



INTRODUCTION

The Utah Department of Health is charged with coordinating statewide efforts to prevent heart disease and stroke, as well as reduce risk factors (high blood pressure). Uncontrolled high blood pressure is a concern for patients diagnosed with high blood pressure. The Utah Department of Health (UDOH) goal is to reduce the impact of heart disease and stroke through strategies that target health systems, worksites, and communities.

The UDOH published the 2013 Environmental Scan results, this was the first assessment to identify if health plans and pharmacists in Utah were working on expanding the role of pharmacists in chronic disease management. At that time, many of the pharmacists were already providing medication therapy management (MTMs), patient education, telemonitoring, and pre-visit planning sessions. MTMs consist of medication therapy reviews, pharmacotherapy consults, disease management coach/support, anticoagulation management, immunization, health, wellness, public health, medication safety surveillance, and other clinical services. Pharmacists were interested in providing more clinical services to patients with chronic health conditions. Since then, new opportunities to increase networking and sustainability of pharmacy roles in health care have evolved.

The purpose of the key informant interviews with pharmacists and health plan representatives were to identify facilitators and barriers of the Utah Community Pharmacy Enhanced Services Network (UT CPESN) network development and use of team-based care strategies for the 1422 Centers for Disease Control and Prevention (CDC) grant. The

UT CPESN is a network of pharmacies focusing on enhanced services to help improve the health of patients in Utah. UT CPESN began recruiting pharmacies in 2017. The UDOH Healthy Living through Environment, Policy & Improved Clinical Care (EPICC) program staff conducted the interviews and focus group and intended for program evaluation. This report are findings from the interviews and focus group related to the network development and team based care experiences.

BACKGROUND

Due to rising healthcare costs, healthcare expenditures and utilization is becoming more important. In Utah, cardiovascular disease hospitalizations were significantly more than any other cause.¹ For the US, the highest health expenditure is treating heart disease among women (\$47.3 billion) and men (\$43.6 billion).²

In the US and Utah, cardiovascular disease is the leading cause of death.^{1,4} In Utah, the age-adjusted coronary heart disease rate was lower (68.9 deaths per 100,000 population) compared with the United States rate (98.8 deaths per 100,000 population) in 2014.³ Close to half of all Americans (47%) have one or more risk factors for heart disease: high cholesterol, smoking, and high blood pressure.⁵

A pilot project in 2013 by the Community Care of North Carolina (CCNC) recognized that high-risk patients visited their community pharmacy 35 times per year compared to 3.5 visits to their primary care provider.⁶ Patients with a chronic disease condition are more likely to visit their pharmacists on a regular basis than their primary care provider.

Pharmacists are more accessible more hours of the day than a primary care provider. Pharmacists are experts in medication and since 2003 PharmD is the standard of entry to chronic disease management.⁷ As a result, pharmacists are more able to provide services beyond dispensing medication.

As the field of pharmacy is changing, pharmacists have an important role contributing to the care and management of high risk patients with diabetes and/or hypertension. In this report, the two main pharmacy topics are related to the network and team-based care.

A. CPESN

CPESN USA is national network of pharmacies committed to providing patients' high quality patient care and better patient health outcomes through community-based pharmacies that are interested in expanding medication optimization and patient care services while working collaboratively with a health care team. The CPESN USA convened like-minded community pharmacists to create a network at a local, state, or regional level. The CPESN for Utah is UT CPESN.

UT CPESN benefits are:

- Local ownership by members
- Support to assist with developing meaningful relationships with health care team
- Receive subject matter expertise
- Analyze pharmacy performance from the value purchaser perspective

The Utah Department of Health and Utah Pharmacy Association are partners in development of the UT CPESN. UT CPESN pharmacies deliver enhanced or clinical services as part of a team that includes a pharmacist, provider, and the patient. The network focuses on quality performance of pharmacy services in enhanced services, provision of high quality patient care, collaborations with healthcare providers, and health plans (payers) to improve healthcare utilization. The goal of the network is to improve quality of care and patient outcomes related to medication use, enhance patients' overall health trajectory and reduce total cost of care. As of

June 2017, the network launched and pharmacies across the state were able to begin joining the network. There are 48 pharmacies with a signed UT CPESN participation agreement.

