American Pharmacists Association

**TESTIMONY OF ALLISON REICHERT, PHARMD**
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**VIENNA AND MOUND CITY, ILLINOIS**

**BEFORE THE U.S. HOUSE WAYS AND MEANS SUBCOMMITTEE ON HEALTH**

**"MODERNIZING CARE COORDINATION TO PREVENT AND TREAT CHRONIC DISEASE"**

**WEDNESDAY, NOVEMBER 19, 2025**

Chairman Buchanan, Ranking Member Doggett, and Members of the Subcommittee:

Thank you for the opportunity to testify today as a member of the American Pharmacists Association (APhA). My name is Allison Reichert. I am a Doctor of Pharmacy, licensed pharmacist, and Vice President of Operations at Bode Drug in Vienna and Mound City, Illinois. My family has operated pharmacies in southern Illinois for over 100 years, and I have seen firsthand how pharmacists evolve to meet the needs of our communities. I am honored to speak with you today about the essential contributions pharmacists make in expanding access to care—particularly in rural communities like mine—and the urgent need to empower pharmacists to help prevent and manage chronic conditions.

In rural areas like mine, pharmacists are often the most accessible healthcare professionals. The pharmacy is not just where people pick up medicine—it is their front door to the healthcare system. When a parent has a question at 7 p.m., when transportation is a barrier, or when a senior is managing multiple medications, the community pharmacist is often the only health care provider available.

Many of my patients have my personal cell phone number, and our pharmacy offers an emergency after-hours telephone line. We bring vaccines, patient education, and health screenings directly to the community, to local businesses, and to assisted living facilities. These services are not just convenient—they are critical, especially for patients managing chronic illnesses[1] such as hypertension, chronic kidney disease (CKD), chronic obstructive pulmonary disease (COPD), diabetes, and heart disease (see Appendix 1 below).

In many rural communities, the shortage of primary care providers and specialists has reached a crisis point. According to the Health Resources and Services Administration (HRSA),[2] over half of all Health Professional Shortage Areas are in rural regions, and only 10% of providers are available in these communities, despite 20% of Americans living there. In many of these areas, pharmacists often step in to fill critical gaps in care—not because they are replacing other providers, but because there simply are no others available. My local health department covers seven counties, with a land area comparable to the size of Delaware, with limited staff. Pharmacists' accessibility, clinical training, and trusted relationships with patients position us to serve as frontline health care professionals, especially when no other provider is within reach.

Transportation barriers are a daily reality for many of my patients. With the nearest provider often 30 to 40 miles away, the pharmacy becomes their primary—and sometimes only—point of contact with the healthcare system. We are open evenings and weekends, we often do not

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[1] Aspen RxHealth. (2024, September 5). *The power of pharmacist-led care in chronic disease management*. Aspen RxHealth. https://resources.aspenrxhealth.com/blog/the-power-of-pharmacist-led-care-in-chronic-disease-management

[2] Weichelt, B., Shakespear, K. D., & Fallgatter, T. (2025, March 7). *Rural workforce recruitment and retention factors* [Policy brief]. National Rural Health Association. https://www.ruralhealth.us/nationalruralhealth/media/documents/advocacy/nrha-policy-brief-workforce-retention-factors-final-3-7-25_1.pdf

require appointments, and we are embedded in the communities we serve. This accessibility[3] positions pharmacists to play a pivotal role in the prevention, early detection, and ongoing management of chronic diseases, as well as potentially acute illnesses.

Community pharmacists provide clinical services[4] such as medication therapy management (MTM), chronic disease monitoring, and patient education to improve health care outcomes and reduce hospitalizations. As part of our clinical responsibilities, pharmacists review laboratory values to assess kidney, liver, and other organ system functions to maximize medication effectiveness and safety. As patients age and develop comorbidities, the complexities of their treatments and necessary adjustments require a level of healthcare access that is often unattainable in rural communities. Community pharmacists can perform clinical functions to provide a more complete picture of a patient's health care status through more frequent interactions because of our accessibility.

I check blood pressures, review lab values, and identify adverse drug events. I communicate with physicians and advanced practice providers (APPs) to intervene when needed. This will be enhanced as interoperability is strengthened among other providers and pharmacists, increasing access to real-time health data to collaborate more efficiently as members of the healthcare team.

