Primary Care Pharmacists in Action

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Session Outline

- Introduction to Primary Care
- Introduction to Emilie's PCN
  - Team members
  - Referral pathways
  - Community resources
- Introduction to Corey's PCN
  - Team Members
  - Referral pathways
  - Community Resources
- Barriers and Enablers to Collaboration

What is Primary Care?

- First point of contact in health systems
- Traditionally provided by a family physician or nurse practitioner
- Types of care provided include:
  - Routine care (eg. Check-ups/physicals)
  - Urgent issues that do not require management in a hospital setting
  - Chronic disease management
  - Maternity care
  - Health promotion and disease prevention
  - Mental health care
  - Liaising with specialist care
  - End-of-life care

What is a Primary Care Network (PCN)?

- Defined by a geographic area
- Collaborative effort to plan and deliver primary care services
  - Primary care providers (family doctors and nurse practitioners)
  - Nursing and allied health
  - First Nations
  - Community organizations
  - Ministry of Health
  - Health Authority

What is a Primary Care Clinical Pharmacist (PCCP)?

- Work directly with patients, primary care providers, and other allied health providers to identify and manage actual or potential drug-related problems
- Support **chronic disease management** by providing patient education and allowing for informed decision making around medication use
- Provide patient and provider **education** on medication-related topics and respond to drug information requests
- Facilitate drug access and coverage
- Co-location and “hub and spoke” models

Pharmacists: Medication management experts

All pharmacists

- Provide clinical services
- Assess, monitor & adjust medication plans to improve patient health
- Help coordinate patient care across health care settings
- Work with family doctors, nurse practitioners & health care team members to develop care plans
- Provide guidance on medication and health

Hospital pharmacists

- Oversee hospital drug distribution
- Work in interdisciplinary acute & specialty care teams
- Manage medications during care transitions (admission, discharge, transfer)

Primary care pharmacists

- May be co-located in a family practice or primary care clinic
- Meet with patients to provide comprehensive medication management, including follow-ups
- Provide consults tailored to needs of patients in the clinic or community

Community pharmacists

- Provide the public with drug & health care advice & resources
- Assess and prescribe for minor ailments and contraception
- Provide immunizations & injections
- Dispense, renew & adapt prescriptions
- Navigate & resolve drug coverage issues
- May provide specialty services (e.g., compounding, blister packaging)

