TAKING RESPONSIBILITY FOR PATIENT CARE:

A Toolkit for Pharmacists Integrated into Primary Care Teams

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Introduction

Health care systems have moved toward a collaborative approach to primary health care and this evolution has had a significant impact on the role of pharmacists. Primary care teams around the world have begun to integrate pharmacists with non-dispensing roles as co-located, collaborative members. In Canada, pharmacists were recruited into many of the province of Ontario's Family Health Teams in 2006 and soon after several other provinces followed the trend.

Pharmacists contribute to patient care on primary care teams by improving medication management through individual patient assessments and population-based interventions, answering drug information questions, and providing education to the team. One study found that the reduction in total health expenditures resulting from the provision of clinical pharmacy services on primary care teams exceeds the cost of providing the services by a ratio of more than twelve to one[1].

Many pharmacists have encountered barriers when integrating into these primary care teams. It is common for pharmacists to experience a lack of role clarity as a result of both patients and other team members not understanding how to utilize their skills[2,3]. Pharmacists are also affected by this issue and are typically unfamiliar with the roles of other team members, creating further difficulties in successful collaboration[2,3]. As well, pharmacists have been found to often lack the confidence and assertiveness required to forge a new role within an existing team[4]. Other frequently reported barriers to team integration include physician resistance, inadequate pharmacist support from management, lack of dedicated workspace, and inadequate pharmacist training[2-5].

In an effort to address these barriers and to assist pharmacists in successfully integrating into primary care teams, Canadian researchers have published the ***Guidelines for Pharmacists Integrating into Primary Care Teams***[6]. These guidelines provide ten evidence-based recommendations relevant to any pharmacist joining an interprofessional primary care team. The authors of these guidelines state that many primary care team pharmacists primarily provide 'reactive care' and essentially function as a consultant, interacting with patients only when referred by another team member (usually a physician). The authors go on to recommend against this reactive approach, in favour of a more proactive role where the pharmacist takes responsibility for patient outcomes by independently identifying opportunities to intervene and improve patient care. We believe that pharmacists would benefit from an expanded discussion on this topic. The purpose of this document is to provide practical suggestions and tools to pharmacists integrated into primary care teams regarding how they can provide proactive care and take responsibility for patient outcomes.

How was this guide developed and how should it be used?

A comprehensive literature search was performed in Embase, Medline and International Pharmaceutical Abstracts to identify publications related to the experiences of pharmacists integrating into primary care teams. In addition, an invitation was circulated (in late 2012) to a network of Canadian pharmacists with experience practising in primary care settings (the Canadian Pharmacists Association/Canadian Society of Hospital Pharmacists Primary Care Pharmacist Specialty Network) to take part in one-on-one telephone interviews to elicit their suggestions and experiences regarding the purpose of this paper. The themes and comments from the transcripts of the 23 completed interviews were used, in conjunction with the papers identified in the literature search, to develop the content, stories and quotes in this document. Each section of this toolkit represents a key theme or recommendation that primary care team pharmacists should follow in order to successfully provide proactive care and take responsibility for patient outcomes.

Table of Contents

Chapter I: Building the foundation ..... pg 5

Chapter II: Maximizing Individual Patient Intervention Opportunities ..... pg 6

Chapter III: Population-Based Interventions and Practice Enhancements ..... pg 10

Chapter IV: Be an educator ..... pg 11

Chapter V: Shared Medical Appointments (SMAs) ..... pg 13

Conclusion ..... pg 13

Useful resources ..... pg 14

References ..... pg 15

Chapter I: Building the Foundation

To successfully provide proactive care and take responsibility for patient outcomes pharmacists must first build a strong practice and integrate effectively into the team. The following ten recommendations (from the ***Guidelines for Pharmacists Integrating into Primary Care Teams***) will facilitate this process of successful integration[6]. For a detailed discussion regarding these recommendations refer to the original guideline published in the Canadian Pharmacists Journal[6].