Interoperability is not just a technical issue—it is a patient care issue, and addressing it is critical to unlocking the full potential of chronic disease management. CMS even recently stated that information blocking of electronic health information to pharmacists causes delays in patient care and prevents clinicians from having a complete picture of the patient's health.

Hospital pharmacists currently perform all the functions I have described, and more, often independently and in collaboration with other healthcare providers. Some states provide pharmacists prescriptive authority to adjust doses, change antibiotic therapy based on culture/sensitivity results, and switch IV medications to oral ones to facilitate discharge planning. These pharmacists have undergone identical didactic and clinical curriculums as community pharmacists; the difference lies in the access to data that drives clinical decision-making. Community pharmacists represent a currently underutilized healthcare resource, with clinical training and skills to prevent the depletion of higher-level services, such as emergency departments.

Despite our clinical training and proximity to patients, community pharmacists are often constrained in the services we can provide sustainably. When healthcare resources are strained, as we see in rural communities, pharmacists demonstrate their ability to deliver essential public

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[3] Morak, D. (2024, December 21). *Pharmacists as key players in managing chronic conditions*. RxLess. https://www.rxless.com/resources/pharmacists-as-key-players-in-managing-chronic-conditions

[4] Centers for Disease Control and Prevention. (2024, April). *Advancing team-based care through collaborative practice agreements: A resource and implementation guide for adding pharmacists to the care team*. U.S. Department of Health & Human Services. https://www.cdc.gov/high-blood-pressure/media/pdfs/2024/04/CPA-Team-Based-Care.pdf

health services, including chronic disease state management, often serving as seniors' only routinely accessible healthcare practitioners for miles. When the ability for patients to get face-to-face care with their providers became even more strained, patients knew they could come to the pharmacy and speak to a healthcare professional about their concerns. As mentioned, I take blood pressures, examine blood sugar levels, and check vital signs. If any of those issues require addressing, I reach out to the provider and initiate an intervention because our pharmacist-to-provider relationships are strong. Our channels of communication with providers are more accessible than what the patient can achieve. However, those avenues of communication between pharmacist and provider are largely via telephone. These interventions can often span hours to days due to our current communication methods before we arrive at an action plan with the provider. An interoperable system would dramatically improve pharmacist-provider communication and enable more rapid adjustments to a patient's chronic disease management. The inability to expand and proliferate these care models is not due to a lack of capability, but to inadequate reimbursement structures and limited access to current patient health data and diagnostics.

