

**Report on the Wisconsin Medicaid Pharmaceutical Care Program:
Multiple-Case Study of 8 Pharmacy Provider Participants**

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INTRODUCTION

Since 1996, Wisconsin pharmacies have had the opportunity to be reimbursed for providing cognitive services to Wisconsin Medicaid fee-for-service recipients under the Wisconsin Medicaid Pharmaceutical Care Program (WMPCP).¹ Since this time, relatively few pharmacies in the state have participated. As of 2003, about 80% of claims have been paid out to 10% of pharmacies², suggesting this small percentage of pharmacies has adopted this new “innovation” into their practice sites.

This investigation is guided by principles of diffusion of innovation theory which are used to frame the study. The WMPCP functions as an innovation in that it is a new and novel opportunity for pharmacy practice. By definition it is the perceived newness that determines its status as an innovation, and its newness requires a decision to adopt (or not).³ Diffusion is the process whereby innovations are communicated over time through various channels to individuals in the same social group—in this case, Wisconsin pharmacists.³ WMPCP has been diffusing to Wisconsin pharmacists since 1996 at varying rates. The intent has been that pharmacists would adopt the innovation into their own pharmacy practice and thus, bill Wisconsin Medicaid for cognitive services to “regain” lost revenue (resulting from the negotiated lower dispensing fee¹).

Participating in WMPCP involves change; it has new documentation requirements, a new process for submitting claims where claims had not been submitted prior, and potentially different resource use in the pharmacy workplace. For some, participation may mean providing more advanced care with reimbursement available. Diffusion of innovation theory was chosen above other theoretical frameworks because it provides a helpful means to understand the process of change. The theory delineates a staged process of innovation as well as characteristics of innovations that assist to explain varying adoption rates. The stages of the innovation process begin with setting the agenda wherein the need for participation is identified. The process moves on to planning change or “matching” in which the innovation is fit into the organization to fulfill the need. Redefining or restructuring means both the innovation and organization undergo some modification which is followed by clarification in which the meaning of the innovation is developed through use and discussion of it among staff and management. Routinization is the last stage wherein the innovation becomes an interwoven part of the organization’s activities. These 5 stages guide the analysis to help answer the question of how WMPCP participation was adopted or not by the case pharmacies.

Characteristics of the innovation that influence adoption are an innovation’s relative advantage, compatibility with existing practices, complexity of use, trialability and observability. The five innovation characteristics applied to this study are:

¹ A thorough description of this program was provided in the March 31, 2005 report to the Community Pharmacy Foundation authored by Mott, Kreling, Hermansen-Kobulnicky and Chou.

² Mott DA, Kreling DH, Hermansen-Kobulnicky C, Chou CH. Report on the Wisconsin Medicaid Pharmaceutical Care Program: Pharmacy Provider Participation and Pharmaceutical Care Claims. August 3, 2004. Funded by the Community Pharmacy Foundation.

³ Rogers EM. Diffusion of Innovations, 4th edition. Free Press: New York, 1995.

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- Relative Advantage - The extent to which WMPCP is seen as better than not recovering any lost money from dispensed prescriptions to Medicaid recipients (*because of the negotiated reimbursement for dispensing rate of \$.50 less per prescription*). This also includes the extent to which participation is seen as better than solely dispensing without additional cognitive services or providing these services without payment from Wisconsin Medicaid, and thus most likely, free of charge.
 - Compatibility – The extent to which WMPCP is seen as consistent with the present needs, values and past experiences of the pharmacies (as potential organizational adopters)
 - Complexity – The extent to which WMPCP is perceived as being difficult to participate in and to fully comprehend.
 - Trialability – How easily a pharmacy can experiment with WMPCP participation on a limited basis.
 - Observability – The extent to which participation in WMPCP and its successes are able to be seen by other potential participants.

According to theory, adoption of an innovation is more likely if potential adopters view it as being less complex and as having greater relative advantage, compatibility, trialability and observability. These characteristics also inform the analysis to help answer the questions of how and why pharmacies successfully have adopted the innovation while others have not.

STUDY AIMS

The primary aim of this study was to investigate how and why pharmacies have succeeded in participating in this program, and why others have not. Embedded is the examination of how characteristics of each pharmacy, the innovation and outside influences have both facilitated and inhibited the process of adopting (participating in) WMPCP. In addition to this report, preliminary findings from this multiple case study informed the variable choice for the related mail survey investigation of participants and non-participants.⁴

METHODS

Design

The method chosen for this investigation is a multiple-case study. A multiple-case study provides opportunity for in-depth case and cross-case analysis (comparisons on a case level). This is advantageous due to the relatively small number of pharmacies that have participated beyond the trial stage (n~84). This method is especially appropriate to use when causality is the focus, as it is in this explanatory study where “how” and “why” are asked.⁵ Another major advantage of this approach is its ability to account for the time element of diffusion theory more so than a typical cross-sectional method (e.g., mail survey), allowing for consideration of the

⁴ Mott DA, Kreling DH, Hermansen-Kobulnicky C, Chou CH. Report on the Wisconsin Medicaid Pharmaceutical Care Program: Pharmacy Provider Participation and Pharmaceutical Care Claims. August 3, 2004. Funded by the Community Pharmacy Foundation.

⁵ Yin RK. Case Study Research Design and Methods, 2nd edition, Applied Social Research Methods Series, Volume 5, Sage Publications: Thousand Oaks, 1994.

changes that occurred in the pharmacies over the six-year existence of WMPCP as of the time of the study.

Guided, semi-structured interviews were used together with structured self-administered questionnaire and claims data. Together, these provide three sources of evidence used for data triangulation; they provide a rich data set to inform the conclusions about the underlying reasons of why and how pharmacies did or did not adopt the WMPCP innovation.

Sampling

Diffusion of innovation theory informed sampling. The sampling frame was a list of WMPCP participants as of March 2003 provided by the Wisconsin Department of Health and Family Services. Pharmacies were chosen as a judgment sample based on the frequency and timing of claims submissions. For the purposes of sampling, innovation adoption was defined to be steady and/or increasing participation rates over the last two or more years. Eight pharmacies were sampled in total.

Three types of pharmacy participators were sampled based on claims data available to the research team. Purposefully represented in the sample were those pharmacies wherein it appears the innovation has been adopted, tried but decidedly not adopted ("rejected") and tried but not yet adopted. Pharmacies in this judgment sample also were chosen to represent various setting types. Represented in the sample are independently owned, franchise, chain, managed care and healthcare system pharmacies. Each case is a separate, distinct pharmacy site, not corporately affiliated with any other case study participant.

Interview and survey data were collected from key informants who serve as the pharmacy owner, director, manager or supervisor. Data were collected from one key informant per site. Informants were identified via self-knowledge, pharmacy colleagues or a telephone call to each pharmacy, as needed. These managerial-level key informants were then mailed a letter inviting them to participate in this multiple case study. A follow up telephone call was placed approximately one week after the letter was received to gain verbal consent and to arrange an interview. A written consent form and survey was then mailed to each key informant per Investigational Review Board requirements. Written consent was gained prior to interview and prior to or at the time of completed survey receipt.

Pharmacies are presented using alphabetical identifiers (A-H) in order to maintain confidentiality. They are listed below, categorized based on available claims data at the time of sampling, according to apparent innovation adoption status:

Adopters:

- Pharmacy A – Independent in a small non-urban area
- Pharmacy B – Independent in a small, non-urban area
- Pharmacy C – Independent in an urban area

Still Trying:

- Pharmacy D – Independent in a small non-urban area
- Pharmacy E – National chain in a large, non-urban area

Pharmacy F – Managed care in an urban area

Tried, Rejected:

Pharmacy G – Health system community pharmacy in a large non-urban area

Pharmacy H – Independent in a small non-urban area

Data Collection

Data were collected using a mailed, self-administered survey and a guided semi-structured interview. Claims data were obtained from University of Wisconsin-Madison collaborators, Mott, Kreling and Chou. Study variables were chosen based on diffusion of innovation theory⁶ as well as previous research pertaining to implementation of change in pharmacy and specifically, pharmaceutical care and WMPCP.^{7,8,9} The dependent variable is evidence of routinization of WMPCP participation and thus, adoption of the innovation. Independent variables considered in the analysis include evidence of each pharmacy organization moving through the process of innovation, facilitators and barriers to participation, innovation characteristics as perceived by each case informant and possible variables emerging from the data.

The key informant pre-interview survey contained four sections: (1) Pharmacy Site's Participation, (2) Pharmacy Site Characteristics, (3) Pharmacy Staffing and (4) Pharmacy Services. A copy is included as an appendix. Survey data collection was done prior to interviews in order to assist and guide interview questioning and to provide additional pertinent data more easily gathered in this manner. Respondents were at times asked to elaborate on survey responses, if information was deemed to be pertinent and yet not already discussed in the interview with acceptable detail.

Key interview questions were as follows:

- How did your pharmacy get started (participating in WMPCP)?
 - What do you think helped you get started?
- What do you think helped you continue to participate?
 - What was most significant?
 - What has changed?
- What barriers did you have at first?
- What barriers have you encountered since then?
 - What was most significant?
 - What has changed?
 - How did you overcome that/these? (or how are you overcoming...?)

⁶ Rogers EM. Diffusion of Innovations, 4th edition. Free Press: New York, 1995.

⁷ Doucette WR & Koch YD (2000). An exploratory study of community pharmacy practice change. J Amer Pharm Assoc, 40(3):384-91.

⁸ Odedina FT, Segal R & Hepler CD (1995). Providing pharmaceutical care in community practice: Differences between providers and non-providers of pharmaceutical care, J Soc Adm Pharm, 12(4):170-9.

⁹ Hermansen CJ & Wiederholt JB. (1997) Pharmacists' Pre-Participation Response to the Wisconsin Medicaid Pharmaceutical Care Project: An Exploratory Study. Podium presentation, American Pharmaceutical Association Meeting, Annual Meeting.

- What advice would you give another pharmacy/pharmacist wanting to participate in WMPCP?

During interviews, based on previous research already identified, the following topical prompts were used, as needed, to assist the uncovering of, and elaboration on, facilitators and barriers to participating.

- Time (paperwork, patient care)
- Documentation
- Reimbursement (slow, inadequate, cumbersome, claim rejections, online, prospective DUR)
- Pharmacists/Technicians (personnel dynamics, poor acceptance, confidence, understanding, motivation/no individual financial incentive?, expertise)
- Employers/Management (encouragement, acceptance, allowing autonomy, communications, decision-making efforts...)
- Patient (poor acceptance, understanding)
- State Medicaid (capability, program, attitude, communications, toll-free helpline, educational efforts)
- State pharmacy organizations (publicity to employers, pharmacists; education, encouragement)
- Workplace/Workflow/Staffing (technician use, software use, limited pt information, increased liability, system has developed...)
- Adoption by other third party payers
- Physician (poor acceptance, access)

All interviews were conducted by the investigator (CJHK). Three were conducted on site at the respective pharmacies and five were conducted via telephone. All interviews were digitally audio-recorded and ranged in length from 39 minutes to 1 hour and 26 minutes.