1. Determine the needs and priorities of the team and its patients
2. Develop a formal pharmacist job description
3. Educate the team about the pharmacist's role
4. Educate yourself about the roles of other team members
5. Ensure the clinic infrastructure supports the pharmacist's role
6. Be highly visible and accessible
7. Ensure your skills are strong
8. Provide proactive care and take responsibility for patient outcomes
9. Regularly seek feedback from the team
10. Develop and maintain professional relationships

How to build trust and respect within a team

A key aspect to building a strong foundation for a successful collaborative practice is developing a relationship of trust and respect with existing team members. Many pharmacists who integrate into a primary care team do not have a pre-existing professional relationship with the other team members; therefore, it is essential for pharmacists to make an effort to build this relationship soon after joining the team. The Primary Care Pharmacist Specialty Network pharmacists who were interviewed agreed that this is perhaps the most important step in the process of developing an effective practice. Providing proactive care and taking responsibility for patient outcomes requires the pharmacist to assume a certain degree of independence and autonomy. Other team members will not be comfortable relinquishing this responsibility to the pharmacist if they do not trust his/her skills and expertise.

Roland Halil (a pharmacist on the Bruyère Academic Family Health Team, Ottawa, Ont.) noted that, "It's all an issue of reputation and trust. I recognized early on that these were key factors for working with other health professionals. We're in a relationship business; we manage relationships whether that's with patients, nurses or physicians. If you don't have a good working relationship, you won't have an optimal impact on patient care".

Many of the Primary Care Pharmacist Specialty Network pharmacists suggested that a good first step is to make time to meet with each team member individually to establish rapport, explain the pharmacist's training and skills, and discuss opportunities for collaboration. Later on, once the pharmacist is busy performing patient assessments and discussing therapeutic recommendations with the physicians in person (rather than just relying on written chart notes), he/she can also assist in building and sustaining trust and respect.

Several pharmacists also described using something they called 'strategic loitering' as a means to get to know other team members better. Strategic loitering refers to spending time in common areas such as a lunchroom or a nursing station when the pharmacist is not seeing patients, in order to interact with and be visible to other team members. Other opportunities to build relationships include: attending team social events, volunteering for committees and regularly attending patient care rounds.

Roland Halil also suggested that when initiating a new program or service with a physician, it is beneficial to test the process once or twice and then to go over the results together to elicit feedback and identify opportunities for improvement, which will also have an impact on building trust and respect.

Jen Lake (a pharmacist on the South East Toronto Family Health Team, Toronto, Ont.) recommends that pharmacists seek out the early adopters on the team (i.e., physicians and other team members who are the most vocal proponents of the pharmacist's role) as allies in the integration process. "Building relationships first with the early adopters can result in them acting as an example of success for the late adopters. Once the late adopters see that there has been success with a particular pharmacist program or service, they may seek out the program themselves or be more open to it. During the relationship building with the early adopters, be sure to very clearly outline for them your skills, abilities, and interests, and offer examples of what you are able to do".

Investing the time and energy to ensure that the pharmacist's role has been optimally integrated into the primary care team is essential for the successful adoption of the suggestions and tools in the subsequent sections of this document. Following the recommendations in the ***Guidelines for Pharmacists Integrating into Primary Care Teams*** and building a relationship of trust and respect with the team will lay the foundation for a collaborative and proactive pharmacist practice.

Chapter II: Maximizing Individual Patient Intervention Opportunities

The most logical and natural way for pharmacists to bring value to a primary care team and improve patient care is through individual patient interventions. Meeting with patients one-on-one to perform comprehensive assessments, identifying medication-related problems, and creating care plans to ensure drug therapy needs are being met is the primary clinical role for a pharmacist in any practice setting. The bottom line is that **pharmacists in primary care teams must take responsibility to find the patients who need their services**, as other team members are very unlikely to do this for them.

Traditionally, pharmacists in primary care teams have relied on other team members (mostly physicians) to identify and refer patients who require a pharmacist intervention, such as a medication assessment. Research suggests that physicians typically refer appropriate patients who ultimately benefit from a pharmacist-led medication assessment[7]. However, physician referrals to pharmacists within a primary care team tend to be very limited and sporadic. Most physicians have large numbers of patients in their practices that could benefit from a medication assessment, but many of these patients simply do not get referred[7]. Consequently, relying exclusively on physician referrals is not recommended. In order to take responsibility for patient care, the pharmacist must proactively and strategically seek out patients for individual medication assessments, in addition to accepting referrals from other team members.