BRITISH COLUMBIA
Ministry of Health

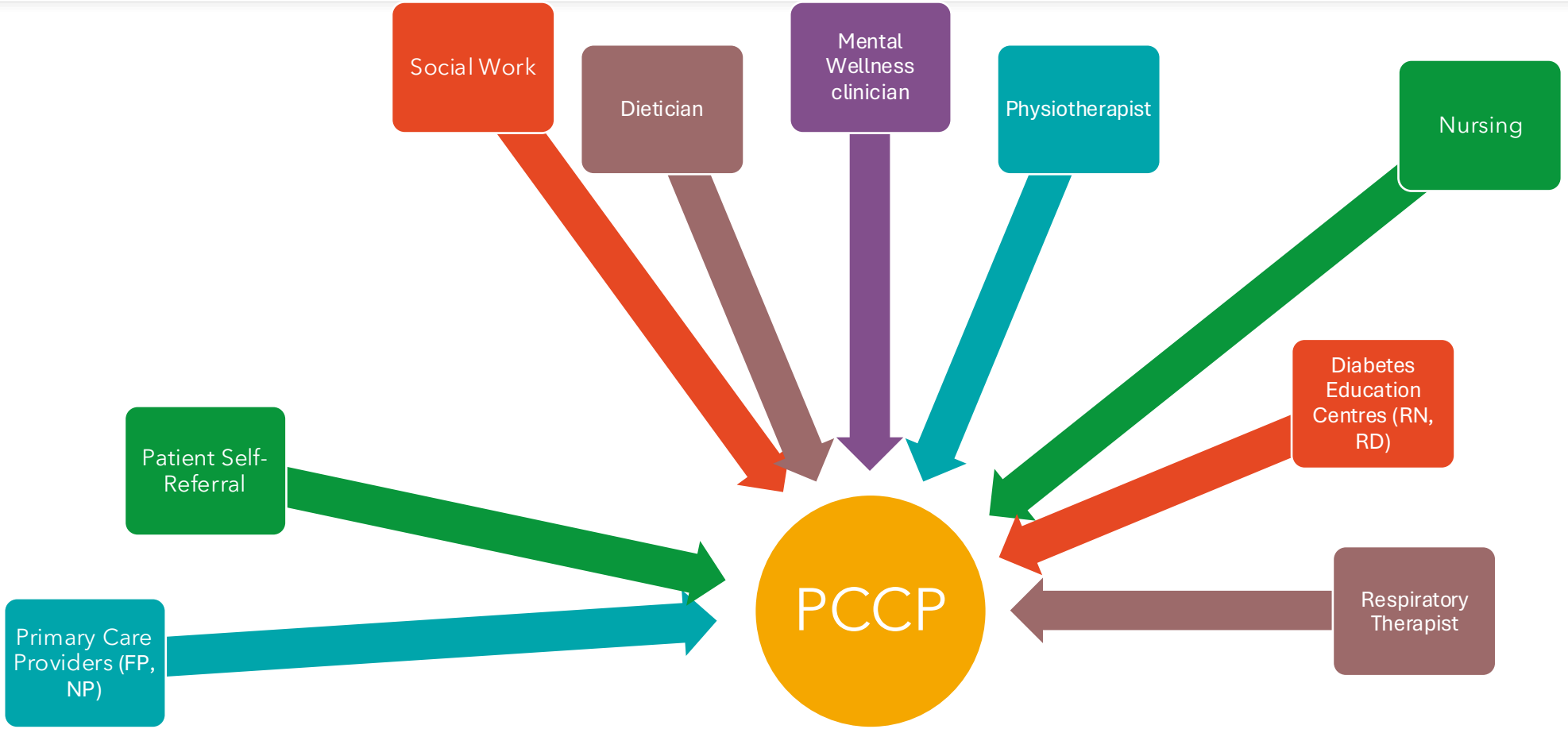
What is a Primary Care Clinical Pharmacist (PCCP)?

- Identify and manage drug-related problems
- Enhance chronic disease management
- Deliver medication & drug information support
- Facilitate medication access
- Integrate into team-based models of care

East Kootenay Primary Care Network

- EK PCN services a large geographical area.
- Communities we serve:
  - Cranbrook
  - Kimberley
  - Creston
  - Elk Valley (Elkford, Sparwood, Fernie)
  - Golden
  - Invermere
- 1 PCCP for all of the EK!

