H. pylori Communication Initiative

Telephone Focus Group Discussions
With
Retail Chain and Independent Pharmacists

REPORT OF FINDINGS AND RECOMMENDATIONS

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Executive Summary

Purpose of the Study

On behalf of the National Center for Infectious Diseases of the U.S. Centers for Disease Control and Prevention, Westat conducted four focus groups by telephone conference call with retail chain and independent pharmacists to profile:

- Awareness of the bacterium associated with peptic ulcer disease (H. pylori);
- Perceptions about how often patients are being prescribed combination therapies associated with eradicating H. pylori;
- Pharmacists’ sources for information about H.pylori;
- Opportunities (and constraints) for pharmacists to interact with patients; and
- Suggestions for patient education on this topic.

Background

Two groups were conducted with pharmacists employed with retail pharmacies. Participants represented national, regional, and local chains of differing sizes in several states as well as a variety of years in practice. In one group with retail chain pharmacists (held June 26, 1997), participants reported that their customer base has an average household income under $35K. In the other group with retail chain pharmacists (June 30, 1997), participants similarly represented different types and sizes of chains, states, and practice experience, but five of the eight participants reported that their customer base has average household income over $35K.

Two additional groups were also conducted with independent pharmacy owners or pharmacist employees. Participants in these groups represented different size stores, geographic diversity, and varying practice experience. In one group (held June 26, 1997), pharmacists said their customer base has household income under $35K; on June 30, participants reported that their customers have household incomes over $35K.

Prospective participants for the groups were identified and recruited by a commercial market research firm specializing in support for medical and healthcare-related qualitative research. A screening questionnaire developed by Westat was administered to prospective participants to assure that they would represent diversity in types and sizes of stores represented, regions of the country, and years in practice. In addition, participants in two groups (one each with retail pharmacists and independent pharmacists) were grouped to include pharmacists with stores serving primarily households with incomes under $35K and two with pharmacists in stores serving customers over $35K. CDC specified these criteria on the basis of incidence statistics for peptic ulcer disease.
All of the group sessions were one hour in length and were facilitated by a professional focus moderator who has substantial experience moderating telephone groups with health-related professionals. Several people from CDC and Westat listened to each group.

Summary of Findings

The following findings emerged from the four focus groups. These are discussed in more detail in Chapter 2 of the report.

- Pharmacists’ General Awareness of *H. pylori*: All of the pharmacists were familiar with the data indicating that a bacterium has been associated with peptic ulcer disease, although there was almost no reference to *H. pylori* by name throughout the discussions.

- Frequency of Prescriptions for Combination Therapies: In general, the pharmacists reported that prescriptions for combination therapies (especially Prilosec and Biaxin) have increased overall in the last few years and that results have been good for many patients, but combination therapies are still a very small percentage of prescriptions filled for ulcer medications.

- Barriers to Prescriptions for Combination Therapy: The pharmacists identified several theories about why combination therapy has not become more prevalent. Most common among these were cost and related insurance issues; ready availability of over-the-counter medications that encourage patients to self-medicate; and physician’s lack of awareness and/or confidence in results, and/or lack of time to conduct the test or “hassle” with insurance issues.

- Pharmacists’ Needs and Preferences for Additional Information: Participants in these groups welcome continuing education (CE) opportunities, especially more creative ones that they described seeing recently, some of which allow them to use fax and Web technology for accessing CE courses. A few people expressed interest in specific topics such as rates of success with different combination therapies and skills for communicating with patients. However, there were also some comments about the need for more information being limited until physicians start writing more prescriptions for combination therapy.

- Pharmacists’ Opportunities for Interaction with Prescription Patients: The pharmacists all agreed that it is important to try to talk with patients about their medications, especially because so few ask questions. But opinion was divided about how easy or difficult it is to find the time. Even with many states mandating counseling for all new prescriptions, some pharmacists said they can do little more than ask patients whether they have any questions. Pharmacists in larger stores that fill more prescriptions per week or in small independent stores with no technicians tended to report having too little time to provide adequate counseling.

- Pharmacists’ Interaction with Customers Purchasing Over-the-Counter Medications: Most of the pharmacists indicated that opportunities are infrequent for interacting with customers who are purchasing medications over the counter. There was general concern about the trend toward
more over-the-counter medications and the possibility that people are self-medicating to save money when a physician should see them.

- Pharmacists’ Interaction with Patients Regarding Ulcer Medication: Only a few of the pharmacists had examples of talking to patients about ulcer disease or treatment specifically. Examples included noticing particular patients seeking multiple refills for a medication like Prilosec or frequently purchasing over-the-counter medications like Pepcid, which could be for ulcers. Almost no one said they had told patients with ulcers about the possibility of a bacterium causing their problem. This was attributed in part to rarely knowing what a patient’s diagnosis was and corresponding reluctance to second-guess physicians.