Claims data used in this analysis include claim frequency and timing per pharmacy, as well as reason, action, outcome and level of service per individual claim.

Data Analysis

Analysis of audio recordings of interviews was conducted using Annotape® Software which allows for the indexing of audio sound bites for organizing and analyzing content. Data from surveys and claims were analyzed and a case study database was created using Microsoft Excel and Word software. The case study database was created to improve reliability and to facilitate analysis.¹⁰ This database includes:

- Case study notes: written during and/or after each interview, document analysis of each informant-completed survey, Annotape® indexing of each interview to organize and analyze content

¹⁰ Yin RK. Case Study Research Design and Methods, 2nd edition, Applied Social Research Methods Series, Volume 5, Sage Publications: Thousand Oaks, 1994.

- Tabular organization of all 8 cases for summary and case-by-case comparisons
- Calculation of pertinent descriptive statistics for cross-case comparisons including frequencies, means, modes, and maximums and minimums. Ratings were noted that varied by more than 1 standard deviation above or below the mean, where applicable.
- Narratives written to address open-ended survey questions, innovation of diffusion theory principles found in the data, and key research questions.
- Cross-case comparisons in which patterns across cases were examined and compared across innovation adoption status (adoption, rejection or still trying).

For all analyses, when necessary to maintain confidentiality, data are presented in such a manner so as to minimize possible identification of participants.

RESULTS AND DISCUSSION

How and why have some pharmacies made WMPCP work in their pharmacies and why have others not? Succinctly stated, three strongly recurring themes from key informants were found in the analysis. Not only are workplace changes needed to accommodate new tasks, there needs to be a very clear expectation communicated in the workplace by a management that truly sees the value of participation. Restated, (1) management must perceive adequate incentives to participate, (2) the expectation to participate must be communicated effectively from management to staff, and (3) workplace changes are needed to accommodate the task-based needs of WMPCP participation, some of which appear as new systems as participation becomes routine.

How these three “requirements” are met varies broadly across cases. They are presented and discussed here in light of the innovation process and innovation characteristics, addressing the primary questions of how and why pharmacies have or have not participated in WMPCP. To begin, a brief discussion of which pharmacies appear to have adopted the innovation and which do not is presented.¹¹

Innovation Adoption

Data from all three sources informed the analysis and resulted in a modified understanding of which pharmacies have and have not yet adopted the WMPCP innovation.

Original classification of pharmacies as adopted, still trying and rejected adoption was based solely on claims data. Based on interview and survey data, these classifications are revised. It is important to note the requirements for innovation including 3 key activities of participation: patient care, documentation and claims submission (and handling). In sum, based on findings from this analysis, reclassification of the 8 pharmacy cases is as follows:

¹¹ In this section, data sources are referenced as follows in the text: (interview), (claims), (survey). Direct quotations or written comments are provided in quotations.

Adopted:

Pharmacies A, B, C, D, E and F

Rejected, but may try again:

Pharmacies G and H

Pharmacies A, B and C were believed to have adopted the innovation during sampling. In all three cases, participation as seen in the frequency of paid claims has been consistent over two or more years with numbers increasing over time. Such numbers suggest participation has become routine at each pharmacy. All 3 pharmacies indicated routinization (per survey), that is, an incorporating of WMPCP participation into the normal work day routine. All 3 have in fact accomplished this in different ways, as will be explained later in this document using insights from the interviews. The type of adoption appears to differ for B than for A and C. The types of claims paid to Pharmacy B are limited by type with 93.1% of claim results being patient education and/or instruction (as opposed to changes in the prescription itself). In this sense, a limited yet proficient form of innovation adoption is observed. It may be significant that all 3 pharmacies are independently owned pharmacies. Owners, as entrepreneurs, are more likely to innovate and take the risks than the general population¹². Also, all three of these innovating owners own only the single pharmacy. Because of this, they may be better able to focus on and instigate the changes needed to implement a program like WMPCP.

Although originally believed to be still trying to adopt, primary data support that Pharmacies D and E have also adopted the innovation. Pharmacies D and E each have a small population of Medicaid recipients to which they dispense prescriptions (7% and 10%, respectively), and thus likely have fewer opportunities to provide and bill for cognitive services as part of WMPCP. This is compared to 25%, 50% and 62% of the patient population receiving Medicaid at Pharmacies C, B and A, respectively. Pharmacies D and E serve only a small percentage of their Medicaid patients (10 and 20% compared to 50% and 60% of Pharmacies B and C).

A unique emphasis on continuity of care and helping those with greatest need is the approach taken by Pharmacy A, in spite of the large number of Medicaid recipients for which prescriptions are dispensed (62%). Only 5% of patients are served through WMPCP (survey). In a related way, staff are "run[ning] out of codes at the end of the year" to use for repeated care given to certain patients, who for example have a compliance problem (interview, Pharmacy A). This same phenomenon was noted by key informants for Pharmacies D and E, and no others lending evidence of these other two pharmacies having worked to redefine WMPCP into their work site. As is discussed under "Communication of Management's Expectations", there is evidence of these pharmacies and their staff working out the meaning of WMPCP and routinizing participation in it.

Pharmacy F appears to have more opportunities to participate than for which it is billing (per interview), however there is evidence of a limited form of adoption based on survey and interview. The key informant used the word "intervention" to describe participation, an internally used term, which lends evidence that new meaning has been created to represent WMPCP participation from within the organization (Stage 4 of the diffusion process). Other evidence of

¹² Lumpkin GT and Dess GG. Clarifying the entrepreneurial orientation construct and linking it to performance. *Acad Manage Reve.* 1996;21:135-172.

adoption includes a belief by management that it has indeed been routinized and the development of documentation system unique to the organization (survey, interview).

A preponderance of 1-2 types of paid claims suggests systematization and a redefining or re-inventing of the innovation in order to better fit the organization (Stage 3 of the innovation process for an organization). The majority of this pharmacy's claims submissions are for pharmacist calls to the physicians on the patient's behalf in order to adjust a prescription (claims, interview). In particular, Pharmacy F claims data show by far the highest rate of drug choice changes (87.8%) as the coded reason for billing Medicaid (mean among 8 cases = 28.3%). Contacting the physician is also the highest of the 8 case pharmacies with 63.3% of claims with this action code (mean = 28.0%). Pharmacist participation in this narrow area of service is highlighted to an extent, as the idea of documenting physician contact appears several times during the interview with Pharmacy's F key informant, an example of which is below:

And it was built into our routine, that if you were to call a doctor for anything or provide any intervention, then we're going to document it. (Pharmacy F, interview)

Thus, pharmacists are encouraged to complete the necessary documentation when they find themselves contacting the physician, thus integrating WMPCP participation into the regular activities of the pharmacy in order to adopt the innovation. This focus also clearly addresses this organization's agenda to prove themselves to the organization's physicians (Stage 1 of the innovation process). Last, Pharmacy F uses an internal hard copy documentation form designed to facilitate and routinize staff pharmacists' participation in WMPCP (interview).

Prior to primary data collection, Pharmacies G and H were thought to have rejected the innovation, however both informants expressed a desire to restart participation, though they had not done this to date. Interesting, this idea of pharmacies stopping and restarting the process was noted by Pharmacy A's informant.

[WMPCP] has had so many fits and starts that it's hard to get people engaged a third, fourth or fifth time." (interview)

This observation is based on the changes in the program over time, which include: going online, introducing prospective drug utilization review, and most recently communicating at the time of adjudication, the dollar amount to be paid for each claim. While several pharmacy informants did note the first two changes have provided more opportunity for participation, Pharmacies G's and H's reasons, however, appear to be more intrinsic to each organization rather than based on the program itself.

Neither Pharmacy G nor H had claims paid by Medicaid for 2003 at the time of sampling. (Pharmacy H's participation had gone from 93 paid claims in 2000 to 4 in 2001 to none in 2002.) Neither reported having routinized WMPCP participation via survey, a finding consistent with claims and interview data. During interview the key informant for Pharmacy H stated a desire to reinvigorate participation efforts, due in part to the heightened awareness from participating in this study. (Participation dropped off after a successful, but disruptive WMPCP-based audit by

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the state.) This informant appears to differentiate himself from the innovators, by seemingly self-identifying as an early adopter. The possibility of future audits proved to be an obstacle that he did not want to have to overcome at that earlier time (interview). Also, while commenting on the desire to try WMPCP again, in contrast to those pharmacists who have been publicly outspoken about how to make WMPCP work he stated, "I wouldn't be the one up there saying that, but I would certainly aspire to be there." (Pharmacy H, interview)

Pharmacy G's informant reported during interview wanting to try to participate again to improve the pharmacy's "bottom line" (finances). "Time" was cited as a significant barrier to participating (in interview and survey), however further elaboration and a look at other survey questions revealed perceived barriers to be: unwilling pharmacists and technicians, difficulties understanding new software and staffing versus workload nuances that do not appear to support participation requirements (interview, survey). It is important to note that no ongoing efforts seem to exist to encourage or facilitate WMPCP participation at either site aside from having useable, but not yet fully understood, software for documentation and claims submission purposes (interviews, Pharmacies G and H).

Incentives to Participate

The two major participation incentives for management among these 8 cases are financial gain and the desire to move the profession forward by, in part, proving pharmacy's worth to outside parties. These two incentives serve as the key agenda-setting elements for those pharmacies that have adopted the innovation as well as those who are "wanting to try again". The two incentives sometimes occur in opposition to each other in that those who stress the one typically downplay or do not mention the other. The two incentives also occur together to an extent, revealing the complexities of remaining financially viable while operating in an almost altruistic manner by looking to the future and the future of the profession. Key informants were asked about this in an open-ended manner in terms of benefits of, and facilitators to, participating (survey, followed up by interview).

According to surveys, financial gain was noted by all pharmacy case informants, however only two pharmacies truly stressed this, and this alone, as a relative advantage to participating (B and G, in interviews). These 2 pharmacy informants wrote comments about the benefit to the organization of WMPCP participation being the "financial incentive" present and the "increased revenue and margin" (Pharmacy B) available to aid the pharmacy's "bottom line" (Pharmacy G). Interestingly, Pharmacy B has the highest number of paid claims per year (claims) and Pharmacy G, per interview, does not appear to have moved beyond Stage 1 of the diffusion process (identifying a financial need).

Specifically, these 2 key informants at Pharmacies B and G stressed the need to profit from participation, while the others did not. The Pharmacy G informant noted the pharmacy's ongoing need to "Mak[e] sure we can bill what we can bill" and "make sure we maximize every opportunity we have" (interview). The Pharmacy B informant explained how the additional funds gained were used to pay for a new "extra pharmacist" who was hired "to get into this [WMPCP] to make up for coming on [being hired]" (interview). Neither key informant spoke of

the need to take advantage of this opportunity to prove the worth of the profession by billing and being paid for cognitive services through WMPCP.

