

Pharmacists' perspectives on providing chronic disease management services in the community — Part II: Development and implementation of services

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Abstract

Background: The need for alternative methods of providing primary care and chronic disease management (CDM) is becoming more urgent. To understand pharmacists' role in this changing health care system, we must better understand their desire and capacity to provide these services.

Methods: Key stakeholders from all facets of pharmacy practice were recruited to participate in focus groups held in Alberta and British Columbia. Qualitative methodologies involving a phenomenological approach with content analysis were used to gather and analyze information.

Results: In total, 36 pharmacists participated in 8 focus groups to identify enablers and challenges to the provision of CDM (reported in Part I). The topic of how such services could be implemented in the community developed naturally from these discussions. Participants expressed a need for changes to both the physical layout of

pharmacies (to incorporate private counselling spaces) and the documentation and information systems used (to improve communication and continuity of care). Furthermore, the intentions of both pharmacists and employers must be communicated effectively to all parties, including patients. Participants also identified an alternative remuneration model as being essential, to allow adequate time for provision of CDM services and to ensure that current high-quality dispensing practices can be continued.

Conclusion: Pharmacists have a tremendous opportunity to change practice and to contribute more to patient care. To guide and implement such change will require that pharmacists restructure their physical and information environments, strengthen their relationships with key stakeholders and develop a sustainable model of practice that includes the needs of the business, the client (patient) and the pharmacist. *Can Pharm J* 2009;142:284-288.

Introduction

To meet the current need for qualified primary health care professionals, one potential solution is to expand the roles of nonphysician health care

providers.¹ If pharmacists are to fill this role, as has been suggested in a number of commissioned reports on the status of health care in Canada,^{2,3} we must better understand their desire and capacity to

provide chronic disease management (CDM) services in the community setting. We conducted focus group interviews with pharmacy stakeholders to gain some insights into this area. To our knowledge, this work represents some of the first Canadian data reflecting pharmacists' thoughts on providing CDM services to patients and on obtaining remuneration for such services in the community setting.

In a previous article, we outlined the factors that pharmacists from Alberta and British Columbia perceived as potential enablers and challenges to providing CDM in the community setting,⁴ grouped according to 4 main themes: the current practice environment, education, remuneration and implementation. Here, we report participants' suggestions for the successful introduction of CDM services through education, a model for remuneration and a plan for implementation.

Methods

The methods for this study have been described in detail elsewhere and are summarized here.⁴ We recruited key stakeholders from all facets of pharmacy practice: staff pharmacists, pharmacy managers and owners from the community setting; pharmacists from the hospital and primary care settings; and regional managers from large-chain retailers. Participants were recruited in both Alberta and British Columbia. For this project, privacy considerations meant that we were limited to convenience sampling. In each province, an invitation to participate in the project was placed in the newsletter of the provincial pharmacy association. In addition, we recruited pharmacists affiliated with local pharmacy practice research organizations. Each participant received a \$50 honorarium.

Given the potential for diversity of thoughts and opinions among the stakeholder groups recruited, each focus group was composed of individuals with similar background and experience.⁵ All focus group sessions were conducted by an experienced interviewer and were recorded and transcribed in full. We continued running focus groups until novel information was no longer being obtained and saturation had been achieved. All analyses, as described previously,⁴ were performed by 2 of the researchers (MR and KAG) using a phenomenological approach to qualitative content analysis.

Results

A total of 36 stakeholders were recruited for this study. The composition of the focus groups has been detailed elsewhere.⁴ With regard to the development and implementation of CDM programs in community practice, participants identified a need

for additional education, a remuneration model and a plan for implementation.

Education

Many of the participants seemed hesitant about their level of knowledge and their ability to provide CDM services to patients. For example, one staff pharmacist said, "We would probably need extensive education, or extensive catching up with the recent studies, the recent guidelines and then a way to keep [up] with any new things so ... we're always on the cutting edge." Some staff pharmacists and managers also felt that training in topics such as literature evaluation and patient education would be required to ensure the success of practice change.

