OTCs for Children

- Update on STDs
- Q and A on Pharmaceutical Care
- CE: Active Patient Partnerships
- Hepatitis A Vaccine
- Coaching Patients
Q and A from the Pharmaceutical Care Project in Minnesota

A three-year project has pharmacists turning theories into real-life practice and developing tools, techniques, and approaches that work.

by Mary Ann Tomeschko, PharmD, Linda M. Strand, PharmD, PhD, Peter C. Morley, PhD, and Robert J. Cipolle, PharmD

Building a Practice for the Future

Throughout the first two years of the Minnesota Pharmaceutical Care Project, we have tried to understand how pharmaceutical care works in the community practice setting (see sidebar, page 31). In essence, our focus has been on turning theory into practice. The result we have achieved is the Comprehensive Pharmaceutical Care practice model. This model has been developed in the practice setting by pharmacists, for pharmacists. While participating in the project, pharmacists have raised important questions that are probably on the minds of others who are contemplating changing their practices to encompass pharmaceutical care.

The question-and-answer format used here will communicate some of what we have learned during the project's first two years. The "conversation" that follows reflects the interaction of ideas that, for better or worse, shaped our attempts to define, develop, clarify, and implement Comprehensive Pharmaceutical Care in the community pharmacy setting.

Clarifying Pharmaceutical Care

- Pharmacists have three questions about pharmaceutical care: how to provide it, how to overcome obstacles, and how to receive reimbursement for the service.
- Pharmacists in the Minnesota project define pharmaceutical care as "finding and responding to the drug therapy problems of patients."
- Patient counseling is only one component of pharmaceutical care.
- Comprehensive Pharmaceutical Care means that the pharmacist's focus moves from the dispensing process to patient care.
- The therapeutic relationship—a key feature of pharmaceutical care—is a partnership between the pharmacist and the patient to work together to patient, identify, and solve drug therapy problems.

Pharmacists John Lock (center), Ted Lock, and Michelle Schultz confer about a patient's therapy as part of a three-year pharmaceutical care project in Minnesota. The project, involving 44 pharmacists, is helping to define the practice of pharmaceutical care.
What Is Pharmaceutical Care?

Q: Every time I pick up a pharmacy journal or talk with someone about pharmacy I am bombarded by the term "pharmaceutical care." The term is used to mean many different things. Just what is it?

A: In the most general sense, pharmaceutical care has become the publicly acknowledged professional mission of pharmacy. Understanding exactly what it means, however, requires going back to the ideals put forth in a 1990 paper written by Hepler and Strand. Titled "Opportunities and Responsibilities in Pharmaceutical Care" (Am J Hosp Pharm 1990; 47(5):555–55), this paper discussed the philosophy of pharmaceutical care and contained a skeletal outline of what practice might be like. However, since neither Hepler nor Strand had actually employed these concepts at the time, they could not detail the practice or discuss the pragmatics of implementing it.

Pharmacists in our project identified three concepts from Hepler and Strand that formed the foundation for their work:

- **Societal need:** Pharmacists must acknowledge that society needs health care providers to address drug-related illnesses—and that pharmacists can meet this need.
- **Caring:** Pharmacists will have to "care" for their patients. This involves assessing a patient's total drug-related needs, doing all that is necessary to meet these needs, and ensuring that no harm is done to the patient.
- **Patient centeredness:** To have a meaningful impact, pharmacists must provide care on a patient-specific basis, with regard to the patient's total drug-related needs.

With these concepts in mind, we created an operational definition of pharmaceutical care. Very simply, pharmaceutical care is finding and responding to the drug therapy problems of patients.

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**The Minnesota Pharmaceutical Care Project**

The purpose of the Minnesota Pharmaceutical Care Project is to determine whether the philosophy of pharmaceutical care, as described by Hepler and Strand, can be implemented in the community practice setting. The Minnesota Pharmaceutical Care Project is a three-year demonstration study, begun in 1992 and conducted by the Peterson Institute of Pharmaceutical Care, a research and program development unit within the University of Minnesota College of Pharmacy. The institute's mission is to design and evaluate pharmaceutical care practice models and educate others about them.