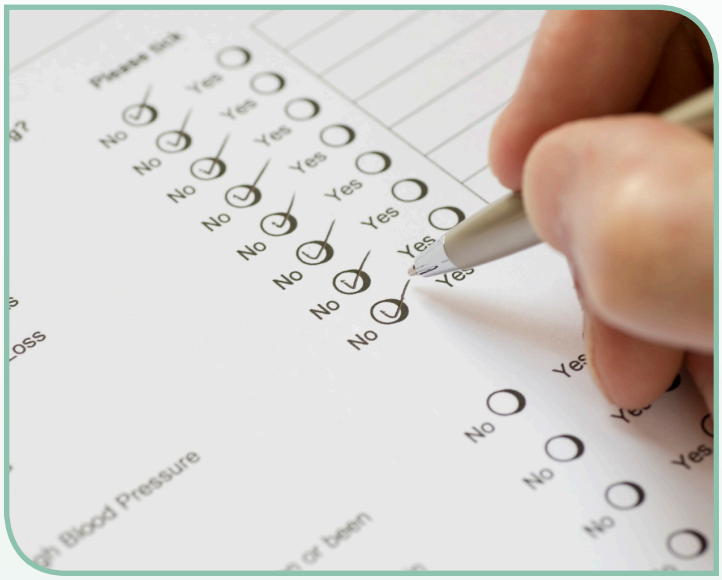
Which patients should meet with the pharmacist?

The **first step** is to decide which patients will benefit the most from a medication assessment and who should meet with the pharmacist. Taking time to determine the specific medication-related needs and priorities of the team and its patients is a useful method of identifying patients who require a pharmacist assessment. For example, some teams may have a primary challenge managing chronic diseases like diabetes and some may have a large geriatric population in which polypharmacy is a concern. Other teams may have younger populations with substance abuse problems, mental health concerns, or smoking cessation needs. Collecting this information could be as simple as obtaining a formal profile of the practice site (if one exists), or by talking with the clinic manager or lead physicians. They key is to identify where the medication management gaps exist within the team and then target those patient groups for individual medication assessments.

A **second approach** to selecting patients who should meet with the pharmacist is to target patients with known risk factors for preventable medication-related adverse events and suboptimal medication management. Common high-risk patient groups targeted by the Primary Care Pharmacists Specialty Network pharmacists who were interviewed include: patients over 65 who are taking multiple chronic medications; patients with type 2 diabetes (especially those recently diagnosed or poorly controlled); new warfarin or insulin starts; patients recently discharged from hospital; patients with a past cardiovascular or cerebrovascular event; patients with newly diagnosed hypertension; and patients with chronic heart failure.

A **third approach** is to utilize a screening tool to identify patients who will benefit the most from a pharmacist-led medication review. Since the risk factors for preventable medication-related adverse events and medication mismanagement are well documented, it is possible to create and validate a screening tool that could be used to identify patients at high-riskfor medication problems, who would benefit from a pharmacist assessment. Langford et al validated a simple five-item questionnaire that patients can self-administer while in the clinic waiting room[7]. They found that the questionnaire took patients less than two minutes to complete and those who answered 'yes' to three or more of the five questions were 'high-risk' and would benefit from a pharmacist assessment[7]. Darcy Lamb (a pharmacist at the West Winds Primary Health Centre in Saskatoon, Sask.) and Derek Jorgenson (an Associate Professor at the College of Pharmacy and Nutrition, University of Saskatchewan, Saskatoon, Sask.) use a variation of this Langford screening tool at a small nurse practitioner-run primary care team in Saskatoon, Sask. (Primary Heath Centre South East). They found that the tool was not successful in their main location (West Winds Primary Health Centre) due to the large size of the clinic and the complexity of the team. However, it has been very effective at Primary Health Centre South East since it is a small clinic with only one receptionist and one nurse practitioner (in addition to the pharmacist). The receptionist manages all of the patient appointments and the nurse practitioner administers the questionnaire to all new and existing patients once per year when they come in for their annual complete physical. Patients who screen 'high-risk' (i.e., three or more 'yes' responses), are automatically booked for an individual pharmacist-led medication assessment. For an example of the screening tool used by Darcy and Derek go to: www.usask.ca/pharmacy-nutrition/primary care.