- Pharmacists’ Recommendations About Patient Education: The pharmacists said that they welcome simple print materials because they are valuable for helping patients learn important information and for serving as a catalyst to further conversation with the pharmacist and/or a physician. They cautioned that patient information must be simple and relatively brief; too much detail, especially about side effects and contraindications, alarms patients and discourages compliance. In addition, they pointed out that senior citizens have unique needs.

Summary of Conclusions and Recommendations

The findings from these four focus groups with chain and independent pharmacists suggest the following guidance for CDC decisions about enhancing the role that pharmacists can fill in promoting greater awareness of *H. pylori* and treatment for it. These are discussed in Chapter 3 of this report.

- Strengthen publicity for existing CE opportunities about *H. pylori* and its treatment.

- Revise publicity approaches or content of CE options to address information interests, such as how different combination therapies compare in efficacy identified in these groups.

- Develop CE opportunities that address some of the time pressures pharmacists face in meeting counseling mandates in general and on combination therapies for *H. pylori* in particular (e.g., special counseling techniques or skills for explaining these therapies to senior citizens).

- Step up efforts to secure press coverage in pharmacy journals and newsletters, especially of issues pharmacists expressed interest in or concern about, such as studies corroborating NIH consensus that *H. pylori* causes ulcer disease and that combination therapies constitute a successful treatment, evolution in Medicaid/insurance carrier trends in coverage/coverage limits, and what is being done to expand physician awareness/acceptance.

- Develop simple attractive patient-oriented print materials about *H. pylori* and
treatment to be displayed in pharmacies.
1. Purpose and Background

1.1 Purpose

Until 15 years ago, peptic ulcer disease was thought to be caused by an excess of gastric acid. Despite many drug regimens that decreased this acid, such as antacids, H2 blockers, and proton pump inhibitors, a high recurrence rate of peptic ulcer disease remained. In 1983, the stomach acid theory of peptic ulcer disease was questioned when a bacterium, H. pylori, was first recognized to be a cause of peptic ulcer disease and gastric inflammation (gastritis). In 1994, after nearly 10 years of skepticism by the medical community, the National Institutes of Health (NIH) convened a Consensus Development Conference on H. pylori to address a variety of questions.

After concluding that H. pylori was the major cause of peptic ulcer disease, the Consensus Development Conference recommended that patients with peptic ulcer disease should be evaluated for H. pylori and, if infected, treated with microbial agents to eradicate the organism. (Helicobacter pylori in Peptic Ulcer Disease. NIH Consensus Statement 1994 Feb. 7-9; 12(1):1-22).

Subsequently, the House Committee on Appropriations stated in its Report 104-659 on the FY 1997 budget for the Department of Health and Human Services (DHHS):

“...The Committee is concerned...about whether the H. pylori discovery has been adequately disseminated to physicians, other health providers, and patients. Therefore, the Committee has provided sufficient funds for CDC to initiate a trans-departmental public education campaign to foster more effective communication between consumers and physicians on H. pylori and its link to ulcer disease...”

Accordingly, Westat, Inc., under contract to the National Center for Infectious Diseases at CDC, has undertaken a series of background research activities for planning this important campaign. One component in the research has been an exploration of pharmacists’ role in influencing consumer awareness about new health information with treatment implications. While the literature reports on a 1994 study suggesting low awareness among primary care providers of the relationship between H. pylori and peptic ulcer disease (A.M. Fendrick, Difference between generalist and specialist physicians regarding Helicobacter pylori and peptic ulcer disease. American Journal of Gastroenterology 91, no 8 (1996): 1544-48), there is nothing to inform campaign planners about the potential role pharmacists could play.

Therefore, this series of focus groups was conducted to determine pharmacists’ awareness of the H. pylori discovery and the nature of their interaction with patients filling prescriptions for ulcer medications and/or purchasing medications over the counter that may be for relief of ulcer symptoms.

1.2 Methodology: About Telephone Focus Groups

The growing sophistication of telephone conference call technology has added a significant
tool to the repertoire of qualitative research methodologies. Westat has made increasing use of conference calls for conducting modified focus groups by phone. As with traditional focus groups, participants are carefully screened and recruited according to proscribed protocols. Instead of convening in person, however, participants are convened via conference call. While traditional face-to-face groups offer opportunities that are not available via conference calls, it is nonetheless possible for a moderator specifically skilled in conducting telephone groups to obtain a rich array of information — including information about participant reactions to creative or other materials requiring visual review — from participants whose perspectives might otherwise go unexamined.