This project is a collaborative effort of the college, the Minnesota Pharmacists Association, and the Minnesota State Board of Pharmacy. Additional support has been provided by Actia Health Plans, The Open Blue Shield of Minnesota, Diversified Pharmaceutical Services (DPS); Gluxo Inc.; Health Partners; PCN Health Systems; and Merck & Co., Inc.

Pharmacists recruited for the project worked alongside investigators to explore how to implement pharmaceutical care. As a result, they have retained personnel, delegated all dispensing duties to technicians, changed their entire work flow, designed a new process for providing patient care, and are now systematically delivering, documenting, and receiving reimbursement for Comprehensive Pharmaceutical Care. In essence, the study pharmacists have redefined community pharmacy practice. The material in the article was developed by pharmacists and staff of this project.

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**Project at a Glance**

- **Prestudy Period (May 1–September 30, 1992):** Staff and volunteers were organized. Twenty practice sites (involving 54 pharmacists) were chosen throughout Minnesota. 5 chain pharmacies, 13 independents, and 2 clinic-based pharmacies.

- **Study Year 1 (November 1, 1992–October 31, 1993):** Ten pharmacists participated in a one-year pilot study to address the questions: "What would the pharmaceutical care philosophy look like in practice?" and "How would pharmacists make the transition?" During the year, the pharmacists and project staff defined responsibilities and processes for delivering pharmaceutical care, developed a documentation tool and a reimbursement formula, created recommendations for pharmacy design and layout, and designed educational materials.

- **Study Year 2 (November 1, 1993–October 31, 1994):** Pharmacists at all study sites were asked to improve the practice model developed by the pilot pharmacists and further refine the implementation process. Pharmacists and technicians received training, the reimbursement model was tested, the computer program was implemented, and experiential certification and accreditation criteria were applied.

- **Study Year 3 (November 1, 1994–October 31, 1995):** This year's objective is to evaluate the Comprehensive Pharmaceutical Care practice model. The researchers will use data generated by the pharmacists to assess the practice model's impact on the prevention, detection, and resolution of drug therapy problems. Researchers will describe and quantify the frequency of drug therapy problems in the ambulatory patient and study the patient characteristics, drug therapies, and medical conditions associated with these problems. When possible, researchers will calculate the value of the pharmacist's service. The researchers will also examine the impact of this service on pharmacists who provide it, on physicians who come into contact with it, and on patients who receive it.
counseling is a drug-information function; the pharmacist provides information to help patients take their drugs more appropriately. The information is drug focused and, in the case of OBRAs, is defined in terms of the type and amount of information to be given and the patients who will receive it.

In Comprehensive Pharmaceutical Care, patient education is only one of several components of the patient service that the pharmacist provides. The pharmacist cannot educate a patient about drugs to be used without first collecting information needed to assess that patient’s entire drug therapy. Then, the pharmacist can make appropriate interventions to ensure that the drug therapy is, and remains, safe and effective. Finally, the pharmacist follows up with the patient to ensure that desired therapeutic outcomes occur and that adverse outcomes have been prevented.

Q: Why is the practice by pharmacists in the Minnesota Pharmaceutical Care Project called “Comprehensive Pharmaceutical Care”?

A: The term “pharmaceutical care” is used so loosely that it has come to mean anything that the pharmacist does. The pharmacists in this project needed to differentiate the practice they developed from value-added services, the counseling mandated by the Omnibus Budget Reconciliation Act of 1990 (OBRA '90), specialty practices, and other work-management systems. Thus, Comprehensive Pharmaceutical Care is provided only when: (1) the pharmacist sees and responds to all of the patient’s drug-related needs, (2) the management system (human resources, physical environment) supports the provision of this service, and (3) a reimbursement mechanism for these services is in place.

