

“Until they know how much you care”: A qualitative analysis of an innovative practice in community pharmacy

Michael Melczak, PhD¹ and Janice Pringle, PhD²

¹Researcher/Project Evaluator, University of Pittsburgh School of Pharmacy, Program Evaluation and Research Unit

²Associate Research Professor, University of Pittsburgh School of Pharmacy, Director, Program Evaluation and Research Unit

Acknowledgements: This study was funded by AstraZeneca

Conflicts of Interest: None

Keywords: Community pharmacy, innovative practice, diffusion of innovation

Abstract

Purpose: *This qualitative study was concerned with investigating community pharmacists' thoughts on the use of two brief scales to measure patient outcomes and therapeutic alliance in the context of their Medication Therapy Management (MTM) services. The scales were originally developed for use in behavioral healthcare, but were used in a novel (community pharmacy) setting as part of a previous parent study. We describe this practice (using these scales in a novel setting) as an innovative practice, report on the pharmacists' experiences with the practice, and discuss relative advantages and disadvantages for integrating the use of the scales as part of routine practice.*

Methods: *Six community pharmacy practitioners participated in a semi-structured interview pertaining to the use of the scales in their MTM services. Pharmacist interviews were transcribed, analyzed according to qualitative content analysis methodology, and presented in relation to the guiding interview questions.*

Results: *Pharmacists had varying opinions on the use of the scales as part of their practice. Initial concerns included patient (mis)understanding about the purpose and proper completion of the scales, as well as apprehension about the use of the information. These concerns were largely resolved through education, repeated use, and routinization. Pharmacists, in general, saw a value to using these scales in clinical practice, for clinical and professional reasons, although there was variability on the degree to which pharmacists integrated the scales into practice after the study completion. Pharmacists had varied opinions as well as on the degree to which the use of the scales would impact medication adherence. Pharmacists were most surprised by how much participation in this study prompted them to reflect on their interactions with patients.*

Conclusions: *Pharmacists, in general, were receptive to participating in the parent study and using two brief scales to measure patient outcomes and therapeutic alliance. Pharmacists had varying opinions on the degree to which the use of these scales could impact patient medication adherence, although they perceived other value and benefits secondary to the interactions. While most pharmacists did not maintain formal use of the scales after study end, they took away general principles of patient-centered care and individualized feedback.*

Introduction

Adherence is the extent to which a patient's behavior coincides with medical or prescribed health advice.¹ Patient medication adherence, or taking medications as prescribed, is considered to be a significant clinical issue.² The Study of Medication Adherence and the Therapeutic Alliance (SMARTA), an industry-sponsored study conducted by University of Pittsburgh School of Pharmacy, was a project intended to assess the relationship between the administration of two scales and medication adherence. In SMARTA, six pharmacists in a community pharmacy chain

administered two brief scales originally developed for use in psychotherapy (the Outcome Rating Scale and the Session Rating Scale, or ORS and SRS, respectively)^{3,4} to patients presenting for Medication Therapy Management (MTM) services. Two hundred and one participants were enrolled in an initial session, and approximately 34% of participants received up to three MTM sessions where the scales were utilized. Results suggested that administration of the ORS and SRS in this context had a positive impact on patient medication adherence.⁵

The purpose of this qualitative study, a secondary study of SMARTA, was to interview participating pharmacists in order to evaluate their thoughts about the use of the scales (which were a chief SMARTA procedure). As noted, the ORS and SRS were originally developed for use in behavioral healthcare and have not been used, to our knowledge, in a community

Corresponding Author: Michael Melczak, PhD, University of Pittsburgh, School of Pharmacy Program Evaluation and Research Unit, 2100 Wharton Street, Suite 720-C, Pittsburgh, PA 15203, Phone: 412.904.6122
Fax: 412.904.6125, Email: Mam142@pitt.edu

pharmacy setting. Given the innovative nature of using these instruments in this clinical setting, we interviewed the participating pharmacists to understand how the use of the scales affected their clinical practice (if at all) and might be adopted and integrated as part of routine practice.