For example, the technique can be invaluable for the following types of groups:

- **Participants who are widely dispersed geographically, even globally, and could not feasibly convened for face-to-face focus groups.** In one series Westat conducted, a variety of environmental health scientists across the nation, were convened to discuss impressions and advice on a prototype publication on environmental health education. Participants whose input was desired but whose location made in-person groups cost-prohibitive were sent advance review copies and then convened via telephone.

- **Participants who are affiliated with organizations or institutions that are competitive with each other in a particular market area.** Participants within an area small enough for recruiting an in-person focus group may be unwilling to discuss proprietary information that they might share with more distant colleagues. Telephone groups enable participants from different markets, states, and regions to participate in the same group and to be more candid than might be the case with a group of colleagues from a smaller area.

- **Participants whose occupations or lifestyles afford little free time, and thus are less likely to be available and willing to commit the greater time required to participate in a conventional group.** Health professionals, social service workers, and corporate executives, for example, are extremely difficult and costly to recruit for traditional focus groups. Their schedules often preclude discretionary commitments that involve the time required for a traditional group—typically two hours for the group itself, plus travel time to and from the focus group location. With a telephone group, busy people can participate from the convenience of an office, their home, a hotel, or any place there is a telephone. This convenience enhances recruiting and may help to ensure greater diversity or representation of some audiences. This has proven especially true as the focus group method becomes more widely used. It is growing more difficult and costly to recruit people who have not been in a group before; however, this trend is much less apparent with telephone focus groups.

The telephone focus group method offers another advantage: the number of observers is not limited to what a travel budget can accommodate. Any number of people can listen, also from the convenience of a home or office in any time zone. Hearing the discussion firsthand is far more
beneficial than reading a report or transcript. In addition, the conference call set-up enables the observers to stay on line after the focus group participants hang up in order to talk with each other and the moderator while recall is fresh.

1.3 Discussion Guide

Westat and CDC developed the discussion guide. The following topics were covered:

- Background explanation for and introduction of participants;
- Discussion about awareness of *H. pylori* and treatment for it;
- Sources of information about *H. pylori*;
- Information needs and preferences for learning formats;
- Nature of interaction with patients filling prescriptions and those purchasing over-the-counter medications;
- Examples of contact with patients regarding ulcer disease or medication;
- Contact with special audiences (elderly; Medicaid); and
- Advice/suggestions about *H. pylori* patient education.

A copy of the discussion guide used to facilitate the groups is provided in Appendix A.

1.4 Recruitment, Scheduling, and Group Composition

Conventional face-to-face focus groups generally have about 8 to 10 participants, but because of the unique communication dynamic associated with telephone focus groups, a smaller number is more preferable. Based on past experience, Westat generally recommends seven to eight participants as an ideal size group. For pharmacist groups, over-recruiting by one person is advised so that an alternate is available in case of an unexpected cancellation. Two of these groups included eight participants; two had six due to an unusual number of late cancellations. All groups included both men and women from a variety of states and regions.

A subcontractor to Westat that specializes in recruiting professionals for health-related research, including telephone focus groups recruited all participants. Recruiters screened all prospective pharmacist participants according to criteria developed by Westat and CDC to assure that all groups would include both men and women, pharmacists with different levels of practice experience, and representatives from various states and regions of the country.

Two groups were recruited to include pharmacists from national, regional, and local chain
pharmacies; two, owners or employee pharmacists from independent pharmacies. One chain and one independent group included participants whose customer base had an average household income under $35K. The other group included mostly participants whose customer base averaged over $35K in income. This customer income criterion did not appear to be an important factor in pharmacists’ responses.

The screener used to recruit participants is provided in Appendix B. Appendix C provides information on each participant’s store name and location and his/her number of years in practice.

1.5 Conducting the Groups

For each group, once all participants were connected by phone, the moderator took a roll call and briefly reviewed the purpose of the discussion and logistical guidelines for the call. (See the first section of the guide in Appendix A for the procedural details provided by the moderator.) She then asked participants to introduce themselves and briefly describe their store. In three of the groups, participants were asked to report the average number of prescriptions they fill in a week. This information was expected to be a useful indicator of how busy a pharmacist might be, but it did not always correlate as expected. Some very large volume stores, it was learned, are more likely to have trained technicians handling responsibilities that free the pharmacist for more counseling time with patients.

All of the major sections of the guide were covered in each group, with the exception of discussion about contact with Medicaid patients. This was included in the guide in anticipation of pharmacists with lower income customers referring to Medicaid’s mandate to provide counseling to all Medicaid-covered customers filling new prescriptions. However, almost all of the pharmacists said their state mandates counseling for all patients filling a new prescription. Discussion in one group about Medicaid patients did not yield information that was applicable only to this audience.