Q: Is Comprehensive Pharmaceutical Care the same as patient counseling, such as that required by OBRA?

A: No. Patient counseling is quite different. Most often,

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Table 1

The Comprehensive Pharmaceutical Care Process

1. **Patient Consultation**
   - Discuss the patient's expectations and concerns about drug therapy, to evaluate the patient's understanding of drug therapy, and to identify the patient's drug-related needs.

2. **Pharmacist's Assessment**
   - Of the patient's entire drug therapy needs, for the purpose of identifying current or potential drug therapy problems.

3. **Creation of care plans**
   - To establish specific therapy goals, a monitoring schedule, and a written patient record, to resolve current drug therapy problems and prevent others.

4. **Patient Education, Recommendations, and Referrals**
   - That will provide individualized, current information about the patient's drug therapy, give instructions for proper use of medications and related products, demonstrate special techniques or devices, and provide health and disease information.

5. **Patient Monitoring and Follow-up**
   - At planned intervals to ensure that new drug therapy problems do not develop, therapeutic goals are being met, and actual patient outcomes are evaluated and documented.

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**Q:** How does the pharmacist provide this patient service?

**A:** The pharmacist provides the service by establishing a therapeutic relationship with the patient, which enables the pharmacist to use consistently the standard Comprehensive Pharmaceutical Care process described here.

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**Q:** What is a therapeutic relationship?

**A:** A therapeutic relationship is a partnership between the pharmacist and the patient characterized by trust and a reciprocal agreement to work together to prevent drug therapy problems—and to identify and solve drug therapy problems when they occur. This relationship allows the pharmacist to gather detailed, and sometimes personal, information from the patient. In return, the pharmacist shares knowledge and expertise with the patient and works on the patient's behalf to ensure safe and effective drug therapy.

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**Q:** What process does the pharmacist use to provide Comprehensive Pharmaceutical Care?

**A:** The Comprehensive Pharmaceutical Care process, illustrated in Figure 1, focuses on direct interaction between the pharmacist and the patient. Other health care providers are included in the Comprehensive Pharmaceutical Care process when they are needed to meet the patient's drug-related needs.
Q: How does the pharmacist assess the patient's drug therapy problem?
A: The pharmacist assesses the patient's drug therapy to determine whether it will be safe and effective and to identify current and potential drug therapy problems. This assessment consists of a set of questions, described in Table 2. These questions integrate the pharmacist's knowledge with patient-specific information collected and documented during the work-up (see figure 1) to help the pharmacist prevent, detect, and resolve drug therapy problems. The information required to answer these questions is more detailed than that needed to dispense medications. To complete the assessment, the pharmacist always needs to know the indication for the drug therapy; all the medications the patient is taking—including those purchased over-the-counter (OTC), supplied through mail order, handed out as physician samples, or obtained in other countries; the patient's chronic medical conditions; and the patient's medication history. At first, pharmacists in our project found it difficult not to assume too many things about the patient's drug therapy. They learned that they had to ask the patient for much more information than they had been asking for in the past.

A complete list of problems that can be identified when the pharmacist assesses the patient's drug therapy can be found in Table 5.

Q: It sounds as though the pharmacist needs a significant amount of information to complete the assessment and create the care plan. How do pharmacists get all the information they need—from the medical diagnosis, laboratory values, and so on?
A: The information systems in community pharmacy practice are far from perfect, but this has not limited us. Patients are a tremendous source of information and have the legal and ethical right to request details about their health status from their physicians so that they can supply the information to pharmacists. Many times, patients are willing to provide pharmacists with information that they do not have time to share with physicians. When pharmacists are unable to obtain necessary and accurate information from patients, they ask physicians for it directly.

Q: Do all patients receive Comprehensive Pharmaceutical Care each time they come into the pharmacy?
A: No, not all patients need Comprehensive Pharmaceutical Care each time. In general, a Comprehensive
Pharmaceutical Care encounter is initiated when a patient:

-Has a new prescription order. The patient can receive the service when picking up the prescription, or if the encounter is likely to be complex or time consuming, during a scheduled appointment or with a follow-up telephone call.