Pharmacies provide the following enhanced services:

1. Adherence Support Services
2. Comprehensive Medication Management
3. Immunizations
4. Medication Synchronization Program
5. Medication Reconciliation
6. Optional Services (home visits, home delivery, adherence packaging, compounding non-sterile, nutritional counseling, care plan development/reinforcement, tobacco cessation services, translation services, targeted disease state programs, transitional care management)

B. TEAM-BASED CARE

Team-based care is defined in many ways to describe a multidisciplinary team approach. The CDC 1422 grant guidelines describes team-based care as team members that process support and shared responsibilities, such as medication management, patient follow-up and self-management support.⁸ The team consist of the patient, patient's primary care provider and other non-physician professionals, such as pharmacists and/or community health workers. Similarly, the *Program Guide for Public Health Partnering with Pharmacists in the Prevention and Control of Chronic Diseases* define team-based care as delivery of health services that include the patient, at least two health providers, and their caregivers to accomplish shared goals and patient-centered care.⁹

METHODS

The key informant interview guide included 10 questions, there were four items related to team-based care experiences and six items related to the network development. The interviews were conducted between June and July 2017. The interviewees were pharmacists who were UT

CPESN or non-UT CPESN members. The interviewers provided a definition of team based care and a one page handout of the CPESN network to prepare the interviewee. The team based care questions focused on challenges and suggestions for including pharmacists in a team-based care approach. The network questions focused on ideas for promoting the network, suggestions to enable the pharmacists to join, suggestions to successfully implement the network, and thoughts about obstacles to successfully implementing the network. The interviews were recorded and lasted between 30 to 60 minutes. The interviewee responses were coded using Dedoose, Word, and Excel.

The total interviewees for the key informant interviewers were nine pharmacists. Six of the nine pharmacists had a participation agreement with UT CPESN participated. Of those, two pharmacists represented a chain pharmacy, two pharmacists represented independent pharmacies, and two pharmacists represented a health plan. Three pharmacists were non-UT CPESN members and represented independent pharmacies.

The focus group was conducted at the June Health Plan Partnership meeting. The focus group participation were representatives from the University of Utah, HealthInsight, Health Choice, Select health, Public Employees Health Plan, Regence, and Molina. Ten focus group participants represented health plans in Utah. The participants were quality improvement specialists and one medical director. The focus group facilitator presented a PowerPoint presentation about the network and definitions of enhanced services then followed by focus group questions.

RESULTS

CPESN UT NETWORK

What is the experience of pharmacists who are involved or not involved with the network?

Five of the nine respondents were a member of the UT CPESN and four respondents were not current members. Most respondents that are members represented larger health systems and retail

pharmacies. Some members of UT CPESN were a member of the five subcommittees and they participated in development of the participation agreements, attended CPESN USA and North Carolina meetings, assisted in development of the Association of State and Territorial Health Officials (ASTHO) project. A majority of respondents involved with the network as a committee member were recruited from other UDOH efforts, such as the diabetes self-management prevention (DSME).

The respondents not involved with the network were mostly independent pharmacies and two of those respondents never heard of the network before. One respondent did hear about the network at the Utah Board of Pharmacy, while another respondent attended one network meeting early on. Three of the respondents were interested in participating in the network. One respondent was already minimally involved, but not a member.

What are some ideas for promoting the network to other pharmacists?

Promote the network through the Utah Pharmacy Association's existing resources. Utah Pharmacy Association (UPhA) is a state association for pharmacists, pharmacy technicians, and pharmacy students practicing in Utah. Most respondents felt UPhA has the capacity to inform members about the network through meetings, listserv, and newsletters. The association holds mid-year and annual meetings for members. At these meetings, the UPhA members can receive information about UT CPESN. Direct promotional materials can be emailed to members in the UPhA member listserv list, such as the UPhA newsletter. Several respondents have presented at the annual meetings to recruit members and increase awareness about the network. Most respondents were members of UPhA. Opportunities for smaller gatherings part of UPhA was recommended by one pharmacist.

“I think we could have informal meeting, let's have an Ogden chapter. I often thought UPhA we ought to have a Ogden, where Weber county, Davis county, to where we could get the smaller groups together on regularly basis,

talk about what needs to be done in pharmacy.”

– Pharmacist

“It is a big deal to have the national presence. I think a pilot project is a great way for us to promote. Someone is going to be able to present this at the public health association, Utah and national.”

