COMPLETED GRANT SYNOPSIS

Integrating Community Pharmacists into Team-Based Care

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Objectives	
The overall goal of this research project was to gain a deeper understanding of collaborative working relationships between pharmacists and other members of the interprofessional care team working in different practice settings. The following specific aims are supported by this goal: 1. To explore successful collaborative practices between community pharmacists in an enhanced services network and other members of the interprofessional care team. 2. To synthesize the data gathered from the focus groups into a resource that will help community pharmacists establish relationships and coordinate care with other health care providers as part of an interprofessional care team.	
Methods	
Design	• This qualitative project was conducted in three stages. The first stage consisted of identifying community pharmacists with a collaborative working relationship with another member of the interprofessional care team (i.e., prescribers or care manager). Community pharmacists who participate in the North Carolina Community (NC-CPESN) were recruited for participation. The NC-CPESN aims to incorporate community pharmacists into team-based care by promoting direct and cohesive working relationships with primary care clinics to provide medication management and other enhanced services. • The second step consisted of conducting focus groups with community pharmacists, prescribers, and care managers who work together as a team to provide patient care. Focus group questions were developed using the theory of social interdependence. This theory is based on five variables: ○ **Positive interdependence** – exists when there is a positive correlation among individuals' goal attainments; individuals perceive that they can attain their goals if and only if the other individuals with whom they are cooperatively linked attain their goals ○ **Individual accountability and personal responsibility** – feelings of responsibility and accountability for (a) completing one's share of the work and (b) facilitating the work of other team members ○ **Promotive interaction** – characterized by individuals engaging in such actions as providing each other with efficient and effective help and assistance and exchanging needed resources such as information and materials ○ **Appropriate use of social skills** – promoting the success of other team members requires participants to have the interpersonal and small group skills needed for high-quality cooperation as well as be motivated to use them ○ **Group processing** – periodically reflecting on how well the team is functioning and how they might improve their work process. • The third stage consisted of conducting a thematic analysis of the transcripts from the focus groups to categorize common themes for relationship development and structure of the team. • The study protocol and consent forms were reviewed and approved by the University of North Carolina at Chapel Hill IRB.
Study endpoints	1. Perceiving that they can meet patient care goals if and only if they work together as a team to provide patient care (positive interdependence) 2. Holding themselves accountable and personally responsible for completing their share of the work 3. Providing each other with efficient and effective help and assistance and exchanging needed resources

	(promotive interaction) 4. Utilizing appropriate social skills such as effective communication, trust, support and conflict resolution 5. Clarifying and improving the effectiveness with which the team provides patient care (group processing) 6. Internal and external barriers to providing team-based patient care

Results

A comprehensive publication is in preparation with co-investigators from the UNC Eshelman School of Pharmacy, University of North Carolina at Chapel Hill. Quantitative results from this study were used to develop an online, interactive resource for pharmacists to learn how to utilize these variables into building and maintaining relationships with other health care providers.

The study sample (*n*= 30) consisted of 16 community pharmacists, 9 prescribers, 5 care managers.

Positive interdependence

Participants from all disciplines described the need to have a face-to-face meeting with other members of the care team to determine shared goals. During this meeting, all team members should share goals and identify services the community pharmacy can offer to help achieve these goals.

Prescribers and care managers felt that having the community pharmacist educate a patient on his or her medications tremendously helped them when they would work with the patient. This allowed prescribers and care managers to reinforce the pharmacist's medication education each time they saw the patient. Prescribers and care managers also believed that community pharmacist providing adherence packaging helped patients improve their adherence to chronic medications.

"You do have your own goal that's in your capacity and what is this you're trying to do. I guess in everybody's case it always depends upon somebody else. I can't do my job effectively if my care team doesn't do their job effectively. We always kind of lean into each other.." – Prescriber

"It really helps us to talk to that doctor and say, 'What is your A1c goal for this patient?' and then we are able to meet with the patients one-on-one to really focus on their adherence and lifestyle modifications to help them reach their goal. So it is just basically an extension of what the doctor provides as far as goal setting. It's more like a health coaching kind of thing." – Community Pharmacist

Individual accountability and personal responsibly

Community pharmacists believed that they were personally responsible for a patient's medication regimen. Prescribers and care managers felt that they had more time to take care of other non-medication related issues when they worked with the community pharmacist to manage the patient's medication regimen. Participants of all disciplines agreed that patients should play an active role as a member of the care team. This can be encouraged by letting patients know who the members of the care team are and how they work together to improve the patient's health.

"I just think everybody has to understand what their role is and be open to having a multidisciplinary team and being okay with missing things and making mistakes every once in a while. We all do." – Prescriber

"They [prescribers] know that we've already done the med part, but there are things that we cannot do, so I think it is knowing your role. And our role is medication, and sometimes there are living conditions that may or may not affect medication. So, we need to have our own separate roles, but then at the same time we need to recognize where they overlap, and to me that is the other piece that's huge." – Community Pharmacist

Promotive interaction

Prescribers and care managers felt that they were able to fill in the gaps when the community pharmacist shared

medication fill history and adherence information. Community pharmacists believed that when they received discharge summaries, medication changes, and lab values they were able to provide better patient care. Participants agreed that team members should work together to determine the resources needed as the resources might be different depending on the patient, setting or situation.

"We had a patient who was a poorly controlled diabetic. I kept augmenting insulin, and it didn't really matter what I did because nothing was working. It turns out he wasn't filling his diabetes medication except for when it was time for an office visit. He would fill them then so he could bring in his pill bottles and show me that he had his medication. The community pharmacy had access to his billing record, of course, so when I talked to them, we demystified a lot of things." - Prescriber

Appropriate use of social skills

Participants of all disciplines agreed that trust and effective communication was necessary for a collaborative working relationship. Participants did not unanimously agree on a specific approach to sharing information. Some used faxing and phone calls while others used secure messaging in an electronic health record. Prescribers encouraged community pharmacists to seek the best approach to sharing medical information. They also believed it was important to determine a point of contact at the prescriber's office. Some prescribers stated they were the point of contact for the community pharmacist while others stated that their nurse served in that capacity.

"Each practice that you deal with has a preference for how they like to communicate, so it's helpful to talk to them and find out what they like. That way they won't wind up with 10,000 faxes on their desk that they don't have time to read." – Community Pharmacist

Group processing

All participants reported that they monitored the impact of providing team-based patient care. Participants monitored impact through assessing medication adherence improvement, clinical outcomes (i.e., blood pressure, A1c), patient satisfaction surveys, and patient medication knowledge.

"We look at certain labs, such as hemoglobin A1c, to see if they are meeting their goal. We will share our success stories with the physicians and nurses at the practice we collaborate with to let them know what we accomplished in a certain period of time." – Community Pharmacist

Conclusion

Incorporation of community pharmacists into team-based care has the potential to improve patient care and outcomes. Results from this study will help inform community pharmacists how to build and maintain working relationships with other members of the interprofessional healthcare team.