-Is on chronic therapy. Such patients receive Comprehensive Pharmaceutical Care on a regularly scheduled basis, depending on the disease, the drugs prescribed, and the patient's needs.

-Identifies a therapeutic problem or suspects that something unintended may be occurring with the drug therapy. Among issues that fall in this category are questions about OTC drugs, concerns about adverse reactions, requests for additional information, and pharmacists' identifying or suspecting problems.

The project pharmacists estimate that approximately 50% of patients who enter the pharmacy in the course of the day require Comprehensive Pharmaceutical Care. The other 50% are there to pick up a refilled prescription or to buy an item that does not require the attention of a pharmacist.

Even though 50% of all patients might need the service, in the initial stages of implementation, pharmacists start with one patient at a time. The financial realities of community pharmacy practice today mean that the service is provided first to patients whose insurance reimburses pharmacists for the service. Pharmacists can then increase their patient load as soon as they are able to invest the additional resources needed to provide Comprehensive Pharmaceutical Care to more patients.

Q: How much time does a pharmacist spend with each patient?
As it depends largely on the nature of the patient's drug-related needs. The average amount of time spent face-to-face with a patient is three to five minutes, which does not include documenta-

**Table 3**

<table>
<thead>
<tr>
<th>Assessment</th>
<th>Drug Therapy Problems</th>
<th>Causes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indication</td>
<td>Unnecessary drug therapy</td>
<td>No medical indication, Addiction or recreational drug use, Nonindication of appropriate, Duplicate therapy, Treatment without adverse reaction.</td>
</tr>
<tr>
<td>Effectiveness</td>
<td>Wrong drug</td>
<td>Dosage form inappropriate, Contraindications present, Condition refractory to drug.</td>
</tr>
<tr>
<td></td>
<td>Dosage too low</td>
<td>Drug not indicated for condition, More effective medication available, Drug interaction.</td>
</tr>
<tr>
<td>Safety</td>
<td>Adverse drug reaction</td>
<td>Wrong dose, Frequency inappropriate, Duration inappropriate, Incorrect storage, Incorrect administration, Drug interaction.</td>
</tr>
<tr>
<td></td>
<td>Dosage too high</td>
<td>Unsafe drug for patient, Allergic reaction, Incorrect administration.</td>
</tr>
<tr>
<td>Compliance</td>
<td>Inappropriate compliance</td>
<td>Drug product not available, Cannot afford drug product.</td>
</tr>
<tr>
<td></td>
<td>Needs additional drug therapy</td>
<td>Does not understand instruction, Patient prefers not to take medication.</td>
</tr>
<tr>
<td>Untreated Indication</td>
<td>None known</td>
<td>---</td>
</tr>
</tbody>
</table>

The actual number of time pharmacists must spend with each patient tends to lessen as their experience in providing Comprehensive Pharmaceutical Care grows, and it depends on several factors:

- The number and types of medical conditions the patient has.
- The number and types of medications involved.
- The number and types of drug therapy problems identified.
- The patient's level of interest and specific needs.
- The communication skills of both the pharmacist and patient.
The degree of openness established between the pharmacist and patient. The reliability of other personnel who can perform their duties while the pharmacist is engaged in patient care—thus keeping the pharmacist free from distractions.

The efficiency of the pharmacy's layout and its measures to ensure privacy.

### Converting Pharmacy Practice

**Q:** What is the first step toward implementing this practice in a community pharmacy?

**A:** A number of changes must occur in the pharmacy before a new and different service can be provided. The first step is to separate dispensing from patient care, both functionally and physically. This action will free the pharmacist to spend more time with patients.

**Q:** Why must dispensing be separated from patient care?

**A:** The pharmacist must devote full attention to the patient when providing Comprehensive Pharmaceutical Care. To allow the pharmacist this time, dispensing functions must be delegated to support personnel (technicians). Obviously, the pharmacist remains responsible for legal dispensing requirements, but other than this, the pharmacist's role in the dispensing function should be primarily supervisory.