Utilizing a combination of the three approaches discussed in this section will ensure that pharmacists target the patients who will benefit the most from their services. A useful overall plan is for the pharmacist to first determine the patient groups that he/she would like to see for individual appointments. Next, it is important for the pharmacist to seek feedback from the other team members regarding this plan to ensure that the unique medication-related needs of the team and its patients are being addressed. Once the team is supportive of the patient groups that will be targeted for a medication assessment, the final step is to develop a strategy to schedule these patients for an appointment with the pharmacist.



How to ensure that the targeted high-risk patients meet with the pharmacist

Remember, the bottom line is that it is a mistake to rely exclusively on other team members to refer patients for medication assessments. Primary care team pharmacists must take responsibility to identify the patients who require a medication assessment and then develop a process to have these patients automatically scheduled for a pharmacist appointment, without waiting for a formal physician referral. We have provided three examples of how to do this.

1. Have the pharmacist identify and contact the patients for an appointment

As the cliché goes, "Sometimes if you want something done right, you have to do it yourself". Many of the Primary Care Pharmacist

Specialty Network pharmacists who were interviewed told us that they regularly spend time in the clinic identifying patients that meet their targeted high-risk criteria (discussed in previous section) and contacting them directly for an appointment. There are several ways that this can be done, but all of the examples tend to follow some common rules. Try to develop a process that is quick and simple, so that a large amount of pharmacist time is not spent each day simply finding patients who need an appointment. Taking advantage of the electronic medical record (EMR) is especially useful for this purpose. Do not forget to rely on the support staff that is available in the clinic, which may be able to assist with contacting patients and arranging appointments. Finally, it is very useful to let the physicians know which patients have been identified for a medication assessment, prior to contacting any of them for an appointment. This will provide the physician with an opportunity to identify patients who might not be good candidates for the service based on factors that are not apparent to the pharmacist. Some patients may have moved to another clinic, recently been diagnosed with a terminal illness or be in the middle of a stressful family crisis, making them less ideal candidates for a pharmacist assessment.

Below are some real-life examples of how primary care team pharmacists identify and schedule high-risk patients without waiting for a physician referral. The key to successfully implementing any of these systems is to very specifically outline the process with the physicians and other team members to ensure the pharmacist does not adversely impact patient flow in the clinic.

Roland Halil (a pharmacist on the Bruyère Academic Family Health Team, Ottawa, Ont.) *comes in first thing in the morning and screens the charts of patients who are scheduled for an appointment with one of the physicians later that day, looking for people who meet his high-risk criteria and who would benefit from a pharmacist assessment. Once any targeted patient arrives for his/her appointment, Roland quickly chats with him/her and explains exactly who he is and why he feels it would be useful to meet with him for a medication assessment. Patients who are interested in the service are immediately scheduled for the next available appointment with Roland, without needing a physician referral. Roland will also make notes or suggestions in the charts of patients who do not require a comprehensive pharmacist assessment if he notices any opportunities to enhance the patient's medication management during his brief chart review.*

At Beaverbrook Pharmacy in London, Ont.*, pharmacists have established a system where patients who have recently been discharged from hospital are automatically scheduled to see the pharmacist before they see the physician, primarily to reconcile the medications that patients need to be on post-discharge. This works well because the hospital provides the team with a daily list of patients who have been discharged. This list is forwarded to reception staff who book patients for a 'piggyback' appointment where they first see the pharmacist and then the physician on the same day. This piggyback approach has been shown to be convenient for the patients and significantly reduces missed appointments.*