–Pharmacist

Reach pharmacists through other coalitions, associations, and licensing entities. Respondents representing independent pharmacies were able to provide information about other ways to reach pharmacists who are not members of the UPhA. One respondent shared that the Utah Coalition of Independent Pharmacies has members across the state (Logan to St. George). Another respondent suggested that members of the Utah Society of Health-System Pharmacists represent pharmacists and technicians from health system, such as Intermountain Healthcare and University of Utah. Licensing entities like the Utah State Board of Pharmacy and Utah Division of Occupational Professional Licensing have the ability to market to pharmacists through their own memberships. Other opportunities are presenting at national associations like the American Pharmacy Association (APhA).

“Utah Board of Pharmacy - But we’ll send that newsletter out to every pharmacy in the state whether they’re a specialty pharmacy, a hospital pharmacy, long-term care pharmacy or a retail pharmacy.”

–Pharmacist

“The board of pharmacy has a newsletter that they used to send out consistently every so often. I don’t remember what the schedule was ... I would encourage using that platform. That goes out to every licensed pharmacist in the state.”

–Pharmacist

Reach pharmacists directly. A few respondents indicated word-of-mouth as an appropriate mechanism to connect to colleagues. As colleagues, they trust each other and can find opportunities to talk at similar meetings they attend. Some respondents suggested using a fax to promote the network by labeling the header “attention to lead pharmacist” and address it from the Utah Pharmacy Association or Utah Department of Health. Pharmacies often receive spam or junk fax that is mostly seen by the technicians. One respondent suggested an approach for drug company representatives to fax an invite for a free dinner.

“We were talking about ... having each of us talk to our colleagues individually. The ones we know, was another idea. I’ve talked to several of my colleagues, my circle of associates who own [a] pharmacy.”

–Pharmacist

What are some challenges for other pharmacies to joining the network?

“Every pharmacist will put up their own road block. For me I think it’s more about how do we break down those roadblocks, how do we make it work, and I think. As I look at this plan, to me I think it works very feasible, I think it makes sense. I’m that guy that preaches patient outcomes and patient compliance all day every day and so, the guy that’s doesn’t see that.”

– Pharmacist

Adequate payment for enhanced services. A few respondents indicated that pharmacists are able to provide enhanced services to some extent, but are not compensated for it.

“So that will be a big hurdle if they will do extra things, and take extra time, and extra resources out of their pharmacy. That will cost their pharmacy money, and so it going come to their bottom line which is very small and very tight, no one wants to do it for free.”

–Pharmacist

“So, in order to be in compliant inside the network. They will have to spend time and resources to become compliant to participate in the network. But, most of those things are already doing, other networks are already established so that part will be easy, but there will be a few things that each pharmacy has to do to be inside this network.”

– Pharmacist

“He says MTMs I heard ... one guy told me, he read a study where MTMs, for the insurance company for every dollar they spend, they get \$9 dollars back. Well, do you want to know what his first response is, his first response was, give me \$3. If you get \$9, why don't I get \$3. Where [is] that balance, I think this is kind of the challenge.”

–Pharmacist

a patient over, oh I don't have time for that.”

–Pharmacist

“Being able to communicate back to the provider, working collaboratively with not only the doctor, working with nurse or in the case of diabetes, nutritionist. That's where you are going to find community pharmacy is the challenge, so where is the money? The money is not in clinical services, most of time we are not paid for it, that's a challenge.”

–Pharmacist

“Ensuring that the standards and the expectations that a patient has are consistently met regardless of which pharmacy they go to. Otherwise, if we have a lot of variation between those core services then they start to have no meaning when I tell a patient you can have this particular service and it works a lot differently than they expected then that become useless to have to separate yourself.”

–Pharmacist

Extra time and resources to meet requirements and to ensure quality of care.

Four respondents felt that any additional services required by the network will take additional time and resources beyond counting pills, for example, the pharmacies may put more time to be compliant with network requirements. Some respondents felt that pharmacies without the infrastructure, such as mom and pop shops will not have equipment to provide medication synchronization using a med sync application. Some pharmacies may need to hire additional staff if the volume of scripts need to be maintained. As well pharmacies without a space to interact patients will need to build a space. Other examples of additional resources is development of a medical record system, creating a mechanism to provide and bill for immunization services, time to write protocols, additional training (e.g., appointment-based model) since some pharmacists are unaware of the workload due to inexperience.