**Q:** What do technicians do after the dispensing and patient care functions have been separated?

**A:** Pharmacists should enter prescription orders into the computer, dispense prescriptions, resolve insurance problems, answer the telephone, order inventory, run the cash register, stock shelves, coordinate deliveries, or sell lottery tickets. Therefore, technicians and clerks become a much more important part of the practice.

Changes of this magnitude require that all pharmacy personnel be informed of the pharmacy's new mission. Employees should understand the changes made, their roles in the new practice, and what to expect. This information is especially important when the implementation process begins, because any change is difficult at first and can feel uncomfortable.

**Q:** Can pharmacy technicians and clerks really be trained and trusted to take all this new responsibility?

**A:** The technicians at the study sites have demonstrated that, with proper training and a modest amount of practice, they can dispense prescriptions as fast as the pharmacists do and have a positive impact on the new patient flow pattern. Implementation of new responsibilities occurs more quickly—in as little as four weeks—if technicians are already proficient on the computer and are familiar with the dispensing process.

**Q:** Will this separation require more pharmacists and technicians?

**A:** The answer depends entirely on how pharmacists and technicians are now being used in the pharmacy. Enough technical and clerical support must be hired to dispense medications while pharmacists are working with patients. We found that once a pharmacy is providing Comprehensive Pharmaceutical Care, a technician is able to fill approximately 55-65 prescription orders per day and handle all other delegated technical functions. A pharmacist, on average, can provide pharmaceutical care to 40-45 patients in a nine-hour shift. Our pharmacies have also found that they need at least one hour at the end of the workday to complete unfinished documentation.

**Q:** Why is it necessary to physically separate dispensing from the patient care function?

**A:** First, because the pharmacist needs a work space outside the dispensing area. Second, because the patient appreciates a private area in which to consult with the pharmacist.

The pharmacist needs a work space outside the dispensing area for research, documentation, and privacy. This work space, which consists of a desk and reference area, is usually in the patient care area to allow easy access to patients.

Patients receiving Comprehensive Pharmaceutical Care have expressed a desire for a private area in which to talk with pharmacists about personal information. For ambulatory patients who require short encounters, most pharmacists use stand-up counseling booths separated by partitions, with waist-high surfaces for writing and a computer terminal. Sometimes an office-type setting is needed for longer appointments and increased privacy. Project pharmacists suggest that all physical changes in pharmacy layout be temporary at first because it takes several months to understand fully the impact of the practice changes and to determine the best configuration.

Pharmaceutical care is finding and responding to the drug therapy problems of patients.
Q: What else is required to get started?
A: Equipment and supplies must be purchased. A fax machine is necessary to receive prescription orders; send refill requests; receive refill authorizations; and communicate with patients, physicians, and other health care professionals. It is also necessary to purchase computer hardware and to gain access to software that allows the pharmacist to document Comprehensive Pharmaceutical Care. Reference books are needed, and a file cabinet for storage and retrieval of reference materials is also useful.

Managing Potential Obstacles

Q: What are the obstacles to implementing Comprehensive Pharmaceutical Care?
A: Project pharmacists have found that being aware of potential obstacles is the first step toward managing them. Their experience reveals that the following may interfere with smooth implementation of Comprehensive Pharmaceutical Care:
- Lack of commitment from the pharmacy owner/manager, practicing pharmacists, and/or technical personnel.
- Poor time management and failure to set priorities for activities.
- Reluctance of patients to accept change and cooperate.
- Physicians’ reluctance to accept the pharmacist in a new role.
- Lack of training and preparation of pharmacists and technicians.
- Resistance by personnel and lack of communication skills.
- Inability of pharmacists and technicians to disengage from the old paradigm and shift to the new paradigm. Pharmacists frequently claim that they “fall back into the old way of thinking.”
- Inadequate use of problem-solving skills.
- Lack of confidence or weak sense of self-esteem.
- Intense pessimism about proposed changes and their consequences among the general public: “I can’t see people accepting us in this role. Maybe they don’t want to talk to us—we’re not doctors!”
- Loss of faith in pharmacy as a profession: “Is this really worth it? Where has everything else that we’ve tried finished up? The profession is on the rocks, and I can’t see it getting off them—not in my lifetime.”
- Belief that the economic angle must be squashed away before the work is done, documented, and demonstrated to be of value: “I don’t think we should do anything until we’re paid to do it.”

