Barriers and best practices related to documentation of electronic care plans: a survey of community-based pharmacies in four states

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Presentations: The American Pharmacists Association (APhA) 2021 Annual Meeting Virtual Poster Hall.

Financial Support:

This work was supported by an Incentive Grant of $1,000 through the APhA Foundation. The sponsor had no role in the study design; collection, analysis, and interpretation of data; manuscript-writing; or in the decision to submit the article for publication.

Conflicts of Interest:

Laura Rhodes discloses that she is the Managing Network Facilitator for CPESN Florida.

Jordan Ballou discloses that she is the Managing Network Facilitator for CPESN Mississippi.

Erin Dorval discloses that she is a luminary for CPESN Florida.

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Word Count: 2117

Abstract: 300

Total: 2417

Number of Tables: 1

Number of Figures: 1

Number of Supplemental Files: 0

ABSTRACT (300)

Background: While the provision of enhanced pharmacy services within community-based pharmacy is increasing, there remains an opportunity to improve efficient documentation of services. The pharmacist eCare plan is defined as "a longitudinal person-centric dynamic plan that represents a patient's and pharmacist's prioritized concerns, goals, and planned interventions and incorporates medication-related information captured by all members of the care team."

Objective: The primary objective was to identify barriers and best practices related to documentation of eCare plans within community-based pharmacies participating in four Community Pharmacy Enhanced Services Networks (CPESN).

Methods: One of two 24-question electronic surveys was distributed to pharmacies in CPESN Florida, Georgia, Mississippi, and Ohio. Pharmacies submitting <10 eCare plans in the prior quarter received a survey to assess barriers to implementation; pharmacies submitting ≥10 eCare plans received a survey to assess best practices for implementation. An independent samples t-test assessed differences in knowledges scores between groups.

Results: Sixty-three responses were received (Barriers=19; Best Practices=44). Best Practices pharmacies scored higher than Barriers pharmacies on the knowledge portion of the survey (9.26 vs. 7.26 out of 13 points, p=.001). Barriers most frequently reported were staffing resources (n=11, 57.9%), perceived time commitment (n=8, 42.1%), and lack of payment for services (n=8, 42.1%). Most Best Practices pharmacies agreed or strongly agreed that they actively involve pharmacists (n=36, 81.8%) and student pharmacists (n=33, 75.5%) in the eCare planning processes. The types of encounters most utilized by Best Practice pharmacies were medication synchronization (n=35, 79.5%), drug therapy problems (n=29, 65.9%), assessment of adherence (n=28, 63.6%), blood pressure monitoring (n=27, 61.4%), and medication reconciliation (n=24, 54.5%).

Conclusions: A difference in knowledge and perceptions exists between pharmacies who regularly eCare plan and those who do not. These trends found should be utilized in creating training to increase eCare planning quality and consistency in community-based pharmacy settings.

Background (565)

The expansion of pharmacist training programs moving beyond product distribution towards comprehensive, patient-centered care has impacted the healthcare ecosystem in many ways. Community-based pharmacists are becoming increasingly equipped to provide enhanced patient care services and intervene to positively impact medication adherence and disease state management.[1]

Research has shown that pharmacist-led interventions present a unique opportunity to decrease overall healthcare costs, decrease hospital readmission rates, and improve patient outcomes through medication synchronization, medication therapy management, transitions of care, chronic care management, and similar programs.[2-5] As highly accessible and frequently visited healthcare team members,[6] community-based pharmacists have many opportunities to make interventions and can provide insight into barriers and issues patients may not disclose to other providers. The Joint Commission of Pharmacy Practitioners' adoption of the Pharmacist Patient Care Process (PPCP) has provided pharmacists a standardized method for implementing the patient care process. Pharmacy schools are now required to teach the PPCP to all students as a part of their accreditation standards.[7-8] Additionally, residency training programs have expanded in recent years, allowing for further specialized training for pharmacists to engage with in direct patient care.[9-10] These factors help ensure that a stream of pharmacists who are equipped to engage in direct patient care enter the marketplace.

