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Compounding Pharmacist Jocelyn Freimuth Puts Numbers to Telemedicine's Personalized Turn

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Sixteen of the new medicines the FDA approved in 2025 were personalized therapies, about 36% of the year's newly approved therapeutic molecular entities and the sixth straight year the category has held more than a third of all new drug approvals, per the Personalized Medicine Coalition's May report. Fifteen years ago that share sat under 10%.

Care delivery is virtualizing on a parallel track. Telehealth utilization climbed 10.1% nationally between the fourth quarter of 2025 and the first quarter of 2026, and mental health conditions accounted for **about 62% of telehealth patients' diagnoses** through late 2025, per FAIR Health's tracker.

Virtual care's original promise was geographic: reaching patients that distance, workforce shortages, or income kept away from treatment. Urban areas still out-use rural ones in every U.S. region, which leaves that promise only partly kept.

Where the two currents meet, a quieter infrastructure question appears: who prepares, ships, and monitors an individualized therapy that a patient started over video?

Jocelyn Freimuth, who holds board certification in sterile compounding, teaches at the University of Tennessee Health Science Center's pharmacy college, and founded the Nashville consultancy firm Camino Compass, co-authored one of the first operational datasets on that question. Working with Michael C. Raiff and Ryan C. Woods, she reviewed a full year of records from a multi-state telemedicine network that pairs personalized therapeutic management with compounding pharmacy services. Their retrospective review covered 482 adult patients treated between January and December 2024.

Inside the Integrated Provider-Pharmacy Model

Integration in the study meant one continuous workflow rather than a referral chain: enrollment, telemedicine visit, provider evaluation, treatment plan, compound prescribing, medication delivery, and ongoing monitoring, with communication running across every step. Compounding pharmacies prepare customized formulations, adjusted doses, combined ingredients, or alternate delivery forms, for individual patients whose needs commercial products don't fit. Patients in the model never dropped out of the workflow to chase a prescription across separate systems.

Evidence came from five record streams: electronic health records, pharmacy dispensing data,

telemedicine encounter documentation, patient satisfaction surveys, and internal operational reporting. Assessment focused on five areas as well, covering provider-pharmacist collaboration, continuity of care, patient access, therapy initiation timelines, and virtual-care workflows.

Cohort makeup mirrored where telehealth demand actually sits. Average patient age was 44.8 years, 57.9% of participants were women, and 18.1% lived in rural areas. Weight management accounted for 40% of primary conditions, hormone optimization for 30.1%, and longevity and wellness care for 19.9%.

Those categories share a clinical feature: dosing rarely stays fixed. Weight management and hormone therapy both run on titration, adjusting strength and formulation against labs and patient response over months. Care models with built-in monitoring suit titration-heavy medicine far better than dispense-and-forget channels, which is much of what the review set out to test.

The Outcomes Jocelyn Freimuth's Team Reported

Every headline measure moved in the model's favor over the study year. Time from prescription to therapy start fell from 10.2 days at baseline to 2.6 days, a 74.5% reduction, and the other measures followed:

- Follow-up compliance rose from 46% to 78% of patients
- Medication adherence climbed from 68% to 87%
- Patient satisfaction moved from 6.4 to 8.8 on a 10-point scale
- Cost per patient fell 19.2%, from \$245 to \$198
- Patients served grew from 312 at baseline to 482, a 54.5% gain in access

Per-patient cost fell while satisfaction climbed 37.5%, a pairing that cost-cutting alone rarely produces.

The Mechanism Behind the Movement

One operational metric may explain the rest. Provider-pharmacist interactions per patient nearly tripled over the same period, from 0.8 to 2.3, in the dataset **Jocelyn Freimuth and her co-authors** assembled. More contact meant earlier dose adjustments, faster answers to side-effect questions, and fewer reasons for a patient to quietly stop treatment.

Compounded therapies raise the stakes on that contact. A customized formulation has no package insert written for the general public, so the pharmacist who prepared it is often the only person who can troubleshoot it. Cutting that person out of the follow-up turns every dose question into a new appointment.

Can One Network's Results Generalize?

Jocelyn Freimuth's team documented the limits plainly. Theirs was a retrospective operational review, not a randomized trial, drawn from a single network's records with the documentation variability and reporting bias internal data carries. Long-term outcome data was limited, and results from one integrated model may not generalize to others.

Open questions still outnumber settled ones. Whether adherence gains hold past the first year, how integrated models compare against conventional specialty pharmacy channels, and whether the cost

advantage survives at scale all remain untested. Their own future-research agenda lists exactly those items, along with expansion to broader patient populations.

Operational reviews still carry weight in a delivery model this young. Randomized evidence takes years to fund and run; first-generation data from working networks is what regulators, payers, and health systems have to reason with in the meantime. Reviews like this one set the baseline that stronger designs will confirm or overturn.

Even read cautiously, the direction of movement is the finding. Seven separate measures, from initiation speed to per-patient cost, shifted the same way once a pharmacist joined the treatment team.

Where Integration Heads Next

Professional bodies have started building the scaffolding. WHO's digital health strategy, ASHP's statement on telepharmacy, and pharmacy-board guidance on telehealth practice all appear in the review's reference list, a sign that the model is moving from improvisation toward standards. Independent compounding pharmacies, the review's background notes, are increasingly the ones supplying telemedicine platforms with customized medication management.

Growth pressure now shifts to the pharmacy side of the model. A therapy personalized over video is only as good as the facility that prepares it, and the compliance bar keeps rising: USP chapters 795, 797, and 800 govern compounding practice, and accreditation reviews test whether a pharmacy actually meets them. Jocelyn Freimuth advises pharmacies on exactly that readiness, from sterile-compounding compliance, to **accreditation best practices**, to inspection preparation.

Jocelyn Freimuth's case for individualization predates the market for it. "The medication should be built to fit the patient, not the patient bent to fit the medication," she said in a statement. Compounding has run on that premise far longer than the current demand cycle has.

Jocelyn Freimuth's next questions already sit on the review's research agenda: whether the gains hold over years, at scale, and against competing delivery channels. Measurement is what she brings to a corner of medicine that has grown faster than its evidence base. Approval counts like 2025's sixteen guarantee the demand will keep arriving; datasets like hers decide what the infrastructure learns from meeting it.

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