With regard to disease-specific training, the existence of a standardized program for CDM was of key importance to many participants:

"If we're going forward as a profession, there needs to be some regularized training set up, so that people can be going forward with the same skill sets. Then you need to do the hands-on stuff, too, where you do a locum or residency in the hospital or some specialized setting where you can learn and actually deal with [the disease-state] before going out." (Manager)

Participants were interested not only in gaining knowledge about various disease states, but also in having the opportunity to apply this knowledge in a monitored environment. They speculated that a mentoring period would increase pharmacists' confidence before they began providing patient interventions independently in the community. They also felt that standardized training would address some pharmacists' concern about accountability for patient outcomes:

"You know, you can't charge \$150 and the outcome is so minimal, it's not going to make a difference to anything. But if you're [going to] be saving re-admissions to the hospital, I think that's huge and then I think you should be compensated accordingly." (staff pharmacist)

Key points

- Few studies have evaluated pharmacists' opinions on the implementation of a chronic disease management (CDM) model. For many such models, numerous challenges, including insufficient remuneration and time constraints, have led to poor uptake.
- Pharmacists are apprehensive about practice change because of perceived barriers to the implementation of new models of practice. Many are concerned that such models will not take into account their professional and business needs. All pharmacy stakeholders should be involved in the development and implementation of a remuneration model.
- Any model that is developed for CDM will have to take into account the preferences and needs of all pharmacy stakeholders. Policy-makers should consider these preferences in the context of prior systems that have failed in the past.

However, many participants did not support the idea of receiving a bonus payment for patients who achieved specific clinical targets.

Remuneration model

Participants identified the need for an appropriate remuneration model as one of the greatest challenges in effecting practice change. They noted that the new model should be distinct from the current dispensing model, to legitimize new practice initiatives. Having an appropriate remuneration model would ensure that pharmacists' contribution to patient care was recognized by patients, physicians and employers, because, as one staff pharmacist put it, "on a corporate level, it does come down to dollars and cents." No clear conclusion could be drawn from the focus group discussions regarding the type of remuneration model that participants felt was best suited to community practice. However, when asked, most staff pharmacists preferred a fee-for-service model, to ensure that they would be paid for all aspects of patient care. Some managers and owners pointed to a capitation model as having the potential to ensure efficient and effective patient care.

Regional managers, store managers and owners were the only stakeholder groups to spontaneously specify dollar values in their recommendations for remuneration. For these groups, it was important that the new remuneration model employ a direct billing process and set adequate fees:

"If you're not paying them at least \$150 dollars an hour, it's not going to be worth [pharmacists'] time; they're [going to] start cutting corners." (owner)

The amounts typically mentioned by management participants exceeded those suggested by staff pharmacists, who, when asked to state a specific value for CDM services, felt that they should be paid enough to cover their current salaries (about \$40 to \$50/hour).

Implementation plan

When discussing the implementation of a new CDM model for community pharmacy, participants identified the need for a clear plan that takes into account the organizational structure of a typical pharmacy and the need for advocacy and support.

In terms of the changes that would be needed in the typical community pharmacy, participants focused on the layout of the store, the computer systems in use and access to documentation software. As part of a successful CDM model, participants identified the need for private consultation spaces to ensure patient-centred care. As one regional man-

ager explained, "pharmacies are really set up for the traditional drug dispensing model. They're not really well set up for those sit-down conversations with patients, over longer periods of time." Participants described this ideal private space as being physically distant from the dispensary, to allow pharmacists to establish their new role as distinct from traditional dispensing functions. This physical separation from the dispensary was also important to participants because a lack of patient awareness has been cited as a barrier to practice advancement.⁴ Some participants even went so far as to suggest setting up private practices, similar to those of physicians, so that they could gain "independence from corporate structures" (staff pharmacist). Given that the implementation of a CDM service model would involve recreating pharmacists' public image, a physical distance between various pharmacy services would help to ensure that patients viewed pharmacists as health care professionals capable of providing a variety of valued health care services.