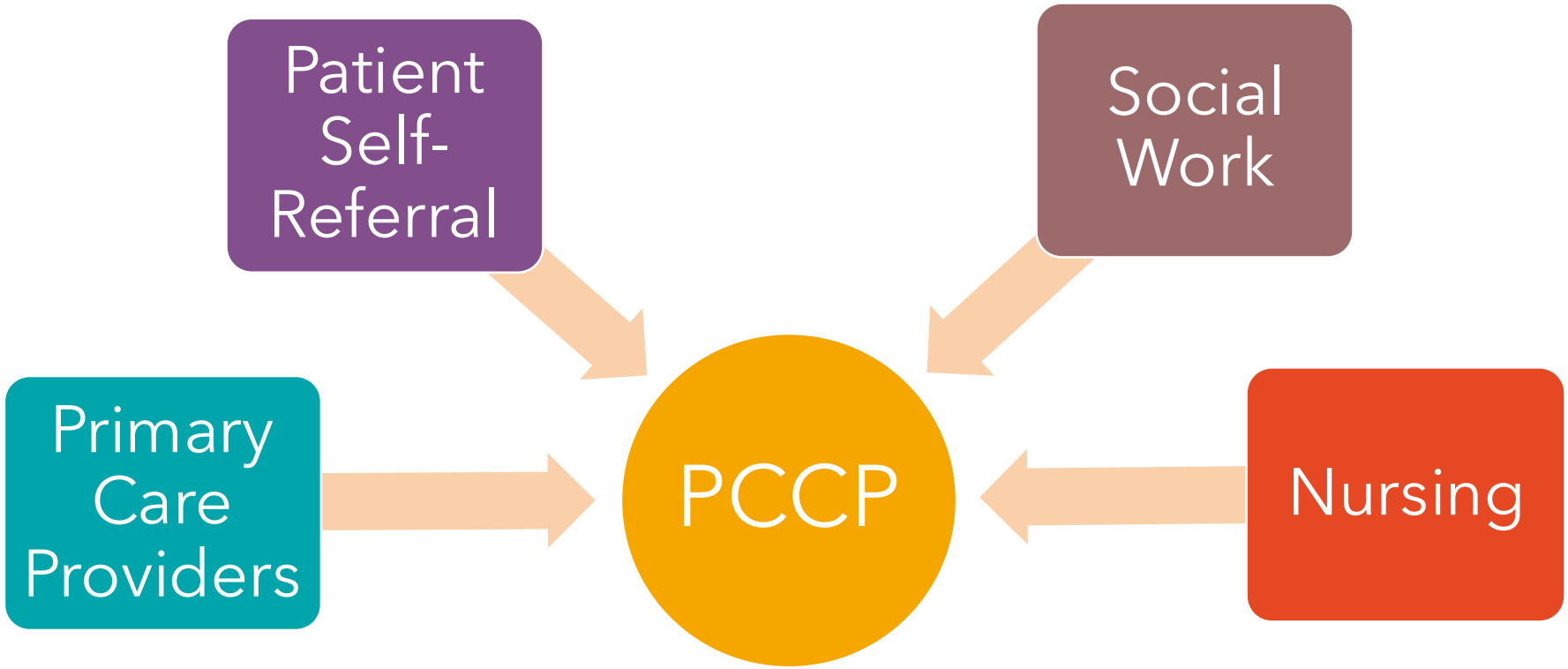
EK PCN – Referral Sources

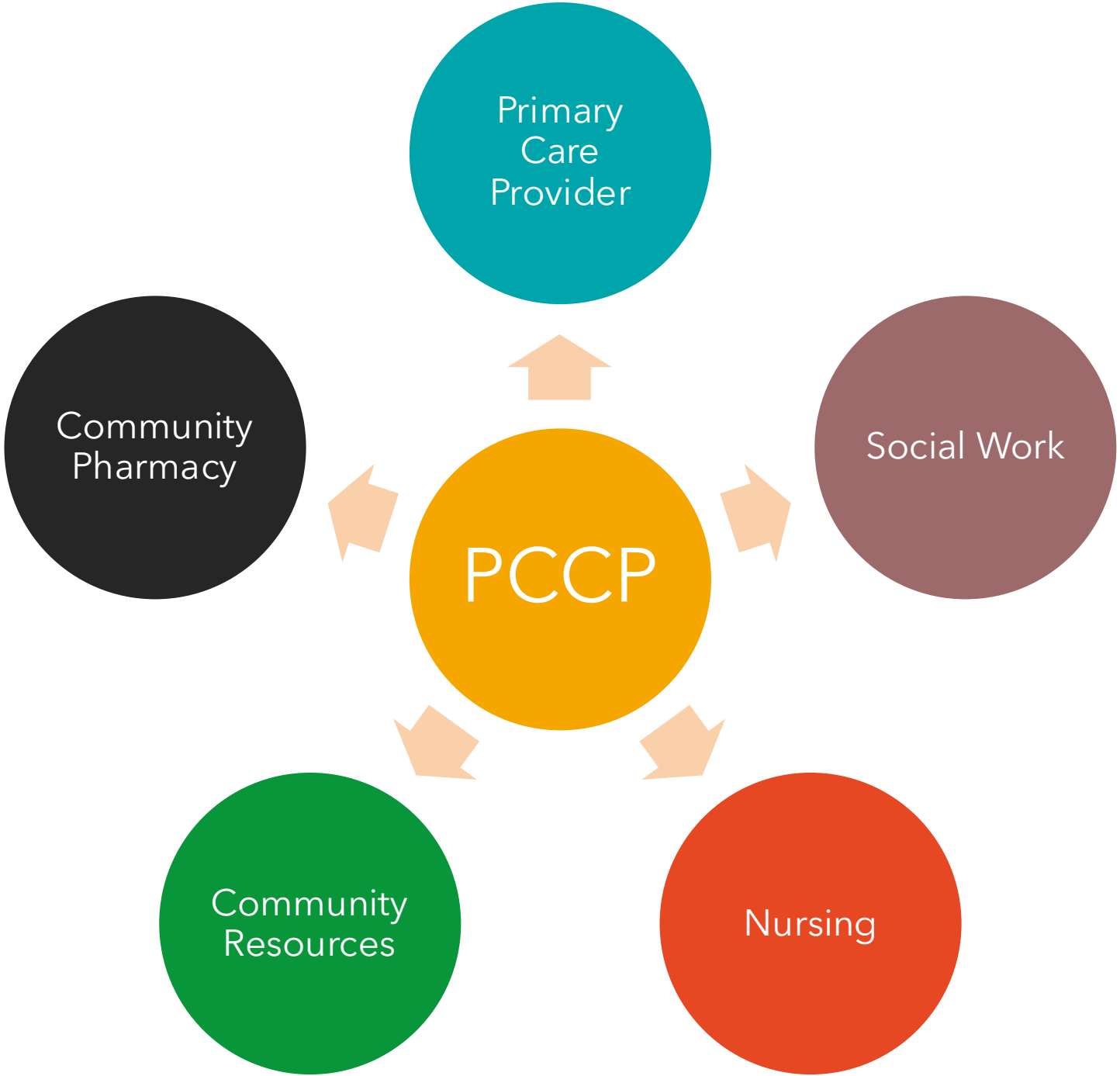


Oceanside Primary Care Network

- 13 member clinics
  - 7 clinics have some type of allied health support
  - PCCP services 5 clinics
    - 20 primary care providers
- Serviced populations include: Parksville, Qualicum Beach, Errington, Coombs, Bowser, Snaw-Naw-As First Nation, Qualicum First Nation, and Mid Island Métis Nation

Oceanside PCN – Referral Sources




Primary Care Provider
Social Work
PCCP
Community Pharmacy
Community Resources
Nursing

Who do PCCPs See?

- Medical complexity
  - polypharmacy
  - frailty
  - chronic disease management
  - condition refractory to treatment or with limited therapeutic options
- Need for care coordination
  - recent discharge from hospital
  - attachment to new provider
  - medication discrepancies
  - medication titration
  - barriers to medication access or optimal use

PCCP Areas of Focus

Preventative Health Needs

- Immunizations
- Smoking cessation
- Screening (CV risk, falls, substance use, etc)
- Patient education

Chronic Health Needs

- Chronic disease management
- Patient education

Acute Health Needs

- Minor ailments
- Medication initiation, titration, and follow-up
- Patient education

Benefits of PCCPs

For Patients

- Dedicated **time** to speak to a pharmacist
- **Shared decision-making** to develop personal care plan
- **Improved understanding** of medications
- Assistance with **addressing barriers** to optimal medication use

For Providers

- **Delegation** of selected patient care responsibilities to the pharmacist
- Written summary of care plan and **action items**
- More **efficient**, focused meetings with patients with complex medication-related needs
- **Improved capacity** to build patient panel

Collaboration With Primary Care Providers

- Case conferencing on complex patients to establish treatment goals and required interventions
- Following-up on medication starts and dose adjustments
- Shared care for chronic diseases (HF, T2DM, HTN, COPD)
- Shared care of dose adjustments for taper of benzos, or opioids

Value Added:

- Frees up provider time
- Reduces therapeutic inertia
- Improves treatment alignment with guidelines/best practice

Example of how pharmacist can collaborate with an interprofessional team

Group session

- Provide education sessions to newly diagnosed diabetic patients along with RN, dietician, and physio.
- Provide group education sessions to COPD patient along with respiratory therapist as part of a Pulmonary Rehab program that runs yearly.