Before describing the qualitative study methods, results, and conclusions, we felt it would be helpful first to describe the instruments themselves and, second, ground the reader in the everyday application of the instruments the SMARTA pharmacists used in the project. Although some technical study procedures were involved in the “day-to-day” work (such as providing information to participants about informed consent), we will describe only the administration procedures after a participant (a pharmacist’s patient) was enrolled in the project.

The SMARTA project

The ORS and SRS are two brief, four-question scales intended to measure participant self-report of general well-being outcomes and perception of the therapeutic alliance, respectively. The outcome constructs for the ORS are “Individual,” “Interpersonal,” “Social,” and “Overall.” The SRS constructs are “Relationship,” “Goals and Topics,” “Approach or Method”¹ and “Overall.” The specific scale questions are presented in Table 1.

Table 1: ORS and SRS Questions

ORS	SRS
How have you been doing personally?	To what degree did you feel heard and understood today?
How have things been going in your relationships?	To what degree did we work on the issues that you wanted to work on today?
How have things been going for you socially?	How well did my approach, the way I worked, make sense and fit for you?
How would you rate how things in your life are going overall?	How would you rate how things were in today’s session overall?

¹ We slightly modified the Approach question on the SRS to reflect the clinical context of community pharmacy rather than behavioral health; thus, the Approach question was reworded to refer to a “pharmacist’s” approach rather than a “therapist’s” approach.

Pharmacists could avail themselves to two administration types for either or both instruments: written or oral (oral versions are presented above). For the written version, participants could complete a visual analog scale, where “negatively phrased” statements presented on the left and “positively phrased” statement presented on the right are separated by a 10 cm line. Participants read both the left and right hand statements and mark their scores with hash marks along the 10 cm continuum for each of the four questions. There are no numbers on the continuum; in order to score the instrument, the pharmacist uses a standard ruler to measure the hash mark to the nearest centimeter and notes the score (1cm=1, 2cm=2, etc.). For the oral version, pharmacists simply read the statements to the participants and participants provide oral responses on a scale from 1-10 (where 1 is worst and 10 is best). Each instrument has a total score of 40, each with a significant clinical indicator described below. Prior to implementation, pharmacists received a one hour phone training/webinar on the theory, administration, and interpretation scales.

For study purposes, pharmacists were to administer the most appropriate version (written or oral) of the ORS at the beginning of an MTM session, and the most appropriate version of the SRS at the end of an MTM session (in this context, an MTM session was defined as an interaction where pharmacist and patient had the opportunity to communicate, for example, during a comprehensive medication review). For the ORS, pharmacists were to score the instruments “in the moment” and use the scores to guide to the MTM session. The ORS has a cutoff point of 25, meaning that any total scale score below 25 is a prompt for the provider to develop a discussion with the participant. For example, a participant may have rated three of the four ORS items with “7s” but rated the fourth item a “2,” for an ORS scale score of 23. The pharmacist would then first invite the participant into a discussion, and, if the participant agreed, would inquire into the significance of that low score. (Specific instances of these interactions will be described in detail in the Results and Discussion sections). For the SRS, pharmacists could administer, score, and provide feedback on the scores within the last few moments of the MTM session, or score the instrument after the session and utilize the information during the subsequent session (if any). The SRS has a relatively higher cutoff point of 36, meaning that any score lower than 36 is also a prompt for the pharmacist to initiate discussion. For example, a participant may rate the pharmacist/session as “10” in three of the four items, but then provide a rating of “5” in the fourth item, for a total scale score of 35. The score would compel the pharmacist to solicit the participant’s feedback on how to improve that score on that item for the next session.

