

From Access to Outcomes: Community Pharmacies Transforming to Improve North Carolina Senior Care

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This article explores North Carolina's looming health care crisis fueled by a growing elderly population, a shortage of primary care providers, and financial and operational constraints in care delivery. It highlights the unique potential of community pharmacies to serve as localized health care hubs that build on trust, access, and convenience. By activating underutilized resources, investing in collaborative care models, and embracing innovation, North Carolina can better prepare for the demographic shift ahead.

Impending Silver Tsunami: Are We Ready?

The United States faces a significant health care crisis, characterized by a growing shortage of physicians, an aging population, escalating medical costs, and complex workforce challenges—particularly in rural areas. With a projected need for 202,800 new physicians to ensure equitable access to care, and North Carolina alone facing a shortfall of 1885 primary care providers, innovative solutions are imperative.^{1,2}

By 2031, 1 in 5 North Carolina residents will be aged 65 or older and will outnumber children (ages 0–17) for the first time ever.³ Think more adult diapers than baby diapers! Moreover, fewer than 40% of North Carolina's 100 counties meet the North Carolina Institute of Medicine (NCIOM)'s target of 1 primary care provider for every 1500 people.⁴ As noted below, health care expenditures continue to outstrip overall inflation, necessitating a more prudent approach to financing and resource allocation.

Traditional methods of addressing these challenges, such as provider relocation incentives or repayment of student loans, are proving insufficient. The current landscape is marked by capital expenditure constraints, supply chain disruptions, data silos, and operational inefficiencies, requiring a shift towards disruptive innovation and the optimization of existing resources. Health care in North Carolina is in need of a solution in which care is coordinated, health data is interconnected, adjudications are transparent, and savings are outcomes based. Leveraging technology, fostering collaboration within local medical neighborhoods, and strategically integrating community pharmacies into the health care ecosystem are essential steps towards

addressing this multifaceted crisis. Activating community pharmacies into health care hubs and training them to become experts in aging in place would be an effective solution.

Commodity or Specialist?

Not all community pharmacies are built the same, and every business has a lifecycle. Many “big-box” pharmacies have matured and failed to create new ways to express value. Unless a pharmacy is vertically integrated and owns a pharmacy benefits management (PBM) company, the middlemen who negotiate and regulate medication claims, the pathway to solvency is in jeopardy. Limited state pharmacy scope of practice laws, a lack of technology infrastructure to offset fulfillment needs (which allows more time for clinical patient care), and scarce predictable and scalable service revenues are also major roadblocks to transformation. Commoditization occurs in any product or services business that allows their competitive advantage to be whittled away with technology advancements, pricing, or utilization. Primary care and pharmacy share the same very uncertain futures, as large and often out-of-state operators have more resources, economies of scale, strategic partnerships, and other competitive advantages to win over consumers, taking away patients from independent practices. Specialization, therefore, is necessary to create durable niche offerings that are desired and needed in the community—ones which cannot be replicated by impersonal telehealth or outside influence because they do not have the same established trust, relationship, or access as the local community providers.

To compete in a world of technology and on-demand consumerism, providers need to focus on their innate unfair advantages. The care delivered in the mountain regions of North Carolina is vastly different from what patients on the coast need, or what is available to them. Owning and working in 17 community pharmacies across various regions of North Carolina has shown that each community presents unique challenges. These disparities stem from geographical difficulties accessing care sites, sociodemographic variations impacting provider availability, transient patient populations, and managed market dynamics. That is why focusing on the individual is so important. Within the practice of pharmacy, providers possess a unique connection to their individual patients, families, and shared community in which they live. Many pharmacists serve on their local boards, donate to their town’s youth sports, and actively participate in other community events. This investment in their own backyards translates into trust that simply cannot be fabricated with any novel offering that software companies build.