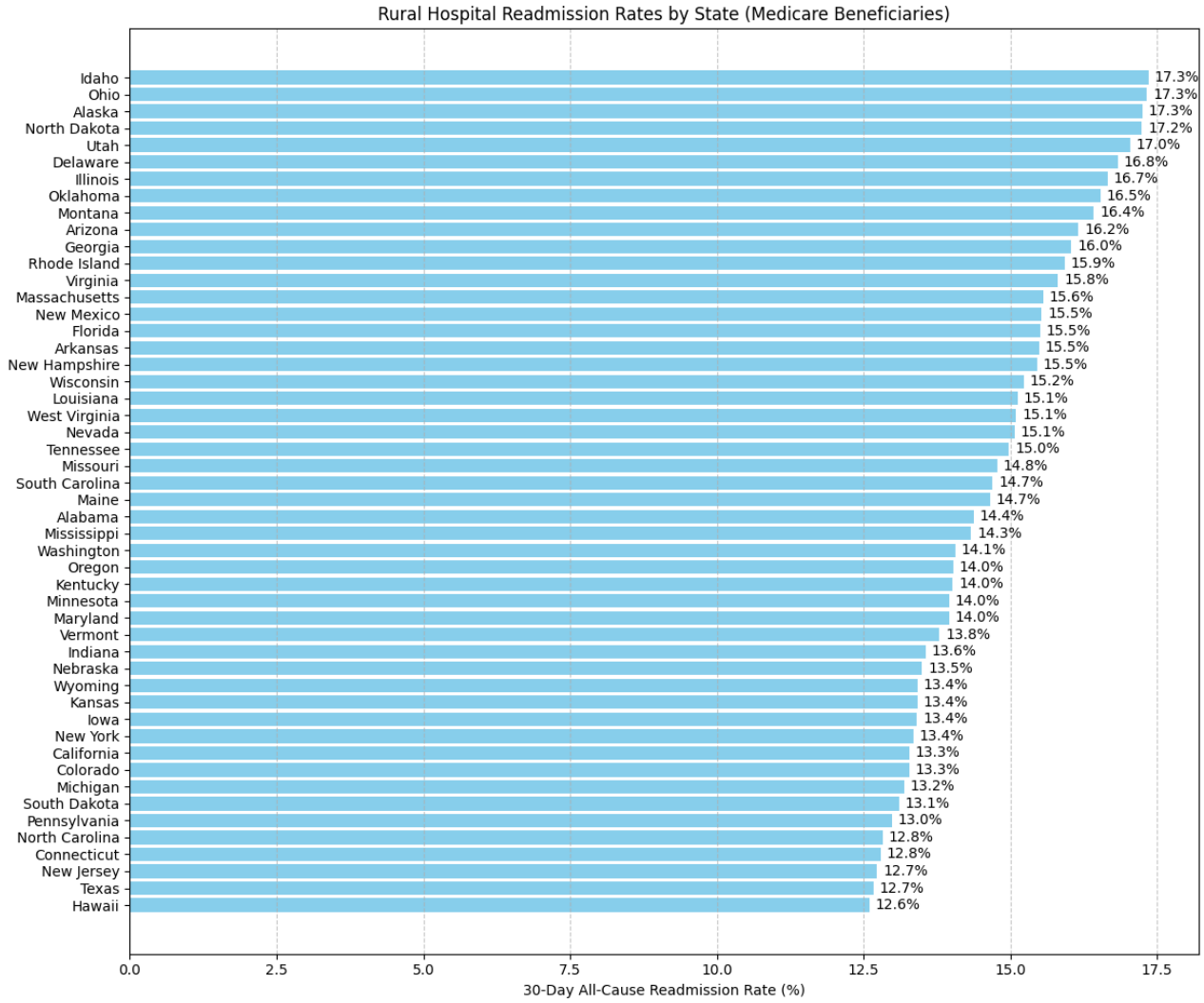
Legislation such as H.R. 3164, the Ensuring Community Access to Pharmacist Services Act (ECAPS), introduced by House by Representative Adrian Smith of Nebraska, Representative Bradley Schneider from my home state of Illinois, and many other members of this Committee, would allow Medicare to reimburse pharmacists for testing and treating common respiratory conditions to ensure seniors retain access to their trusted local pharmacists. This legislation represents a shift in how patients can access healthcare resources that are available but underutilized by the current healthcare environment. Pharmacists stand ready to help fill the access and utilization gaps facing rural seniors in Southern Illinois and across the country.

Pharmacists strengthen care teams and improve communication with physicians. We are committed to collaborating with physicians, APPs, nurses, and other health professionals to form a more connected and responsive care team. Collaboration with all levels of the health care system is already a cornerstone of the pharmacy profession. Our goal is to use this collaboration to extend the reach of healthcare into communities that need it most. We believe that integrated care is the future of rural health care—and pharmacists are ready to contribute meaningfully to that vision. Legislation like ECAPS not only increases pharmacist visibility on important health metrics but also facilitates the communication of information obtained by pharmacists back to providers.

If pharmacists are incentivized to provide clinical services, we can help reduce health disparities, lower costs, and improve outcomes—especially for patients living with chronic conditions in rural America. For example, CMS data[5] (below) indicates that rural hospital readmission rates are rising, as part of a broader rural health crisis.