Methods

The sample for this study was purposive and included the six community pharmacists who participated in SMARTA. The data collection method was a single-session, semi-structured interview, conducted by the principal author (M. Melczak) via telephone and tape-recorded. The interviews took place approximately 60 days after the end of SMARTA. Pharmacists were interviewed separately, not as part of a focus group. Pharmacists were provided with the semi-structured interview questions beforehand to prepare for the interview. The study was approved by the University of Pittsburgh IRB. Before actively participating in the interview, pharmacists were provided with an informational script satisfying University IRB consent procedures. The script described the study design and research procedures, the voluntary nature of the study, and the recording procedures. Participants then gave verbal consent to participate in the study. Even though the sample size was small, identifying information was redacted from any transcription, and confidentiality was stressed. Pharmacists were compensated for their participation in the interviews, which lasted approximately 30 minutes on average (range 15-35 minutes).

The questions for the semi-structured interview were based on key concepts from diffusion of innovation theory⁶ and suggestions from the developer of the ORS and SRS.⁷ The questions included:

1. Did you have concerns about using these instruments in your practice? If yes, what were those concerns? Do those concerns still exist? If yes, please describe how they continue. If no, please describe how your concerns were resolved. Do you have any new concerns?
2. How did the patients respond to the instruments when you first applied them? How do they respond now?
3. Describe the degree of integration of these instruments into your routine practice at this time, including any facilitators or barriers to integration.
4. Describe the potential value, if any, for integrating these instruments as part of routine MTM service.
5. An original goal of this study was to assess patients' responses to the ORS/SRS questions and their medication adherence. As a pharmacist, what are your thoughts about the use of these tools and medication adherence? That is, do you think medication adherence is improved through the use of these tools, is made worse, or is not affected in either direction?
6. Was your work affected by using these instruments? If so, what difference has emerged? How do you think your patients/clients are different, if at all?
7. What surprised you the most?

While these questions appear to be fixed and finite, pharmacist responses often led to new questions or different ideas. Data were analyzed in terms of the guiding questions or interview-generated ideas through the use of a qualitative content analysis methodology.

Qualitative data can be analyzed in numerous ways. With qualitative content methods, data analysis can follow a systematic procedure.^{8,9} First, the original recorded communication was transcribed as closely to verbatim as possible, including both interviewee and interviewer statements. Then, each response, ending at each question, was reviewed to get an overall impression of the response. Participant responses were then approached as "meaning units"¹⁰ in relation to the guiding interview question. Statements were then evaluated in terms of their degree of fit with the guiding question and presented as evidentiary extensions of the question domains. For example, one overarching domain of Question 1 was "concerns." Respondent statements that provided evidentiary support of these domains were included in results. Statements that did not support that domain were not included or included in other domains. Thus, the purpose of this methodology was not to derive a conceptual domain, but to evaluate statements with a degree of fit to those so given as guiding questions.

Results

Six pharmacists were interviewed (five female and one male). We did not ask for other demographic information. During transcription, one of the interviews was lost due to a technical malfunction; the pharmacist was not re-interviewed. The following results are from five pharmacist interviews. Pharmacist quotes are notated by a respective code (P1, P2, etc.).

Question 1: Concerns

Pharmacists had concerns about the use of the scales for a number of reasons. First, pharmacists had concerns about patients- and perhaps themselves- being able to understand the administration of the instruments.

P1: I knew that approximately 30% of the population was illiterate in some form or another...

P3: ...but on the first one where you have the line, I had a lot of problems just wanting to write on the line how they felt, so it was very hard to explain what the first line was...I just think the first line was confusing for a lot of the patients....Maybe it was just me.

P5: ...the biggest concern was and somewhat still exists in that, um, the education level of the

patients...some of my patients have a hard time relating a number to how they're feeling.

One pharmacist also had concerns about the amount of time it would take to administer the instrument:

P1: ... the patient interaction would take a considerable amount of time.

And, accordingly, there was a concern if the time cost would yield a benefit.

P1: ... it was important to me and the rest of my team that we be able to make this worth our time.

One pharmacist had a concern about the "authenticity" of the encounter.

P2: ...First of all, my concern, initially, was, "How was I going to administer these scales and not make it seem like I just wanted some feedback?"

There also appeared to be anticipatory anxiety about asking "personal questions" of the patients, and how the patients might respond to these questions:

P2: ...oh my goodness, how am I going to get them to participate...(the patient might think) 'I don't even want to think about that'....