“We realized time is the biggest concern for the pharmacies, I don't have time for that. I will tell you that you are going to get pharmacies that say, check check check, we do all that, sign up. And then, the provider sends

Data system and management. Two respondents stated that integration of data with external systems may not be feasible due to compatibility or administration concerns. Pharmacies in corporate status may find it more difficult than independent pharmacies to approve decisions about data sharing and integration/exchange. One respondent indicated that seasoned pharmacists who prefer manual documentation of services may have less buy-in using other forms of technology to document services.

What are some suggestions for enabling pharmacies to join the network?

Increase representation from small to large pharmacies across the state. Four respondents stated several ways to reach pharmacies. One respondent felt a champion team of independent, grocery pharmacy, and corner store pharmacy would speak to their partners to get buy-in. One respondent suggested that a personal invitation to

talk about the network is one method, but for those with busy pharmacies just getting in contact with the pharmacy manager will be important. But for independent pharmacies, make sure the owner is contacted instead of the pharmacy manager. To reach most pharmacies, sales representatives from wholesale channels already have good relationships with pharmacies and can be a source of distribution of information (e.g., McKesson, Cardinal, AmerisourceBergen). One respondent indicated there is no one communication method to reach most pharmacies in Utah.

Provide evidence that the network is working and with payer support. Three respondents focused on payer relationships and ways to provide evidence to support recruitment. One way to enable pharmacies is to engage payers early-on to demonstrate support that pharmacies will be compensated in the future. One other respondent indicated that the network should provide documentation of progress as sort of educating potential pharmacies in joining the network. As well, one respondent indicated that any patient experience should be consistent across CPESN providers and have sustainable services for payer relationships.

“You need to find a payer to buy-off on, it’s a small one, whether it’s EMI, whether it’s PEHP, somewhere we are going to start and have success.”

–Pharmacist

“The other thing is going to be able to demonstrate. So, getting the data from all the different pharmacies and being able to, getting it is going to be a challenge, but then synthesize it and for it to share it.”

–Pharmacist

Describe expectation of enhanced services. Not all pharmacies are alike, some pharmacies may not have done some of the enhanced services and will require support in drafting a collaborative agreement or conducting medication adherence suggested one respondent. Another respondent stated that the network should offer options for

enhanced services and to be clear about expectations, as well as offering alternatives to documentation of data (paper versus software med sync program) for mom and pop shops.

What suggestions do you have for effectively implementing the network in Utah?

Several of the respondents felt that the logistics of launching the network is important, supporting pharmacists, payer engagement and media presence.

Focus logistics of launching the network. Conduct constructive meetings that deal with issues immediately, development of an appropriate timeline for pharmacies to join the network rather than the two weeks, and offering consistent communications from the central group and the board of directors to member pharmacies.

“... an average text is answered within 10 seconds. The average email I answered in 3 days. So the mode on how you get that information to people and the speed at which you get that to people can make a big difference.”

–Pharmacist

Support pharmacist’s role in the network services. One respondent felt that the network may want to support pharmacists in expanding their services through additional trainings, such as MTMs, immunizations. One respondent stated that pharmacists should become recognized health professionals for billing purposes. In Utah, pharmacists are not recognized as health care providers, so they cannot bill services. In Washington there is a law for pharmacists that are considered health professionals and are able to charge for services to commercial payers. In addition, one other respondent stated that pharmacists who want to or volunteer should be part of the recruitment and as a result, they may even see an increase in patients. As well, targeting remote pharmacies in small communities through media may increase reach to those areas.

“Down the road, I think you will see more pharmacies, I think I want to be part of, as they see the success of the network.” – Pharmacist

“The federal government doesn’t recognize pharmacists as healthcare providers, so we have no ability to bill on our own.” –Pharmacist

Marketing for buy-in continuously. One respondent felt that marketing should focus on third-party payers to create a payment model. This means getting payer engagement before the momentum fizzles stated one respondent. One respondent felt that a continuation of proving the model is effective and are sought by many stakeholders (e.g., payers, pharmacists). As an example, the Asheville project In North Carolina has provided some evidence and publications in the Journal of American Pharmacy Association.

“Look if you are willing to pay us a little more than 50 cents to give somebody their pills. If you are willing to pay more, we can maybe help keep those patients out of the hospital. I think that concepts needs to be marketed. So marketing has to be a part of it.” –Pharmacist

“Pharmacists [want] to see proof there is something in it for them – that there is this path to compensation.” –Pharmacist

What do you think could be the greatest obstacles to implementing a successful network?