While the provision of enhanced pharmacy services is increasing, there remains an opportunity to improve in efficient documentation of patient care services. Since the implementation of the Health Information Technology for Economic and Clinical Health (HITECH) Act in 2009, electronic health records (EHRs) have been broadly implemented across a variety of healthcare settings, from large health systems to small practice sites.[11-12] However, widespread integration of electronic care planning in the community-based pharmacy setting has lagged outside of medication therapy management. One reason for this delay is that the electronic care plan (eCare plan) initiative and medication management Systematized Nomenclature Of Medicine Clinical Term (SNOMED CT) codes utilized in eCare plans were not published and formally available for use until 2016.[13] The National Council for Prescription Drug Programs defines the pharmacist eCare plan as "a longitudinal person-centric dynamic plan that represents a patient's and pharmacist's prioritized concerns, goals, and planned interventions and incorporates medication-related information captured by all members of the care team".[13-15]

The PPCP is intended for documentation facilitated by health information technology, enabling pharmacists to obtain needed patient information and communicate interventions to other members of the healthcare team.[7] It is for this reason that the utilization of eCare plans has the potential to improve continuity of care and, in turn, deliver a way to input data that may ultimately be used to define value expression for community-based pharmacist-provided enhanced services. Clinically integrated networks, such as the Community Pharmacy Enhanced Services Network (CPESN USA), are networks of pharmacies that coordinate patient care with broader care teams to provide medication optimization and enhanced

services for complex patients. There are approximately 50 local networks that fall under the CPESN USA parent organization, of which most represent a single state (e.g., CPESN Florida). All pharmacies within these local networks offer enhanced services beyond prescription dispensing and are held to quality assurance standards, which are defined by CPESN USA and include expectations for quantity and quality of eCare planning.[16] Many CPESN pharmacies have embraced the eCare planning initiative, while others have been slower to implement it. Importantly, barriers and best practices to implementation of eCare planning have not yet been described in the literature.

Objectives (39)

The primary objective of this study was to identify barriers and best practices related to documentation of eCare plans within community-based pharmacies who are members of the Community Pharmacy Enhanced Services Networks (CPESN) of Florida, Georgia, Mississippi, and Ohio.

Methods (371)

We performed a cross-sectional study of community-based pharmacies in four states relating to documentation of eCare planning. This project was approved by the Institutional Review Board of Palm Beach Atlantic University and all respondents were provided written informed consent. Pharmacies were included if they are participating pharmacy in CPESN Florida, Georgia, Mississippi, or Ohio. Using historical reports of eCare planning quantities, the research team determined if each participating pharmacy achieved the metrics set forth in the CPESN USA eCare planning standard, which requires 10 eCare plans to be submitted each quarter. Pharmacies who submitted <10 eCare plans in the third quarter of 2020 received the barriers survey. Pharmacies who submitted 10 or more eCare plans in the third quarter of 2020 received the best practices survey. Pharmacies were excluded if they were not participating pharmacies in one of the aforementioned CPESN networks.

An electronic link to one of two 24-question surveys was distributed via email using Constant Contact to the primary contact at all participating pharmacies in CPESN Florida, Georgia, Mississippi, and Ohio. Data was collected via two online Microsoft Form surveys. Items common to both surveys included voluntary consent, demographics, knowledge, perceptions, and goals of eCare planning. Pharmacies were asked to identify goals their pharmacy team had for eCare planning in an open-ended response format. The Barriers survey included questions identifying barriers to implementation of eCare planning as well as the preferred method(s) to address barriers through educational materials. The Best

Practices survey included questions identifying best practices in workflow, staff utilization, and timing of eCare planning. The survey remained open for 14 days with a reminder sent on days 7 and 12. An incentive of a drawing for a $50 Visa gift card was offered to those who completed the survey. Two pharmacies from each network were randomly chosen to receive a $50 Visa gift card.