Focus group participants were also concerned about poor access to patient information and documentation systems. The pharmacists felt that having access to patients' records would allow them to appreciate the entire picture of a patient's health, because they would be able to see the "tests [patients have had] done or see what the latest cholesterol panel looks like" (staff pharmacist). This access would in turn enable them to make better-informed decisions regarding patient care. Having access to documentation systems was also of key importance, because "we have to make sure whatever we say is documented, otherwise [it's as if] we never saw the patient, or didn't do anything" (staff pharmacist). Comments like this one stemmed from pharmacists' contention that although in some instances they were already providing additional services to patients, the lack of documentation meant that their contributions were not recognized.

Obtaining support for the advancement of pharmacy practice was another concern for participants:

"I think the most important thing in the beginning is having a pharmacist who's [going to] do [CDM], a patient who's interested, and a doctor [to support the program]." (staff pharmacist)

Regional managers in particular were concerned with the perceived lack of support from patients: "I don't think the public can even fathom that there is another service that the pharmacist can provide." The same regional manager went on to describe his struggle to grow his business: he found that patients and physicians needed constant reminders about

the services his pharmacy could provide and the value they added to patient care.

While recognizing the importance of support from patients, staff pharmacist participants were also concerned with the impact that provision of CDM services would have on their coworkers. Unlike the regional managers, they emphasized the importance of staff “buy-in” to any CDM program. More specifically, their apprehensions related to who would perform their current duties if they were providing CDM to patients, recognizing that “someone else is going to have to pick that [extra work] up” (staff pharmacist). Thus, each of the various players in community pharmacy practice had slightly different views on where support would be needed if a CDM program were to be created.

All participants expressed interest in implementing CDM into their practices, but the focus groups also brought to light some gaps in communication between staff pharmacists and management. One staff pharmacist stated that while management often verbally supported the idea of implementing CDM in stores, staff pharmacists, from their point of view, were then expected to integrate these new tasks into their already busy workflows without additional support.

This perceived concern over employers’ unrealistic expectations served to complicate the issue of seeking support from stakeholders. Although support from patients and physicians was of great importance to participants, many viewed such support as unobtainable without a more unified vision of the pharmacist’s role in patient care.

Discussion

Over the course of the focus group discussions of CDM services in the community, participating pharmacists described the current practice environment and discussed their thoughts and opinions on how best to develop and implement a new model of care incorporating such services. Participants identified numerous issues of concern, including the need for private counselling spaces, given the current physical layout of community pharmacies; the lack of documentation and information systems; and the need for support from patients, physicians, pharmacists themselves and their coworkers. Participants also sought a sustainable remuneration model to fund pharmacists and their businesses and improved educational opportunities in this practice area.

The advancement of pharmacy practice, the creation of a sustainable CDM program, and integration of a new remuneration model are complex topics that dictate a multifaceted approach to implementation. This complexity was exemplified within

the advocacy and support theme, with staff pharmacists focusing their attention on gaining the support of coworkers, while regional managers directed their attention toward securing interest from patients. This and other examples from the discussions do not necessarily indicate a lack of recognition of other stakeholders’ concerns; rather, they indicate only that the primary focus of each group was different. Keeping this diversity in mind, we summarized participants’ overriding recommendations as follows:

1. Develop a comprehensive practice and business model for the provision of CDM services by pharmacists.
2. Ensure that remuneration is sufficient to encourage uptake and adequate to cover all expenses, including staffing and the creation of “protected” time for pharmacists to dedicate to CDM.
3. Establish and communicate managerial support to pharmacists by addressing issues such as lack of physical space in the pharmacy.
4. Give pharmacists access to information systems, including patients’ medical records and CDM-specific documentation systems.
5. Develop and disseminate pharmacy-specific clinical guidelines for CDM.
6. Increase training for pharmacists in the retrieval and evaluation of clinical information.
7. Market pharmacists’ CDM services to key stakeholders, including patients, physicians, employers and other pharmacists.
8. Create a culture of responsible patient-centred care.