But how do we use this trust to help patients receive and improve their care? Pharmacy owners who support value-based care partnerships, adapt their business models around the whole patient, and integrate with those who can offer differentiated solutions to help their patients achieve better outcomes will be prepared for the next evolution of community pharmacy. Centuries-

old community practices here in North Carolina have survived because they adapt. Pharmacies will continue because their communities need them to, and the medical community should support them as they evolve, because the medical community needs pharmacies as well.

In Plain Sight

Each local community pharmacy operates independently, fostering a unique dynamism and agility. Their ability to adapt swiftly during crises such as the COVID-19 pandemic, offer in-home medication, immunization, and screening services, and collaborate with accountable care organizations (ACOs) to facilitate care gap closures to mitigate the risk of expensive hospitalization highlights their invaluable contributions. They are not solely driven by volume and profit alone, but rather a sense of community improvement that creates a durable and long-lasting relationship with their patients—often regardless of price. Community pharmacists are motivated by a sense of community improvement, forging enduring relationships with their patients that transcend mere transactional interactions.

Community demographics, technology, and managed markets have transformed many local independent pharmacies into “big-box” conglomerates cornering every new shopping center, but we are now witnessing the impact of cookie-cutter care. Major “big-box” pharmacies without a PBM are either closing or are being purchased because they do not control the reimbursement structure. The model of volume over quality is now destroying their existence.⁵ Disenfranchised loyalty, overburdened staff, and ineffectual patient outcomes are the cost of shareholder value versus stakeholder commitment. Capital destruction has the pendulum swinging back towards focusing on the patient.

The Centers for Medicare and Medicaid Services (CMS) Innovation Center created a path for pharmacies to be recognized as partners in health with a grant issued to Community Care of North Carolina in 2014. The grant financed the creation of a network that has grown to 270 North Carolina community pharmacies—known as the Community Pharmacy Enhanced Services Network (CPESN NC)—that focuses on adherence and care management. As a pharmacy network, CPESN USA has grown to over 5000 pharmacies across the country. This movement has been instrumental in allowing independent operators to form a clinically integrated network (CIN), which allows for clinical or financial partnerships with health plans, payers, or provider partners.⁶ However, the movement has been slow to recruit the remaining more than 300 pharmacies in North Carolina due to lack of reimbursement for services, PBM/plan acceptance, and reluctance by other CINs to partner or share patients for fear of leakage or reduced potential revenue from their systems.⁷ Their preference to form care management systems that utilize centralized call centers and narrow networking with their own or preferred vertical systems has continued to

delay and cost employers and state governments time and money due to their low engagement rates.⁸ For example, how many people answer calls from unknown numbers considering how many spam calls target unsuspecting individuals? However, if the local pharmacist from the pharmacy in town calls from a known number, their patients are much more likely to answer.

Patients demand trust built by relationships, choice, and local convenience. Roughly 9 in 10 people live within 5 miles of a community pharmacy, which is one of the reasons patients prefer to frequent their local pharmacies up to 12 times more than their local primary care office.⁹ The local pharmacies are ready to make these touchpoints meaningful with medical interventions. However, the instruments are missing to create a network effect whereby each additional pharmacy brought into the network catalyzes more accretive outputs and thus creates improved outcomes. The aim is to ultimately create a virtuous cycle of growth and engagement. Finding the right balance between innovation, incentives, and attributions is necessary.

Carrots and Sticks

In 2024, a few insurers started pilot projects to allow pharmacies to help with health risk assessments, diabetes management, and telehealth services in regionalized areas.¹⁰ This is a great start. And yet, retrofitting their platforms, attributing patients, and analyzing return on investment takes time, as most systems are created for medical transmissions based on time, risk, or encounter type, and not on pharmacy adjudications based on value-based interventions. Patience is needed for the infrastructure modifications and workflow reorganizations to happen for both the payer and pharmacies; however, lower PBM reimbursements continue to force many pharmacies to close across the state. While this transition continues, no pharmacy without a vertical PBM is safe. Between January 1, 2022, and July 1, 2024, a total of 100 community pharmacies closed in North Carolina.¹¹ This has deepened the health care desert in many rural areas as both primary care and rural hospitals continue to close at alarming rates.¹² These are hardworking health care providers who are willing and wanting to stay in their rural areas with no way to help their communities due to the lack of proper reimbursement or scope of practice allowances which enable them to work at the top of their licenses.

