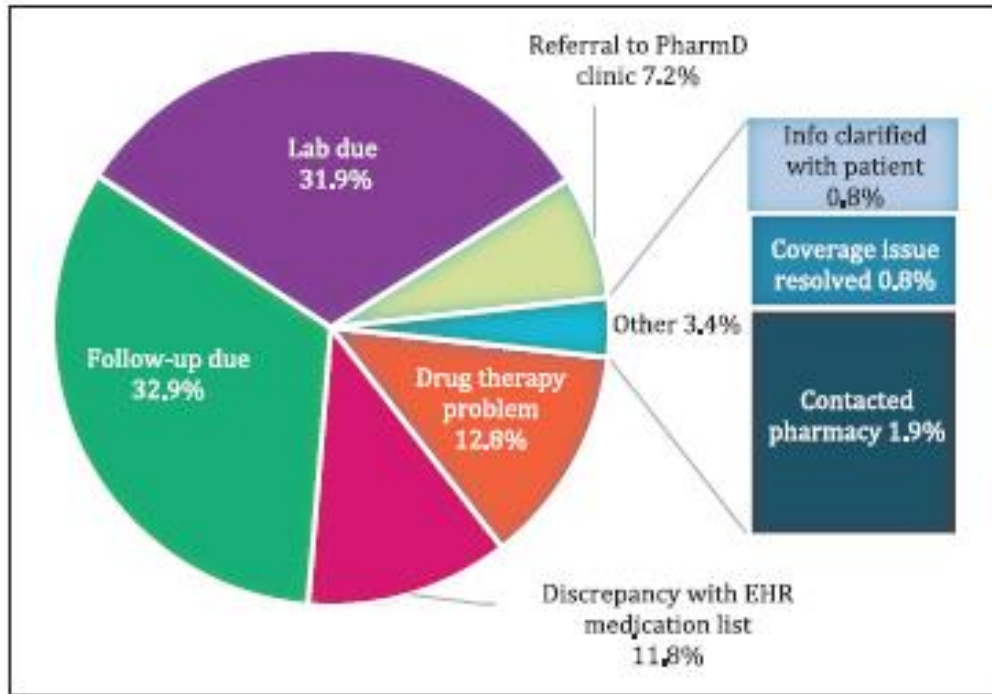
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Case Study 2

Figure 2. Pharmacist refill interventions by type [N=642].

Pharmacist Interventions
- Encounters with interventions: 453 (36.1%).

- Total interventions: 642.

- Types of interventions
  - Follow-up visit due – 32.9% (n=211)
  - Lab due – 31.9% (n=205)
  - Drug therapy problem (DTP) – 12.6% (n=81)
  - Med list discrepancy – 11.9% (n=76)
  - Referral to pharmacy clinic – 7.2% (n=46)
  - Other/coverage clarification – 3.4%

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Drug Therapy Problems

DTP Category	n (%)	Examples
Dosage too low	20 (24.1%)	Titration/renal dosing adjustments
Requires different drug	18 (21.7%)	Diabetes med switches to guideline-preferred agents
Dosage too high	17 (20.5%)	Safety adjustments
Unnecessary therapy	17 (20.5%)	Stopping aspirin in low-risk patients
Requires additional therapy	6 (7.2%)	Adding statin for ASCVD prevention
Non-adherence	3 (3.6%)	Missed meds
Adverse drug reaction	1 (1.2%)	Creatinine rise on lisinopril

Resolution of DTPs
- Resolved/addressed: **37.3% (n=31)**

- Not addressed: **55.4% (n=46)**

- Indeterminate/lost to follow-up: **7.2% (n=6)**

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Case Study 2

Key Conclusions

•**Feasibility:** One pharmacist FTE could manage refill needs for a moderately sized FQHC (~120k visits/year).

•**Impact:** Pharmacists identified clinically important issues (dosing, unnecessary meds, med list errors).

•**Continuity:** High rates of lab/follow-up interventions support safe care and adherence.

•**Limitation:** Over half of DTP recommendations were not acted on within 3 months, showing need for stronger pharmacist authority or follow-up systems

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Challenges & Barriers

- Regulatory variability across states

- Provider acceptance & trust

- Reimbursement limitations

- Technology & EHR access gaps

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Implementation Strategies

- Build collaborative protocols

- Use decision support tools & EHR integration

- Train pharmacists in chronic disease management

- Pilot programs with clear metrics

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Future Directions

- Provider status legislation

- Expansion of telepharmacy

- AI & automation support

- Pharmacists as primary access points

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Questions

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