Many pharmacists are already tackling the logistics of how to provide effective patient-centred care. For instance, Willink and Isetts⁵ studied 4 successful and innovative community practices in the United States to determine the characteristics differentiating these practices from their more traditional counterparts. They found that the 4 successful sites had a philosophy of practice that helped in determining the services that would be provided and a

Points clés

- Il existe très peu d'études portant sur le point de vue des pharmaciens concernant la mise en œuvre d'un modèle de prise en charge des maladies chroniques. Plusieurs de ces modèles ne sont pas bien reçus par les pharmaciens parce qu'ils présentent de multiples problèmes, notamment une rémunération insuffisante et des contraintes de temps.
- Les pharmaciens craignent un changement dans l'exercice de la profession à cause des obstacles qu'ils anticipent au moment de la mise en œuvre des nouveaux modèles de pratique. Un grand nombre d'entre eux craignent que ces modèles ne tiennent pas compte de leurs besoins professionnels et d'affaires. Tous les intervenants en pharmacie doivent participer à l'élaboration et à la mise en œuvre du modèle de rémunération.
- Tout modèle de prise en charge des maladies chroniques doit tenir compte des préférences et des besoins de tous les intervenants en pharmacie. Les décideurs doivent considérer ces préférences dans le contexte des modèles antérieurs qui n'ont pas fonctionné.

sense of responsibility for patient therapy and care decisions. The sites also had processes in place that allowed pharmacists to develop relationships with their patients and management systems that took into account the physical environment, documentation, recruitment and remuneration. Furthermore, pharmacists had the opportunity to apply and continually update their clinical knowledge.

In a similar vein, other researchers have tested community-based CDM programs.⁶ Arguably, the most successful program has been the Asheville Project in the United States, through which, over the past decade, pharmacists have improved the delivery of diabetes and asthma care to city employees.⁷⁻⁹ Part of what has made this program unique is its reliance on established and ongoing remuneration for these innovative CDM services, the application of a complete and intensive disease-specific education program and the notable buy-in from patients, employers and pharmacists.⁷ In addition, each of the respective resources and supports were put into place simultaneously, which maximized the chances for success.

Consistent with these previously reported findings from established practices, the participants in our focus groups identified a sense of responsibility for patient care and a need for disease-specific education programs and sustainable remuneration systems. Even so, pharmacists in Alberta and British Columbia have yet to translate this desire into sustainable practice change. To be successful in this effort, pharmacists will require support through modifications to the systems within which they function, to the physical layout of the pharmacy and to the ways in which

they communicate with other health care professionals. In addition, a cornerstone of this model will be realistic remuneration for the services they provide, an aspect that is often inadequate.^{10,11}

As we discussed previously,⁴ one major limitation of this study was restriction of recruitment to a convenience sample of participants. As such, the focus groups may have been more representative of pharmacists interested in change than of the general population of pharmacists. That said, our findings are consistent with those of similar studies in the area of pharmacy practice change,^{12,13} which suggests that our participants were representative of other pharmacists around the world who have been asked to discuss these topics. As well, if these pharmacists had an above-average interest in providing CDM services, as indicated by their willingness to participate in the focus groups, it is likely that their concerns as outlined here are understated, but not qualitatively different from those of the general pharmacist population.

Conclusions

Pharmacists need a new model of care and have a tremendous opportunity to fashion the future of their profession and to improve patient care. Increasing demands on the health care system have created a gap in which pharmacists can demonstrate their potential. Given the need for change in the provision of primary care in Canada, any reluctance to seize this opportunity and effect change will probably result in the obsolescence of pharmacists and their profession. This prospect is significant as the profession seeks to adopt new models of care. ■

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