Erin Yakiwchuk (a pharmacist with the Saskatoon Health Region, Saskatoon, Sask.) and Dave Blackburn (an Associate Professor with the College of Pharmacy and Nutrition, University of Saskatchewan, Saskatoon, Sask.) *created and evaluated a program called CCARP (Collaborative Cardiovascular Risk Reduction in Primary Care)[8]. With CCARP the pharmacist screens the charts of patients who are scheduled for a physician appointment the following day, and calculates a 10-year Framingham Risk Score on all adult patients regardless of their reason for the visit. Those who are at a moderate or high 10-year risk of cardiovascular (CV) events are targeted for a pharmacist medication assessment if they have at least one uncontrolled CV risk factor.*

> *Several pharmacists described how they use the clinic EMR to identify patients who meet their criteria for a medication assessment. It is very common for pharmacists to use the EMR to simply run a report of all the patients in the clinic who fall into any of their targeted high-risk groups. It is then easy to go through the list to systematically contact patients for an appointment with the pharmacist (after the physicians confirm that all would be ideal candidates).*

It is important to remember, when contacting patients directly for an appointment with the pharmacist, that most patients will not be accustomed to this type of service. Be prepared to explain to the patient the unique nature of the pharmacist's role in the team, the reason why you are contacting him/her for an appointment and what will happen when he/she meet with the pharmacist. Similarly, if members of the support staff are contacting patients for this purpose, they must be trained to have this conversation with the prospective patients. Some pharmacists have developed a brochure, which describes their services and that can be shared with patients to educate them about the role of the pharmacist and the process for the medication review. For sample pharmacist brochures go to: www.usask.ca/pharmacy-nutrition/primarycare.

2. Encourage Patient Self-Referrals

Many pharmacists attempt to educate patients directly about the pharmacist's services that are available in the team and the types of patients who will likely benefit from a medication assessment, in an effort to encourage targeted high-risk patients (or anyone who is having concerns, questions or troubles with their medications) to arrange an appointment with the pharmacist directly, without a physician referral.

One method of encouraging patient self-referrals is to create promotional posters and have them displayed in patient waiting areas and examination rooms. These posters can provide general information about the pharmacist's role and the services provided, encouraging patients to ask questions if they want to know more about the service or to simply schedule an appointment at the reception desk. Alternatively, the posters can target specific high-risk patient groups, encouraging these patients to make an appointment directly with the pharmacist.

Barry Power (a pharmacist with the Rideau Family Health Team, Ottawa, Ont.) uses smoking cessation posters to generate patient self-referrals. He recommends phrasing posters as a question rather than a statement to engage the reader. For example, better success was found when the poster read, "Do you want to quit smoking?", rather than displayed as a statement that the pharmacist can help with smoking cessation. Following the question, the poster encourages patients to request an appointment with the receptionist. Both types of posters can be placed in the waiting areas, in the examination rooms, in clinic restrooms and anywhere else where they can act as a reminder to the patients (and the other team members) about the presence of the pharmacist and the services that he/she performs.

Other pharmacists suggested that it is useful to regularly rotate the location of the posters as well as the graphics on the posters, to make them more noticeable. For sample promotional posters go to: www.usask.ca/pharmacy-nutrition/primarycare.

Some pharmacists also create brochures explaining their role and ensure that they are placed in a visible area in the waiting room and examination rooms. These brochures can also be made available to other team members (especially reception staff) who might need to explain the role of the pharmacist to patients on the pharmacist's behalf. For sample pharmacist brochures go to: www.usask.ca/pharmacy-nutrition/primarycare.

3. Educate Other Team Members

It can also be useful to educate other members of the team to identify the targeted high-risk patients who need a medication assessment. Physicians, nurse practitioners, and other patient care providers will be more likely to help the pharmacist identify patients for individual medication assessments if they are well educated about the role of the pharmacist and the patients who need to see the pharmacist. This can be accomplished by meeting with other team members individually or as a group during staff meetings or team rounds. The promotional posters and brochures, created originally for patients, can actually be very useful in educating other team members about who to refer to the pharmacist, if they are strategically located in examination rooms.

