Report of the Task Force on Manpower Shortage

Members Present:
Dianna C. Drake (TN), (chair); Ann D. Abele (OH); Paula Bailey Hinson (TN); Jeffrey Lindoo (MN); Martin H. Michel (MO); Michael Patrick (OR); and Richard R. Smiga, (PA).

Others Present:
S. Patricia McSherry, executive committee liaison; Carmen A. Catizone, executive director/secretary; Janice Teplitz, NABP staff.

Invited Guests:
Edwin C. Webb, Pharmacy Manpower Project; Brian Gallagher, NACDS.

The Task Force on Manpower Shortage met December 2 – 3, 1999, at the Marriott Suites Hotel in Rosemont, Illinois. The Task Force was established by the NABP Executive Committee in response to concerns regarding the short and long-term effects of the pharmacist manpower shortage on the provision of cognitive services and the protection of the public health. Task Force members reviewed and accepted the following charge:

Charge of the Task Force on Pharmacy Manpower Shortage:
1. Review the data from the Pharmacy Manpower Project and other information sources (i.e., number of pharmacy closings, shortened hours of service, etc.) to assess the impact on the public health of the current and future availability of pharmacists.
2. Examine whether changes in regulations are needed to address any constraints or barriers placed by the system on the availability of pharmacists to serve the public health.

Background:
During the last five years, health care futurists, practitioners, academicians, and administrators have traveled divergent paths to reach a single, inescapable conclusion that the United States is facing a critical shortage of practitioners in several key health care professions, including pharmacy.

Historically, the profession of pharmacy has attempted to track specific pharmacist demographic data through a periodic census of practitioners. The most recent such census was conducted from 1989 to 1992, by the Pharmacy Manpower Project (PMP), a consortium of pharmacy’s professional associations. The underlying mechanism of the PMP census was the licensure renewal process of the state boards of pharmacy. The 1992 Project results indicated that there were about 194,500 licensed pharmacists in the United States, with approximately 172,000
actively practicing. Current estimates have boosted that figure to around 204,000 licensed pharmacists.

In November 1995, a report by the Pew Health Professions Commission entitled, “Critical Challenges: Revitalizing the Health Professions for the Twenty-first Century,” cast doubt on some long-held assumptions about future pharmacy manpower needs when it predicted a surplus of health care practitioners in the year 2000, including 40,000 pharmacists. Assuming a growing dependence on paraprofessionals, a consolidation of chain pharmacies, and an increased reliance on automation, the report recommended among other things, closing 20 to 25 percent of the schools of pharmacy.

Four years later, invited guests C. Edwin Webb, secretary of the Pharmacy Manpower Project and Vice President of Professional Affairs and Health Policy for the American Association of Colleges of Pharmacy (AACP), and Brian Gallagher, Director of Pharmacy Regulatory Affairs for the National Association of Chain Drug Stores (NACDS), told the members of the Task Force on Manpower Shortage that the Pew Report appears to be out of touch.

While chain pharmacies did consolidate to some extent, they also expanded their operations; and while there has been increased reliance on pharmacy technicians and automation, pharmacists have expanded their scope of practice to include disease state management and collaborative practice. Added to this expanded role are the demands of an aging population that is increasingly reliant on prescription drugs and a projected growth in the number of drugs prescribed annually to 4 billion prescriptions. The result is a substantial pharmacist workforce shortage.

The Task Force agreed that the manpower shortage is a long-term problem for which there is no single solution. They discussed a number of possible remedies and identified several opportunities for change that could lessen the effects of the shortage.

**Recommendation 1:**

The Task Force on Manpower Shortage encourages NABP to work with pharmacy’s professional associations to develop a mechanism that can accurately and continuously track supply- and demand-side workforce demographics.

**Background:**

Unlike other health care professions, including physicians and physical therapists, pharmacy has not monitored the career progression of its practitioners. As a result, there is no single database or storage mechanism that can instantly report the number of practicing pharmacists, their personal demographics, their practice sites, the state(s) in which they hold licensure, or the number of hours they work.