Legislation to regulate transparent and fair business practices would go a long way to assuage this trend from continuing. If this fails, not only will more pharmacies and medical practices close, but any opportunity to create equitable health care access closes with them. Costs to the state will continue to increase, and you will have sicker patients needing to be tended by their families, many of whom will be unable to work because of the burden caused by driving their mom or dad 50 or more miles to the nearest pharmacy or clinic.

PBMs have asymmetrical control over pharmacies and exert their conditional reimbursement practices predicated on motivations or behaviors that are outside the influence of pharmacists.¹³ This results in negative or low reimbursements and leads to pharmacy closures. Anything designed from contingencies creates disconnected, ephemeral incentives. A better design would be one of a partnership model where all parties have the motivation to design systems around the patient and are mutually sharing the benefits or losses of inefficiency. Cooperation leads to shared skills and knowledge, the exchange of team resources and data, and, more importantly, encouragement and help for each practitioner to do their best. Intrinsic motivations are more powerful and durable than extrinsic consequences. Trust, transparency, and coordination are necessary.

Intentional Investment and Alignment

A strategy focused on recruiting, training, mentoring, deploying, and retaining health care professionals is crucial. However, maximizing the potential of the existing workforce within community pharmacies is equally vital. Providing pharmacy technicians with clinical training in areas such as hypertension, diabetes management, nutrition, electronic health monitoring, social determinants of health (SDOH) assessments, and home-based services can significantly enhance their contributions.

Transforming community pharmacies into health care hubs requires addressing regulatory telehealth laws, fostering education within pharmacy schools to embrace technician training, developing interoperable technologies for data transfer and collaboration, and providing incentives to repurpose workflows. Intentional investment in these areas will unlock the potential of community pharmacies to serve as comprehensive care providers.

Transformation of McDowell's Pharmacy: A Catalyst for Change

McDowell's Pharmacy, an established institution serving the community of Scotland Neck, North Carolina since 1901, has proactively addressed the challenges of fluctuating medication reimbursements by strategically pivoting to a value-based care model. Recognizing the diverse needs of its patient population, the pharmacy identified distinct segments requiring either transactional, low-complexity care or comprehensive, high-complexity care. Previously operating under a primarily volume-driven model, McDowell's Pharmacy has shifted its focus towards optimizing patient outcomes and enhancing community health. This transition was further motivated by the closure of other local health care providers, prompting McDowell's Pharmacy to envision itself as a comprehensive health care hub and a primary point of access for patients.

Through a thorough analysis and risk stratification of its patient panel, McDowell's Pharmacy identified a critical need to expand services for homebound and special needs patients. In collaboration with Truentity

Health, a North Carolina-based medical and software company, the pharmacy implemented remote monitoring of complex patients' physiological biometrics. This initiative is complemented by monthly health coaching consultations that address conditions such as hypertension and diabetes, provide nutritional education and behavioral modification support, and promote preventive care. Preliminary data from the Rural Pharmacy Health Initiative, as reported by the University of North Carolina Eshelman School of Pharmacy, demonstrate the effectiveness of these interventions in mitigating patient risk and slowing disease progression.¹⁴ Furthermore, the partnership with Truentity Health has generated substantial revenue, enabling McDowell's Pharmacy to scale its programs effectively.

McDowell's Pharmacy continues to expand its scope of services through strategic partnerships with local medical providers, aiming to address gaps in care and leverage artificial intelligence-driven insights for enhanced patient care planning. Additional services include medication adherence support and assistance with care transitions. Notably, the pharmacy has established a local home health agency and is now recognized as a valuable resource for families seeking to support aging parents in maintaining independent living, establishing its expertise in the field of aging in place.