Several of the respondents indicated that payer relationships and the changing profession with expectations of the network services could be the greatest obstacles. Two respondents indicated other obstacles are money to sustain the network and

specific logistics in launching the network (e.g., data management, ecare plans).

Changing profession and expectation of network. For example, pharmacies are currently paid to fill prescriptions and mail order options are provided by payers that could replace the pharmacist's role at some point. So, it's important for pharmacists who have worked with the pharmacy industry for years to see the value of raising their level of practice to include enhanced services. Pharmacies part of the network will need to provide a high level of service, so consistency of services are delivered across pharmacies to ensure comparable patient experiences.

“We get feedback from some our pharmacies, I don’t see the value in doing this, I get paid from the prescription. I don’t get paid for ... again, it rolls down to payment, there is no financial incentive.” –Pharmacist

“We are trying to work with some of our pharmacies to enhance their technology and some of them are like we don’t need it. We just want to fill pills.” –Pharmacist

Payer relationships and demonstrate success. Two respondents suggested developing relationships with payers right away for the network to demonstrate progress, such as screening costs at pharmacies are cheaper than at hospitals and can result in overall savings.

“Because a lot of the programs we do are not measured, we don’t see the outcomes, it’s hard to see the measurement. But if it’s monitored by the network, this network will give us a report, a report and show us what we are doing. Then we can go back to the payer and say look we saved you \$40,000 this year.” –Pharmacist

“... everything there’s some value there, but a \$2 value and a \$20 value are two different things.” –Pharmacist

“I think the health plans will buy in... People change insurance so much that do I really care about how your health is today because I’m not going to pay for you when you have the heart attack.”

–Pharmacist

TEAM-BASED CARE

Team-based care is defined as using a team approach, made up of a primary care provider and another non-physician team member, including a nurse, pharmacists, dietitian, or community health provider, to collaboratively support a patient in the management of chronic diseases. This may include medication management, patient-follow-up, medication adherence, and self-management support. The team-based care experiences of respondents varied from current experience or no experience to previous experience. Each experience is described below.

CURRENT TEAM-BASED CARE EXPERIENCE

Respondents with current experiences in team-based care, stated experiences of specific team-based care strategies, data and information technology, relationships between team-based care members, services provided, patient outcomes, and primary care provider buy-in.

Use of varying team-based care strategies.

Current use of team-based strategies vary across clinical and community pharmacy locations. One respondent indicated that he/she is situated in a clinic focused on diabetes care using team-based strategies that includes a pharmacist, social worker, and care manager. While this is an ideal structure for diabetes patients to interact with more than one health professional, the respondent feels confident that national examples of team-based care in North Carolina and Virginia are becoming more common for pharmacists to contract with physicians one-on-one. Another respondent overseeing multiple community pharmacies stated that one community pharmacy located in an urban area was able to intake referrals from a physician residing in a rural community 1.5 hours away. The physician referred diabetes patients to a diabetes self-management

education (DSME) program in place of a diabetes educator who recently left the physician office.

“I lead a team of pharmacists that support primary care physicians and their clinics as part of a multi-disciplinary team. Their involvement is primarily about medication management, ensuring patients are taking care of or understand their medications, understand how to take them, how to access them.”

–Pharmacist

“I practice in a clinic ... now our team is a social worker, nurse, a care manager, CNA, the physician, pharmacists and that is fairly common in almost all our community clinics at this point and that’s been more than a formal role where we do collaborate and bounce ideas off each other.”

–Pharmacist

Buy-in across team-based care members. The buy-in of the pharmacists, physicians, and patients is crucial in understanding a successful financial structure. One independent pharmacy understands the financial buy-in for pharmacies could take time, although, one respondent not currently involved with the network indicated that a medication therapy management (MTM) model regarding payment structure could work for the network. Whereas, one community pharmacy was able to have primary care provider and patient buy-in to support self-pay patients for DSME services.

“I think, the goal is for us to move in the right direction, but the current state ... from what I understand and what I’ve observed. The community pharmacists, I like to use the word community versus retail because we serve the community. I don’t know if the prescribers yet view the community setting as being a provider, so I think that a culture shift that needs to happen. Whereas in the inpatient setting, the pharmacists are already inserted in the team. We just need to get to that point.”