Individual care

- Shared appointment with nursing to provide full diabetes assessment.
- Work collaboratively with RN at discharge to ensure f/up in the community.
- Work collaboratively with Diabetes Education Centres (DEC) to provide medication recommendations.
- Provide medication adjustment recommendations on heart failure medication with the heart failure clinic and nursing team.

Collaboration with Nursing and Allied Health

- Coordinating care of chronic diseases
  - Education on non-pharmacological aspects of chronic disease (e.g. diet)
  - Physical exam (e.g. foot exams)
  - Shared care clinics
- Organizing case management
- Addressing social barriers to health (working with social worker)
  - Income
  - Housing
  - Mental health
  - PCARE coverage

Example of collaboration with Registered dietician

- Collaboration through diabetes management
- RD provides:
  - counselling on diet management
  - carbohydrates counting
  - Insulin dosing and carbohydrates management
- Pharmacist provides:
  - medication advise
  - dose adjustment
  - Management of side effects
- Collaboration on management of gastrointestinal disease such as constipation or diarrhea

Example from Oceanside PCN: COPD Clinics

- Joint visit with PCN RN and pharmacist
- RN completes assessment tools (CAT, mMRC) and performs physical exam (listens to lungs, O2 saturations, etc)
- RN reviews immunization status and updates if required
- Pharmacist reviews COPD medications (efficacy, compliance, technique, etc)
- Pharmacist creates COPD Action Plan
- Primary care provider is presented with COPD Action Plan to review and pharmacist/RN provide suggestions for therapy adjustments as required
- Referrals made to RT as needed

Example from the EK: Pulmonary Rehab

- 8-week pulmonary rehab program available for COPD patients.
- Organized by RT and pharmacist and work collaboratively with allied health (RN, RD, SW, Physio) to provide education on COPD management (meds, action plan, diet, immunization, end-of-life planning, monitoring for symptoms, coughing techniques, etc.)
- Each session is 2 hours long with 1 hour of education and questions, and 1 hour of exercise with RT and physio.

Collaboration with Community Pharmacy

- Communicating dosage changes or tapering plans clearly
- Arranging blister/compliance packaging
- Arranging in-home services
  - Insulin administration
  - Medication assistance

Collaboration with Hospital Pharmacy

- Communication with hospital pharmacist on community care plan and patient's long-term goals.
- Arranging discharge follow-up when appropriate.

Would love to work more collaboratively with hospital pharmacy!

Example from EK PCN: Discharge follow-ups

- Working with nursing to follow-up on all discharge from our small community hospital (no acute care pharmacist available)
- Once patient is discharged home, primary care nurse and pharmacist get notified and we contact the patient to ensure seamless transition home.
- My role:
  - ensuring medication adherence
  - clarification of changes that were made in hospital
  - Arranging blisterpacking as needed
  - Ensuring meds are stopped or re-started appropriately (i.e. adding stop date to clopidogrel as indicated in EMR)

Collaboration with Community Resources

- Respiratory Therapy in Community (RTiC)
  - Respiratory disease education
  - Breathing exercises, paced activity
  - Inhaler education
  - Pulmonary rehab course
- Mental Health and Substance Use (MHSU)
  - Counselling resources
- Diabetes Education Centres (DEC)
  - Dietary education
  - Insulin pumps
- Community Health Services
  - Medication assistance
  - Heart Failure clinic
- Community Virtual Care
  - COPD, CHF, HTN

Enablers to Collaboration

- Technology
- Scheduling time
- Finding a niche
- Quality improvement
- Co-location
- EMR access

Quality improvement examples

- Penicillin allergy de-labelling project
- Zopiclone dose in patient >65yo
- Deprescribing sulfonylureas in patients with A1C < 7%

Barriers to Collaboration

- Clinical inertia is real
- Distance
- Lack of shared documentation systems
  - PharmaNet logs
- Physical space
- Lining up different schedules

Questions?

Thank you!