Conclusion

The “silver tsunami” is not a distant wave—it's at our doorstep. To meet the needs of an aging population and an overburdened system, we must rethink where care happens and who can deliver it. Strategically integrating community pharmacy into the health care ecosystem, leveraging technology, fostering collaboration, and investing in workforce development will create a more efficient, resilient, and equitable health care system in North Carolina.

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REFERENCES

1. Association of American Medical Colleges. The complexities of physician supply and demand: Projections from 2021 to 2036. March 2024. Accessed May 12, 2025. <http://www.aamc.org/media/75231/download>
2. Petterson SM, Cai A, Moore M, Bazemore A. State-level projections of primary care workforce, 2010-2030. Robert Graham Center. September 2013. Accessed May 12, 2025. <http://www.graham-center.org/content/dam/rgc/documents/maps-data-tools/state-collections/workforce-projections/North%20Carolina.pdf>
3. Venkatagansan D, Freeman R, Reddy S. North Carolina's older adult population to almost double in the next 20 years. North Carolina Office of State Budget and Management. November 16, 2023. Accessed May 15, 2025. <http://www.osbm.nc.gov/blog/2023/11/16/north-carolinas-older-adult-population-almost-double-next-20-years>
4. Galloway E, Spero J, Wilson H. Primary care access in North Carolina is not equally distributed. The Cecil G. Sheps Center for Health Services Research blog. March 24, 2020. Accessed May 14, 2025. https://nchealthworkforce.unc.edu/blog/primary_care_nc/
5. Digital team. Walgreens closures: Full list of 54 stores closing in 2024. FingerLakes1.com. May 14, 2025. Accessed May 12, 2025. <http://www.fingerlakes1.com/2025/05/14/walgreens-closures-full-list-2025/>
6. Integrating pharmacists in to the medical home team. Community Care of North Carolina. Accessed May 14, 2025. <http://www.communitycarenc.org/population-management/pharmacy/community-pharmacy-enhanced-services-network-cpesn>
7. Independent neighborhood pharmacies: Accessible and affordable care; trusted and valued health care providers. National Community Pharmacists Association. Accessed May 15, 2025. <http://www.ncpa.co/pdf/state/North-Carolina.pdf>
8. 10 essential call center insurance KPIs for 2024. Convin blog. April 19, 2024. Accessed May 14, 2025. <https://convin.ai/blog/2024-insurance-call-center-kpis>
9. Strand MA, Bratberg J, Eukel H, Hardy M, Williams C. Community pharmacists' contributions to disease management during the COVID-19 pandemic. *Prev Chronic Dis*. 2020;17:200317. doi:[10.5888/pcd17.200317](https://doi.org/10.5888/pcd17.200317)
10. Trautman S. More than a script: Partnering with community pharmacists. Blue Cross and Blue Shield of North Carolina blog. July 23, 2024. Accessed May 12, 2025. <http://www.bluecrossnc.com/blog/expert-takes/more-than-a-script>
11. Gulamali F. NC independent pharmacies are disappearing as prescription prices soar. So where's the money going? The News & Observer. September 13, 2024. Accessed May 12, 2025. <http://www.newsobserver.com/news/business/article291131200.html>
12. Aldridge R. 700+ rural hospitals at risk of closing. North Carolina Medical Society. March 19, 2025. Accessed May 14, 2025. <https://ncmedsoc.org/700-rural-hospitals-at-risk-of-closing/>
13. US Federal Trade Commission. Pharmacy benefit managers: The powerful middlemen inflating drug costs and squeezing main street pharmacies. July 2024. Accessed May 12, 2025. http://www.ftc.gov/system/files/ftc_gov/pdf/pharmacy-benefit-managers-staff-report.pdf
14. Rural pharmacy health initiative. Carolina Across 100. Accessed May 14, 2025. <http://carolinaacross100.unc.edu/program-four/>