–Pharmacist

Access to patient records is dependent on setting.

Use of health information technology between pharmacists and physicians is necessary in tracking patient progress. Two respondents were not able to access electronic health records (EHRs) and one of respondents received forms of clinic visit summaries from patients that gradually declined overtime. The purpose of the clinic visit summaries were to reinforce patient-primary care provider treatment discussion. One of the respondents with no EHRs access uses Enterprise RX to track patient medication and progress internally, but it's not linked to personal records. Another respondent located within a clinic is able to access patient data and address cost benefit analysis by collecting measurements of clinical, clinical flow, financial, and healthcare utilization.

Positive patient outcomes. Several respondents indicated that medication management, collaboration with physicians, or a supportive environment resulted in improvement in adherence, compliance, and better patient outcomes. One respondent was able to identify a process to flag patients who are high risk patients within their computer database and then provide further patient education at the same visit.

“The patient’s the winner when you have team-based care because everybody talks to each other you have collaborative practice between everybody and the patient ends up with better health, as long as they follow your advice, which sometimes is difficult.”

–Pharmacist

Services provided. Future enhanced services should be based on patient needs were stated by two respondents. One respondent provided compliance packaging for patients with multiple prescriptions, since physicians refer patients and is interested in discharge counseling once the new pharmacy opens next to a larger health system. One other respondent stated that once the team-based care effort diminished, the pharmacists were able to continue patient education services for some patients.

Relationships. All respondents indicated collaborative relationships exist in their team-based care approaches. Two respondents from health systems were able to function as a multi-disciplinary team and apply team-based care since their office was embedded in a clinic. One of respondents indicated use of future work on pharmacy-to-pharmacy collaborations in the community setting. Respondents in a community setting expressed additional obstacles to team-based care, such as getting everyone on board with the team-based care, approaching primary care providers near clinics to establish relationships as directed by the UPhA president, pharmacists are not recognized as a health care provider by law, and communication between pharmacist and the primary care provider. However, some respondents in the community setting had a collaborative relationship that supported pharmacist decision making of therapy changes and in intake referrals by the primary care provider. One respondent indicated use of the agreements in the future, while one respondent does not currently use collaborative agreements.

“Being a small town pharmacy as we are, feels like we have been involved in team-based care from the very first day because the community physicians rely on us a lot to advise and collaborate with the patients and do follow-up whether it's chronic condition whether it's acute condition...”

–Pharmacist

“Getting everybody onboard is number one. I think getting the physicians to understand that we are not trying to make life miserable. That we are actually trying to increase the care... there’s one we are dealing with ... 29 meds taking every single one ... we compliance package her... and now all of a sudden, guess what, month into it we feel better. This doctor called me the other day, “I appreciate what you have done for her. I have struggled with her for years.””

–Pharmacist

NO TEAM-BASED CARE EXPERIENCE

One respondent indicated not having current experience in team-based care. The respondent suggested the physicians in the community were interested in team-based care and for pharmacists to bill for services; however, physicians were not able to attain office space for the pharmacy. The respondent felt pharmacists are not recognized as health care providers and would have to continue using the traditional model for pharmacy, which is billing for product and not services. Although, the respondent is able to provide diabetes self-management prevention programs and at times updated physicians on new guidelines. The respondent also worked with physicians to assist patients who can't afford A1C tests and were able to provide feedback of the results to the physicians.

“Our existing providers have had multiple invitations to go out and put pharmacies in at the medical clinics here in town, but we’ve always run into some challenges primarily around billing for anything but product. And so the model has always had to be you keep a pharmacy billing for product and the team-based care was extra on the side.”

–Pharmacist

PREVIOUS TEAM-BASED CARE EXPERIENCE

Pharmacists felt valued and were part of team when they were in a clinic or Indian Health Service setting. Four respondents had previous team-based care experience. Two respondents indicated previous experience in a clinic setting as a pharmacist, not as a current administrator. The two respondents were part of a team that consisted of clinical staff that worked on anticoagulation and smoking cessation, while one of the respondent collaborated with asthma care and outpatient clinics alongside primary care providers. These respondents felt they were part of a team and were valued. Whereas, two other respondents started their pharmacy experience in Indian Health Service, an entity that provides health services to American Indian and Alaska Natives. The respondents who worked for Indian Health Service felt like they were part of a team with other clinical and support staff,

thus, provided more direct patient care within their line of profession.

