COMMENTARY

Integrating Family Medicine and Community Pharmacy to Improve Patient Access to Quality Primary Care and Enhance Health Outcomes

Mark A. Munger, PharmD,a David N. Sundwall, MD,a Michael Feehan, PhDa,b

a University of Utah College of Pharmacy, Salt Lake City, Utah
b Kantar LLC, New York, New York

Submitted June 7, 2017; accepted August 2, 2017; published May 2018.

Keywords: integration, family medicine, community pharmacy, patient, primary care

Health care in the US remains dysfunctional despite well-intentioned efforts to revitalize the system. Delivery is fragmented, per capita investment is the highest of any nation in the world, and the return on the health care dollar ranks as one of the lowest of industrialized nations.1-3 Efforts to revitalize the system have focused on integration of high-value health care that places the family physician as a central component.4-6 In concert with this effort is the underlying movement toward bringing health care closer to the patient. Being able to help patients understand and deliver their own self-care through personalization and prediction of disease, thereby helping them to prevent or preempt their own disease progression is paramount to this movement. Community pharmacies are numerous throughout the US, located in rural, suburban, and urban centers, and are the most frequently visited health care setting.7 As such, they provide an opportunity to focus on preventive, self-care and chronic disease management strategies that can deliver high-quality health care. Closer integration of family physicians with community pharmacists could enhance the capacity of both practices to perform their missions, thereby providing a common link to improve health throughout the country.

Recently, a large, comprehensive patient-centric U.S.-based population study to model the demand for community pharmacy advanced services was conducted.8,9 There were 9,202 participants who provided valid responses to a 30-minute survey in a Discrete Choice Experiment (DCE) model, where they indicated which pharmacy they would prefer from multiple pairs that varied in the degree of services offered. The optimal pharmacy that maximized the switch rate (the probability of adult patients changing from their current baseline pharmacy) offered an integrated health electronic record system, a comprehensive level of point-of-care diagnostic testing, and some level of physical examination procedures. A similar survey was offered to 292 community pharmacists.9 Responses were similar to patients; however, the switch rate was fourfold higher from their current base pharmacy to this optimal pharmacy configuration. The optimal pharmacy was then shown to 50 public and private reimbursement decision-makers who were involved in an advisory or leadership role in decision-making within the organization regarding coverage and reimbursement policies and/or protocols for various types and locations of primary health care services. Two-thirds of payers were very likely or likely to reimburse for the optimal pharmacy services. This study provides empirical support for convenient primary care services in the community pharmacy setting. Since 1967, primary care has been promoted as the foundation for improved health care system.10 Developing strategies to foster closer integration of family medicine with community pharmacy is a potential partnership to this end. One potential strategy would be to build on existing relationships between family practitioners and community pharmacists, and partnering to deliver a broader range of primary care services in the communities where they live and work. Delivering a broader array of primary health care services in a convenient community pharmacy setting, with family practitioner oversight and teaming could improve the quality of health care services, as has been shown in community pharmacist-family medicine collaborative studies.11-13 This could occur especially in places where health care access is lacking and improve value in terms of better health outcomes through improved access and quality. Better leveraging synergistic interactions around the education, skills, and service of physicians and pharmacists may assist in ameliorating challenges presented by trends in the national shortage of family physicians. There are currently 67,000 community pharmacies in the US with 92% of the population living within 1.6 miles of a community pharmacy.7 Building models of enhanced local care by

Corresponding Author: Mark A. Munger, University of Utah College of Pharmacy, 30 South, 2000 East, Room 4958, Salt Lake City, UT 84112-5820. Tel: 801-581-6165. Fax: 801-581-3716. E-mail: mmunger@hsc.utah.edu
activating pharmacy setting resources with closer collaboration and oversight from family medicine could improve care particularly in rural and disadvantaged communities where access to family medicine can be challenging and limited. Community pharmacy could greatly benefit from this integration through provision of preventive care, teaching of patient self-management techniques, and collaborative provision of chronic disease state management. Family medicine would benefit from extending the geographical reach of their practices into local settings for certain limited conditions and approaches.

Successful integration and collaboration of family physicians with community pharmacists could involve shared goals. These include aligning leadership to reduce fragmentation and foster continuity of care; defining roles and responsibilities to ensure accountability; developing and supporting appropriate incentives, and managing change.11 Both disciplines share a common goal of population health management through community engagement in defining population health needs to improve health. Importantly, goals must be sustainable and transferable from community to community to build enduring impact and value. Shared collaborative use of data and analytics is essential to continually improve care. The use of enhanced collaborative electronic medical record information exchange can mitigate the risk of patients “falling between the cracks” of less connected practitioners.

Enhanced educational and training programs will be needed for pharmacists to better integrate practice with family physicians. Team-based education focused on chronic care management, preventive medicine, and greater interdisciplinary education opportunities, especially in ambulatory care settings will be necessary.14-20 Pharmacists will need to be taught how to be dedicated patient advocates and care navigators. Currently, there are scant best practices available in pharmacy schools that deliver this type of curricula framework. Departments of family medicine, however, have implemented community-oriented primary care curricular.21 Integrating pharmacy students into family medicine clerkship experiences with collaborative training of student physicians and pharmacists by physicians and pharmacists working in strategic partnership could be undertaken. This could better align the two disciplines from training to practice, thereby sustaining the goal of closer integrative practice. A model of a network of community pharmacies and family physician offices could offer greater opportunities for interdisciplinary education.

The role of the family physician as the leader and gatekeeper to health care access is evolving in the new culture of medicine. Community pharmacists can align more closely with family physicians to bring a more integrated health care system to the local community level, thereby enhancing improved outcomes to patients and communities across the nation.

REFERENCES


16. Bell SK, Krupat E, Fazio SB, Roberts DH, Schwartzstein RM. Longitudinal pedagogy: a successful response to fragmentation of the