The IMPACT Program

Pharmacists in Family Practice: A Resource

PHYSICIAN INFORMATION PAMPHLET

How Does Working with an Integrated Pharmacist Help My Practice?

- The pharmacist becomes a new resource for the practice team.
- Patients benefit from the expertise of both physicians and pharmacists early enough in their care to prevent and reduce drug-related problems.
- Drug expertise can consistently reach a greater number of people in the primary care setting.

"Sometimes you get so deeply into the management of a patient that it's nice to have somebody sort of stand back and give you a nice overview."

– IMPACT demonstration project participating physician

IMPACT – Integrating family Medicine and Pharmacy to Advance primary Care Therapeutics.
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IMPACTx
Integrating family Medicine and Pharmacy to Advance primary Care Therapeutics

WHAT IS THE IMPACT PROGRAM?

The goal of the IMPACT program, as the acronym suggests, is to Integrate family Medicine and Pharmacy to Advance primary Care Therapeutics. A growing body of research supports our belief that having pharmacists working in family practice settings enhances patient care.[1] This pamphlet is the product of more than 10 years of planning and collaboration between investigators, government and community leaders.

In the 1990s a group of family physicians asked a community pharmacist to develop a consultation service to help them optimize care for elderly and complex patients. That initiative was so successful it grew into the Seniors Medication Assessment Research Trial (SMART), which then lead to the IMPACT Program.

IMPACT integrated non-dispensing pharmacists with enhanced clinical skills into family practice settings. Pharmacists:

- Identified patients' desired therapeutic outcomes
- Identified patients' actual and potential drug-related problems
- Developed therapeutic plans and recommended options
- Discussed recommendations with physicians
- Gathered and disseminated drug, disease prevention and health promotion information to patients and other health care providers to ensure safe and effective pharmaceutical care
- Identified and implemented many office system medication management and prescription renewal enhancements (e.g., acquired electronic CPS copies for all office computers)
- Helped practice team deal with drug recalls
- Assisted in teaching students and role-modelling interdisciplinary care

The IMPACT experience provides concrete examples of how to integrate pharmacists into a variety of family practice settings. The project demonstrates how important it is to have a well-organized start-up, early and ongoing support, and strategies to overcome common obstacles.

"When [a] drug withdrawal occurred, the clinic staff turned to me for advice on how to approach this, and to draft a letter for distribution to patients. It's great to be utilized as a source of information."

– IMPACT demonstration project participating pharmacist

What is the Impact of Drug-Related Problems?

Drug-related problems, one of the most common preventable causes of morbidity and mortality, lead to increased hospitalizations and service costs.

Up to 30% of all emergency department visits are drug-related. Between 25% and 39% of adverse drug events could be prevented. Errors occur most often at the prescribing stage. Recent North American studies show preventing drug interactions leads to fewer hospital admissions for the patient.[2]

What Does an Integrated Pharmacist Contribute?

- Prescribing optimization (e.g., medication assessments of older patients, patients with chronic disease or chronic medications, patients with drug-induced adverse effects)
- Education opportunities (e.g., drug therapy updates, in-services for support staff, patient education)
- Immediate access to objective drug information
- Operational efficiencies (e.g., resolving Limited Use and Section 8 issues, organizing drug samples and creating office strategies for efficient monitoring and prescription renewals)

[1] Sellors J et al., A Randomized Controlled Trial of a Pharmacist Consultation Program for Family Physicians and Their Elderly Patients. *CMAJ* July 8, 2003;169(1):17–22.

[2] Einarson TR. Drug-related hospital admissions. *Ann Pharmacother* 1993;27:832-40. Hohl CM et al. Polypharmacy, adverse drug-related events and potential adverse drug interactions in elderly patients presenting to an emergency department. *Ann Emerg Med* 2001;38:666-71. Tafreshi MJ, et al., Medication-related visits to the emergency department: a prospective study. *Ann Pharmacother* 1999;33:1252-57. Gurwitz JH et al., Incidence and preventability of adverse drug events among older persons in the ambulatory setting. *J Am Med Assoc* 2003;289:1107-16.

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One Example of an IMPACT Pharmacist

Before joining the Bruyère Family Medicine Centre in Ottawa, Natalie Jonasson completed her Bachelor of Science in Pharmacy and worked in a variety of community pharmacy settings. She completed IMPACT training and continues to enhance her skills in cholesterol and diabetes management.