“My residency training after I was done with school was in Indian Health Service facility and in that environment, it is very much about that getting things done regardless of what your role is so again. So, that same idea of working together with nurses, physicians, physical therapy was a part of a team.”

–Pharmacist

What are some challenges you have encountered with team-based care?

Additional challenges stated by respondents include timely communication, ability to bill for services, and adapting to cultural change in using the team-based care approach by pharmacists. Four respondents with community pharmacies mentioned communication as a challenge in team-based care, especially the speed of communication between the primary care provider and pharmacists. One respondent indicated communication between the primary care provider and insurance regarding coverage and up-to-date prescription scripts. Three respondents stated pharmacists are not able to bill for services, thus, some felt that team-based care is considered extra services and is not reimbursed for. Some pharmacists indicated that working with seasoned or older pharmacists using only the traditional model (prescription fills only) is a challenge in team-based care. Other challenges was trust between pharmacists and primary care providers, certain pharmacists not sharing patient information, pharmacists with limited access to patient profiles, and pharmacists not trained in documentation of clinical interactions.

“...we’ve tried to develop this team-based approach with the local clinic where we’ve discussed multiple times, is how to access patient profiles, how to gain access to their electronic data. Most of the EHRs there is liability involved with a physician’s office allowing us to access theirs and ... access offsite.”

–Pharmacist

“Access to communication and exchange of medication information is slow. Communication and exchange of healthcare information is a big challenge for us.”

–Pharmacist

“One interesting finding kind of may be related to trust, but its knowledge for sure on the physician's part. So they understood that we have PharmD degrees, which is a clinical degree, a doctorate degree ... but when it came to do I trust a pharmacist with in their clinical decision making that was a lower score so that just surprised us.”

–Pharmacist

“... one of the biggest one is breaking tradition, like if the setting tradition has not been team focused and a lot of providers are older. Getting people to change what they are doing, change their way of thinking is a big barrier, obstacle. It's the biggest one I've seen.”

–Pharmacist

What suggestions do you have for effectively including pharmacies in this team approach?

A few pharmacists indicated pharmacists need to be inspired to see the value of the team-based care approach and having pharmacists take ownership of the success. Two respondents indicated reimbursement methods to compensate for pharmacists services outside the traditional role of filling prescriptions. Several respondents stated having a centralized data system (i.e., CHIE), access to electronic medical records, and possibly using health plan data to measure better outcomes. One respondent indicated that personal health information could be an issue when working in a team-based care setting. A few respondents supported education to primary care providers and pharmacists about team-based care – to ensure teams are trained. One respondent felt that evidence of network success will earn the trust of primary care providers. Lastly some indicated that having a communication method for pharmacists and

primary care providers that are not located in the same clinic is important.

“... to somehow to get the pharmacists to feel some ownership of success. Like making them feel like they are part of the making it successful instead of being a naysayer.”

–Pharmacist

“I think this is a great first step moving in that direction for one, helping the organization's that have community pharmacy see the value in taking care of patients, this is a big deal. ... They don't [pharmacists] realize that their education and frequent interaction with patients is extremely valuable to healthcare and the wellbeing of the patient.”

–Pharmacist

“Most often that's a comfortability and understanding, if you don't understand something sufficiently you are scared to try you are scared to see how it is going to fit with your current workflow, you don't know enough about to be able to make an informed decision. So, that most often is a matter of education, a matter of giving a really good marketing message. That's something that maybe the Department can help ...”

–Pharmacist

“Proactive. We got to be proactive. On the outside of the health system, when we are in private practice. We need to be proactive on our side and reach out to the physician and help them manage the patient with the tools and expertise and flexibility that we have on our side ... simple because we are touching and seeing the patient several times a week...”

–Pharmacist

“EHR access would be key. We've got to have a way to see more data. Now since electronic prescriptions have become more proliferative.”

–Pharmacist

HEALTH PLANS

What are your initial thoughts about the network?

The initial thoughts of health plan representative's after the presentation was funding to support the initiative. The next thought was a reporting system that is aligned with HEDIS measures or other measures. The reporting system would need to identify gaps for health plans to address improvements. As well, a better understanding if pharmacies have sufficient capacity to provide additional services by pharmacists and other paraprofessionals like a pharmacy technician.