After survey closure, data was exported to Microsoft Excel for analysis. Descriptive statistics were utilized to evaluate data. An independent samples t-test assessed for differences between knowledges scores between the barriers survey group and the best practices survey group. This analysis was performed using SPSS v.26 (IBM, 2019). Qualitative data was gleaned from open-ended questions and analyzed thematically using inductive and deductive coding.

Results (511)

There were 181 Barriers surveys distributed via Constant Contact to participating pharmacies meeting the Barriers criteria; of these, 173 surveys were successfully delivered and 19 survey responses completed (response rate 11.0%). There were 108 Best Practices surveys distributed; of these, 107 surveys were successfully delivered and 44 survey responses were completed (response rate 41.1%). Demographic characteristics of survey respondents are available in **Table 1.**

Knowledge and Perceptions

Best Practices pharmacies scored higher than Barriers pharmacies on their knowledge surrounding eCare planning (9.26 vs. 7.26 out of 13 points, CI -4.0 to -1.2, p =.001). Best Practices pharmacies more frequently reported the perception that eCare planning enhanced their value to payers and providers, enhancing the quality of care for their patients, and viewed eCare planning as a valuable use of their time that should be an integral part of their team's workflow. In contrast, Barriers pharmacies more frequently reported views on eCare planning as too much work with not enough return on investment (**Figure 1**).

Barriers

The barriers most frequently reported as preventing pharmacies from completing 10 or more eCare plans in the previous quarter included staffing resources (n=11, 57.9%), the perceived time commitment associated with eCare planning (n=8, 42.1%), and the lack of payment for services (n=8, 42.1%). Other barriers reported were eCare plan technological/transmission issues, staff receptiveness, unwillingness to change workflow, or new costs associated with eCare planning technology. Additional

themes gleaned from open-ended explanations included COVID-19 challenges and staff turnover. Most pharmacies reported a preference for additional training by their local CPESN networks (n=7, 36.8%) vs. CPESN USA, their eCare planning vendor, or national or state pharmacy associations. A preference was expressed for the training to be in the format of a pre-recorded webinar (n=11, 57.9%). Qualitative analysis revealed that Barriers pharmacies' goals included involving non-pharmacist staff in the eCare planning process and meeting the eCare plan standard by completing more eCare plans.

Best Practices

A majority of pharmacies either agreed or strongly agreed that they actively involve pharmacists (n=36, 81.8%) or student pharmacists (n=33, 75.5%) in the eCare planning processes, while pharmacy technicians and other staff were less utilized. Most teams submitted eCare plans throughout the day (n=35, 80.0%) and throughout the month (n=39, 88.6%). Others submitted either in the morning (n=2, 4.5%) or at the end of the day (n=7, 16.0%). Themes for best practice workflow implementation identified from open-text responses included flagging/notating prescriptions or bags for potential encounters, using a basket to collect encounters written for later documentation, focusing on specific patient populations monthly, and utilizing an overlap in pharmacy staff as an opportunity to complete and document encounters. The types of eCare plan encounters most utilized by Best Practice pharmacies were medication synchronization (n=35, 79.5%), drug therapy problems (n=29, 65.9%), assessment of adherence (n=28, 63.6%), blood pressure monitoring (n=27, 61.4%), and medication reconciliation (n=24, 54.5%). Qualitative analysis revealed Best Practices pharmacies' goals including increasing the number of eCare plans, altering workflow to allow for increased resources to complete eCare plans, increasing knowledge to be prepared for payer opportunities, and increasing types of eCare plans utilized.