Many of the pharmacists that we interviewed spoke about the importance of engaging support staff and receptionists to identify suitable patients for a medication assessment. These team members tend to know the patients very well and interact with them on a regular basis. If they understand the role of the pharmacist and the types of patients who need to see the pharmacist, they can very effectively triage patients for medication assessment appointments. Therefore, these support personnel should be well informed about the role of the pharmacist and be prepared to explain the role to patients. Having promotional brochures available to support staff can also be helpful.

In summary, pharmacists cannot rely exclusively on physicians to refer the patients who require a medication assessment. In order to maximize opportunities for individual patient interventions and take responsibility for patient outcomes, pharmacists must proactively target patients who will benefit from a medication assessment and have those patients identified and scheduled for a pharmacist appointment, without the need for a physician referral.

Chapter III: Population-Based Interventions and Practice Enhancements

Population-based interventions and practice enhancements refer to services that a primary care team pharmacist provides that have an impact on the overall health of the clinic's patient population or that enhance the medication management processes of the entire team. These interventions may or may not result in the pharmacist interacting directly with individual patients, but can still be an excellent way for pharmacists to take responsibility for the pharmaceutical care of patients in the clinic. The reality is that despite making an effort to proactively and strategically identify high-risk patients for individual medication assessments, there will always be some 'downtime' when there are no individual patient assessments scheduled. Consequently, implementing some of these population-based interventions will allow the pharmacist to take responsibility for the care of patients who are not targeted for an individual assessment. This section provides some examples of these population-based interventions and practice enhancements.

Searching the electronic medical record (EMR) for inappropriate or unsafe drug therapy

Primary care team pharmacists should take advantage of the functionality of the EMRs that are becoming common in most clinics. Most EMRs have a 'search' function, allowing the user to run reports linking various sources of data in the EMR. For example, most EMRs will allow the pharmacist to print a report of all of the patients over the age of 65 years who are taking amitriptyline (a drug from the Beers list), or any other concerning medication(s). This can be an extremely valuable way to identify high-risk medication use scenarios within the clinic population, with a small investment in time. Consequently, in addition to using the EMR to run reports of patients who meet the criteria for an individual medication assessment (discussed in the previous section), many primary care team pharmacists regularly search

the EMR for these potentially dangerous medication use scenarios. These searches are different in that they do not often result in the pharmacist meeting with the patient for a comprehensive medication assessment, rather they result in the pharmacist identifying and intervening on a focused medication-related problem, sometimes without interacting directly with the patient.

The variety of search options is only limited by the pharmacist's imagination and knowledge of inappropriate or unsafe medication combinations or scenarios. Some examples are: patients over the age of 65 taking any drug from the Beers list; people on the combination of an ACE inhibitor, ARB and spironolactone; people taking high-dose domperidone or citalopram; people taking simvastatin >80 mg per day; people taking multiple drugs that prolong the QT interval; people with diabetes and a recent A1C >9%; people with asthma taking salbutamol, but no maintenance inhaler, etc. There truly is no limit to the number of searches that can be performed. One of these interventions, related to osteoporosis management, was recently described in detail in the Canadian Pharmacists Journal[9]. It can be useful to subscribe to services such as Health Canada's MedEffect email advisories (www.healthcanada.gc.ca/medeffect), FDA Alerts or the Pharmacist's Letter to regularly identify ideas and opportunities to search the EMR for patients on unsafe, ineffective or inappropriate medication regimens.

Keep in mind that many of these potentially unsafe scenarios are going to be completely reasonable and acceptable in certain patient cases and professional judgment must be exercised when alerting other team members about these patients. Be careful not to assume these situations represent inappropriate care, as this could be damaging to team relationships and respect for the pharmacist's role. In some cases pharmacists may choose to contact these patients individually (by phone or by scheduling an appointment) to collect more information prior to making a recommendation. In other cases, it may be appropriate to collect the necessary information in the patient's chart and simply alert the physician of the situation, providing him/her with a recommended course of action.

Additional examples of population-based interventions and practice enhancements

Addition examples of population-based interventions include:

- Develop a medication reconciliation process for patients discharged from hospital
- Create a policy and procedure for how the medication sample cupboard is used
- Create nomograms or flow sheets to support other team members to manage high-risk drugs (e.g., warfarin or insulin dosing nomograms)
- Develop a repository for useful medication-related websites, databases, and clinical practice guidelines for use by all team members

For additional examples please refer to the ***IMPACT Practice Enhancement Guide***, available at http://www.impactteam.info/practiceEnhancements.php.