P4: ...I think it was a little more personal than some people I thought might be willing to discuss

Question 1: Resolutions

Pharmacists provided various resolutions to their concerns, including the alternative instrument administration (i.e., reading the questions to patients instead of patients filling out the scales themselves), breaking the "awkwardness" barrier, generating revenue (at least for the purposes of the study), "just doing it", and proposing instrument redesign.

P1: Number one, my fears were resolved about the illiteracy problem, because you gave a script to be able to allow the patients, be able to read to them...and then as far revenue generating or making this worth our time, um, I think that it certainly was. After we got into and got going...I did not feel the interaction took longer, maybe about 5 or 10 minutes longer than it normally would.

P2: I think once I got it into a routine, once I felt comfortable, once they felt comfortable with it, I think it was not a problem.

P4: My concerns were resolved by just doing it basically.

P5: I think maybe pictures would be really good for some people, you know like the pain scale with smiley faces...

Question 2: Patient Responses To Instruments Upon First Application

Pharmacists noted that patients responded differently to both the instrument administration as well as the content of the instruments. In some cases, the actual patient response was commensurate with the pharmacists' concerns. With regard to the former:

P1: Some were shocked...When I would put the piece of paper in front of them they were like, "What...what am I supposed to do?" ...it was a little bit difficult to comprehend, so I had to explain it probably to almost every single patient...

P2: A lot of them didn't understand it...

P3: ...for the most part they were OK with it. They were like, "What is this pharmacist giving me this for?"...but you know generally they responded well.

P5: When I first applied it, the patients were kind of apprehensive... (based on my patients' background) I think the apprehension was "are you going to sell my information or have my name listed on anything?"

With regard to the latter, pharmacists reported that some patients responded emotionally, which in turn reflected pharmacists' concerns about lack of training and patient unpredictability.

P1: I had one patient that we ended up opening a Pandora's Box... sometimes you get information you didn't expect or you didn't realize you were going to get and you don't know how to handle because you haven't been trained. I ended up putting a tissue box in my consultation area because more times than not patients did end up crying during our sessions.

P4: I mean, some people get kind of emotional about it and when you kinda opened the can of worms you didn't know what was there...

Question 2: Patient Responses After Additional Applications

Pharmacists reported that while some patients refused to do additional surveys, most said that administering the scales became easier, awkwardness melted away, and some patients perceived a value in the service.

P1: ...Once they filled it out, they had no problems doing it.

P2: Um, no, no. I think once I got it into a routine, once I felt comfortable, once they felt comfortable with it, I think it was not a problem

P3: ...For the most part they were OK with it....They've gotten more used to it as I call them and you know do their second session, their third session, and a lot of them have really opened up a good opportunity to improve on the relationship that we

probably wouldn't have had without the follow-up so, it was a good tool for sure, especially it seemed like you could really tell some things were really bothering people they may not have planned on talking about otherwise. So, but, um, all in all, I only had like two people tell me they didn't want to participate, so...

P4: ...for the most part people are forthright and, um, comfortable responding and actually take it as something, um, as a good service.

Question 3: Degree of Integration, Facilitators and Barriers

After completion of the study, we do not believe pharmacists maintained actual use of the scales, but note that most have made modifications to their practice, or at least had a shift in clinical practice philosophy: that an emphasis on “care” over knowledge can foster better relationships.

With regard to modification of the initial practice, one pharmacist derived a unique, abbreviated metric to evaluate individual “stress”:

P1: I have taken this part of the study...and integrated it into my patient encounters at the clinic...I shortened it to one sentence and I give them numbers one through five.

This pharmacist's statement also demonstrates that while the philosophy underpinning the use of the scales is important, there are also perceived constraints in this process, such as limited time. Accordingly, while the original scales were also very brief and could be administered in a few minutes, further refining to one question suggests the pharmacist's perceived time constraint.