Four of the other WMPCP participants (Pharmacies A, C, D, and E) specifically noted the need to prove the profession together with noting the lack of financial gain that participating has produced thus far. These key informants view financial benefits as being at the most a means of "breaking even". At the same time, however, the limited financial gain is juxtaposed with the benefits of proving the profession and the related ability to provide better patient care.

After doing this for a couple of years and standing back, looking at it from the perspective of profitability...it's a break even chore that we do. And that's okay because we're giving better care to the patient, and we're documenting it to the state and we're showing that pharmacists can improve health or decrease costs.
(Pharmacy C, interview)

In relation to the "break even" reality of participating, key informants acknowledged how time consuming participation has been, and still is, in terms of documentation and claims handling. The Pharmacy A informant in interview referring to the billing levels based on time explained, "If it isn't billable at a level 12 or 13 or 14 it is almost not worth...spending time on it, because reimbursement is so small...there are mechanical problems...it takes a while."¹³ Continuing in the interview, the Pharmacy A informant asked the rhetorical question of "Why would I pay someone \$50 an hour to do that?" which illustrates the difficulty these pharmacies are experiencing in trying to make participation worth it financially. This same pharmacy has "not been able to get the technicians to understand [the billing process]. It requires clinical judgment. None of them came through clinical training...[even though they are certified]...when it comes to these value judgments, they're not able to do it and by the time we write it out and tell them...it wasn't worth the time and so we're doing it ourselves" (Pharmacy A, interview).

Another pharmacy informant who cites professional reasons to participate explicitly described the reimbursement rates being outdated and based on research conducted by University of Wisconsin School of Pharmacy faculty in the early 1990s (Pharmacy E, interview).

It [the reimbursement schedule] hasn't been updated since 1996 [the year the program began]...about \$60 an hour...there's definitely, in my opinion, no financial incentive to do this any longer because there was somewhat low pay to begin with and now it's less...

This pharmacy has conducted an internal analysis to determine the cost of pharmacist services per hour specific to the pharmacy's operations and realizes the difficulty of even breaking even with participation. In spite of this lack of financial advantage, these pharmacies persevere in order to better the profession (not themselves), functioning just a bit altruistically on behalf of present and future practitioners. When asked why the pharmacy participates, Pharmacy E informant stated,

¹³ Levels of service range from 0-5 minutes, 6-15 minutes, 16-30 minutes, 31-60 minutes and 61 or more minutes and are labeled 10, 11, 12, 13, and 14, respectively.

Because I want to change the profession and I'm unhappy with the way it was practiced previously....I'm not disappointed in anyone who practiced before me, but I am disappointed that...it's such a slow process. I thought it would be all done by now. (Pharmacy E, interview)

An overlapping subset of pharmacy key informants noted the desire to "prove pharmacy". When it comes to many key informants, it is this desire that has propelled them forward to not only try the innovation, but to continue in spite of obstacles. For the managed care Pharmacy F, it has been a matter of "proving [the] pharmacy department's usefulness" to the affiliated staff physicians (survey, supported in interview). Interviews of the other pharmacy informants strongly reveal this same desire to prove the profession, but more so to outside parties. Speaking on behalf of other WMPCP participating pharmacies and their pharmacists, the key informant for Pharmacy D asserted,

[For] the vast majority of them...the money involved is not the highest priority. It's important, but I still argue that by and large the people who have taken up the banner [have done so] because it's the right thing to do. (interview)

It is interesting to note that while Pharmacy D spoke of "taking up the banner", this informant acknowledged participation in WMPCP has assisted the site's participation in other available programs, referring to the more recently implemented Senior Care in Wisconsin (and later, Navatis, a pharmacy benefit management payment program). Both of these offer opportunities to bill for cognitive services provided to non-Medicaid patient populations. "That's the advantage financially, one more huge group willing to pay for it" (Pharmacy D, interview)

In addition to incentives for management, informants were asked about any existing staff incentives (by categorical question and follow up interview question). Six of 8 pharmacy key informants (all but Pharmacies B and G) noted on their survey, the categorical response of "personal satisfaction" as an incentive for pharmacy staff pharmacists to participate in WMPCP. It is not known whether these managers are projecting their thoughts onto staff or whether staff would concur independently. However, an example to support the latter conclusion found in Pharmacy A's key informant in reference to a somewhat recent pharmacist hire. This pharmacist is participating in WMPCP, not receiving financial rewards herself, and yet she is:

...getting these fees back [for the pharmacy and] really grabbing a hold of this because she's getting positive feedback.... She's seeing the dollars coming back... she thinks she's getting paid for the value that she actually provided. (interview)

Only one pharmacy noted a specific means by which staff currently realizes direct financial gain through participation (Pharmacy B, interview). An "extra" pharmacist at this site supplements his/her own salary through participation as a means of providing a competitive salary (interview). Other key informants did indicate the need for staff pharmacists to participate in order to keep the pharmacy financially healthy which then contributes to staff salaries in such a way that the staff need not concern themselves (Pharmacies D and G, interview). In addition to personal satisfaction, Pharmacy F indicated (per survey and interview) the incentive of

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professional recognition during employee reviews and via an organizational newsletter which highlights pharmacy level participation in comparison to other pharmacy sites within the managed care organization.

While these personal incentives for staff were not gathered directly from staff pharmacists, they are certainly an indication of management's expectations for them. How these expectations and others were (and are) communicated to staff is described in the following section.

Communication of Management's Expectations to Participate

Various organizational communication patterns exist among the 8 pharmacies in relation to the innovation. Notably, the 6 pharmacies that have adopted the innovation indicated a clear employer expectation that staff participates (Pharmacies A-F). How this is communicated varies across pharmacies. Means of formal and informal communication are used, some of which involve staff in decision-making and strategizing. The pharmacy culture communicates expectations in subtle and non-so subtle ways while something known in diffusion theory as an "innovation champion" helps to move innovation adoption forward within individual sites. Last, hiring practices communicate expectations.

To begin with, formal communication from management to staff includes intra-organizational newsletters (Pharmacies A, C and F, interviews), as well as team creation (Pharmacy C, interview) and regular meetings (Pharmacies A, C, D, F). Regular newsletters are used by adopters of WMPCP to reinforce operational needs or changes in the pharmacies (A, C, F). For Pharmacy C, the weekly newsletter given to all staff contains,

anything that's going on, anything we're struggling with, things that we need to improve on, things that are happening in the industry, anything I want them to know. (interview)

Purposeful meetings with or without leadership team designation are held by some. These meetings are held by Pharmacies A, C and D to explicitly discuss and make changes related to WMPCP participation. Other meetings contain only reminders and instruction for participation (Pharmacy F). Frequency of meetings includes weekly, biweekly and monthly as well as sporadically, based on need (Pharmacy D).

Pharmacies A, C and D use meetings to work towards redefining and restructuring both the innovation and pharmacy (stage 3 of the innovation process). Although not formally organized meetings, Pharmacy E strives to accomplish the same results by using informal staff and management discussion in order to work through change and restructure participation (interview).

In particular, Pharmacy D informant spoke of using staff meetings to help staff to trust the management and to involve staff in the process of change. This includes involving technicians who may have questions and disagreements with management to make sure everybody is "on the same page".

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We discuss things and we really [communicate] the culture that we can disagree here, but we've got to get an answer. And our experienced technicians know they can come to us and go, "Could you guys just get it together which way you want to do this?" so we try to have...consistency [across pharmacists who when they participate in WMPCP] because then you get good performance....but part of that is that everyone has to perform at the same level. (interview)

Meetings at Pharmacy D occur as needed to communicate these expectations and to involve the staff (pharmacists and technicians).

In addition to Pharmacy D, inclusion of technicians and/or bookkeepers is viewed as critical by others. In the case of technicians, meetings will turn into training sessions in order to facilitate WMPCP participation.

We have morning training sessions...and during these times we reinforce what we put in the weekly newsletter....so we use [these] mornings to answer questions the [technicians] may have, any obstacles they may see or any concerns they may have on the process of billing...anything related to change. (Pharmacy C, interview)

For Pharmacy C, success in implementation of, and continuation in, WMPCP has been made possible, in part, by "empowered technicians". This pharmacy's management worked to increase the professionalism of the technicians as one means of moving the practice forward. They were encouraged to become certified and all but one did. This served to communicate that management expects more to not only the technicians, but the pharmacists as well.

We're developing a culture of patient care, and so the expectation is changing. So as we do it, more is expected of the pharmacist and then more is expected of the technician, so the level of care improves, so we'll be ready for the next step." (Pharmacy C, interview)

Although pharmacists are typically the initiators of participation and it is their license and ability which are required to provide the services, technicians, bookkeepers and other support personnel do participate. Management that has successfully adopted WMPCP is careful to include these pharmacy staff members in discussions, top-down communications as well as in decision-making. It is remarkable that no pattern was found regarding technician certification. Pharmacies that have successfully adopted WMPCP range in their employment of certified technicians (0 to 7). Technicians' roles vary from supporting pharmaceutical care activities to serving as reminders to participate to helping to revise and restructure the pharmacy's workflow. Their role expectations together with those for the pharmacists are a part of these pharmacies' cultures.

For some, this expectation is an integral part of the pharmacy culture. Pharmacies A, C and D, all independently owned, indicated a cultural expectation created within the pharmacy that staff pharmacists and management will actively participate in WMPCP (interviews). An example of this is found in the comment, "it's our culture" (Pharmacy D, interview) when referring to

participating in WMPCP and seeking other financial supports for providing pharmaceutical care. Pharmacy A informant strongly asserted that participation in WMPCP "is expected" while acknowledging that "...it's a burden, a big burden" (Pharmacy A). While elaborating upon the empowerment and certification of the site's technicians, Pharmacy C informant described this cultural expectation (interview):

We're developing a culture of patient care, and so the expectation is changing... as we [develop this culture], more is expected of the pharmacist and then more is expected of the technician, so the level of care improves, so we'll be ready for the next step.

This same informant went on to elaborate on this culture and its communication via a leadership team made up of pharmacists and technicians.

And the culture is that we're taking care of patients. We have a mission statement. We have goals. We have areas of priority we want to work on. We [the leadership team members] communicate this with the staff and the expectation is we do more and the [staff members] want to buy in. (Pharmacy C, interview)

A culture of innovation is present in Pharmacy E. This informant indicated, "all pharmacists [at the site] are trained...and encouraged to bill [to Medicaid]" (interview). In addition, this informant explained the pharmacy is quick to try "new ideas". Changes are discussed, tried and sometimes fully implemented as almost an ongoing activity. All staff members contribute the ideas and the input to effect change in this pharmacy (interview).