1.6 Analysis

Focus groups are distinctly useful as a research technique in that they permit in depth examination of complex issues. They provide a flexible tool for exploring participant awareness, attitudes and beliefs, behavior, motivation, intentions, and concerns relative to a particular topic or set of topics. Focus group findings are not statistically representative in the way that a probability study is, but they can be structured to reflect characteristics of a given population. The written summary of focus group findings contains a synthesis of results wherein all groups are analyzed collectively, general themes are identified, and contrasts between groups are presented.

The steps used to examine the findings were followed to give researchers an initial overview of all of the groups and then to enable selective study of individual groups and topic areas. As with all qualitative research, the value of focus group findings is dependent on researchers examining results systematically. Furthermore, the procedures used to analyze focus group results are not standardized, which heightens the importance of addressing the data systematically.
The process used to analyze this series of focus groups is based on that recommended by Krueger (1994). In short, Krueger notes that the process for analyzing results must be systematic and verifiable. He recommends processing each group briefly at its conclusion, then developing a total picture of all of the groups, and finally considering particular groups and responses to specific questions.

In analyzing the data, the research team sought common themes, points of interest, and tendencies among participant comments. Westat used a four-step process:

- **Step 1.** Once all four groups were completed, the available data, including observer notes, audiotapes, transcripts, and information about the participants’ backgrounds were compiled. All data were initially examined at once in order to absorb a complete overview and to begin noting potential trends and patterns for further examination. This activity was conducted by three members of the research team individually and then subsequently examined and synthesized by the one of those three.

- **Step 2.** Following this primary overall assessment, the findings from each group were more closely considered one at a time. During this stage of analysis, each group’s findings were examined to discern how they reflected, differed from, or added to tentative observations made during Step 1. This secondary, close examination of individual groups was designed to continue the overview process while adding more in depth analysis.

- **Step 3.** The third step in analyzing these focus group findings was to consider the information one topic at a time. Conclusions drawn from scrutinizing each discussion topic across the groups were compiled and compared. Quotes that highlighted the discussion were extracted from notes and transcripts and used to illustrate points. Additionally, the research project manager who listened to all four groups, but was not involved in preparing the initial draft of the report, examined the conclusions for accuracy.

- **Step 4.** The final task was to examine the conclusions drawn from the findings in terms of practical implications.
2. Discussion of Findings

The following findings emerged from the series of four focus groups.

2.1 General Awareness. All of the pharmacists were familiar with the data indicating that a bacterium has been associated with peptic ulcer disease, although there was almost no reference to “H. pylori” by name throughout the discussions:

Everyone knew that a bacterium has been associated with ulcers, but almost no one referred to the bacterium by name in any portion of the discussion, even after the moderator used the name in posing questions to the participants. In general, the pharmacists indicated they had begun hearing about the bacterium in the last 1 to 4 years, although one said he had heard of it as long ago as 10 years and another said a professor in pharmacy school theorized in 1959 that a bacterium causes ulcers.

There were no notable differences in level of awareness between pharmacists working in chain stores and those in independent stores or even between pharmacists with more experience and those with less experience. Younger pharmacists were also equally as aware as more experienced pharmacists because many were in pharmacy school when the discovery was widely publicized.

2.2 Frequency of Prescriptions for Combination Therapies. In general, the pharmacists reported that prescriptions for combination therapies (especially Prilosec and Biaxin) have increased in the last few years and that results have been good for many patients, but that combination therapies are still a very small percentage of prescriptions filled for ulcer medications.

Almost no one indicated that prescriptions for combination therapies are frequent. One pharmacist who did, however, was in Utah, where he reported that Medicaid covers combination therapy as a first-line treatment. He said:

“Medicaid has indicated that it’s kind of a first-line consideration without even having documentation of whether it is in fact being caused by the bacteria...they’re using it quite frequently as a first line protocol...” (independent pharmacist)

This was in sharp contrast to most state Medicaid programs, which most pharmacists said exclude or limit coverage for expensive combination therapy. Another pharmacist said that combination therapy prescriptions have increased so much that he has nearly lost his Prilosec and Zantac business.