The pharmacists who are now providing the service experienced some measure of all of the obstacles listed above, but none experienced the trauma of facing them all at once. Thus, before implementing the service, it is important to develop a plan to prevent or deal with each of the obstacles listed. In our project, common-sense solutions were always the most useful.

Q: Is it necessary to tell patients about the changes in the service they will receive? If so, how is it done?
A: Not only is it necessary to notify patients, but it is also essential to change their expectations. Pharmacists must educate patients, which our pharmacists have done in a number of ways:
- They have developed a different “look” and “feel” in the pharmacy to produce the appropriate ambiance. Patients need to recognize and feel that things are different.
- They have added clearly visible signs to the pharmacy to explain the changes and to indicate new areas of service, handed out notifications and bag stuffers, and sent follow-up postcards.

All pharmacy employees should be prepared to explain clearly to patients the new roles of pharmacy personnel, relationships between the pharmacist and patient, and their performance expectations. They should be able to provide coherent, concise replies to patients’ questions and to offer equally forthright explanations in response to “What is going on here?”

However, more effective than telling the patient about the service is actually providing it. Only then can the patient experience its benefits, which go a long way toward changing patients’ expectations.

Q: What kind of training or preparation does a pharmacist need to provide Comprehensive Pharmaceutical Care?
A: It is common for pharmacists to express feelings of inadequacy about the knowledge and skills required to make this transition in their practices. All pharmacists who are motivated and have a desire to make these changes are, no matter how long they have been out of school, have been able to manage the educational demands of the program. Instead of emphasizing the acquisition of new knowledge, our training emphasizes learning to ask the right questions and developing good investigative and research skills. Pharmacists are taught to use the patient care process to think through patients’ problems.

How Do Patients React?

Q: How do patients react when pharmacists provide Comprehensive Pharmaceutical Care?
A: As the study pharmacists found most patients to be cooperative from the start. Patients reported that they understood the purpose of Comprehensive Pharmaceutical Care and expressed surprise that “it did not happen sooner,” particularly as the “problems have been around a long time and it’s been hard to get answers from anyone.” Patients come to expect the service once it has been offered and explained.
Q: How should pharmacy personnel deal with patients who are not interested in the service?
A: Any patient has the right to refuse the service offered. However, our pharmacists have found that when patients are unwilling to participate, it is usually because the service is new and unknown. They may not understand it and may even resent the intrusion into what they see as the physician’s domain. It is important to emphasize the cooperative nature of care and all of its checks and balances. Pharmacists find that approximately 1% of all patients simply do not have time to become involved in Comprehensive Pharmaceutical Care. This choice should be respected.

What About Reimbursement?

Q: To provide Comprehensive Pharmaceutical Care, pharmacists clearly cannot get paid only the customary dispensing fee. Are pharmacists being reimbursed for providing the service?
A: Although project pharmacists are being reimbursed by third party payers in a pilot program, no guarantees have been made that reimbursement will be available after the project is completed. However, if this service is to survive the test of time, it will be necessary to obtain reimbursement for it. The data generated by the pharmacists now providing Comprehensive Pharmaceutical Care will help to demonstrate the service’s value.

Our pharmacists are presently implementing a system for changing patients directly for the service.

Q: What system is being used for reimbursement?
A: We evaluated all types of reimbursement systems before choosing the one that would best reflect the pharmacist’s work in Comprehensive Pharmaceutical Care: a resource-based relative-value scale.