As a bridge between management's own incentives and the need to communicate management's expectations, one finds the "innovation champion" which was noticeably absent from Pharmacies G and H. This management level individual serves as the one whose full support helps the organization overcome any indifference or resistance to WMPCP participation. According to diffusion of innovation theory, without this champion, the idea of participating is likely to die when working within an organization.¹⁴ A clear example is Pharmacy E's key informant, a self-proclaimed champion of the innovation who admits to being "gungho" about this opportunity for the pharmacy profession (interview). This innovation champion expresses a remarkable confidence and clarity about leading and motivating pharmacy staff to participate, using informal discussion to break down resistance and create change (interview).

It is clear from interviews in particular, that other innovation champions exist at Pharmacies A and D where the management-level key informants admit resistance by staff and yet have worked to overcome such resistance through persuasion and modeling (interview).

These findings support the significance that one management level individual can be extremely influential regarding innovation adoption through effective communication. Movement of these individuals from one job to another is likely to create innovation rejection (at the old site) and

¹⁴ Rogers EM. Diffusion of Innovations, 4th edition. Free Press: New York, 1995.

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adoption opportunities at the new. The significance of a single staff pharmacist also was noted in interviews.

Non-managerial pharmacists have also served as innovation champions, but perhaps to a lesser degree. Pharmacies B, C and F have had less resistance to WMPCP implementation, however, in each case, a specific individual has reportedly helped move participation forward more than others. Pharmacy F saw increased participation when a certain pharmacist began working. The lateral move within the same managed care organization allowed the key informant to notice the drop in participation that resulted at the site from which the pharmacist came. Participation at the site new to the pharmacist was believed to have increased because of her own participation as well as her influence on others (interview). For Pharmacies B and C, a staff pharmacist or resident has explicitly aided in the transition to WMPCP participation by helping to implement or develop the revised workflow and workplace structures (interviews, Pharmacies B and C, respectively).

In addition to pharmacists, pharmacy clerkship students were reported to have made a significant difference in trial and adoption for Pharmacies A and F, acting a bit like change agents who entered the existing sites and situations with more knowledge about WMPCP or just more interest in it than others (interview).

For Pharmacy F, within the organization as a whole, the innovation champion is the management level informant who handles nearly all claims on behalf of the pharmacists and the organization, keeping staff abreast of changes to the program and encouraging staff to participate (interview). Without this individual, WMPCP participation likely would not be occurring at all. As it is, this informant admitted there needs to be more pharmacist participation (interview); organizational newsletters for communication but may not suffice. Although not discussed by Pharmacy F's informant, face-to-face communication may be required that purposely involves staff in the decision-making activities related to changes associated with WMPCP and other reimbursement opportunities. This type of communication with active staff involvement is seen with the more successfully participating Pharmacies A,B,C,D,E.

Another means of communicating management's expectations are the hiring practices. Pharmacy B hired a pharmacist with the explicit intent of having this pharmacist "head up" the pharmacy's participation (interview). Pharmacy D noted the advantage they have of hiring new pharmacy graduates who want to do more than dispense prescriptions (interview).

In some cases, hiring procedures make it clear that participation in this program, as well as other billable service opportunities, is part of a pharmacist's work responsibilities.

...as we attract new pharmacists...we have well over a decade of pharmacists now, educated in pharmaceutical care and looking for those practices, and so they come searching for that and so it's a little easier to attract [and hire them]"
(Pharmacy D, interview)

The Pharmacy C informant described a redefining and refining of the organization's staff by way of expectations becoming ingrained. A level of peer pressure that has developed as a

result of this pharmacy's leadership team efforts to implement change related to WMPCP participation. This cultural pressure permeates the staff, pharmacists and non-pharmacists alike.

As we do more, the people want to buy in...and you either buy in or you leave.... [If they didn't like it] they'd be gone....it's that peer pressure from others, the staff... "Come on we're billing for Medicaid and you're not. Why aren't you doing it?" Those expectations are there. I did have a pharmacist who was somewhat resistant to it, and he left, he left. (Pharmacy C, interview)

Those pharmacy managers that have not adopted the innovation (Pharmacies G and H) appear to have not yet communicated (G) or not adequately communicated (H) expectations. For Pharmacy G, it appears such expectations are not optimistic about WMPCP participation, nor perhaps realistic, based on how other case pharmacies have routinized WMPCP without becoming exclusively clinically oriented (Pharmacies B, E in particular). When asked to comment on possible future WMPCP routinization, the key informant noted (in stark contrast to those pharmacies with a culture of participation and more advanced patient care),

"the culture of pharmacy almost eliminates [being clinically oriented].... When we first started...[we were] going to be clinically oriented. Well we were clinically oriented, losing money...[I would] like us to be clinically oriented, but we've had to cut our professional staff." (Pharmacy G, interview)

When asked about communicating expectations and incentivizing staff pharmacists, this same informant who views the financial incentive from a managerial standpoint within a large corporate structure, commented on the opposition to using financial incentives for staff (assuming financial as primary when asked about staff incentives and motivation strategies):

"I've never been one to do that...pay them extra to do their job...I doubt it will happen. I think they should just do it...gives you a lot more professional satisfaction that you're doing your job better. That's the way I'm going to proceed with it." (Pharmacy G, interview)

The vagueness of how to motivate staff using professional satisfaction in this "still trying" pharmacy is contrasted to the ways in which pharmacies that have adopted the innovation motivate their staff pharmacists to participate. To reiterate, these include formal recognition during employee reviews and organizational newsletters (Pharmacy F) as well as various means of using professional satisfaction. This includes the direct involvement of staff in planning, implementation and problem-solving activities related to WMPCP participation (Pharmacy A, C, D) and helping pharmacists to see and verbalize advantages and barriers to participating in hopes of overcoming the latter (Pharmacy E).

Pharmacy H noted the same kind of "prove the profession" incentive and yet appears to be unable to communicate that to his staff. Instead he noted a strong desire of staff pharmacists to put in an 8-hour day and go home; these pharmacists do not appear to be motivated by the desire to better the profession.

They don't understand as well as I'd like them to that if they were to submit the claim, it's actually benefiting the profession and them indirectly. Because it's letting third parties know what we're doing. We know what we're doing, we do it every day. But, unless we get used to documenting it by sending a claim in or just simply documenting and sending a claim that we know we're not going to get paid anything on...unless we're willing to take that step and take the time to do that, we can never expect that third parties will understand completely what we're general, they don't seem to be able to use that as impetus to do it. They need more than that. They want to complete their day and go home.... (Pharmacy H, interview)

This pharmacy informant believes this lack of interest in WMPCP participation is related to pharmacists' more than ample salaries, rather than looking ahead to what their participation could mean for the profession itself (interview). From the interview, it appears Pharmacy H's managerial informant is not able to stimulate the interest among his staff. This informant disclosed a lack of confidence in leadership, motivating and communicating skills and blamed the pharmacy's lack of participation on these self-perceived short-comings. His comments shed light on the important role of effective management in WMPCP participation.

In particular, this informant noted the lack of management education and the difficulties he has communicating with female employees.

I don't have the best...I'm simply not the best manager when it comes to managing people....and this has all come from experience. And when that happens you're molded by your experiences and your reactions are based upon *your experiences and that's not necessarily the best...unless you have a good foundation... education in administration...knowledge in psychology...and administration....I have no education in management.... I'm afraid I'm more defensive than offensive, putting out fires instead of preventing them....and I communicate better with men than women.* (Pharmacy H, interview)

Without ability and confidence in one's managerial communication-related skills to motivate and lead staff, participation by staff may be quite unlikely. Related to this observation is the "innovation champion", presented earlier, who needs to be an effective communicator (as well as a role model).

Workplace Changes to Accommodate WMPCP Needs

It doesn't integrate itself into the normal workflow of a pharmacy....because you have to do all the coding, you have to do the documentation and you have to provide the service and then bill for it. And it has to be done after you've already billed for it once. It's like a disincentive to go back into it. You're redoing your work all over again. (Pharmacy A, interview)

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Most pharmacies that have adopted the WMPCP innovation have made significant accommodations in the workplace to address participation needs. (Pharmacy F is an exception.) These pharmacies' informants, in interview, described how they overcame the difficulties of incorporating claims handling and billing procedures, as well as documentation requirements, into their daily routine. Making changes to provide more or different patient care was not emphasized by key informants, yet the cognitive services are clearly the driving force behind WMPCP participation. All pharmacies indicated they essentially are billing, or would bill, for services they already provide at their sites.

This section examines the workplace accommodations required for WMPCP participation and presents evidence in three sections: the patient care activities for which pharmacies bill, the documentation requirements and finally the claims handling. In accordance with earlier re-categorizations, each pharmacy is grouped under either "adopters" (A-F) or those that have not adopted (G and H). The pharmacy cases are examined and cross-compared to explain and illustrate the variety of activities and decisions made to adopt this innovation. The 2 pharmacies that have not adopted the innovation are examined in light of what informants indicate would be necessary to accomplish this feat.

Accommodations by Innovation-Adopting Pharmacies (A-F)

In general, many decisions and a great deal of change have been necessary for pharmacies to adopt WMPCP into their existing pharmacy practices. The Pharmacy C informant described this as "putting the pieces together" and here describes the many decisions related to the documentation and billing requirements—the processes that were new to most pharmacies.

...you have the documentation necessary, what do you look for? Do you get documentation software? Do you have hard copies? And what do you do with that information? Do you put it on the back of the prescription? Do you file it along with the prescription? Do you have separate files? And how do you file? And how do you follow up? And what flags in the computer system are necessary? And how do you know you're getting paid and how do you put the right codes in? There are diagnosis codes that are necessary and on and on and on. It's like layering. You have to develop one layer after another until everything is complete. It's a series of steps that are necessary to create this product. (Pharmacy C, interview)

The ways in which the 6 apparent adopters in this multiple case study have taken these steps varies. There are 4 archetypes in which there are distinct differences in how the workplace was adapted to accommodate the needs of WMPCP participation. Pharmacy B stands alone as a unique participator and as the top participator in number of paid claims while Pharmacy F represents another type of unique, but limited, participator. Pharmacies A, D and E have more similarities among themselves than differences while Pharmacy C has some unique attributes and thus, is presented separately.

How have these pharmacies made participation in WMPCP a normal part of the workflow?

Pharmacy B

Two years ago we hired a new pharmacist, an extra pharmacist. He was going to get into this to make up for coming on [being hired]. With some help from other people and the computer company...it saved us a lot of time and paperwork. There was an extra person doing the billing...now since we've gone to electronic and have the extra help, we're doing quite well. (Pharmacy B, interview)

Pharmacy B is the top participator in number of paid claims topping out at 1807 in 2003, more than 3 times the number of claims paid by the next highest participator. This pharmacy provides an interesting case of billing for care that has reportedly already been provided to patients. In this case, an "extra pharmacist" (interview) was hired to facilitate participation. This pharmacist's role is not to provide additional patient care services per se, but rather it is to be the expert in the pharmacy regarding the billing process. The remaining pharmacists perform most of the patient care activities for which the "extra" pharmacist bills.