It was far more common for the pharmacists to report that while there are more prescriptions filled for combination therapies since news about the bacterium became more widespread a few years ago, market share for combination therapies remains very small.
Comments such as the following were common:

_We been seeing some good success with the combination antibiotic. People who have tried quite a few of the other drugs and have gotten relief seem to take this and get much better results than with antacids or H2 antagonists._ (chain pharmacist)

_Oddly enough, the doctors around our community are still basically prescribing just the Prilosec and the Pepcid and all those H2 blockers; they are really not using antibiotics that much. I don’t know why. We’ve only dispensed the pack therapy. I forgot the name of it. We use it so rarely, we don’t even have it...I couldn’t really tell you its success rate._ (chain pharmacist)

_We occasionally see a few doctors trying it, but it’s nowhere near the kind of numbers that you see for H2 and your Prilosec. It seems to be not accepted quite as well..._ (chain pharmacist)

_Nothing has written for [the combination therapy] even though it has been detailed in our area. None of our doctors have tried it yet, at least where I am._ (chain pharmacist)

_Only the gastro-entomologists [sic] are prescribing it._ (independent pharmacist)

_I’ve only had two prescriptions (for Prilosec-Biaxin combination). Most patients are still receiving H2 blockers or Prilosec alone._ (independent pharmacist)

_Some of the pharmacists even reported that combination prescriptions have actually declined, especially since consumer media coverage died down and more medications such as Zantac, Pepcid, and Tagamet have become available for over-the-counter purchase. For example:_

..._Generally speaking, we’ve seen even a decrease in the amount of interest. Certainly maybe a year ago, they were using a number of the prescriptions in combination. This last six months has been slow...interest has kind of dropped off..._ (chain pharmacist)

_Some of these pharmacists indicated that they have seen good results for patients who try the combination therapies and suggested that it is disturbing not to see more combination prescriptions. For example, participants said:_

_It seems like if this is a cure, with as many patients as I have with this problem, we ought to be using it._ (chain pharmacist)

_If it is beneficial, it’s unfortunate [that so few physicians] are prescribing it._ (chain pharmacist)
Hardly like 1 percent or a fraction of a percent of the prescriptions we fill for ulcers are for the combination therapy. Why is this? If it's true [that this is a cure] then the only [explanation] is the price factor. (chain pharmacist)

I don’t see that most of the physicians are getting involved in this. (chain pharmacist)

[Physicians] are still prescribing Zantac for symptomatic relief and generic Zantac’s coming out in two weeks. That’s all we’re doing: treating the symptoms, not the problem. (chain pharmacist)

2.3 Barriers to Prescriptions for Combination Therapy. The pharmacists identified several theories about why combination therapy has not become more prevalent. Most common among these were cost and related insurance issues; ready availability of over-the-counter medications that encourage patients to self-medicate; and lack of physician awareness and/or confidence in results and/or time to conduct the test or “hassle” with insurance issues.

The pharmacists had several theories about what may be influencing slow acceptance of combination therapy for ulcers. The theories cited above were mentioned several time each. A full list of the pharmacists’ theories about barriers to acceptance follows:

- High cost and resistance from Medicaid, HMOs and other insurers to cover the treatment;
- Availability of low-cost medications over the counter encouraging patients to self-medicate;
- Lack of physician commitment due to limited detailing, time constraints for conducting test and complying with insurance requirements, and/or insufficient data establishing efficacy;
- Pharmacist discomfort about second-guessing physicians’ prescriptions;
- Diminished consumer media publicity and corresponding low patient awareness and demand;
- Pharmacists’ reluctance to question doctors’ prescriptions/absence of diagnosis on prescriptions to facilitate inquiries about choice of treatment;
- No reimbursement for pharmacists’ counseling time;
- Physician reluctance to choose from so many options and corresponding reluctance to write multi-prescription treatment;
• Complicated regimen for patients to comply with possibly impeding good results; and

• “Conspiracy” of “billion dollar” industry for antacids and H2 blockers.

Some of the typical comments made about these theories included:

A great many of the third-party payers and Medicaid automatically eliminate anything that has any cost to it...The doctors turn around and say ‘[I’m] not going to be bothered by all this. I’ll just go back and treat the patient as I did before and forget about it.” (independent pharmacist)

Lack of physician education is the problem. You tell [patients] to go try this new treatment and the doctor says, ‘What’s that?’ (chain pharmacist)

I don’t think they’ve proven 100 percent of the time there’s a bacterial cause of an ulcer. (independent pharmacist)

I haven’t really read anything about whether they say now that the therapy’s been tried for a year at least — whether it has proven to be effective. (independent pharmacist)

I think public awareness would be the catalyst that would stimulate the best interest in it. If the public is introduced to it...they will pressure the doctors into having to do something which would, in turn, open the doors for the pharmacy to give our input. (independent pharmacist)

If you ask me what the reasons is [why there are so few prescriptions for combination therapy] I would have to say doctors respond to what the detail salesmen say to them...but, as far as I know, none are, so doctors just keep treating it with the regular medication they’ve always written and then patients with Pepcid and others that have gone over the counter, they’re self-medicating. (independent pharmacist)

The problem out here is getting the insurances to pay for the combination because it is so expensive. (independent pharmacist)

2.4 Pharmacists’ Primary Sources for Information about H. pylori. The pharmacists said they had first started hearing about H. pylori and treatment for it from several sources, including (in order of frequency mentioned): pharmacy trade journals, consumer media, and physicians’ prescriptions. Only one person mentioned APhA continuing education.