In the wake of the Pew Report, the Pharmacy Manpower Project redirected its focus to track the demand for pharmacists at the national level. The Pharmacy Manpower Project has developed an Internet-based index that tracks the demand for pharmacists regionally across the country. The index is calculated from the reports of an advisory panel composed of individuals representing various practice sites in each of the nation’s four geographic areas. These individuals are responsible for filling pharmacist positions in their respective organizations and were recommended to the Project by pharmacy’s professional associations. The early data from the
index reveals critical and unfulfilled demands for pharmacists in the Northeast and central regions of the country and moderate demands elsewhere. Based on the information presented, the Task Force noted that further distinction within the index’s response scale may be helpful.

The Task Force expressed concern that the profession of pharmacy has no readily available and accurate source of supply-side information. While the data gathered by the 1992 Pharmacy Manpower Project census was useful at the time, seven years later it is no longer accurate and cannot be updated without considerable expense.

Task Force members recommend that the state boards of pharmacy, NABP, and other professional organizations collaborate on the development of a database that, in addition to such basic demographic information as name, address, phone number, date of birth, and state(s) of licensure, could track practice sites, job classification, full/part time employment, etc. Such a resource, the Task Force believes, would be of tremendous benefit to the profession.

Recommendation 2:

The Task Force on Manpower Shortage encourages the NABP Task Force on Standardization of Technicians’ Role and Competencies to consider the elimination of pharmacist-technician ratios and delegate all dispensing functions, with the exception of the final check, to the technician. All clinical, judgmental functions, such as DUR and patient counseling, should remain with the pharmacist.

Background:

Although the NABP Model State Pharmacy Act does not specify pharmacist/technician ratios, the 1999-2000 Survey of Pharmacy Law indicates that 35 states have instituted technician to pharmacist ratios in ambulatory care and institutional care settings. The Survey also indicates that 15 states do not currently impose such a ratio.

The Task Force discussed the results of a survey conducted by Arthur Anderson Consultants for NACDS. The survey, which was based on 354 responses and a series of on-site inspections, classified 89 separate activities handled routinely by pharmacists. These surveyed activities were grouped within nine categories that included presentation of the prescription, processing of the prescription, preparation of the order, dispensing/delivery, drug utilization review, administration, inventory-related tasks, disease state management, and other health-related activities. According to the survey results, pharmacists typically spend two-thirds of their time (68 percent) on non-clinical, non-judgmental tasks that could be handled by pharmacy technicians or ancillary personnel.

The Task Force expressed support for delegating insurance and third-party claims and non-judgmental dispensing functions to support staff, but stressed the importance of requiring the pharmacist to perform the final check and to maintain responsibility for all clinical, judgmental functions, including drug utilization review, patient counseling, and disease state management.

To assure that pharmacy technicians are appropriately trained to handle the dispensing role, the Task Force stated their support for the Model Act’s Model Rules for Pharmaceutical Care, section 2 A(2)(b), which states:

The Pharmacist-in-Charge shall develop or adopt, implement, and maintain a Pharmacy Technician Training Manual for the specific practice setting of which he is in charge.

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shall supervise a training program conducted pursuant to the Pharmacy Technician Training Manual for all individuals employed by the Pharmacy who will assist in the Practice of Pharmacy. The Pharmacist-in-Charge shall be responsible for maintaining a record of all Pharmacy Technicians successfully completing the Pharmacy’s Technician training program and an objective assessment mechanism. The Pharmacist-in-Charge shall attest to the Board of Pharmacy, in a timely manner, those persons who, from time to time, have met the training requirements necessary for registration with the Board.

The Task Force also discussed the proposal by some boards to create a new classification of pharmacy personnel to perform the dispensing function. They rejected the proposal, believing it to be unnecessary if the technician training requirements of the *Model Act* are followed.

**Recommendation 3:**

The Task Force on Manpower Shortage recommends that the NABP Executive Committee ask the Committee on Law Enforcement/Legislation to develop model language that would enable the operation of central fill pharmacies.