> *"[As] a people-oriented person, I value my relationships with patients and the opportunity to work with other members of the health care team."*
>
> *– Natalie Jonasson, IMPACT pharmacist*

What is My Role?

Introduce the pharmacist to the patient as another health care professional collaborating with your team. Review advice of the pharmacist and then ultimately determine the management approach.

What are Drug-Related Problems?

Definition: "An undesirable event, a patient experience that involves, or is suspected to involve, drug therapy, and that actually or potentially interferes with a desired patient outcome."

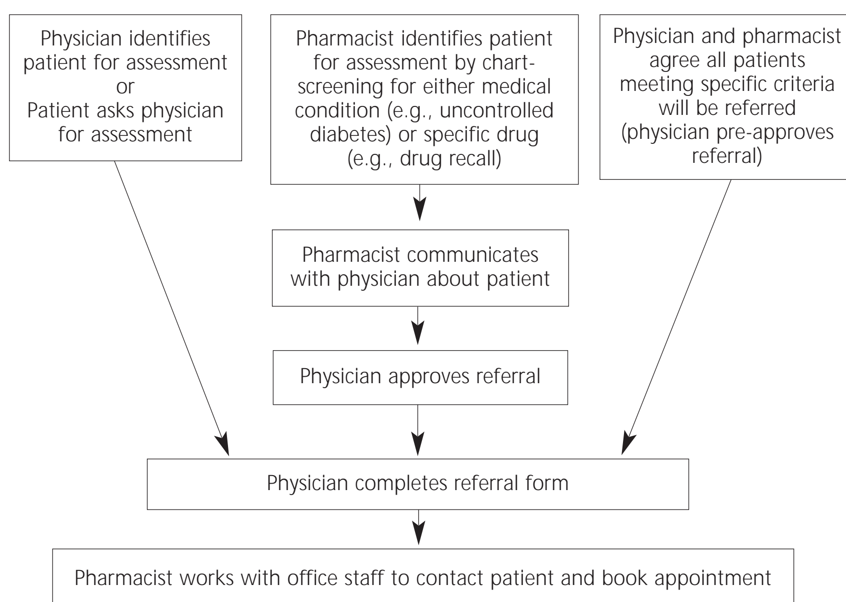
Types of Drug-Related Problems:

- Requires a drug
- Too much of correct drug
- Drug no longer needed
- Adherence issues
- Drug selection not optimal
- Adverse drug reactions
- Too little of correct drug
- Drug interactions

— Strand LM, Morley PC, Cipolle RJ, et al. Drug-related problems: their structure and function. DICP Ann Pharmacother. 1990;24:1093–97.

PATIENT REFERRAL

How to Refer



Who to Refer

- **Chronic conditions** (e.g., blood pressure, cholesterol, pain, arthritis)
- **Multiple medications** (to simplify, ensure appropriate dosing times, manage or prevent drug-related problems)
- Possible **adverse drug events** or **drug interactions**
- Recently **hospitalized** (for counselling on medication changes)
- On a drug with **high risk for adverse events**
- Medication **adherence** issues
- Medication **counselling** needed (e.g., starting a new medication)
- Tapering or **changing** a medication

You may choose to have some patients become automatic referrals, such as people with diabetes or asthma.

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Stages and Steps for Integration

Stage 1: Introducing Integration

- Read this pamphlet
- Meet pharmacist
- Participate in orientation discussions

Other activities occurring at this time: recruiting and hiring; pharmacist hosts presentation at practice site and presents materials; site manager or office staff member prepares site profile and work station for the pharmacist.

PHARMACIST ASSESSMENT

Date of baseline assessment: 14-Jun-2005

Patient Name [illegible]
Date of birth: [illegible]
Health Card Number: [illegible]
Chart number: [illegible]
Physician: [illegible]

Reason for referral

- [x] Comprehensive medication assessment
- [ ] Patient medication adherence issues
- [ ] Taking drug at high risk for adverse events
- [x] Suspected Adverse Drug Reaction
- [x] Provide patient education about medication
- [ ] Monitoring related to drug therapy
- [x] Suboptimal control of chronic disease
- [ ] Recent Hospitalization
- [ ] Other

Description:

Thank you [illegible] for the very interesting and challenging referral of [illegible] whom I saw in the office on the 14th of June 2005. Thanks as well for the letter which accompanied the referral and made clear your priorities in her treatment. I had some concerns with the large amount of non prescription medications that [illegible] is using as well, both in the way of vitamins and natural based remedies, many of which have little evidence of efficacy. I tried to address that with her but noticed some reticence on her part to stop them. I will attempt to address that on follow up. I have put together some recommendations below for your consideration.