These pharmacists reported learning about H. pylori from several sources, especially
pharmacy trade literature such as the *Pharmacist Letter* and consumer news (everything specifically cited was broadcast — e.g., CNN, 20/20, 60 Minutes, and MTV.) A few of the pharmacists said it was patients’ prescriptions that had first alerted them to the new treatment for ulcers. Two of these pharmacists mentioned calling physicians to inquire about why they had prescribed a particular combination of drugs. In one group, pharmacists described physicians who are prescribing combination therapies as “forward thinking” or said that the combination therapies are coming from gastroenterologists more than primary care physicians.

The pharmacists generally indicated that they glance at a journal or newsletter during a lull at work and may bring it home if an article catches their attention. The *Pharmacist’s Letter* was cited more often than other professional literature as a good source for general information because it has concise news and also addresses what has been in the consumer media that is relevant to pharmacists.

### 2.5 Pharmacists’ Needs and Preferences for Additional Information

Participants in these groups indicated that they welcome continuing education opportunities, especially more creative ones that they described seeing recently and opportunities to utilize fax and Internet technology for accessing CE courses. A few people expressed interest in specific topics such as rates of success with different combination therapies and skills for communicating with patients. However, there were also some comments about the need for more information being limited until physicians start writing more prescriptions for combination therapy.

The pharmacists recommended that information be available through continuing education courses. Some people noted that they appreciate the increasing range of formats and media for accessing courses and the creative approaches some pharmaceutical firms take. One participant described a brief course about medications that were about to go over the counter (GyneLotrimin and Tagamet) to which information was packaged with an entertainment video.

The pharmacists expect to receive CE opportunities primarily through pharmaceutical companies, although one mentioned an APhA seminar on peptic ulcer disease and another participant said universities sometimes offer seminars.

There were very few specific information topics about *H. pylori* that the pharmacists expressed interest in. These included:

- The “best” regimens;
- If combination therapies work;
- Degree of success with different therapies;
- The “true” infection rate; and
- If this is an actual cure.
One pharmacist said an especially useful course he had taken was one sponsored by Pfizer on skills for communicating with patients, a subject that was not taught in pharmacy school.

Several of the pharmacists — including everyone in the second group with chain pharmacists — said that the information they already have is sufficient or that they do not think they could use more information until there is more combination prescription activity. For example:

*I don’t know if I have enough information. I haven’t tried to pursue a whole lot of information on it because I haven’t used that much of [the combination therapy.] If I felt I was using it more, then I’d try to educate myself.* (independent pharmacist)

*I’d like to be more informed, but...it would be like having information you can’t use because the patients aren’t asking about and the doctors aren’t prescribing it.* (independent pharmacist)

2.6 Pharmacists’ Opportunities for Interaction with Prescription Patients. The pharmacists all agreed that it is important to try to talk with patients about their medications, especially because so few ask questions. But opinion was divided about how easy or difficult it is to find the time. Even in states that mandate counseling for all new prescriptions, some pharmacists said they can do little more than ask patients whether they have any questions. Pharmacists in larger stores that fill more prescriptions per week or in small independent stores with no technicians tended to report having too little time to count on providing adequate counseling.

It was expected that pharmacists in chain stores, which fill the most prescriptions, might be least able to provide personal counseling, and that independent pharmacists would have more time and be better acquainted with customers. This was true only to some extent; there were more independent pharmacists who said they personally know their customers by name and a chain pharmacist who admitted his company encourages him not to spend time with patients. However, several chain pharmacists (including most participants in the first group with chain pharmacists) said they know their customers and have plenty of time to talk to them, while some independents reported that financial pressures and not being able to afford technicians puts constraints on their counseling time. Comments included:

*...the best way I have found is one-on-one with my customers — to explain to them how to take [medication]. It just reinforces important things...[if] I explain it, they get more out of that than any other thing they could do. It’s time consuming and almost impossible to do, but we try to squeeze it in.* (independent pharmacist)

*We even have a room set up for counseling, but how do I get there to spend the time? I’m training my techs to help me do that, but it’s a struggle to spend the time to tell you the truth. I’d like to, and I feel guilty all the time. We provide leaflets and I do...*
say, ‘Please call me with questions’ and I do try to go over the leaflets, but I don’t have enough time to sit down. (independent pharmacist)