This same pharmacist also noted a “core element” in practice, which refers can be described a “vision” or “mission statement”:

P1: The core element that I truly believe will help establish a trust and bond with these patients, as well as increase their compliance is...“People don't care how much you know until they know how much you care”.

One pharmacist noted a shift to what is often termed “patient-centered” or patient-focused care:

P3: It's really helped me I guess be more personal and take away from my agenda and look more, you know, at what it is the patient really wants to get out of this...

Another pharmacist did not maintain use of the scales, but saw a niche opportunity:

P4: I actually have not used it outside of the study eligible patients, but I could see a niche, potentially, for it.

The niche here is an investment in personal relationships, building relationships, and fostering trust that can impact adherence. Potential value is also addressed in the next section.

A final pharmacist noted asking broad questions about personal well-being as an introduction before inquiring directly about medicines. The focus here appeared to have shifted from a medication management ethos to a health management ethos:

P5: So I guess I open up with more general broad questions to see how they're doing and not dive so much right into their medicines.

Question 4: Potential Value

Pharmacists, in general, did see potential value for the general line of questioning or interaction (although not necessarily the formal use of the scales). The value for the use of the scales included identifying medication issues that might otherwise have gone unknown and hence unaddressed, using specific feedback to improve services, and maintaining focus on patient needs. Feedback from patients also helped to improve services not simply in the moment with a particular patient, but across all patients, suggesting a ripple effect.

P2: But it was interesting the feedback that I got, which was all positive: “But we were glad that you were here to help with this and with this,” so they gave me specific examples, which helped me better my MTM sessions with my other patients. So I knew exactly the things I need to make sure I am doing from asking the patient, so it kept me on focus.

P3: ...it spurred a lot of good conversation and I was able to identify things you might not necessarily would have identified...

P4: (referring to the therapeutic alliance scale) I think it's a good way to evaluate your performance as a health care profession and finding ways that you can improve on certain things and aspects.

Question 5: Perceived Impact of the Intervention

Pharmacists were asked to what degree they believed their intervention would have on patient medication adherence. Pharmacists had varying opinions, from beliefs in positive outcomes to uncertainty to skepticism.

P1: I think it will positively impact compliance.

P2: That's still a question mark, because, based on the follow-ups, it seems like it's helping, but I'm not

sure if it's the fact that it was tools that were used, or the fact that we're calling back checking in on them which we said we would do, call you and make sure things were ok...so the debate is still out on that in my book

P4: I think potentially there is some benefit there... but I don't know necessarily how you delineate the true cause of it...

P5: I think that's a difficult question for me to answer.

A few pharmacists noted an “intervening variable” for medication adherence: trust. These pharmacists believed that creating a trusting relationship would make their recommendations easier to accept and to follow.

P3: Um, I definitely think that it incorporates a level of trust in the pharmacist in our recommendations, so I think it would improve adherence.

P5: I think it helps because I think it helps with that trusting relationship and then they're more willing to listen to your recommendations and they actually see you as someone they can come to with other problems, not just “Hey I can't get my medicine refilled”.

Question 6. Impact on Work and Perception of Patients

This question asked pharmacists how participating in the study impacted their perception of their own work and of their patients. One pharmacist noted that participation allowed her to reflect on her own professional values and refocus on her patients.

P1: I was um very convinced this would be a positive impact on our patients, but had no idea how much it would impact myself as a provider. I think it has made me a better provider.... I had gotten into the rut where I wasn't seeing the patient any more, honestly, and this study helped me realize that, um, I'm missing the most important part, which is the patient.... I'm starting to see that I'm developing a relationship more like I used to when I first got out of pharmacy school and was gung-ho about patient care.

A second pharmacist suggested that understanding a patient's personal life informed her clinical decision making, but more so contributed to seeing the patient as a person.

P2: So it kinda changed my direction on how I handled patients, because you never know what their personal life is like... and then for me trying to assist them from a medical standpoint, it was just, I don't know, kinda made me think about the things I recommended as far as a cost-wise, because many

said money was a situation for them, it was hard for them to pay for medications, so therefore their quality of life was low...so it kinda changed my direction in how I look at my recommendations and things I say to my patients, which I've done all along, but this kinda opened my eyes to it because now I can actually see this person when I asked them about their quality of life...