RECOMMENDATIONS

You might consider switching [illegible] narcotic pain killer to transdermal fentanyl in an effort to more adequately control her pain perhaps with less effect on her bowel function. I would recommend the fentanyl 25mcg patch to be applied q72 hours. Reassessment of the ongoing need for NSAIDs, naproxen and ketorolac might follow.

You might consider using a higher dose of gabapentin to address [illegible] neuropathic pain. I would recommend 400mg tid for now increasing upward based on response and tolerance to 2000mg daily. This might best be attempted once narcotic treatment of her pain is dealt with.

You might consider a number of things to attempt to more adequately address [illegible] constipation
1 Increase her dose of docusate to 200mg bid
2 Change bisacodyl 3 tabs once weekly to daily use of senna (Senokot) 1-2 tablets daily
3 Discontinue the daily use of Colyte

You might consider discontinuing the pinaverium that [illegible] is using for irritable bowel. There is a lack of consistent evidence as to its effectiveness and better clinical evidence for tegaserod, which she is now using. This is particularly evident in IBS with predominant symptoms of constipation.

You might consider discontinuing the amlodipine as [illegible] hypertension seems to be very well controlled and it might be aggravating her constipation.

PRESCRIPTION MEDICATIONS

Bisacodyl (Dulcolax) 5 mg, 2 Tablet(s) PRN
Conjugated estrogens (C.E.S) 0.625mg, 1 Tablet(s) QD ac
Conjugated estrogens (Premarin) .625 mg, 1gm twice weekly Cream
Domperidone (APO-domperidone) 10 mg, 1 Tablet(s) QID ac + hs
Fentanyl (Duragesic 25) 2.5 mg, 1 patch every 72 hours Disc (SR) With Food
Fosinopril (Monopril) 10 mg, 1 Tablet(s) QAM ac
Gabapentin (APO-gabapentin) 400 mg, 1 midmorning and evening Capsule(s) BID
Hydrochlorothiazide (APO-hydro) 25 mg, 1/2 Tablet(s) QAM ac
lactulose (PMS Lactulose) 667mg/ml, 2-3 tbls liquid QD ac
Methylprednisolone acetate (Depo-medrol) 40 mg, 1/month Suspension

Sample recommendation

Stage 2: Developing Relationships and Initiating Patient Assessments

- Participate in five-minute one-on-one meet and greet with the pharmacist to establish how to work together
- Begin participating in 10-minute patient assessment discussions with the pharmacist
- Explain and support the role of the pharmacist when discussing assessments with patients

Other activities occurring at this time: initial patient assessments, drug information requests.

Stage 3: Expanding the Program

- Continue to review patient assessments and provide feedback to the pharmacist
- Identify educational needs the pharmacist can fulfill
- Participate in a group meeting to identify areas of the practice the pharmacist can help improve

Other activities occurring at this time: patient assessments; initiatives to improve office systems (e.g., discussion of practice medication needs report, consensus building, educational activities).

Will the Pharmacist Make Changes Without Talking to Me?

No. The emphasis is on a team approach. The pharmacist is a resource to the family practice. To preserve the relationship and avoid fragmentation of care, you retain the leading role in diagnosing illness, prescribing medications and consulting pharmacists.

> You might consider using a higher dose of gabapentin to address neuropathic pain. I would recommend 400mg t.i.d. for now increasing upward based on response and tolerance to 2000 mg daily. This might best be attempted once narcotic treatment of her pain is dealt with.

Need More Information?

This pamphlet is just a sample of available resources. It is part of the IMPACT Pharmacist Program Toolkit: How to Integrate a Pharmacist into Family Practice. For detailed appendices and IMPACT project results, or to comment on this pamphlet, visit our website: http://www.impactteam.info.

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