[5] Centers for Medicare & Medicaid Services. (2024, November). *Rural health reports and publications*. U.S. Department of Health & Human Services. https://www.cms.gov/priorities/health-equity/rural-health/reports-publications

**Image 1. 30-day all-cause readmission rates for rural hospitals across all 50 U.S. states, based on CMS Medicare data**




In my home state of Illinois, 17 out of every 100 Medicare patients discharged from rural hospitals were readmitted within 30 days. Hospital readmission rates remain a major focus of Medicare, and rural community hospitals see this as a challenge due to the number of chronic illnesses in our communities (especially diabetes, hypertension (HTN), and COPD). Higher readmission rates often indicate challenges in care coordination, chronic disease management, or access to follow-up services, while lower rates may reflect stronger outpatient support, better medication adherence, or more effective discharge planning. Behind every readmission statistic is a patient who could have been reached earlier at their pharmacy if the system allowed it.

Multiple data sources support the notion that pharmacist interventions contribute to lower hospital readmissions:

- The Clinical Pharmacist Practitioner Rural Veteran Access (CRVA) initiative by the U.S. Department of Veterans Affairs (VA) showed that 255 pharmacists provided comprehensive medication management (CMM) to over 230,000 veterans, 58% of whom were rural, which led to improved outcomes.[6]
- A retrospective observational study conducted at a rural, integrated health system specialty pharmacy assessed the clinical and financial impact of pharmacist interventions for 232 patients. The most common primary interventions were drug-drug and drug-disease interactions, medication administration, counseling, and medication adherence support. Providers accepted or acknowledged 94.5% of pharmacist interventions. Pharmacist interventions resulted in $176,872.09 of cost avoidance over four months. Pharmacists significantly reduced adverse drug events (ADEs), which are a major contributor to healthcare costs. The estimated cost of a single ADE was $8,668.69, and pharmacist interventions helped avoid these costs. The probability of an ADE occurring without pharmacist intervention was: 60% for potentially lethal errors; 40% for serious errors, and 10% for significant errors.[7]

Patients in rural communities are struggling with chronic disease management. This is not a failure of their providers, but a result of a lack of currently available healthcare resources and providers. We know that rural patients have higher rates of chronic health conditions compared to patients in urban areas (See, Appendix 1). This includes the "Big 3" of cardiovascular risk factors—Hypertension, Hyperlipidemia, and Diabetes —but also includes an increasingly important area of concern: obesity. Rural community pharmacists are in an environment where our patient population has higher rates of disease, fewer providers to manage these conditions, and must sometimes travel great distances to access whatever healthcare is available to them. I see so many of my patients on at least a weekly basis. This level of interaction is beyond the reach of their providers due to the demands of their services. I help patients understand their lipid panel, blood pressure readings, and diabetic lab values. I can identify when a patient is experiencing an ADE and is not taking their medication as prescribed because of it. Treatment regimen compliance is a major driver of chronic disease management, and pharmacists have the greatest access and visibility on how a patient is handling their treatment. I can communicate with providers to bring this valuable information

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[6] Martinez-Vigil, C. (2023, December 4). *Pharmacist practitioners are perfectly positioned to improve rural access to care*. American Society of Health-System Pharmacists. https://news.ashp.org/news/meetingnews/2023/12/04/rural-access-to-care

[7] Lopez-Medina, A., Towne, T., Franke, L., Zahorian, T., Lane, L., Skrtic, A., Fitzpatrick, C., Giavatto, C., Wash, A., & Mourani, J. (2024, September). *Exploring the impact of alternative funding programs on medication access and clinical outcomes* [Poster presentation]. NASP 2024 Annual Meeting & Expo. https://naspnet.org/wp-content/uploads/2024/09/45-OPR45-OR-Poster-AM24.pdf

to light and work with them to make appropriate adjustments that can significantly reduce their patients' chronic disease burdens. Preventive medicine in chronic health conditions can reduce hospitalizations, emergency department visits, and dramatically increase the quality of life in our patients. Providers cannot address what they do not know or see about their patients, and pharmacists can contribute a great deal of information on their patients that can be shared to improve outcomes.

In my current practice, I already routinely communicate with family practice APPs and physician specialists, including those in neurology, oncology, cardiology, and endocrinology. Here are a few specific examples:

1. A patient came in on Friday afternoon with respiratory symptoms. Currently, the best option I have for that patient is to tell them to go to the nearest critical access hospital emergency room (ER), which is 30 miles away. While I, as a practitioner, know that it is the best option for my patient, I also know that for our already strained healthcare system, that is not the answer.