A third pharmacist noted that developing a “personal approach” was a perceived value to a patient who might not have otherwise presented for services.

P3: “One lady came in with her husband and I went through the whole process. She wanted to come in for one after that...I don't know if that would have happened without him participating because I think it was a more personal approach that appealed to her....Typically I don't, I probably don't have as much of a personal approach before I started doing this study, so I know it's helped me a lot, too.

Another pharmacist repeated a previously mentioned maxim, “They don't care how much you know until they know how much you care.” This maxim constituted what appeared to be a mission statement for daily practice. There is also further evidence of the belief that a trusting and caring relationship can contribute to patient adherence, or at least promote the perception of better service.

P4: Just show how much you care then they'll start listening to you. I tried to be more diligent in using this as part of my own day to day practice...hopefully they're getting better care, or they're feeling like I'm more attentive.

Finally, the fifth pharmacist noted that once patients became accustomed to being asked questions about quality of life (or possibly therapeutic alliance), that information was consequently provided up front. Such a change might suggest reduced time and clinical burden and allow for better clinical efficiency.

P5: (about asking the questions in a routine manner)...but I think they're more willing to provide me with the questions up front instead of me having to dig and dig and dig for it. So I think that's the biggest I would say.

Question 7: Most surprising

Pharmacists were asked “what surprised you the most” about participating in the study. Again, there were varying responses, but mostly positive ones, ranging from practice change to acceptance of the innovation. One pharmacist noted a “wake-up call” and another noted the ease of

instrument administration. One also said that the study would inform the education of students.

P1: What surprised me the most is what a wake-up call it was for me...and how much it changed the way I practice. That's what surprised me... The most surprising thing was that it changed the way I practiced.

P2: I think the main thing that surprised me the most was, again, the self-assessment on some of the patients that I was seeing...it definitely changed the way I um carry out my MTM sessions, and definitely it's also a teaching tool for my students.

P3: How easy it is to ask the questions!

P4: That it was well-received for the most part.

Discussion

In SMARTA, we defined our innovation as the administration of the ORS and SRS within the context of community pharmacy MTM services. While pharmacists may have, to some degree, previously incorporated elements of patient-centered, outcome-informed care to their MTM practice, we are not aware of formalized systematic measurement of the particular outcomes advanced by the ORS and SRS, specifically measurement of therapeutic alliance within this clinical context. While our own lack of awareness should not be taken as an indication that such measurement does not exist, we are mostly confident that the formalized use of these scales in MTM practice could be described as an “innovative” practice.

Adoption and maintenance of an innovation depends on a number of factors, including the relative advantage of the innovation over old ways of doing “business,” its compatibility with existing values, experiences, and needs, its complexity (or, better said, simplicity), its trialability (the ability to experiment with the innovation for brief periods), and its observability (where the results of the innovation can be seen both individually in within a group or system).¹¹

First, we see that participating pharmacists perceived there to be advantages to using the ORS and SRS. The advantages included:

- The (relatively) brief amount of clinical time it took to administer the scales.
- The identification of otherwise unknown (or uninvestigated) medication therapy management issues.
- The potential to positively impact medication adherence.
- The development of trust, which pharmacists correlated with the likelihood of adherence.
- The potential to positively impact quality of life.

- Ease of asking questions.

In these perceived advantages, we note overlap with other factors for adoption of an innovation, such as simplicity (in both ease of asking questions and relatively short amount of time to ask questions). Given that this was a time-limited study, we may also state that this innovative practice afforded participating pharmacists with the chance to experiment with the innovation (trialability). We also note that one pharmacist was particularly enthusiastic about this intervention. Such a pharmacist might be considered to be an “early adopter” or an “innovation champion.”¹² Such champions often lead the further development of innovative practices throughout their respective professional communities.

While there were perceived advantages, there are also perceived challenges to adoption.

