PHARMACY
ASSOCIATION
OF SASKATCHEWAN

Pharmacist Guide for SMAP

Compiled by the Pharmacy Association of Saskatchewan

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Pharmacist Guide for SMAP

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Introduction

The Pharmacist Guide for SMAP (the Guide) is a support document developed by the Pharmacy Association of Saskatchewan, intended to help pharmacists meet the requirements of the Saskatchewan Medication Assessment Program (SMAP) Policy and Procedure document (the Policy) and related bulletins. As such, pharmacists must defer to those documents for complete and up-to-date policy, documentation and billing requirements.

The purpose of the Guide is to provide a step wise approach to complete a medication assessment and care plan for patients participating in a Saskatchewan Medication Assessment Program, with the overall goal of guiding pharmacists to complete a high quality medication assessment through any funded or private program.

The order of steps in this document is an example of one way to provide a medication assessment. You can customize the order of the steps based on your personal preference and the patient scenario.

The Mandatory SMAP Documentation Forms (Appendix B) developed by the Drug Plan and Extended Benefits Branch (DPEBB) may not be representative of the amount of space you need to complete your assessment. Be sure to retain all necessary additional paperwork for complete documentation.

This Guide will be developed over time as the Saskatchewan Medication Assessment Program continues to be evaluated by the DPEBB. All revisions to the Guide and to the Policy will be communicated to PAS members when they occur.

Section 1: Collecting Essential Patient Information

Chapter 1: Obtain consent prior to the start of SMAP

Pharmacists must "obtain and document patient or patient representative consent", according to the Policy. This mandatory requirement allows a patient to participate in the program.

Provide the Declaration of Consent form (Appendix B) to the patient or their caregiver and ensure they understand the service. Have them sign the form before collection of any information or other portion of the assessment begins. The patient may read and sign the form days in advance of their appointment, or just prior to the appointment.

Chapter 2: Print off and review PIP profile and review eHealth Viewer (or equivalent)

It is a requirement within the Policy to print-off (and retain for audit purposes) the patient's PIP profile and to review the eHealth Viewer or other local health records. This information is key to collecting a thorough and complete patient history, formulating strong recommendations and performing a high quality medication assessment.

- This information can be reviewed during this step in the process, or used to complete Step 6: Collect a detailed history of each medical condition, as described later in the Guide.
- The PIP "*Pre-Admission Medication List*" form provides the last 4 months of dispensed medication and can be used for this step and to complete the Comprehensive Patient Interview process with the patient.
    - Note any potential medication issues you may see.
- The eHealth Viewer provides patient lab values, vaccination history, four months of their PIP profiles and other information that may be relevant to the SMAP.
    - Note the dates and results of the last relevant lab values such as A1C, INR, TSH, LDL, etc.
    - Calculate and document eGFR/CrCl, Framingham Risk Score, and any other calculations as needed.

TIP
Depending on the scenario the PIP profile and eHR Viewer information may be gathered prior to or after the patient/caregiver interview. However, accessing this information prior to an interview may help formulate interview questions that are focussed and can save you time.

TIP
Reviewing PIP and the eHealth Viewer prior to a patient interview can make the interview more efficient. For example, confirming that a patient had their A1C done in the last three months may save you time asking questions about their blood sugar history. Also, being able to cross reference their PIP profile to the list of patient identified medications within the interview will ensure medications dispensed at a different pharmacy will be identified. This will likely save you time by having more accurate documentation sooner.

Section 2: Comprehensive Patient Interview and Medication Record

Chapter 3: Systematic approach to the comprehensive patient interview (using 9 steps)

Step 1: Arranging the interview

- Arrange an interview time with the patient/caregiver that will allow for minimal pharmacist distractions.
- Invite caregiver(s), family members etc. as appropriate.
- Confirm time with patient/caregiver if pre-set.
- Tell the patient/caregiver to bring all medications to the interview:
    - including currently used prescription and non-prescription medications such as pills, creams, inhalers, patches, drops, vitamins, herbals, etc. and,
    - any expired or unused medications.
- Ensure the interview space allows for patient privacy and offers a physically comfortable environment. For example, offer a comfortable chair, minimal background noise, etc.

Step 2: Beginning the interview

- Introduce yourself.
- Explain the purpose of the interview and why you will be asking them questions related to their medications and health.
- Describe the process of the interview.
- Estimate the length of time you have to spend with them.
- Ensure the patient/caregiver has completed the Declaration of Consent form before proceeding. Documented written consent is a mandatory requirement of the SMAP.
- Remind them that the conversation is confidential.
- Explain that this process is meant to be collaborative. You will be communicating with their family practitioner about any issues that arise and you will typically not make changes to their medications without discussing it with their practitioner first.