*Overall, the companies that we work for would prefer us to be as productive as possible away from the customer, putting the dollar first. I’m not going to reveal who I work for, but I know that they say one thing and want another. It’s the bottom line, but I do what I can to make sure the customer understands what they’re doing.* (chain pharmacist)

*I work in a chain and I spend a lot of time talking to people. You know everybody by their first name...and I can recognize them by voice. I get a lot of calls and questions and I’m not really all too busy...* (chain pharmacist)

Most of the pharmacists said it is rare for patients to initiate conversation or ask questions about their prescription medications, especially when they are in the store. In fact, one said that in North Carolina, it is so widely assumed that people will say they do not have questions, that pharmacists are not permitted just to ask ‘Do you have any questions?’ Pharmacists must provide basic information, even if the patient does not seem interested. Some pharmacists in other states said they must document that counseling was offered and said that inspectors come around to make sure that pharmacies are complying with these mandates.

2.7 Pharmacists’ Interaction with Customers Purchasing Over-the-Counter Medications. Most of the pharmacists indicated that opportunities are infrequent for interacting with customers who are purchasing medications over the counter. There was general concern about the trend toward more over the counter medications and the possibility that people are self-medicating to save money when a physician should see them.

Most of the pharmacists reported having little opportunity to interact with patients purchasing over-the-counter medications. They also expressed concern about the increasing number of these medications, which may be prompting patients to self-medicate to save money instead of seeing physicians. For example:

*The biggest question I get is, if they’re paying cash, they want to know if they can double up on what’s over the counter to make it [as effective as] a prescription.* (chain pharmacist)

2.8 Pharmacists’ Interactions With Patients Regarding Ulcer Medication. Only a few of the pharmacists had examples of talking to patients about ulcer disease or treatment specifically. Examples included noticing particular patients seeking multiple refills for a medication like Prilosec or frequently purchasing over the counter medications like Pepcid, which could be for ulcers. Almost no one said they had told patients with ulcers about the possibility of a bacterium causing their problem. This was attributed in part to rarely knowing what a patient’s diagnosis was and corresponding reluctance
to second-guess physicians.

In the few examples pharmacists gave about discussing ulcer disease with patients, exchanges had usually involved the pharmacist inquiring about symptoms someone was taking a medication for, how long they had been experiencing symptoms, and in the case of the OTC purchases, whether the person had seen a physician. In one case, the pharmacist said he usually calls physicians’ nurses to verify that a prescription is to be refilled. Another pharmacists said he had advised a few people to ask their doctors about the possibility of an ulcer and a bacterial cause. Several such patients returned later with a prescription for combination therapy.

The pharmacists noted that they rarely know what someone’s diagnosis is. This increases the need for counseling intervention, especially where ulcer disease is suspected. Without counseling, pharmacists cannot determine whether someone might benefit from consulting their doctor about the possibility of a bacterial cause. This is even more problematic with patients purchasing over-the-counter medications such as Pepcid, Tagamet, and others that could be for simple heartburn.

Almost none of the pharmacists said they call physicians to ask about ulcer medications. One said he does call nurses to verify if a prescription for something like Prilosec alone is supposed to be filled again.

Comments about discussing ulcers and ulcer treatment included:

The percentage for me [of patients who ask any questions about ulcer medication] is so low, it’s really not worth mentioning. (chain pharmacist)

95-99 percent of the time, without counseling, I couldn’t make out whether [the prescription] is for GERD or an ulcer or something else. (independent pharmacist)

2.9 Pharmacists’ Recommendations about Patient Education. The pharmacists said that they welcome simple print materials because they are valuable for helping patients learn important information and for serving as a catalyst to further conversation with the pharmacist and/or a physician. They cautioned that patient information must be simple and relatively brief; too much detail, especially about side effects and contraindications, alarms patients and discourages compliance. In addition, they pointed out that senior citizens have unique needs.

There was strong support for print material in general and on this topic in particular. One pharmacist said he has pamphlet on GERD; another mentioned a brochure from Abbott on Biaxin that was appropriately simple. There was also a strong emphasis on the importance of simple language and illustrations. For example:

... sometimes no counseling is the best counseling. Too much information is
confusing people. (chain pharmacist)

The only way people are going to know about this is if somebody brings me some information I can put out or if I physically tell each person on an H2 antagonist, ‘Hey, you know, you can do this [now.]’ That’s very challenging because I don’t have time all day to sit there and tell everybody. (chain pharmacist)

If you really want to inform the public, give the pharmacist the opportunity to distribute brochures...there is interest in this type of therapy. (independent pharmacist)

Print material is definitely useful. Everybody today has a thirst for more knowledge. Most of my patients are in an upward middle class area. They can read and are very into what’s going on with their health. As long as the information is kept simple and easy to understand, I have found it beneficial. (independent pharmacist)