As mentioned earlier in this document, Pharmacy B has adopted the innovation on a somewhat limited basis, billing almost exclusively for patient education or counseling (93%) compared to the 8-pharmacy mean of 35% (claims). What this pharmacy has not focused on are the other possible results of services such as adjusted fills and compliance aid development (claims). Providing advanced pharmaceutical care services (e.g., disease management activities) to patients appears limited. A separate patient care area apart from dispensing is "somewhat" used (survey), however, the informant during interview indicated "most [patients] are in and out of there" suggesting only brief service care opportunities.

This pharmacy's billing process has become very routine with this "aggressive" pharmacist facilitating participation by handling nearly all of the claims (interview, survey). Certain codes are emphasized systematically in order to gain payment, a logical approach for this site that has 50% of its patient population receiving Medicaid. This narrow focus by Pharmacy B appears to be expanding due to seemingly small, new opportunities found within the WMPCP system. This system, devised by Medicaid, includes prospective drug utilization review computer prompts and a restrictive drug formulary. Thus, Pharmacy B informant sees new opportunity for systematic and strategic billing to add to the pharmacy's revenue.

The state mandated the switch to over-the-counter Prilosec...so it's all billable...until we get everybody changed, we'll have a lot [of claims]. An extra \$10. (Pharmacy B, interview).

As far as the process for handling claims, they are submitted at the time of dispensing or closely afterwards by this "extra" pharmacist. Without this pharmacist, the pharmacy would not be able to participate because they did not have the manpower to accomplish this prior to the hire. According to interview, each pharmacist has his/her own specific area of primary responsibility regarding workflow with the new hire "working on the computer", another checking and yet another handling the phone and patient consultations.

[Workflow] changed with the new person and [WMPCP] sort of integrated into it. He'll be on the computer and notify you... 'we've got this new person on inhalers, take them aside and show them everything' or he'll do it. And he'll send techs over to type in refills or something. (Pharmacy B, interview)

The fact that Pharmacy B requires an additional pharmacist to participate in this program is telling in terms of the time and clinical judgment required for claims submission. Although technician staffing hours increased, in part, due to WMPCP participation according to the key informant, technicians do not handle the claims in this pharmacy, nor do bookkeepers (interview). One might initially assume an additional pharmacist hire would result in more advanced levels of care due to having more time available through staffing. However, the arrangement in this pharmacy reveals the additional hire resulted in the ability to receive reimbursement for the types of cognitive services that were already being provided. It clearly follows that this pharmacist's salary is subsidized by WMPCP reimbursed funds (interview).

Pharmacy B handles documentation via computer, using a commonly used software in Wisconsin pharmacies, QS-1. This pharmacy's participation went from 3 claims in 1999 and no claims in 2000 to 300 in 2001. This jump in WMPCP participation is notably after the system went on-line. When asked how this pharmacy continues to bill, being able to do so electronically, on-line was a huge factor, second only to the pharmacist hire, followed by integration into the workflow.

We dropped [WMPCP participation] unless there was something big...[Now] I don't think there's a day when we don't do them. When you look through everything they pay for...it's what you're doing all the time....[but] if you can't do it electronically and can't keep it going with your workflow, ...that's why others aren't doing it." (Pharmacy B, interview)

Pharmacy B management obtained the binder made available for a modest fee through the efforts of Pharmacy Society of Wisconsin (PSW) and former WPhA President¹⁵ John Bohlman who worked with this software company to develop the appropriate codes, etc. The complexity of participating in this innovation was reduced with this binder, a finding consistent with the ease with which the innovation was adopted by this pharmacy following the new hire. This same decrease in complexity as a result of binder usage also was noted by Pharmacy A, D and E informants (interview, survey).

For Pharmacy B, participation in WMPCP appears to be quite compatible with the organization's existing practices and available resources. The new pharmacist was hired with WMPCP participation in mind, and claims submissions are for cognitive services the pharmacists had already been providing.

It is important to note that while other third party payers are now paying for cognitive services, WMPCP seems to have a relative advantage to the others due to a broader range of billing possibilities and a higher rate of reimbursement. This is the case in spite of the more difficult

¹⁵ President of the Wisconsin Pharmacists Association (WPhA) which later merged with the health system statewide organization to become Pharmacy Society of Wisconsin.

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billing process with WMPCP. Pharmacy B informant compared WMPCP to Navatis, a private third party payer's program.

[Navatis] is actually easier than the state plan. [But] they don't pay for as much...they don't pay for as many things...but it's an easier process....They have a dummy NDC you just send through as a fake prescription and they pay you. (Pharmacy B, interview).

The new pharmacist was clearly a successful attempt to carefully fit or "match" the innovation into the existing organization in order to address the financial need perceived by the management. This is referred to as Stage 2 of innovation diffusion. In this staged process, it appears this small organization has quickly moved through Stages 3 and 4 to routinize participation. The relationship between the organization and the innovation appears to be well-defined (Stage 4) in that claims submission has become a steady and reliable means of financial gain as is evidenced in the use of monies to fund a portion of the new pharmacist's salary. Clearly, there may be occasions to restructure or redefine during which the innovation and/or the pharmacy changes. Addressing changes in Wisconsin Medicaid's formulary or prior authorization drugs may provide such opportunities (e.g., billing for Prilosec switches). Receiving immediate notice of how much will be paid per claim during online adjudication (a recent WMPCP change starting October 2003) may influence this as well.

Pharmacy F

It's spilled into our routine. That sheet is just right there. It's pretty effortless if you...make a phone call [to the doctor] and then just, you can see you can get rewarded from just that little effort....the sheet on the counter just triggers your memory too. (Pharmacy F, interview)

Pharmacy F is unique in that it is one of 3 pharmacies that have devised an internal form to use as documentation. For Pharmacy F it also serves as a cue to action for staff pharmacists. The pharmacy is unique in that it is one of many sites within a managed care organization. Although Pharmacy F has had the lowest number of paid claims among those deemed to have adopted the innovation, it is adoption at the organizational (administrative) level that is most apparent.

When compared to Pharmacy B, one sees there is no single staff pharmacist who handles billing, but rather an individual in centralized management who submits nearly all of the claims, submitting them in batches every 2 to 3 weeks. This same person handles rejected claims as well (interview). A special arrangement exists; staff pharmacists who provide a billable service to Medicaid recipients are asked to document the care and forward documentation to this manager. It is this individual rather than the staff pharmacist who then submits the claims using the documentation provided. Staff can submit the claims themselves, but most do not (interview).

Documentation is completed by hand, using an in-house documentation form (hard copy). Some pharmacists create computerized documentation, however not all do and it is not required by the organization. The hard copy is required (as WMPCP requires some form of documentation) and it is not only submitted for payment centrally, it is also retained centrally in case of audit. The

hard copy (single sheet of paper) serves as a means to document care, and as a cue to participate in WMPCP. It is a system to keep participation "as painless as possible" (interview). Interestingly, pharmacy students on clinical rotations were mentioned as an additional means to aid pharmacist participation. These students are required to complete clinical interventions and so,

...that helps with them coming through and having to do so many interventions, it just reminds us to keep going with it. (Pharmacy F, interview)

Reminders seem to be critical in this organization wherein the management level person who champions the cause (claims handler) only occasionally staffs the organization's dispensing pharmacies and is not in daily face-to-face contact with all staff pharmacists. Technicians also serve to remind pharmacists of a billing opportunity that presents itself during dispensing (interview).

This emphasis on being reminded to document supports the lack of purposeful expansion of services, and instead, the desire to prove pharmacy (to the organization's physicians).

...we are here to provide a service for the patients [physicians are] serving as well and just that documentation of what we're doing gives a little edge of why we're still needed and that's important for the organization. (Pharmacy F, interview)

Also, the centralized storage of hard copy documentation forms likely limits their use in any future clinical manner; documentation is unlikely to be accessed for follow-up activities related to more advanced forms of care. In addition a high percentage of paid claims are those in which the physician is contacted (63.3%) and which address a needed adjustment in the prescription (85.7%) rather than activities that may lend themselves to more continuous patient care such as patient compliance education or disease management education. This is confirmed by the strong emphasis placed on documenting calls to the physician: "if you were to call the doctor for anything" (interview). In addition, Pharmacy F does not have a separate area for pharmacy services apart from the dispensing area (survey) as there is no space (interview), perhaps resulting in fewer claims paid for patient education and counseling (claims).

A finding that stands in contrast to the other 7 pharmacies presented in this multiple case study is that no significant changes in staff workflow other than completing the hard copy documentation form are noted by the key informant. This may due to, in part, to there being relatively few paid claims compare to other pharmacies [insert]. Also this pharmacy has had few paid claims (only 8%) over 15 minutes compared to the 8-pharmacy average of 40% over 15 minutes in length (claims). The systematic focus to document already provided-for services may also be a reason. Just as was noted with Pharmacy B, billing is for care already provided in the form of specific and limited types of interventions (although different kinds). The type of WMPCP participation this pharmacy has engaged in appears to be quite compatible with existing practice and procedures. In discussing how WMPCP participation was begun, the informant matter-of-factly noted:

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We didn't think anything of it. It was announced they were going to pay... we put together a sheet... that we keep by most of the main filling terminals. And then it just has everything to fill out, what insurance it was... we even have them document if they do a change or service on a cash patient.... And it was built into our routine, that if you were to call a doctor for anything or provide any intervention, then we're going to document it. (Pharmacy F, interview)

Indeed, participation in WMPCP as viewed by staff is likely to be merely documenting already provided interventions. This opportunity has prompted documentation of interventions for more than just Medicaid recipients as well. Last, the managerial level key informant is the individual who likely spends the most time handling claims, and yet reports only an average of one hour per week doing this. While this number seems low in comparison to the number of participating sites within the organization, this may be due to the batching process which may increase efficiencies and skew perceptions when translated to weekly hours.

Pharmacies A, D and E

Pharmacies A, D and E have many similarities (and a few differences) to how they have incorporated, redefined and made WMPCP participation their own. These are presented here.

When asked via survey to rate those groups or organizations that have supported WMPCP participation, Pharmacies A, D and E rated PSW as the highest. This may be due, in part, to the fact that all 3 began participating in earnest when the program started (claims). Indeed, PSW has not been as active in assisting pharmacies with WMPCP as of late when compared to its beginnings. This contribution of PSW included the program's inception through negotiation with state legislators as well as the statewide traveling "classes" and the binder already mentioned for which the current and then outgoing association president was instrumental in developing.