Chapter IV: Be an Educator

Pharmacists are the 'medication management experts' on the team and can help to teach other team members about how to provide optimal drug therapy, thereby having a positive impact on the entire patient population in the clinic. An additional benefit of taking on an educator role includes the fact that the other team members will become more aware of the pharmacist's strengths and abilities, which will foster the development of trust and respect, leading to more effective overall collaboration. This section of the toolkit provides specific examples of how a primary care team pharmacist can 'be an educator'.

Create a monthly newsletter

Some pharmacists, such as Derek Jorgenson and Darcy Lamb (pharmacists at West Winds Primary Health Centre, Saskatoon, Sask.), create a monthly newsletter (called ***RapidRx***) that contains information about new developments in pharmacotherapy. The newsletter is sent via electronic mail to all team members at West

Winds Primary Health Centre. The success of these types of regularly scheduled newsletters will be dependent on the relevance of the information, ease of read and visual appeal. The RapidRx newsletter is created so that it has no more than three topics per issue and it can read in two to three minutes, focusing the content on the 'bottom line' and providing references and links where readers can go to read more detail on the topic. For sample RapidRx Newsletters go to: www.usask.ca/pharmacy-nutrition/primarycare.

Alternatively, Barry Power's team in Ottawa prefers short, informal, and sporadic email updates, rather than more formal monthly newsletters. Barry finds this method to be more effective for his team because it addresses issues immediately as they happen, whereas with a monthly newsletter there is a risk of having outdated information by the time it is sent out. As well, he found a shorter, more informal message was better received (by his team) than a longer newsletter.

Every team will have unique preferences and learning styles; therefore, it is strongly recommended to ask the team how they would prefer to be kept up-to-date on urgent advancements and advisories that occur on a regular basis in the world of pharmacotherapy. Other options, in addition to creating a monthly email newsletter or sending sporadic single-issue messages are: posting paper copies of warnings, advisories or new guidelines to a bulletin board within the clinic or providing informal verbal summaries of the issues during team meetings.

Provide formal presentations or lectures

Several pharmacists described how they regularly provide formal lectures to their team during dedicated education days or weekly 'lunch and learn' education sessions. These presentations typically focus on a therapeutic topic such as: new Canadian diabetes guidelines, management of chronic heart failure, or treatment of depression. The success and usefulness of these formal presentations and lectures will depend upon the dynamics of the team. If all, or most of the team members take lunch at the same time, or if there is a regularly scheduled time set aside each month for team education sessions, then this option can be considered. Both success and disappointment was reported with this suggestion when Primary Care Pharmacist Specialty Network pharmacists were interviewed; thus, it will be important to gauge the team's willingness to participate prior to investing a lot of time in developing these formal presentations. Teams that regularly have students, interns and residents (from various disciplines) participating on the team may be particularly interested in this option since they will be looking for good educational opportunities for the learners.

Regardless of the style (formal vs. informal) or format (newsletter vs. formal lecture) of the educational intervention, pharmacists can play a key 'educator' role within primary care teams. Not only will this service be highly popular with the other team members, it will also assist the pharmacist to take responsibility for patient outcomes by improving the medication-related competency of the other members of the team.

Chapter V: Shared Medical Appointments (SMAs)

After the pharmacist has been working as part of the primary care team for a while, and after a strong relationship has been developed between the pharmacist and the other team members, it may be possible to engage in conducting SMAs or other types of group programs. There are different types of SMAs, but they are basically an interdisciplinary group of health care providers who come together to structure interactive education sessions on a topic relevant to a group of patients with a common illness or condition. By doing this, the education may be provided simultaneously to a large group of patients instead of having to repeat the material on a one-on-one basis. In addition, questions posed by one individual often apply to others in the group, making the discussion portion of the SMA particularly useful. This can provide answers to common questions and also encourages networking between the participants, which allows for peer support from other patients diagnosed with the same condition.