- Pharmacists received compensation for participating in the study but not afterwards. Pharmacists wanted to make sure the practice was worthwhile in terms of time and money.
- Although the innovation was perceived as “easy” and “brief,” the perception of impact on time was still reported.
- Some pharmacists doubted about the effectiveness to the intervention without evidence.
- Some pharmacists had concerns about the use of the scales/the design of the scales with specific populations.
- Some pharmacists had initial anxiety, specifically with regard to patient emotionality or other serious personal issues. There was a clear concern about having a lack of training to deal with emotional issues, as well as the potential time costs emotional issues may take.

For some challenges, we believe that adoption of the innovative practice could be ameliorated through better training and education. Pharmacists received a one hour training prior to implementing the intervention, but it is likely that a more detailed training could reduce implementation anxiety. During training, we stressed, for example, that pharmacists were not expected to be “psychotherapists” but were encouraged to discuss any personal issues within the context of medication adherence. Furthermore, continued technical assistance and support would likely be beneficial to pharmacists should they implement this intervention in clinical practice.

For other challenges, there are larger systemic or institutional considerations, such as compensation for additional services. Finally, with the publication of the parent study, we hope that it provides pharmacists with at least preliminary evidence of the observability of the intervention and can begin to lay the foundation for future change in their pharmacy practice.

Conclusion

Pharmacists, in general, were receptive to participating in the original SMARTA study, which included the use of the ORS and SRS to measure patient outcomes and therapeutic alliance (with a distal goal of drawing correlation between the administration of these scales and medication adherence). Participation in the study encouraged pharmacists to reflect on their professional interactions with patients, and, for some, encouraged a shift in practice philosophy (i.e. take up a patient-centered stance). This shift was demonstrated by at least one pharmacist who noted the phrase, "They don't care how much you know until they know how much you care." Pharmacists had varying opinions on the degree to which their interactions could impact patient medication adherence, although they perceived other value and benefits secondary to the interactions, such as development of trust. While pharmacists did not maintain formal use of the scales after study end, they took away general principles of patient centered care and inquiry into aspects of life that may impact adherence.

References

1. Julius RJ, Novitsky MA, Dubin WR. Medication adherence: A review of the literature and implications for clinical practice. *Journal of Psychiatric Practice*. 2009; 15(1): 34-44.
2. Haynes RB, Ackloo E, Sahota N et al. Interventions for enhancing medication adherence. *Cochrane Database of Systematic Reviews*. 2008; 2. Art. No.: CD000011. DOI: 10.1002/14651858.CD000011.pub3
3. Duncan BL, Miller SD, Sparks JA et al The Session Rating Scale: Preliminary psychometric properties of a "working" alliance measure. *J Brief Therapy*. 2003; 3(1): 3-12.
4. Miller SD, Duncan BL, Brown J et al. The Outcome Rating Scale: A preliminary study of the reliability, validity, and feasibility of a brief visual analog measure. *J Brief Therapy*. 2003; 2(2): 91-100.
5. Pringle J, Melczak M, Aldridge A, Snyder M, Smith RB. Study of medication adherence and its relationship to therapeutic alliances: Results from an innovative pilot study within a community pharmacy MTM practice. *Innovations in Pharmacy Practice*. 2011; 2(1): Article 33.
6. Rogers EM. Diffusion of innovations (4th Ed.). *New York: Free Press*.1995.
7. Miller S. Personal communication with M. Melczak, August, 2009.
8. Zhang Y and Wildemuth BM. Qualitative analysis of content. Retrieved from http://www.ils.unc.edu/~yanz/Content_analysis.pdf June 1, 2011.
9. Granhein UH and Lundman B. Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness. *Nurse Education Today*. 2004; 24:105-112.
10. Ibid. p. 106.
11. Rogers EM. Diffusion of innovations (4th Ed.). *New York: Free Press*. 1995, p.15.
12. Coakes E, Smith P. Developing communities of innovation by identifying innovation champions. *The Learning Organization*. 2007; 14(1):74-85.