The second highest rated support source for Pharmacies A, D and E was other Wisconsin pharmacists. Managers/owners reported contact with other Wisconsin pharmacists to troubleshoot and compare notes about WMPCP specifics such as figuring out how to bill for special situations for which there appear to be no available codes (Pharmacy D, interview). The need for troubleshooting in this way appears to be related to the length of time these pharmacies have been participating. It also relates to the range of services, and focus on the same individuals for repeated care (and related billing) which has resulted in quandaries about exactly how to overcome limits to billing. The pharmacy informants described taking part to varying degrees in some form of "network" of WMPCP participants that has developed over time to support and assist each other. Pharmacist D commented on a sense of collegiality that emerged because of WMPCP participation.

Part of working together really came out of this...there was that professional drive...working with our peers. (Pharmacy D, interview)

Because of this communication about the innovation, its observability has been quite high for these participants. Knowing others are participating may contribute to continued participation of

these pharmacies. Pharmacy D also noted the PSW Independent Network that management uses to email other independent owners with questions or concerns about the program. Similarly, Pharmacy E (a chain pharmacy) noted contact with others throughout the state with whom the informant has developed working relationships due to this program.

Claims processing at Pharmacies A and E is handled by the pharmacists. In some cases, claims are submitted at the time of service, or as close to it. For others they may be submitted at the end of the day or even a few days later (Pharmacy E, interview). Pharmacy D pharmacists handle claims differently in that a technician/bookkeeper submits many of them. Pharmacists print the computer screen information, write any additional information that is needed and give it to this bookkeeper to submit. When asked how it is done in Pharmacy A (offering the example of what Pharmacy D does), the informant noted that once they are at the point where Pharmacy D would print the screen and give the document to a bookkeeper to submit, Pharmacy A pharmacists just bill it themselves.

What we would do is, after we're at that point, we'd just bill it. It only takes about 3 more seconds, and you've already done the documentation, you've got the coding done, so you just might as well bill it. ...If there's a problem with it, then we would give it to a bookkeeper. (Pharmacy A, interview)

For documentation, Pharmacy E uses an internally-designed card used to ease the burden of pharmacist participation and documentation. This prescription-sized card serves as the primary means of documentation in this pharmacy, as the existing computer software program does not provide what is needed for computerized documentation (interview). This card is similar to the single hard copy page created by Pharmacy F's organization, and yet it only serves to facilitate participation in WMPCP and no other third party payer programs. Pharmacy E informant described how this more "user friendly" documentation form was needed rather than the exact format provided by the program.

What we really need is something more concise and less labor intensive and I said, why don't you design a documentation form that we can staple to the prescription with almost all of the required components, without "are you pregnant? And are you breast-feeding? Do you have liver disease and do you smoke?" on this form. So we're using this as sort of the SOAP format... (Pharmacy E, interview)

Pharmacy E's manager has helped to make participation routine and systematized by training all staff pharmacists to submit claims online (interview, survey) and by talking with staff "about what claims [they] can do on a more frequent basis" (interview).

For Pharmacies A and D, documentation is handled via computer, although each began with hard copy documentation due to the fact that WMPCP claims submissions were originally made using hard copy forms. Just as with the hard copy usage by Pharmacy E pharmacists, this computerized documentation occurs around the time the service is provided, and it is facilitated by a purposeful, sought-after understanding of the software's capabilities. Documentation takes the form of the SOAP or close to it (interviews).

In addition to computerized documentation, a hard copy is (or used to be generated), however this hard copy varies across pharmacy. Pharmacy A currently completes SOAP notes for each cognitive service provided (via computer) and occasional hard copy SOAP notes to document services that cannot be billed online (interview). Pharmacy D began using hard copy paper charts (file folders) as documentation in the form of SOAP notes and still retains these charts in the dispensing area. Pop-up notes were used in the patients' computerized files to alert them to the filed, hard copy documentation. Now, this pharmacy has since converted to computerized documentation due to adoption of a new dispensing system.

This new dispensing system represents not only new technology, but new workflow in which the Pharmacy D pharmacists no longer perform prescription computer entry. While not solely linked to WMPCP participation, this change goes hand in hand with the state program participation.

You have to be flexible....The employees have to be flexible too....The biggest skill that had to change....[pharmacists] were still doing entry. It was a tough sell....That's a tough sell, but that's where the training came in....When you used to be the entry person, you were doing that cognitive thing [then], and...you wonder when am I going to do it? ...getting the pharmacist off the computer and then knowing...what can be done by a technician were key. (Pharmacy D, interview)

This same pharmacy management went on to describe a system in which the cash register was removed from the prescription dispensing area, once again changing workflow to allow pharmacists to focus more on patient care activities for Medicaid and non-Medicaid recipients alike.

When it comes to patient care, all three pharmacies (A, D and E) blend dispensing and more advanced pharmaceutical care activities that may or may not be directly associated with a dispensed prescription. Each pharmacy began the pharmaceutical care activities (e.g., focused counseling to improve compliance, asthma management) prior to the inception of WMPCP. According to interviews, care has not changed significantly if at all in response to the opportunities WMPCP presents to obtain payment for services.

Pharmacy C

Pharmacy C is the second highest participator in number of claims. Similar to Pharmacy B, this pharmacy experienced a significant increase in number of paid claims from 2002 to 2003 (18 to 521, claims) due in part, to an innovative champion of sorts (a resident) and site-wide perseverance. Although Pharmacy C did not hire a pharmacist to lead participation, significant workplace changes occurred at the same time and since to support WMPCP participation. This pharmacy has a new work environment specifically designed to accommodate the already provided and ever-expanding pharmaceutical care activities (interview). Several years ago, a resident on site played an integral role in helping Pharmacy C move from trial to adoption of WMPCP in this pharmacy. The intent of the management is to expand into even more, referring to WMPCP's billing opportunities as "the first step" for itself and the profession (interview).

52
3.83
1.2

We were already doing the work, the interventions and we were starting to document, and we needed to find a way to bill Medicaid. It required an infrastructure change...the resident was assigned to figure out what was required to bill Medicaid, the documentation necessary, and then we had to work with our software vendor...a number of cycles, we hand-billed originally, we had a lot of rejections and then it finally clicked, and it required a resident to orchestrate it” (Pharmacy C, interview)

Here again one sees billing for services that was already being provided, prior to WMPCP. By participating in the program, the main idea is to have a secure funder to pay for what these pharmacists were already doing. This pharmacy was able to have their resident take participation in WMPCP on as their residency project. Having a singular person devoted to it in this manner is similar to Pharmacy B, yet different in that the resident’s salary was not dependent on participation and the resident did not take on all billing activities, but rather helped to answer questions and devise systems to integrate into the existing workflow. One key aspect of this, was to “work out” the software in terms of its use to submit claims online (interview).

In addition to the resident, a leadership team has been a critical contributor to adoption of this innovation. This team consisting of pharmacists and non-pharmacists has worked to implement a great deal of change. To address gaps in knowledge it has looked to a single Wisconsin pharmacist who had been successfully participating already in WMPCP. Pharmacy C reports primarily the support from this single pharmacy owner and no support from PSW. This latter observation may be due to the later start of Pharmacy C as perhaps an early adopter of WMPCP rather than innovator. The informant asserts that PSW and the Department of Health and Family Services did not provide the helpful “tools” necessary to move into innovation adoption.

I know they’re supportive, but they’re not very helpful. I don’t think we’ve given the average pharmacist *the tools* to take that step....I really think it’s an infrastructure change that is necessary before a pharmacist is ready to do it.

When asked to explain about these tools, instead of describing the physical environment as the “infrastructure change” comments would suggest, this informant spoke of pharmacists learning to document as a discipline (knowledge and skills) and pharmacists learning why participation is important (to move the profession forward).

Claims submissions appear to be handled by well-trained and highly motivated technicians and documentation is done by pharmacists using a hard copy only (interview). Pharmacy C had originally planned to use a computerized software program but it did not interface with the existing software used for dispensing and it was deemed to be too cumbersome. The current system is like that of Pharmacies E and F in that it involves in-house designed forms, however it is much more elaborate. Hanging files are used for each patient and forms include a pharmaceutical care form that uses the SOAP note format, progress notes, a place to document communication with other providers and specific sheets for certain types of disease states. When

asked how this documentation system works, the informant emphatically noted how it efficient it is and how the files are located close to the pharmacy workstations (interview).

"Still Trying" Pharmacies G and H

In contrast to Pharmacies A through F that have adopted WMPCP in some form by changing the workflow in systematic ways, Pharmacies G and H have not. While this is true for both G and H, how these pharmacies have responded thus far to WMPCP is quite different. Differences between the 2 are described here, as well as differences between these 2 and the other 6 pharmacies.

In each of Pharmacies G and H, claims submissions have been handled by pharmacists rather than technicians or bookkeepers (interviews). This seems to be the more common approach across adoptive pharmacies with only a few exceptions. Differences, however, appear in the types of claims paid to these pharmacies in the past.

According to claims data, Pharmacy's H previous participation was quite systematic, a quality that may lend itself to restarting participation and eventually making it routine again. This pharmacy had the highest percentage of claims in which pharmacists intervened due to a drug use or patient behavior (93.1%), the highest percentage for talking with the patient for the action code (91.2%) and the highest percentage for developing a compliance aid (result code) (90.2%). Consistent with this focused approach, Pharmacy H reported the more recent ability to print out information pertaining to a particular drug (e.g., patients starting a certain generic drug) and using this information weekly to find opportunities to bill for cognitive services. Thus, management is keenly aware of opportunities to become efficient and routinized in WMPCP and appears to have begun participating again.

If we were the instigator of going back and getting that changed by the doctor [a switch from brand to generic], then there is a mechanism of which we've become quite efficient at using the right codes and being able to send that claim in. That's how we handled it initially. Since then, we either do it right then if we have time, or...we've become very knowledgeable in this one area...so it doesn't take very long. (Pharmacy H, interview)

This type of systematic approach to billing for just a few types of interventions also is seen by Pharmacies B and F. In contrast, Pharmacy G has had more variation.

Compared to Pharmacy G, data from Pharmacy H more strongly support the likelihood of this pharmacy eventually adopting the innovation. While Pharmacy H currently receives payment for cognitive services outside of WMPCP (as do the adoptive pharmacies, A-F), Pharmacy G does not (survey). According to claims data, Pharmacy H received payment for 93 claims in 2000. This was the second highest number of paid claims of the 8 case study pharmacies, an indication of the earlier commitment or drive to participate that had waned. Regarding the success of each practice, while H regards its level of success to be very good in the past year, G reports only fair success (survey) and admitted to operating at a loss during the past year (interview) due in part to environmental changes in the workplace. The adoptive pharmacies

report very good to excellent success. Again, this comparison supports the possibility that Pharmacy H is in a better financial position to invest the money needed to adopt the innovation that could take the form of extra meetings, a new hire, a change in the use of resources for consulting or the reworking of workflow. Although Pharmacy G, as a part of a health system, may be better able to assume the cost of any employee-related infrastructure changes that could be necessary, recent loss of staff does not bode well for future WMPCP participation (interview).

