

Community Pharmacy Patient Care Services Survey

This is a brief survey developed by Shenandoah University ~ Bernard J. Dunn School of Pharmacy ~ through a grant from the National Community Pharmacists Association (NCPA) Foundation, regarding patient care services that may be offered at your pharmacy. The purpose is to establish important baseline benchmarks for documenting pharmacists' expansion into patient care service niches. Please be assured that your responses to this survey will be kept **completely confidential**. Data from the survey will be reported in aggregate form only. The only identifying information we request is the name of your pharmacy, and the city and state in which you are located to prevent duplication of responses. This identification will not be used for any other purpose, and will be removed after the data is compiled and confirmed. For questions, contact the project director, Gina Peacock, Ph.D., at (540) 545-7230 or GPeacock@su.edu. Please fax your completed survey directly to Dr. Peacock at (540)665-1283 by May 19, 2006.

Pharmacy name _____

Pharmacy city, state _____

1. Estimated annual **total pharmacy** sales volume (most recent fiscal year) \$ _____

2. Estimated annual **prescription** sales volume (most recent fiscal year) \$ _____

3. Check ONE of the following that best describes your average daily prescription volume:

- < 100 100-199 200-299 300-399 ≥ 400

4. Check ONE of the following that best describes the population of the area your pharmacy serves?

- < 20,000 From 20,000 to 50,000 > 50,000

5. Indicate the total number of full-time equivalent employees involved in operations. Count each 40 hrs/wk worked by part-timers as one full-time equivalent. (Example: 5 full-time employees plus 2 part-time employees each working 10 hrs/wk equals 5.5 employees).

Pharmacy manager/owner _____

Staff pharmacist(s) _____

Technician(s) _____

Pharmacy intern(s)/Clerkship student(s) _____

Pharmacy resident(s) _____

Other employee(s) (clerk, cashier, etc.) _____

Total full-time equivalent employees

6. Which of the following credentials are held by **any** pharmacy employee? (Check ALL that apply.)

- | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>Board of Pharmaceutical Specialties (BPS)</p> <ul style="list-style-type: none"> <input type="checkbox"/> Nuclear Pharmacy <input type="checkbox"/> Nutrition Support Pharmacy <input type="checkbox"/> Oncology Pharmacy <input type="checkbox"/> Pharmacotherapy <input type="checkbox"/> Psychiatric Pharmacy <input type="checkbox"/> Certified Diabetes Educator (CDE) | <ul style="list-style-type: none"> <input type="checkbox"/> Certified Disease Manager (CDM) <input type="checkbox"/> Certified Geriatric Pharmacist (CGP) <input type="checkbox"/> Certified Clinical Nutritionist (CCN) <input type="checkbox"/> Certified Pharmacy Technician (CPhT) <input type="checkbox"/> CPR <input type="checkbox"/> Medical Billing Specialist <input type="checkbox"/> Other |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

7. Place a check mark in the appropriate columns below regarding services provided by your pharmacy and indicate the cash payment amount and the estimated annual revenue generated by each service by entering the dollar amount:

| Service | Offered | Separate Fee Charged | Cash Payment (\$ amt.) | Third Party Billed | Estimated Annual Revenue (\$ amt.) |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|----------------------|------------------------|--------------------|------------------------------------|
| Example Response | ✓ | ✓ | \$20 | ✓ | \$4000 |
| AIDS specialty services | | | | | |
| Anticoagulation therapy monitoring | | | | | |
| Asthma management | | | | | |
| Blood pressure monitoring | | | | | |
| Cancer awareness education (breast cancer, colon cancer, skin cancer, etc.) | | | | | |
| Comprehensive medication reviews ("brown bags") | | | | | |
| Diabetes training/management | | | | | |
| Dyslipidemia monitoring/management | | | | | |
| Hospice care | | | | | |
| Immunizations (indicate which types by checking the appropriate box(es) below): <input type="checkbox"/> pneumococcal <input type="checkbox"/> influenza <input type="checkbox"/> travel <input type="checkbox"/> other | | | | | |
| Natural medicines counseling | | | | | |
| Nutrition management | | | | | |
| Osteoporosis screening/management | | | | | |
| OTC medication management | | | | | |
| Pain management | | | | | |
| Smoking cessation | | | | | |
| Weight management | | | | | |
| Other: | | | | | |
| Total estimated annual revenue from patient care services | | | | | |

8. Estimate the percentage of patient care services revenue that is received from each of the following sources:

- _____ % Private pay
- _____ % Third party (private)
- _____ % Medicare
- _____ % Medicaid

9. Patient care services are provided by: (Check ALL that apply.)

- Pharmacy employees
- Outside groups (non-employees brought in to give vaccinations, blood pressure screenings, diabetes education, etc.)