Individual patient assessments and interventions can also be scheduled with a variety of the team members, if necessary, prior to or after the group education sessions. Diabetes focused SMAs have demonstrated the ability to improve A1C results, microalbumin testing, foot exams, lipid testing, aspirin use, patient satisfaction, physician satisfaction, provider productivity, self-efficacy, diabetes knowledge, quality of life and self-glucose monitoring. SMAs can be developed for patients with any chronic condition, including diabetes, heart failure, lung disease, obesity and cardiovascular disease (to name just a few). A detailed discussion on the topic of SMAs is beyond the scope of this document; however, this is a particularly useful (and increasingly common) method for pharmacists to take responsibility for patient outcomes in a primary care team. For more information on conducting SMAs refer to the ***Useful Resources*** section at the end of this document.

Conclusion

The recent health system movement toward a collaborative approach to primary care and the subsequent emergence of interprofessional primary care teams in many countries has presented an unbelievable opportunity for the profession of pharmacy. Never before have large numbers of family physicians and other health professionals formally requested the presence of a pharmacist directly on their team and never before have so many health system payers been willing to fund the service. This is perhaps a once in a lifetime opportunity for pharmacists to take up the challenge and solidify themselves as an invaluable member of these primary care teams. By following the recommendations in the ***Guidelines for Pharmacists Integrating into Primary Care Teams***, along with the suggestions and tips within this document, pharmacists wishing to practice as integrated members of primary care teams will have all of the tools and resources required to be successful. However, it is important to recognize that this integration process does not happen overnight and pharmacists must be patient, persistent and have realistic expectations. Even the most successful pharmacists experience setbacks or temporary failures and most find that it takes many months before they feel completely comfortable in this new role. The good news is that many of the pharmacists who were interviewed during the development of this document commented that this primary care team role was their "dream job" and that the hard work invested during the initial integration process had reaped unbelievable dividends. It is our intention that this toolkit will provide some assistance to pharmacists looking for their dream job as an integrated member of a primary care team.

Useful Resources and Websites

- Information about how to link into the Primary Care Pharmacist Specialty Network.
  http://www.cshp.ca/cshpNetwork/psn/index_e.asp
- IMPACT Pharmacist Toolkit. Contains additional tips and suggestions for pharmacists on primary care teams.
  Must request a free password prior to downloading the toolkit. **http://www.impactteam.info/resourceDownloads.php**
- The Patient Centered Medical Home: Integrating Comprehensive Medication Management to Optimize Patient outcomes.
  Useful information regarding the primary care team role in the United States.
  http://www.accp.com/docs/positions/misc/CMM%20Resource%20Guide.pdf
- Family Health Team Implementation Checklist. Useful tips created for pharmacists in Ontario.
  http://www.health.gov.on.ca/en/pro/programs/fht/docs/fht_implement.pdf
- Ontario Pharmacist Association Family Health Team Resource Kit.
  http://www.impactteam.info/documents/fht_toolkit.pdf
- Role of the Pharmacist in Primary Health care: Pharmacy Coalition on Primary Care.
  http://napra.ca/Content_Files/Files/Saskatchewan/Publications/PCPC_Submission-final.pdf
- McDonough RP, Doucette WR. Developing collaborative working relationships between pharmacists and physicians. J Am Pharm Assoc 2001;41(5):682-92.
- Information about ADAPT Education Program, which can be useful for all primary care team pharmacists.
  www.pharmacists.ca/adapt

Additional information regarding Shared Medical Appointments:

www.improvingchroniccare.org/.../group_visit_starter_kit_copy1.doc

http://www.ihi.org/knowledge/Pages/Tools/GroupVisitStartKit.aspx

http://www.fmdrl.org/group/index.cfm?event=c.showWikiPage&pageId=322

http://www.hqontario.ca/Portals/0/Documents/qi/learningcommunity/Roadmap%20Resources/Advanced%20Access%20and%20Efficiency/Step%205/pc-nha-group-medical-appointments-manual-en.pdf

http://www.clinicalmicrosystem.org/toolkits/shared_medical_appointments/

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