Facilitating collaboration between pharmacists and physicians using an iterative interview process

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Abstract

Objective: To elicit and describe mutually agreed upon common problems and subsequent solutions resulting from a facilitated face-to-face meeting between pharmacists and physicians.

Design: Descriptive, exploratory, nonexperimental study.

Setting: Wisconsin from October to December 2011.

Participants: Physicians and community pharmacists.

Intervention: Face-to-face semistructured interviews with pharmacists and physicians from the same community, informed by previous individual interviews.

Main outcome measures: Methods to enhance collaboration and barriers to implementing collaboration between pharmacists and physicians.

Results: Physicians and pharmacists generated ideas in which collaboration could improve patient care, including controlled substance monitoring, medication adherence, collaborative practice agreements for point-of-service issues, and a mechanism for urgent communication. Methods on how to collaborate on these issues also were discussed.

Conclusion: Bringing physicians and pharmacists together for a face-to-face interaction that was informed by information gained in previous individual interviews successfully stimulated conversation on ways in which each profession could help the other provide optimal patient care. This interaction appeared to dispel assumptions and build trust. The results of this project may provide pharmacists with the confidence to reach out to their physician colleagues.

Keywords: Collaboration, community pharmacists, physicians.

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In an effort to improve coordination of health care and cost effectiveness of care for all Americans, the Affordable Care Act (ACA) was enacted in 2010.[1] This was primarily motivated by the widespread agreement of the need for fundamental reform of both health care delivery and payment systems.[1] As part of the ACA, health care providers were encouraged to focus on building accountable care organizations (ACOs). The primary function of ACOs is to coordinate care among providers and ensure that patients receive high-quality and efficient services.

Embedded in the idea of ACOs is the need for increased collaboration between health care providers from different health care settings,[2] such as hospitals, primary care clinics, and community pharmacies. Most patients receive medical care from multiple health care providers and pharmacies that may not be part of the same health care organization.[3] This often can complicate the ability of health professionals to access patient information, as it can be located in many places. Therefore, a challenge facing policy makers is ensuring implementation of ACOs across settings and communities.[4] Physicians and pharmacists practicing in different settings need to be able to communicate and collaborate effectively and efficiently to ensure that patients receive high-quality, patient-centered care. Because physicians and community pharmacists do not interact face-to-face regularly, physicians may have incorrect perceptions or may generalize expectations from other pharmacist encounters. Hughes and McCann[5] found that physicians perceive community pharmacists to be retailers primarily—an image that was, and likely still is, in conflict with that of a health care provider.

Many community pharmacists, who interacted with physicians and medical students primarily during pharmacy school, are uncomfortable with and lack the confidence to assert recommendations about their patients' medication therapy.[6] Community pharmacists, who are focused on taking care of patients quickly and efficiently, frequently interact with physicians or their nurses to clarify concerns or ask quick questions. Community pharmacists rarely engage in lengthy discourses or discussions about patient health, such as what takes place during rounding in a hospital. With reimbursement rates squeezing community pharmacists more and more, no financial incentive exists to extend the time required to fill a prescription.

For community pharmacy to move toward a patient-centered model, cooperation and buy-in from other health professionals who recognize the value of community pharmacists are essential. A number of successful physician–pharmacist collaboration models have appeared in the literature. However, most are typically conducted in an information-rich ambulatory clinic where physicians and pharmacists are housed in the same building, allowing for greater face-to-face interaction.[7,8] These projects may not be generalizable to a free-standing community pharmacy.[9] Several studies have been conducted that build on the model of collaborative working relationship, which synthesizes the collaborative process between physicians and community pharmacists into five stages of collaboration. These studies have described physician and pharmacist characteristics that influence development of collaboration.[10,11] However, no studies could be found describing an effective process by which physicians and community pharmacists, who work in separate settings and do not share the same computer system, learn how to develop and sustain a collaborative relationship.

At a Glance

Synopsis: This is the first study to describe an effective process by which physicians and pharmacists—working in separate settings and not sharing the same computer system—can develop and sustain collaborative relationships. Face-to-face semistructured interviews with pharmacists and physicians from the same community were used to build trust, dispel assumptions, and stimulate conversations about efficient, quality collaborative patient care. These results can provide pharmacists with the confidence to reach out to their physician colleagues.

Analysis: *Several barriers to pharmacist–physician collaboration exist. For example, physicians described how they interact with patients in the confines of an office visit structure, and when a pharmacist makes a request to the physician during a time that does not coincide with the office visit, the physician has three choices: (1) spend the nonreimbursable time to consider the recommendation; (2) add the note to the chart and make the change at the patients' next office visit (but without feedback to the pharmacist about his/her decision); or (3) disregard the pharmacist's request due to time pressure, lack of clarity about the request, or lack of perceived clinical relevance.*

Objective

We sought to elicit and describe mutually agreed upon common problems and associated solutions resulting from a facilitated face-to-face meeting between pharmacists and physicians.

Methods

Eight physician–pharmacist dyads were recruited through either the Wisconsin Medical Society or the Pharmacy Society of Wisconsin. The dyads were formed based on the following criteria: close geographic proximity so that physicians and pharmacists would have a shared patient population and a job position that required prescribing/dispensing to ambulatory home-dwelling patients.