If outside groups are brought in, please specify for which services: (Check ALL that apply.)

- | | |
|-------------------------------------------------------------|------------------------------------------------------------|
| <input type="checkbox"/> AIDS specialty services | <input type="checkbox"/> Immunizations |
| <input type="checkbox"/> Anticoagulation therapy monitoring | <input type="checkbox"/> Natural medicines counseling |
| <input type="checkbox"/> Asthma management | <input type="checkbox"/> Nutrition management |
| <input type="checkbox"/> Blood pressure monitoring | <input type="checkbox"/> Osteoporosis screening/management |
| <input type="checkbox"/> Cancer awareness education | <input type="checkbox"/> OTC medication management |
| <input type="checkbox"/> Comprehensive medication reviews | <input type="checkbox"/> Pain management |
| <input type="checkbox"/> Diabetes training/management | <input type="checkbox"/> Smoking cessation |
| <input type="checkbox"/> Dyslipidemia monitoring/management | <input type="checkbox"/> Weight management |
| <input type="checkbox"/> Hospice care | |
| <input type="checkbox"/> Other (Please specify.) _____ | |

10. Indicate below any of the services that are performed under collaborative practice agreements with another healthcare provider: (Check ALL that apply.)

- | | |
|-------------------------------------------------------------|------------------------------------------------------------|
| <input type="checkbox"/> AIDS specialty services | <input type="checkbox"/> Immunizations |
| <input type="checkbox"/> Anticoagulation therapy monitoring | <input type="checkbox"/> Natural medicines counseling |
| <input type="checkbox"/> Asthma management | <input type="checkbox"/> Nutrition management |
| <input type="checkbox"/> Blood pressure monitoring | <input type="checkbox"/> Osteoporosis screening/management |
| <input type="checkbox"/> Cancer awareness education | <input type="checkbox"/> OTC medication management |
| <input type="checkbox"/> Comprehensive medication reviews | <input type="checkbox"/> Pain management |
| <input type="checkbox"/> Diabetes training/management | <input type="checkbox"/> Smoking cessation |
| <input type="checkbox"/> Dyslipidemia monitoring/management | <input type="checkbox"/> Weight management |
| <input type="checkbox"/> Hospice care | |
| <input type="checkbox"/> Other (Please specify.) _____ | |

11. Indicate the choices below that best describe the area in which the patient care services are provided. (Check ALL that apply)

- Private counseling room (approximately _____ sq. ft.)
- Semi-private counseling area
- Pharmacy counter
- Off-site (senior centers, retirement communities, etc.)

12. Indicate below the pharmacy employees involved in delivering patient care services and whether the employee is directly involved with patients **OR** provides a supportive or administrative role. (Check ALL that apply)

| | Direct | Supportive |
|-------------------------------|--------------------------|--------------------------|
| Pharmacist | <input type="checkbox"/> | <input type="checkbox"/> |
| Pharmacy student | <input type="checkbox"/> | <input type="checkbox"/> |
| Pharmacy resident | <input type="checkbox"/> | <input type="checkbox"/> |
| Certified pharmacy technician | <input type="checkbox"/> | <input type="checkbox"/> |
| Pharmacy technician | <input type="checkbox"/> | <input type="checkbox"/> |
| Other pharmacy employee | <input type="checkbox"/> | <input type="checkbox"/> |

13. Which of the following best indicates how patient access to services is most often initiated?

- Self-referral
- Pharmacist-referral
- Physician referral
- Referral by other healthcare provider
- Pharmacy screening programs
- Other (please specify) _____

14. How are patients scheduled for patient care services? (Check ALL that apply)

- Walk-ins
- Individual scheduled appointments
- Scheduled blocks for specific disease state
- Other (please specify) _____

15. Are patient care services documented? Yes No

If yes, how?

- Written patient chart
- Electronic patient chart or file
- Other (please specify) _____

16. What outcomes do you measure and document to determine the effectiveness of patient care services? (Check ALL that apply)

- Patient quality of life
- Patient-specific parameters
- Pharmacy economic factors
- Patient economic factors
- None
- Other (please specify) _____

17. Which of the following CPT codes do you use to bill for Medication Therapy Management Services (MTMS)? (Check ALL that apply and indicate in the space provided approximately how many times you have billed each code):

- 0015T _____
- 0016T _____
- 0017T+ _____

Thank you for your time in completing this survey. Please fax the completed survey to Dr. Gina Peacock at (540)665-1283 by May 19, 2006.