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RESEARCH NOTES

Care team perspectives on community pharmacy enhanced services

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ABSTRACT

Objectives: To determine the awareness, collaboration, and perceived values and barriers of enhanced pharmacy services from care managers and primary care practice responders.
Methods: An electronic questionnaire was sent to 1648 primary care practices and 600 care managers that work in 76 North Carolina counties containing an enhanced-service community pharmacy. Questionnaires were distributed in January 2017 and responses collected for 7 weeks. The questionnaire collected data on the awareness and perceived value of enhanced pharmacy services, preferred method and level of communication for referral, and barriers to using enhanced services. Data were gathered with the use of Likert-type, rank-order, dichotomous, and multiple-choice questions. Data were analyzed with the use of descriptive statistics, and group mean responses were compared by means of *t* tests.
Results: Data analysis was performed in March 2017. Response rates were 5.4% (n = 89) from practice responders and 45% (n = 270) from care managers. In the responses received, 35% of practice responders and 88% of care managers were familiar with enhanced services offered by community pharmacies. A majority of respondents thought that enhanced pharmacy services are valuable, with more than 85% of practice responders agreeing that partnering with an enhanced-service pharmacy can help to improve patient health outcomes. Lack of knowledge of enhanced-service pharmacies, services offered, and the referral process were identified as significant barriers for practice responders.
Conclusion: Community-based pharmacies have an opportunity to collaborate with patient-centered medical home teams to provide enhanced pharmacy services, but provider outreach and education on enhanced services offered and the referral process are necessary to maximize this collaboration.

High-functioning health care teams require collaboration among providers, including physicians, nurses, pharmacists, behavioral health specialists, and case managers, as well as nonclinical supportive staff and administrators.[1,2] These high-functioning teams work together to provide high-quality patient-centered care.[2] Many national organizations have supported the incorporation of pharmacists into the health care team,[3-5] and primary care practices that collaborate with clinical pharmacists demonstrate higher provider and patient satisfaction.[6-8] In addition, the incorporation of pharmacists into the health care team leads to positive patient outcomes and reductions in cost of care through decreasing medication-related errors[7,9] and improving patient medical conditions.[8,10,11] Continuity between different care settings and providers is associated with lower costs of care,[12,13] lower chance of departing from clinical best practices,[12] and lower rates of hospitalizations or extended lengths of stay.[11-13] One study noted that patients receiving the most fragmented care had an average total cost almost double that of patients receiving the least fragmented care.[12]

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In an effort to improve the quality of care and lower overall health care costs, North Carolina developed a primary care case management program consisting of more than 1800 patient-centered medical homes and an interdisciplinary care management team that spans all 100 counties in the state. This program, developed by Community Care of North Carolina (CCNC), includes care teams with physicians, nurse and social work care managers, behavioral health specialists, and clinical pharmacists that collectively provide care to more than 1.6 million Medicaid enrollees with the goal to better manage medical, social, and behavioral health conditions to improve patient outcomes.[14] CCNC care managers work throughout the community to meet the needs of high-risk patients by working with the patient's medical home to facilitate communication across settings and providers, connecting patients to needed resources, and improving patients' ability to self-manage their care. Care managers, typically located separate from the patient's primary care provider office, may work with patients and providers through a variety of means based on the patients' or collaborative visits with the provider and patient.[15] CCNC care managers have historically worked with CCNC clinical pharmacists to comanage medication needs of patients cared for within the medical home. CCNC clinical pharmacists provide medication management to high-risk patients, including after discharge, to help reduce preventable hospitalizations and emergency department visits.[16] CCNC care managers and clinical pharmacists use a web-based documentation portal that accesses prescription claims data, medication lists across a variety of care settings, and documented medication-related problems.

In 2014, CCNC began an initiative to expand the reach of their existing pharmacy program by engaging community pharmacies, thereby creating more opportunities for high-risk patients to work with a pharmacist as part of their local CCNC care team. The goals of this community pharmacy enhanced services network (CPESN) align with CCNC: to improve quality of care and patient outcomes related to medication use, enhance patients' overall health trajectory, and reduce total cost of care.[17] The key to accomplishing these goals is active integration of community pharmacists with the larger care team, including primary care providers and care managers, within the patient-centered medical home.[17] To better achieve this integration, CPESN pharmacists were provided access to the web-based documentation portal already used by CCNC care managers and clinical pharmacists.

As of September 2016, CCNC's CPESN network consisted of 275 community-based pharmacies across 76 counties in North Carolina. These pharmacies are committed to providing enhanced services to broaden the availability of medication management resources to the patients in greatest need. Community pharmacists were identified as ideal partners for this effort because North Carolina Medicaid claims data have indicated that the portion of the population most in need of medication management visit their local pharmacy 20-35 times annually.[17] Examples of enhanced pharmacy services include synchronizing chronic medications, using medication adherence packaging, delivering medications to the patient's residence, and identifying medication therapy–related problems and developing a care plan with follow-up. Details of the medication management services provided by CCNC's CPESN pharmacies have been discussed in previous publications.[18] Since the time of this study's completion, CPESN USA networks have grown across the country, each with variations in the enhanced services offered based on patient needs in the area.[17]

Early results have shown that patients of CCNC's CPESN pharmacies are 4% to 5% more adherent to chronic medications than patients using pharmacies outside of CCNC's CPESN.[17] Although medication adherence data is positive, formal evaluation of the program remains under way, and little is known about the knowledge, perspective, and collaboration by primary care practices and care managers regarding the pharmacy network or services it offers.

Objective

To determine care managers' and primary care practice responders' awareness of CCNC's CPESN, collaboration with participating pharmacies, and perceived values and barriers of enhanced community pharmacy services.

Methods

An online survey was developed to gather information from CCNC primary care practices and CCNC care managers who were located in a county with a participating CPESN pharmacy. Specialty practices as well as practices or care managers located in a county without a CPESN pharmacy were excluded. The survey consisted of approximately 15 items (combination of Likert-type, rank-order, dichotomous, and multiple-choice questions). Demographics, such as practice type, patient population, practice setting, number of practice locations, county or counties of practice, number of prescribers, number of patients receiving enhanced pharmacy services, and responder role, were collected. Questions addressed awareness of CPESN pharmacies, knowledge of enhanced services, perceived value of services, referral process to CPESN pharmacies, collaboration with pharmacies, and barriers to using the services. See Appendices 1 and 2 for the survey tools. The surveys were piloted by 18 CCNC pharmacists who did not complete the final survey. Results of the pilot were used to revise and improve the survey for readability and comprehension. A total of 1648 surveys were sent to CCNC primary care practices and 600 to CCNC care managers via e-mail via Qualtrics (Provo, UT). Primary care practice surveys were sent to CCNC's main contact within the practice to complete on behalf of the practice site(s). Surveys were available for a 7-week period from January to March 2017, and 2 reminder e-mails were sent to nonresponders. Data were analyzed with the use of descriptive statistics. Mean responses to questions about perceived value and barriers to enhanced services from care managers and practice site responders were compared by means of a 2-tailed t test of independent samples. Because the samples are independent, the F test for the significance of the variances of the 2 samples was used to determine if pair variances should be assumed as equal or unequal. P values and SDs are reported for comparisons of mean responses. This study received exemption from the Institutional Review Board at the University of North Carolina, Chapel Hill.