

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

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.”

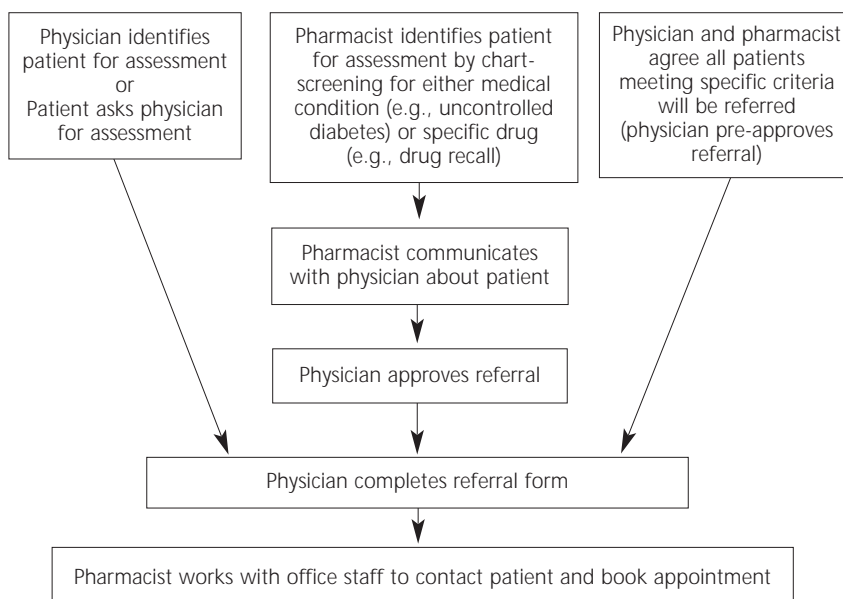
Types of Drug-Related Problems:

- 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.

STAGES AND STEPS

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: [redacted] Reason for referral

Date of birth: [redacted]

Health Card Number: [redacted]

Chart number: [redacted]

Physician: [redacted]

Comprehensive medication assessment
 Patient medication adherence issues
 Taking drug at high risk for adverse events
 Suspected Adverse Drug Reaction
 Provide patient education about medication
 Monitoring related to drug therapy

Suboptimal control of chronic disease
 Recent Hospitalization
 Other

Description:

Thank you [redacted] for the very interesting and challenging referral of [redacted] 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 [redacted] 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 resistance 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 reducing [redacted] 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 [redacted] 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 [redacted] constipation

1. Increase her dose of loperamide to 200mg tid
2. Change loperamide 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 prokinetic that [redacted] 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 antispasmodic as [redacted] 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

Dompriidone (APO-dompriidone) 10 mg, 1 Tablet(s) QID ac + 1ta

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 tble liquid QD ac

Methylprednisolone acetate (Depo-medrol) 40 mg, 1month 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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