The top "performers" as far as number of paid claims are Pharmacies A, B and C. All of which are independently owned pharmacies. Because Pharmacy H is an independently owned pharmacy, it may have a better chance of adopting this innovation, due perhaps to the ability of management to take more chances and make more autonomous decisions. In contrast Pharmacy G is owned by a health care system, has several layers of bureaucracy and may be less apt to take chances if management, who now appears receptive, is not convinced changes will be profitable (interview). This is significant as most pharmacies that have adopted the innovation in this study noted WMPCP participation to be at best a break-even, rather than a profitable, venture.

New software that allows for documentation has been purchased and is in use by both Pharmacies G and H. This advance is promising and yet, the technology must not only be purchased, but tried and tested in order to really gain a comfort level for every day use. Pharmacy G reports their Windows®-based software as being easy, however also relates the phenomenon of only using those software attributes one has to use each day (interview). Thus, pharmacy staff is likely to have a learning curve ahead of them with revamped WMPCP participation. Pharmacy H also reports having better Window®-based software now that is more efficient for submitting claims and documenting pharmaceutical care activities (interview). Pharmacy H has also implemented automatic dispensing equipment to help handle the expanding prescription volume which is the highest of the 8 pharmacies (claims).

Both pharmacies reported staffing shortages. Pharmacy H notes a shortage of pharmacists with a space limitation and an increase in prescriptions dispensed (survey, interview). A future move within 2 years will assist in WMPCP participation, however staffing may not grow (interview). Similarly, Pharmacy G shows a workplace that is likely to change, describing how a new staffing model is being considered which will include more technician time (interview).

Results Summary

In summary, 6 of the 8 case study pharmacies appear to have adopted the WMPCP innovation. Motivational incentives for participating are primarily financial (Pharmacy B) or primarily to prove the worth of the pharmacy profession (Pharmacies, A, C, D, E and F). The 2 pharmacies that appeared to have rejected the innovation both indicated a desire to try again, however the likelihood of this occurring seems stronger for Pharmacy H than for Pharmacy G. Consistent with the adoptive pharmacies, incentives for participation cited by these other 2 pharmacies are financial gain (Pharmacy G) and proving the profession (Pharmacy H). These 2 incentives were identified by key informants who serve in managerial positions at the case pharmacies.

Staff incentives noted by these informants included financial gain (Pharmacy B only) and organization-based professional recognition (Pharmacy F only). Personal satisfaction was by far

the most cited reason staff would participate. Related to these findings is the requirement that management be able to communicate the expectations that participation in WMPCP is what is desired. The extent to which management projects their own desires and attitudes onto their employees is not measurable, yet it seems to be occurring, with reports of there being a "culture of participation" at some of the pharmacies.

Behind every adopter in this study is an effective manager who is able to communicate expectations about WMPCP participation. In some cases, this manager or owner has been the "innovation champion" who has pushed WMPCP participation and truly made it possible for the pharmacy. Without these champions, participation would likely be dropped, a phenomenon that may explain other pharmacies' rejections of WMPCP (going beyond these 8 case pharmacies). To communicate expectations, it seems managers and owners first need to have a positive attitude about WMPCP. This positive attitude is generated by either assurance of financial viability through participation, a sense of optimism about the profession or an underlying altruism toward future pharmacists, participation is unlikely.

For some case pharmacy staff, participation is required as a condition of hire, for others it is expected or strongly encouraged. As already mentioned, for some it is described as being a part of the culture of the pharmacy itself. Nearly every pharmacy that has adopted the program has made sure to include staff pharmacists and technicians in the planning and implementing process. While top-down styles of management can certainly be effective in some situations and perhaps even necessary, by involving staff, employees are empowered and may be more likely to "buy in" to the changes necessary in the pharmacy.

Changes to the work environment and work flow are the norm in order to participate, and the movement in most of these pharmacies has been to routinize—to make the innovation an integral part of the daily routine. Changes to pharmacies include: learning how to fully use new software to handle claims submission and documentation), handling prescription dispensing activities in new ways and developing specific routines to handle claims submissions and rejected claims. Each pharmacy site is somewhat unique, although trends are identified including a division of labor specifically designed to incorporate documentation and claims handling. For some this means immediate claims submission by staff pharmacists, while for others it means batching of claims with submission by another (supervisor or bookkeeper).

Documentation for some is via computer and for others it is done using in-house designed hard copy forms intended to streamline the documentation process and/or provide a visual reminder to participate. For some, these changes have been made through trial and error, with the help of specific pharmacists in the state who had already been successful with WMPCP participation and with the help of consultants or ingenuity and time spent from within the organization.

The types of claims billed are quite focused for some and somewhat diverse for others. Most adoptive pharmacies reported some strategic approaches they have taken to maximize the opportunity for billing (all legal and quite logical). For some, participation includes taking advantage of new opportunities such as billing for prospective DUR-related changes across all Medicaid recipients through systematic searches, batching or reminders for staff. For others, participation includes finding new, creative ways (sometimes with the help of the Department of

Health and Family Services) to bill for care provided to the same individual who has "maxxed out" their codes for a certain type of service for a given year.

Participating in WMPCP has reportedly increased revenues to participating pharmacies, however it is a "break even" endeavor at best for all but one pharmacy in this study (Pharmacy B). When Wisconsin pharmacists were surveyed in 1996 about WMPCP as an upcoming program, the biggest barrier to participating noted was "time"¹⁶, a general and ill-defined reason. Of the 8 pharmacies in this study, only 2 noted this as a barrier in its ill-defined form, and it was notably the 2 pharmacies which have not adopted the innovation. Other barriers reported by these 2 pharmacies are technician and pharmacist unwillingness. Interestingly, with the adoptive pharmacies (A-F), we see other reported barriers, revealing staff motivation and finding time have been overcome through effective management, systematizing and workflow changes. The "newer" barriers to participating relate to billing procedures, coding conflicts, non-billable services and software difficulties. These barriers are being overcome through perseverance, networking and creative problem-solving with the help of peers and the Department of Health and Family Services.

CONCLUSIONS AND RECOMMENDATIONS

The intent of this investigation was to address the questions of why and how pharmacies have (or have not) participated successfully in the Wisconsin Medicaid Pharmaceutical Care Program. Through case-analysis and cross-case comparison of claims data, surveys and interviews, key informants provided insight to what has (and has not) worked for each pharmacy. Key requirements to successfully participating in WMPCP include having a manager or owner who is positive about WMPCP and is committed to participating. This manager or owner must have a clear agenda (financial or professional) with an effective means of communicating with staff and even involving them (technicians included) in planning and implementing changes needed.

For one pharmacy in particular, participation in WMPCP has been a lynch pin in the movement toward and ability to sustain pharmaceutical care. Could this be the case for others? How can participation in WMPCP and other programs which reimburse pharmacies for cognitive services be improved? The following recommendations are provided to interested parties including the Community Pharmacy Foundation, the Pharmacy Society of Wisconsin, the state of Wisconsin's Department of Health and Family Services, the national pharmacy associations and individual pharmacies and pharmacy organizations, based on study findings:

- Promote participation specifically to pharmacy managers and owners, as well as to staff pharmacists, as a means of moving the profession forward and providing opportunity for greater personal satisfaction among staff.
- Encourage managers/owners who are trying to participate to involve staff pharmacists and technicians in the planning, implementing and evaluating of necessary changes to the workflow and work environment as a means of empowerment and "buy in".

¹⁶ Hermansen CJ & Wiederholt JB. (1997) Pharmacists' Pre-Participation Response to the Wisconsin Medicaid Pharmaceutical Care Project: An Exploratory Study. Podium presentation, American Pharmaceutical Association Meeting, Annual Meeting.

- Provide new, and improve on existing, educational opportunities (continuing education and PharmD programs) in management and communications in the workplace to build managers' confidence to lead and motivate staff, and to manage change.
- Provide new, and improve on existing, educational opportunities (continuing education and PharmD programs) in the area of documentation of patient care to help managers and staff become more proficient and comfortable documenting what they do.
- Encourage managers/owners to find ways to make participation systematic in order to gain payment for existing services without creating cost-prohibitive claims handling practices.
- Encourage and advise managers/owners to consider developing an in-house hard copy documentation system which can provide both a reminder to staff and a means of streamlining the documentation process, decreasing the complexity of WMPCP and making it more compatible with existing workflow and resource use.
- Encourage managers/owners to hire with the expectation that new hires participate in the program.
- Work to revise the payment schedule which was established in 1996 to improve the relative advantage to participating, moving it up from being a barely "break even" endeavor for most.
- Find successful WMPCP participators who are willing to share their successes, communicating helpful advice via face-to-face workshops and other means (e.g., publications, presentations).
- Develop a network, and support existing networks, for pharmacy managers/owners to communicate with each other, sharing ideas and solutions to problems, working to improve the extent to which participation is visible and decreasing the complexities that exist through mastery.

Perseverance and optimism are likely to be what separates those who reject the innovation from those who adopt it. Based on interviews, it is highly apparent that participation in WMPCP is not an easy process. It can be, however, a rewarding one. The future of the profession in Wisconsin and nationwide may depend on the perseverance of managers and owners who accept the challenges of innovating in this manner.

I think the average pharmacist doesn't understand why the program is important...after doing this for a couple of years and standing back looking at it from the perspective of profitability...it's a break even chore that we do. And that's okay because we're giving better care to the patient, and we're documenting it to the state and we're showing that pharmacists can improve health or decrease costs. It's the first step of whatever comes next....until we can prove we can do this and do it well, I don't think the state or any other payer's going to say 'Let's turn to pharmacy for the answer'. There's no history that we're even doing the basics. So I think we need to take these first steps before we can move on to say we can claim to benefit the future health care system of the nation." (Pharmacy C, interview)

Appendix: Pre-Interview Survey to Key Informants

University of Wisconsin and University of Wyoming
Investigation of the
Wisconsin Medicaid Pharmaceutical Care Project

Pre-Interview Survey

Thank you for agreeing to take part in our study. We ask that you complete and return this survey within the next 7 days. It contains 31 primary questions and the following FOUR parts:

Part 1: Your Pharmacy Site's Participation

Part 2: Pharmacy Site Characteristics

Part 3: Pharmacy Staffing

Part 4: Pharmacy Services

PART 1: Your Pharmacy Site's Participation

1. First, consider your pharmacy site's participation in WMPCP. By "participation", we mean there being at least one pharmacist who provided a billable patient service followed by a claim submission.

Indicate below the extent to which each employed pharmacist (including yourself) has participated in WMPCP in the last 6 months. (Mark with an "X" the ONE BEST answer) Also, use an "X" to indicate which pharmacists, if any, are "opinion leaders" at your pharmacy. Consider an opinion leader to be one who is able to influence others' attitudes and behaviors about pharmacy practice, informally, in a desired way, with relative frequency. Use an "X" to indicate who, if any, of the pharmacists are or have been in pharmacy leadership positions at the local, state or national level.