"... for me to present something like this to my management team, they would want to have some of that data because they would want to know what the return on investment is going to be and if it's going to be valuable to invest in that money. Are we going to see some quality results or return on that?"

–Pharmacist

What suggestions do you have for successfully engaging health plans to the network?

Health plan representatives indicated that the network would have to show outcomes that close gaps in care, reduce emergency room costs, and other outcomes that is supported by data. The ease of data exchange to the health plan would reduce extra work. One representative stated that if the network can show value to the process that more people would be more willing to say yes.

"I have a question about duplicate of services as part of the case management team ... we do a lot of what you are describing already from the complex management team.... I'm thinking one part of this would be the pharmacists to talk to the case managers and say ..."

–Health Plan QI

What challenges do you foresee your health plan and/or other health plans to engaging with the network?

The health plans are interested in the network providing more evidence or results about cost related outcomes. One health plan representative stated that certain rural patients will not be reached due to limited network availability. Other challenges were data, return on investment outcomes, crossover data, reduced gaps, as well member communication and provider education about the network. One health plan representative felt she/he did not have enough information to provide input about the challenges going forward.

"I think that if you reduce ER visits by 0.5% that's not really going to make a difference, but if you can show a reduction of 5-7% then all of a sudden it starts making sense to spend."

–Health Plan QI

"Member communication, things to give the members, which is a barrier in some cases. Medicare members, everything has to be approved."

–Health Plan QI

What could be the role of health plans within the network?

One role is to educate providers about the network after the data and return on investment information is obtained; therefore, engaging providers will not be hard. Another role is to save costs.

Pharmacists providing direct patient care, what do you think about it?

Health plan representatives stated that pharmacists do not have enough time to provide services and access to patient information to provide patient care. Others felt it's a burden on the pharmacists to be taking over some of the primary care responsibilities and realm of patient care, thus leading to trust issues and some services may infringe on the role of the primary care provider. In

addition, one respondent indicated if the \$30 per month is sufficient for patients that may require more care, such as those with chronic health conditions.

“... a lot of these people, sure they want to trust their pharmacists, do they trust them as much as their primary care provider?”

–Health Plan QI

Do you think pharmacists using enhanced services can improve patient outcomes related to chronic conditions?

Some did agree that pharmacists can improve patient outcomes because patients see their pharmacists more than their doctors.

REFERENCES

1. Utah Heart Disease and Stroke Prevention Program. *The Impact of Heart Disease and Stroke in Utah*. Salt Lake City, UT: Utah Department of Health 2012.
2. Soni AN. Top 10 Most Costly Conditions among Men and Women, 2008: Estimates for the U.S. Civilian Noninstitutionalized Adult Population, Age 18 and Older. Statistical Brief #331. Rockville, MD: Agency for Healthcare Research and Quality; 2011. Available from: http://www.meps.ahrq.gov/mepsweb/data_files/publications/st331/stat331.shtml
3. Utah Department of Health. *Complete Health Indicator Report of Coronary Heart Disease (CHD) Deaths*. Available from: https://ibis.health.utah.gov/indicator/complete_profile/HrtDisDth.html [Accessed 8th December 2017].
4. National Center for Health Statistics. *Health, United States, 2016: With Chartbook on Long-term Trends in Health*. Hyattsville, MD; 2017.
5. Fryar CD, Chen T, Li X. Prevalence of Uncontrolled Risk Factors for Cardiovascular Disease: United States, 1999–2010. NCHS Data Brief, No. 103. Hyattsville, MD: National Center for Health Statistics; 2012.
6. Community Pharmacy Enhanced Services Network. *A Leader in the Value-Based Pharmacy Movement – Part One* [Internet]. Community Pharmacy Enhanced Services Network; n.d. [cited 2107 Dec 7]. Available from: <https://www.cpesn.com/newsroom/new-news-item/>
7. Roark, T. *Utah Community Pharmacy Enhanced Services Network*. [Lecture] Tooele. November 2016.
8. Centers for Disease Control and Prevention, *Cooperative Agreement DP14-1422 Performance Measure Profiles Draft v.4*. Centers for Disease Control and Prevention. Draft v.4, 2015.
9. Morrison CM, Glover D, Gilchirst SM, Casey MO, Lanza A, et al. *A Program Guide for Public Health Partnering with Pharmacists in the Prevention and Control of Chronic Diseases*. Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. 2012.



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