2. An elderly cardiology patient who wishes for more communication between the pharmacist and another healthcare provider. Their cardiologist told the patient he was happy to discuss any issues with a community pharmacist, but he did not have one on staff at his practice. This told me two things: 1. Healthcare providers are willing to collaborate with rural community pharmacists, and 2. We need an interoperable system to facilitate that collaboration better.

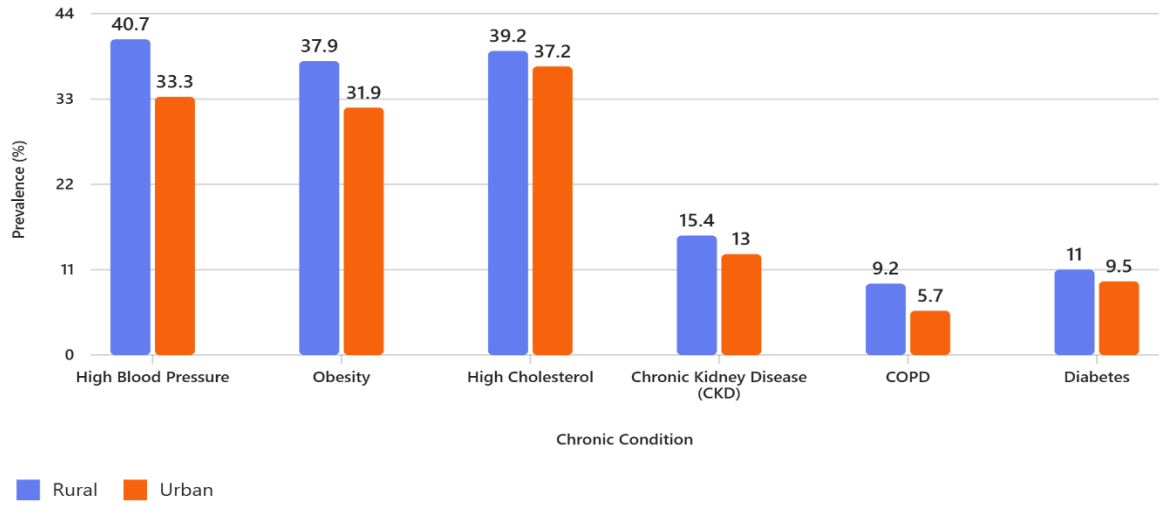
With the empowerment of legislation like ECAPS, pharmacists could play a more active role in facilitating necessary healthcare actions. Myself, and pharmacists like me, are ready, willing, and capable to make meaningful contributions to patient care. We want to contribute more meaningfully to rural healthcare teams. ECAPS can help us accomplish all of these goals by integrating us into the active healthcare environment, allowing reimbursement to elevate our workflows, building bridges with our healthcare partners, and delivering a dramatically better healthcare product for patients in our communities.

I was raised in a pharmacy, my father is a pharmacist, and it is part of my family's and my own identity. As I grew up, I saw the profession evolve from simple prescription and refill processing to patient education, to MTM, to healthcare screenings, to, most recently, coordinating with physicians, APPs, and nurses to help treat patients with chronic health conditions. I have seen pharmacists provide quality care to patients in my community and across the country, but we can do more to help. I ask that you give us that opportunity.

Thank you for your time and for your commitment to improving access to care. I look forward to your questions.

**Appendix 1:**

**Image 2: The prevalence of key chronic conditions between rural and urban populations in the U.S.**




**Data from the CDC[8] and CMS[9].**

**Key Insights:**

- **High blood pressure and obesity are significantly more prevalent in rural areas.**
- **High cholesterol, CKD, COPD, and diabetes also show notable rural disadvantages.**

[8] Matthews, K. A., Spears, K. S., & Anderson-Lewis, C. (2025). Rural health disparities: Contemporary solutions for persistent rural public health challenges. *Preventing Chronic Disease*, 22, E27. https://doi.org/10.5888/pcd22.250202

[9] Centers for Medicare & Medicaid Services. (2024, November). *Rural health reports and publications*. U.S. Department of Health & Human Services. https://www.cms.gov/priorities/health-equity/rural-health/reports-publications