WMPCP Participation Level in last 6 months					Opinion Leader? Local, State or National Leader in Pharmacy Profession?
	Not at all	A little bit	Quite a bit	A lot	
Pharmacist A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> opinion leader at pharmacy site <input type="checkbox"/> leader in profession (local, state or national)
Pharmacist B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> opinion leader at pharmacy site <input type="checkbox"/> leader in profession (local, state or national)
Pharmacist C	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> opinion leader at pharmacy site <input type="checkbox"/> leader in profession (local, state or national)
Pharmacist D	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> opinion leader at pharmacy site <input type="checkbox"/> leader in profession (local, state or national)
Pharmacist E	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> opinion leader at pharmacy site <input type="checkbox"/> leader in profession (local, state or national)
Pharmacist F	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> opinion leader at pharmacy site <input type="checkbox"/> leader in profession (local, state or national)
Pharmacist G	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> opinion leader at pharmacy site <input type="checkbox"/> leader in profession (local, state or national)
Pharmacist H	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> opinion leader at pharmacy site <input type="checkbox"/> leader in profession (local, state or national)

2. Did WMPCP participation ever become **routine** at your pharmacy site?

- no
- yes

3. What **incentives** exist for pharmacists to participate in WMPCP at your pharmacy site?

- financial
- merit
- personal satisfaction
- none
- other -- please describe: _____

4. Is pharmacy staff participation?

- optional
- required
- other - please describe: _____

5. How **useful** have each of the following parties been in supporting your pharmacy's efforts to participate in WMPCP? (Write the corresponding number in each blank.)

- 1-Not at All
- 2-Somewhat
- 3-Moderately
- 4-Very
- 5-Extremely

- Pharmacy Society of Wisconsin
- School of Pharmacy faculty
- Wisconsin Pharmacy Examining Board
- Wisconsin Department of Health and Family Services
- Pharmacy students
- American Pharmaceutical (Pharmacists) Association
- American Society of Health-System Pharmacy
- Other pharmacists in Wisconsin
- Other pharmacists outside of Wisconsin
- Other _____
(please list)

PART 2: Pharmacy Site Characteristics

6. Describe your pharmacy in terms of **ownership**.
- sole proprietorship
 - partnership
 - incorporated
7. Describe your pharmacy in terms of **number of units** it is associated with, by ownership/incorporation.
- single store
 - one of less than 10 stores
 - one of 10 or more
8. During the past 12 months, which of the following have **changed** in your pharmacy site?
(Check all that apply)
- Physical layout of pharmacy
 - Workflow of the pharmacy
 - Staffing patterns
 - Staffing numbers increased
 - Drug information resources, access
 - Collection of patient lab data
 - Non-lab information collected about patients
 - System for documenting patient care
 - Skills and knowledge of the pharmacists
 - Responsibilities & activities of pharmacy techs
 - Interactions with physicians
 - Relations with non-physician health care practitioners
 - Marketing activities
 - Asking patients to pay for pharmacy services
 - Financial incentives for pharmacists
 - Billing for pharmacy services outside of Medicaid
9. How much **resistance** to change have you encountered among pharmacy site staff regarding WMPCP participation?
- none
 - a little
 - moderate amount
 - a lot
 - extreme amount

10. How have aspects of WMPCP participation been **communicated** within the pharmacy organization (extending beyond the individual pharmacy site, if applicable)?

Check all that apply. Then, rank the top 3 (as applicable), with "1" as the most common and "3" as the third most common.

<u>Check</u>	<u>Rank</u>	
_____	_____	During staff meetings
_____	_____	Intra-organizational written communication
_____	_____	Informally and verbally
_____	_____	Top-down (from management to staff)
_____	_____	Dialogue between management and staff
_____	_____	Dialogue among staff only
_____	_____	Other: _____

11. Overall, how **adequate** is the availability of each of the following resources to participate well in WMPCP? (Write the corresponding number in each blank.)

- 1-not at all
- 2-somewhat
- 3-moderately
- 4-very
- 5-extremely

- ___ System for documenting patient care
- ___ Skilled and knowledgeable pharmacists
- ___ Skilled support personnel
- ___ Staffing levels

- ___ Time to provide services
- ___ Time to bill services
- ___ Access to needed drug information
- ___ Access to needed patient information

- ___ Patient willingness to be served
- ___ Relations with other health care practitioners
- ___ Management Support
- ___ Patient record keeping system

- ___ Access to capital
- ___ Equipment and supplies
- ___ Physical facilities (excluding equipment and supplies)
- ___ Marketing experience

12. Use the following scale to answer each of the questions below. In each blank, put the number that represents your response.

- 1-Not at All
- 2-Somewhat
- 3-Moderately
- 4-Very
- 5-Extremely

- _____ How **competitive** is the market in which your pharmacy is located?
- _____ How **important** have relations with prescribers been in your efforts to develop new pharmacy services?
- _____ How **important** has staff support been in your efforts to participate in WMPCP?
- _____ How **competent** is your staff to provide pharmaceutical care?
- _____ How **flexible** is your pharmacy, when faced with a need for change?
- _____ To **what extent** do you follow written procedures and policies at your pharmacy?
- _____ How **important** have staff rewards been in your efforts to participate in WMPCP?
- _____ To **what extent** do you believe that the success of your pharmacy is under your control?

- _____ How **confident** are you that your pharmacy will be able to profit from participation in WMPCP?
- _____ How **self-confident** are you that you can lead your pharmacy successfully through a transition to providing new pharmacy services routinely?
- _____ How **tolerant** of risk are you, regarding your pharmacy?
- _____ How **comfortable** are you with new technology in your pharmacy?
- _____ How **committed** is your pharmacy toward providing new pharmacy services as a business strategy?
- _____ How **visible** would you say your WMPCP participation is to your patients who receive Medicaid?
- _____ How **confident** do you feel that your efforts to participate in WMPCP will pay off?
- _____ To **what extent** have you kept your staff informed of plans to participate in WMPCP?

- _____ How **congenial** would you say relations are among pharmacy staff?
- _____ How **easy** was it to submit a claim for WMPCP when the pharmacy first tried it?
- _____ How **compatible** is WMPCP participation with your daily pharmacy operation?
- _____ How **easy** is it to **provide the services required** for WMPCP participation?
- _____ How **easy** is it to **complete the documentation** for WMPCP participation?
- _____ How **easy** is it to **handle the claims** for WMPCP participation?
- _____ To what extent does your pharmacy staff think WMPCP participation is **advantageous**?
- _____ To what extent have you **heard or learned about others** participating in WMPCP?
- _____ To what extent has participation in WMPCP been a **time burden** to your pharmacy?

13. How big is the community your pharmacy site serves?

- Rural (<2,500 population)
- Small non-urban (2,500-25,000 population)
- Large non-urban (>25,000 - 50,000 population)
- Urban (> 50,000 population)

14. Please estimate the current % of revenues for each of the following areas for your pharmacy site.

- % dispensing prescriptions
- % other professional services
- % other (general merchandise, etc.)
- 100 %

PART 3: Pharmacy Staffing

15. Please indicate the extent of **non-pharmacist staffing** at your pharmacy site. Write in the number of staff in each area:

	Full-time (≥ 30 hrs/wk)	Part-time (< 30 hrs/wk)	How many certified?
Head pharmacy technician(s)			
Pharmacy technicians			
Non-pharmacist managers			
Sales clerks			
Other			

16. How many individuals does your pharmacy site have in the area of **management**? (Indicate the **NUMBER** of individuals next to each title)

- Owner(s)
- Lead or head pharmacist(s)
- Shift manager(s)
- Store manager(s)
- Other: _____

17. How many combined years of experience are there in **management** at your single pharmacy site?

combined years

18. Realistically speaking, how many individuals have **power and control** over "how things are done" at the pharmacy site?

___ individual(s)

19. Indicate the number of pharmacists with the following **credentials** at your pharmacy site. (Indicate the # next to each credential)

- ___ B.S. Pharmacy (terminal degree)
- ___ Pharm.D. (terminal degree)
- ___ M.S. Pharmacy (terminal degree)
- ___ Completed a pharmacy residency or fellowship
- ___ Are board certified in a specialty area

20. During the last 12 months, about how many hours per week (on average) have **you** spent, in addition to your regular work responsibilities, to participate in WMPCP?

_____ hours/week

PART 4: Pharmacy Services

21. Does your pharmacy have an area for providing pharmacy services, *separate* from the dispensing area?

- ___ no
- ___ yes → If yes, how often is this area **used for patient care**?
 - ___ very little
 - ___ somewhat
 - ___ a lot

22. Which statement in each section below (A and B), applies *best* to your pharmacy site?

A. Do you **provide** cognitive, patient care services **outside of WMPCP** participation?

- ___ yes, currently we do
- ___ not currently, but we used to, before WMPCP began
- ___ no, never have

B. Do you **receive payment** (from patients directly or from third party payers) for cognitive, patient care services **outside of WMPCP** participation?

- ___ yes, currently we do
- ___ not currently, but we used to, before WMPCP
- ___ no, never have

23. Do you have a **documentation system** for patient care in place, other than for dispensing?

- no, documentation is not systematized at the pharmacy
- yes, documentation is systematically done on the computer (only)
- yes, documentation is systematically done on paper (hard copy only)
- yes, documentation is systematically done on computer and hard copy

24. Compared to 12 months ago, how would you rate your pharmacy's **focus on dispensing**?

- a lot less
- somewhat less
- about the same
- somewhat greater
- a lot greater

25. How would you rate your pharmacy's **success** (as you define it) over the past 12 months?

- Poor
- Fair
- Good
- Very Good
- Excellent

26. During the last 12 months, how many prescriptions per day (on average) has your pharmacy site dispensed?

_____ Rx/day

27. Estimate the **proportion of patients** dispensed prescriptions at your pharmacy site who receive **Medical Assistance**.

_____ % → Of these, what estimated proportion is **served** by your pharmacy's **WMPCP participation**?

_____ % of Medicaid patients served through WMPCP

28. Identify what you see as the **major costs** of *your pharmacy* participating in WMPCP?
(monetary or not)

- a. _____
- b. _____
- c. _____

29. Identify what you see as the **major benefits** of *your pharmacy* participating in WMPCP?
(monetary or not)

- a. _____
- b. _____
- c. _____

When implementing or participating in the WMPCP, what have been the **biggest barriers and facilitators** that *you and/or your pharmacy* encountered?

30. The 3 top **barriers** you encountered:

- a. _____
- b. _____
- c. _____

31. The 3 top **facilitators** you encountered:

- a. _____
- b. _____
- c. _____

**Thank you for completing the survey portion of the study.
Please drop this in the mail today, using the enclosed postage paid envelope.**