Discussion (631)

Pharmacies who are members of the CPESN USA network must meet eCare planning requirements that define the quantity and quality of eCare plan submissions. The concept of eCare planning is a crucial aspect of the appointment-based model embraced by the organization, which seeks to shift pharmacies' focus from passively filling prescriptions to proactively synchronizing pick-up dates for chronic medications, enabling monthly medication reviews and opportunities to identify and act on medication-related problems and optimization.[18] Documentation of patient encounters provides a record of data (e.g.: blood pressure, glycated hemoglobin percentage, lipid panels, INR levels) to

demonstrate value-based care to other healthcare providers as well as payers. We sought to learn reasons why pharmacies were or were not documenting eCare plans and how they were doing so.

It appears Best Practices pharmacies submitted more specific, measurable goals for quality and quantity of eCare planning compared to Barriers pharmacies, who had more generalized goals. The Best Practices pharmacies' increased awareness and focus on meeting those goals may have contributed to their success in eCare planning. There is data surrounding SMART (specific, measurable, attainable, relevant, and time-based) goals and their usefulness in creating successful projects in the workplace which is applicable to setting goals for patient therapy.[19,20] Further, more pharmacies in the Best Practices survey had been eCare planning >1 year, while more Barriers pharmacies reported eCare planning <1 year. This additional time may have allowed Best Practices pharmacies to practice, adjust workflow, or attend trainings on eCare planning to enhance their knowledge and implementation. It is important to note that at the time of the survey, pharmacies in both groups had shifted their focus toward preparing to receive COVID-19 vaccines, which may have influenced responses at the time regarding time constraints. One of the Best Practices pharmacies' most utilized eCare plan encounter types included medication synchronization, which aids in adherence and convenience to patients since it aims to decrease their number of trips to the pharmacy.[17] This is another minimum requirement by CPESN USA that participating pharmacies must adhere to, which may explain why it was the most widely reported eCare plan encounter type.

Barriers pharmacies more often had documentation systems that did not communicate with their dispensing software. They also reported time constraints, staffing resources, and lack of payment for services as barriers to implementation. At this time, there are many emerging opportunities in payment for pharmacies by contracting with individual payers for specific enhanced services. To be able to engage with payers in this manner, pharmacies must first have a process to capture data on patient outcomes, which means having a streamlined process to integrate eCare planning into the pharmacy's workflow. Having this process prior to high-stakes expectations of deliverables is crucial to ensuring the opportunities are met with success. Best Practices pharmacies found it helpful when the computer systems communicated with one another, when documentation occurred as part of the workflow, and when more than one type of pharmacy staff were engaged in the process. For pharmacies looking to implement eCare planning into their work setting, we encourage setting specific, measurable, attainable, relevant, time-based goals as well as utilizing best practices such as those listed throughout. These practices, along with identifying payer opportunities, may be useful to include in training programs for pharmacies currently struggling to implement eCare planning into daily workflow.

There are limitations in our study. Several pharmacies were co-owned and operated, oftentimes having the same primary email contact for their CPESN network profiles. The program utilized to create and distribute the emails did not allow for more than one email to be sent using the same email address for differing store locations. The Barriers pharmacies had a lower response rate, which may suggest that these pharmacies are already less engaged based on their lack of eCare plans submitted.

Conclusion (118)

A difference in knowledge and perceptions exists between pharmacies who regularly eCare plan and those who do not. The most frequently identified barriers to eCare planning were the perceived time commitment, staffing resources, and current lack of payment for services. Best practices for eCare planning involved creating specific goals, utilizing pharmacists and student pharmacists, and documenting as encounters occur. These trends in barriers and best practices found across states should be utilized in creating training to increase and elevate eCare planning quality and consistency in the community pharmacy setting. Further study is necessary to determine the implications of eCare planning on demonstration of community pharmacist value to both third-party payers and to other members of the healthcare team.

Acknowledgement: The authors would like to thank Alison Haas, PharmD, RPh, and Connor Bowers, PharmD, RPh, for assisting with data collection for Ohio participants. The authors would also like to express appreciation to CPESN Florida, CPESN Georgia, CPESN Mississippi, and CPESN Ohio for their participation.

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