**Background:**

Central fill pharmacies offer a relatively new approach to the drug dispensing process. Rather than maintain a full supply of drugs in every pharmacy outlet for on-site dispensing, central fill sites fill prescriptions from a single site and deliver them to several community pharmacies for dispensing. The result is a dispensing process whose volume allows it to take advantage of the high-speed and accurate automated dispensing equipment that is often too costly to be used by a single community pharmacy, while freeing the pharmacist to spend more time on patient care interactions. The Task Force endorses such innovative use of technology and believes if properly implemented, central fill pharmacies can relieve the pharmacist of non-clinical, non-judgmental tasks and permit a more judicious use of his/her time. At the same time, the Task Force notes that there should be a distinction between central fill and mail order pharmacies. They recommend that regulations for central fill pharmacies provide that the prescription label reflect information about the dispensing pharmacist at both the central fill pharmacy and the outlet where the prescription is dispensed.

**Recommendation 4:**

The Task Force on Manpower Shortage recommends that state boards of pharmacy review jurisdictional testing requirements that restrict the initial or reciprocal licensing of pharmacists to a limited number of times per year.

**Background:**

In addition to the NAPLEX, a number of boards of pharmacy require pharmacists seeking to transfer their license or candidates applying for initial licensure to sit for a state-specific examination, such as a wet lab, errors or omissions exam, or a law exam other than the Multistate Pharmacy Jurisprudence Examination (MPJE). These state-specific exams may be offered only a few times during the year, sometimes causing a delay in the awarding of licensure. In light of the manpower shortage, such jurisdictions may wish to consider offering these state-specific exams
more frequently to speed the licensing process.

**Recommendation 5:**
The Task Force on Manpower Shortage recommends that NABP support the development of a standardized prescription benefit card that may be used by all insurance and third-party payors.

**Background:**
It is estimated that about 70 percent of prescriptions are covered by one of many insurance companies, each of which has a unique benefit card that must be handled individually by pharmacy staff. The result of this nonstandard approach is a loss of productivity on the part of pharmacists. The Task Force reviewed the draft model legislation developed by a coalition of pharmacy organizations to require a standardized card that complies with the mandatory and conditional fields established by the National Council for Prescription Drug Programs (NCPDP). Task Force members believe that the universal acceptance of the standard card will improve patient care and permit pharmacists to spend more time on patient-specific pharmaceutical care.

**Recommendation 6:** The Task Force on Manpower Shortage recommends that NABP encourage pharmaceutical manufacturers to supply medications in standardized unit of use packaging to facilitate the drug distribution process.

**Background:**
Pharmaceutical manufacturers distributing stock medications to most European, Canadian, Australian, and New Zealand jurisdictions utilize standardized unit of use packaging that permits the pharmacist to fill a prescription without opening the stock bottle, counting the pills, and repackaging the medication for dispensing. Implementation of a similar approach in the United States would provide greater protection to the patient by reducing dispensing errors and freeing the pharmacist to devote his or her time to post-DUR and patient care activities.

**Recommendation 7:**
The Task Force on Manpower Shortage recommends that NABP encourage the integration and consistent use of standardized bar code technology in the drug distribution process.

**Background:**
Manufacturers have available to them standardized bar code procedures that may be used to identify drug products. Unfortunately this technology is not consistently used. The Task Force believes that this bar code scanning technology, coupled with standardized unit of use packaging discussed in Recommendation #7, will reduce errors and ease the drug distribution process. Software vendors should encourage the use of bar code technologies in the final prescription verification.

**Additional Comments:**
The Task Force on Manpower Shortage discussed several additional opportunities for maximizing the pharmacists’ ability to provide cognitive services to patients. These include the
use of electronic transmission of prescriptions, automated dispensing and robotic technology, and electronic reference software. These issues are addressed in the *NABP Model Act* and the Task Force encourages the state boards of pharmacy to compare this model language to their state regulations.

Following the presentation by C. Edwin Webb of the American Association of Colleges of Pharmacy, the Task Force noted that from the information presented, it appeared that the creation of additional colleges of pharmacy will not provide a viable solution to the pharmacy manpower shortage.