The fee-for-service approach did not seem appropriate for many reasons. First, the health care system is beginning to move away from this method toward a more accountable, patient-outcomes basis for payment. Second, a fee-for-service method does not focus on what the patient needs; it focuses on what the pharmacist does. The consensus in our project was that the pharmacist should not be paid for performing specific functions because they may vary by pharmacist. Rather, the pharmacist should be paid on the basis of patient need. The fee-for-service approach does not allow for this.

Although pharmacists may one day be paid on the basis of a capitation system, we do not, at present, have enough information to select this approach. For capitation payment to benefit all parties, the pharmacist must know the costs of providing the service, the financial risk associated with it, and the service’s impact on the patient. Ultimately, data gathered through this project will help to provide the information needed to design a capitation system of payment.

The resource-based, relative-value scale was selected, first of all, because it is consistent with the payment system established for physicians and other health care providers. This method of payment is based on the level of the patient’s need, and it allows the pharmacist to be paid for everything that is done on the patient’s behalf. Finally, the concept of a resource-based, relative-value scale is consistent with the service provided in Comprehensive Pharmaceutical Care.

Q: How does the resource-based, relative-value scale work?
A: This system pays the pharmacist at one of five different levels. The level of payment is based on patient need: for example, payment is determined by the number of medications the patient currently takes, the number of medical conditions for which the patient is under treatment, and the number of drug therapy problems the patient is having. The levels of service vary from the simplest, most straightforward needs of patients at level 1 to the most complex needs of patients at level 5. A different level of “work” is provided by the pharmacist at each of the five reimbursement levels. The “work” is determined by the following:

- The pharmacist’s work-up of drug therapy.
- The pharmacist’s assessment of drug therapy problems.
- The complexity of the pharmacist’s decision making in care planning and evaluation.
- The nature of the risks of the drug therapy problem(s).
- The amount of counseling and/or care coordination needed.
- The amount of face-to-face time spent with the patient.

The computerized documentation program used by the pharmacists automatically evaluates the patient information to determine the appropriate level of payment.

Q: What about programs that pay pharmacists to make interventions?
A: Several “intervention-focused” programs are being introduced into the marketplace. Most of these programs are designed to pay pharmacists a fee for making specific interventions selected by third party payers, such as substituting generics and identifying duplicate therapy. These approaches, as with the current dispensing-fee system, pay pharmacists for only a small part of what they do. Therefore, in the long term, these programs are unlikely to resolve the financial difficulties of today’s community pharmacy. Whether or not these programs can provide adequate care for the patient is also unclear.

Q: What else can pharmacists do to increase the likelihood that reimbursement will be forthcoming?
A: Documenting activities and results in the Comprehensive Pharmaceutical Care process is absolutely necessary if pharmacists are to be reimbursed.
Q: Has a formal documentation system been developed for Comprehensive Pharmaceutical Care?

A: Pharmacists use a patient care documentation software program. The basic documentation criteria for the system include patient demographics, relevant medical history, complete medication record, pharmacists' assessments of patients, care plans and problem statements, goals for resolving or preventing identified problems, pharmacists' interventions and monitoring parameters, follow-up plans, actual patient outcomes, and pharmacists' evaluations.

Developing new patient records can be time consuming, but once the patient record system is in place, patient work flow and workload can be managed quite easily with the help of well-trained pharmacy technicians and clerks.

Q: Do all pharmacists have to deliver Comprehensive Pharmaceutical Care before it will be accepted and reimbursed?

A: It is unrealistic to expect all pharmacists to accept this practice model now or in the foreseeable future. It is also difficult to imagine that the necessary training and implementation programs will be available soon for all pharmacists who want to provide Comprehensive Pharmaceutical Care.

It is necessary, however, that enough pharmacists accept this practice model so that all patients enrolled in a particular payer's plan have access to the service. Patients who pay for this service will also expect to have the service available when and where it is needed. Efforts at the Peters' Institute are now directed toward broad dissemination of this practice model in community pharmacy practice.

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