I would like to see more leaflets from pharmaceutical companies that are colorful and clear and would back up what you are saying...You can talk to the patient and in the meantime, give them a piece of paper and he goes home and reads what you just told him. I really haven’t seen anything from the pharmaceutical companies on this type of combination treatment to hand out to patients. (independent pharmacist)

There were a number of suggestions about preparing information that will be useful for senior citizens in particular. For example, it was pointed out that they need large type and often-prominent reference to toll-free numbers. There was also emphasis on seniors’ frequent need for conversation to accompany print material. One pharmacist said she often has an older person explain to her what they understand so she can verify that they are adequately informed. (independent pharmacist)

There were very few suggestions about content and included only:

Addressing the limitations of over-the-counter medications; and using illustrations of the stomach and ulcers. There was also a comment about how difficult it is to explain antibiotics because they are used for so many purposes and because it is so important to take the full course of the prescription.

Chain pharmacists indicated that technically, they are supposed to obtain corporate permission before displaying materials, but that they have considerable latitude to make decisions about what is appropriate for their store. Only one person said she is required to keep countertops clear, but she regularly stocks brochures on various topics so that she can make information available if someone inquires. (For example, she said information about quitting smoking is requested.)

There was some concern about becoming inundated with questions and concerns now
that more consumer information urges people to “ask your pharmacist.” As one participant put it:

*I think the worst thing they could have ever done is a lot of these drug companies started advertising like on television. At the end, it says, ‘Ask your pharmacist.’ I mean you get so many calls, especially after they bring it on 20/20 or 60 Minutes. All you get is calls all day. Seldane, look at Seldane.*

There were very few suggestions about materials other than print. One pharmacist said he personally likes things like refrigerator magnets, but he also thought that these are too small to provide much information and are not as appealing to patients. There were a few suggestions about making a video available that patients could borrow or view at their physician’s office. One said they include health information on the tape people hear while they are on hold.

A few pharmacists talked about community activities they undertake to assist patients. For example, some said they respond to requests for speakers and one noted that he does “grab bag” days in a senior citizen complex where residents can bring him their medications and ask questions about them.
3. Conclusions and Recommendations

Findings from this series of focus groups indicate that pharmacists are familiar with *H. pylori* and with combination therapy treatment for it, and that their interaction with patients encompasses opportunities for providing information that could increase patient awareness of the bacterium. However, the findings also reveal that pharmacists need information and tools to make the most of their brief contact with patients. Potentially productive strategies for assisting them could include the following:

**Strengthening publicity for existing CE opportunities on this topic:** Only one of the pharmacists was aware of a CE opportunity on peptic ulcer disease. Low awareness and use of CE opportunities is limiting pharmacists’ access to data they say they need about which therapies work, “true infection rate,” and other information that must be covered in available courses.

**Revising publicity approaches or content to address identified information interests could attract more attention and use:** Low awareness may also be attributed to a sense among pharmacists that they have limited need for more information about *H. pylori* until more physicians begin prescribing drugs to combat it.

**Developing CE opportunities that address some of the time pressures pharmacists face in meeting counseling mandates in general and on combination therapies for *H. pylori* in particular:** One pharmacist spoke highly of a Pfizer seminar on developing skills for communicating with patients. Others spoke about how difficult it is to make adequate time for talking with patients about therapies that are new and complex like combination therapies for *H. pylori*. Still others referred to the special needs of elderly patients. Perhaps new CE curricula that address some of the communication skills unique to these therapies and/or to seniors would attract more attention.

**Stepping up efforts to secure press coverage in pharmacy journals and newsletters:** Pharmacists read their professional literature. The *Pharmacist’s Letter* was named often as a concise source for information in general and about *H. pylori* specifically. Coverage of information that could help address barriers to acceptance would be of interest, for example, data supporting consensus that *H. pylori* causes ulcer disease and that combination therapies constitute a successful treatment; evolution of Medicaid/insurer policy trends on coverage; efforts to expand physician awareness; and other topics that could help stimulate renewed interest among pharmacists in expanding their own understanding.

**Developing simple attractive print materials for display in pharmacies:** The pharmacists said they welcome patient information that is simple and brief to help patients learn more about important health topics and medications as well as to equip them with something that often serves as a catalyst to conversation with the pharmacist or a physician.
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H. PYLORI AWARENESS AND TREATMENT/TELEGROUPS WITH PHARMACISTS
REPORT OF FINDINGS AND RECOMMENDATIONS

APPENDICES

A Focus Group Discussion Guide
B Screener for Recruiting Focus Group Participants
C Focus Group Participants
D Findings from Individual Groups