Chapter 4: Complete Sections I, II and III of the "Comprehensive Patient Interview" Form

Step 3: Gather/confirm general patient background information

- Complete Section I: Medical History.
- The patient may feel more at ease by beginning the interview process by asking easy to answer and simple questions such as their demographics, physician information, allergies/intolerances etc.
- If appropriate, have the patient/caregiver fill out Section I on their own and instruct them to bring the completed forms and all of their prescription and non-prescription medications to the pre-arranged interview***.***

> ***FYI***
> ***Cannabis is being used more often for medical reasons and may soon also be legalized. We recommend asking and documenting medical cannabis use and recreational marijuana use as part of the background information gathering.***

Step 4: Determine the patient/caregiver's primary concern(s)

- The primary intent of any medication assessment is to understand and address the patient's medication and health needs, to your best ability.
- Be clear at the beginning of the interview that the focus of the interview is on their concerns about their medications and/or health.
- Use open ended questions such as "*What is the biggest concern about your medications*?" and "*What are your biggest concerns about your health*?" (rather than closed-ended questions like "*Do you have any concerns about your mediations*?").

- You do not need to address their concerns immediately; make note of them and move on with the interview making sure to address them by the end of the interview.

Step 5: Collect a complete list of medications and associated indications

- Begin documenting in Section II: Medications
- Have the patient's PIP profile printed off in advance to confirm with patient/caregiver.
    - Complete and clarify Current Medications & Doses and Indications with the patient/caregiver.
    - It is often useful to collect a simple but complete list of medications and associated indications before collecting the detailed history of medical conditions (which will occur in the next step). Explain to the patient that at this point in the interview you are going to only be collecting
        - names,
        - doses (how they are actually taking each medication), and
        - indications for each of their medications.
- Discourage going into great detail about each medication until you have completed the initial list:
    - Explain that you will go into more detail in the next steps.
    - Finalizing the mediation list helps to keep the process simple and more efficient before moving on to the more complex history discussion.
    - Having a finalized medication list can also be a natural end to an interview in the cases of a complex patient that will require more than one meeting.

> ***TIP***
> ***To save time, consider filling in the Personal Medication Record form (Appendix B), as you confirm medications in Step 5.***

Step 6: Collect a detailed history of each medical condition

- Complete Section II: Medications.
- Assess each medical condition with the patient, one at a time. Document in the Notes portion of the form:
    - Begin by asking open-ended questions, such as "*Can you tell me about your (asthma, diabetes, heart failure, etc.) symptoms?*
    - Then, use a series of more specific and focused questions to probe for more detailed information about each medical condition, if necessary, such as:
        - Onset (*When did X start?*),
        - Duration (*How long has X been happening for?*),
        - Location (*Where on your body do you feel X?*),
        - Frequency (*How often is X happening?*),
        - Severity (*On a scale of 1 – 10, how severe is X for you? Have you ever been hospitalized for X? When?*),
        - Adherence (*How do take, how often do you take, and/or how do you remember to take your medication for X?*). If any devices such as inhalers are being used, or if the patient is applying a cream, patch, drops etc. assess adherence by asking/reviewing how to properly use the medication. (*Tell me/show me how you use X?),*
        - Side effects (*Are you experiencing symptoms or side effects because of your condition or medication that you would like addressed?*), and
        - Finish with any other relevant or open ended question that will complete the information you will need to know about that specific medical condition (*Is there anything else about X you would like to discuss?*).
    - Clarify with and educate the patient, and document any discrepancies or knowledge gaps for each medical condition (and throughout the entire interview process), as needed.
    - Be sure to inquire with the patient and note:
        - medical conditions that are not being actively treated with medications, and
        - medications they have taken in the past but have now stopped.

- If you haven't already:
    - Note the dates and results of the last relevant lab values such as A1C, INR, TSH, LDL etc. for each medical condition.
    - Calculate and document eGFR/CrCl, Framingham Risk Score, and any other calculations as needed.
- Document all relevant information. You may require additional space to write your notes. Be sure to retain all documented information for audit purposes.

TIP
Try your best to maintain the systematic process, but also be flexible addressing the patient's concerns outside of the step by step approach.

TIP
If you require more space to document the history of medical conditions, be sure to retain all additional papers with information that you have collected in the interview.

Step 7: Assessment of medication understanding and adherence

- Complete Section III: Assessment of Medication Understanding and Adherence.
- It is required by Policy to check-mark the answers to Assessment of Medication Understanding and Adherence.
- You may have already gathered the answers to some of these questions throughout out the interview process. However, be sure to assess the questions with the patient that may still be outstanding within the document.

TIP
Use the answers to these questions as a guide for a recommendation of and to document the need for compliance packaging, or other areas of adherence that may have been previously missed.

Step 8: Review of systems

- Complete Section III of the Comprehensive Patient interview with a review of systems.
- This is also known as a "head to toe assessment", which uses a series of quick closed ended questions to ensure every issue has been accounted for.
- It is common for patients to not tell you about medical problems for which they are not taking any medication (e.g, diarrhea, blood in stool, dizziness), but which are obviously very relevant to the medication assessment process. This step will ensure you don't miss any of important issues.
- Begin by telling the patient that you are going to finish up the interview by asking them a series of "yes/no" questions, just to make sure that you didn't miss anything.
    - Document responses in order of systems appearing in Section III, asking them if they are having any trouble with each of the body "systems", starting from the head, and moving down towards to toes. For example:
        - Are you having any trouble with your vision?
        - Any problems with your hearing?
        - What about any problems with your sinuses? Any coughs, sore throat, dry mouth or allergies?
        - Etc.
    - You may not need to ask again about a body system that was already discussed in detail in an earlier part of the interview.
- If new concerns arise, you may need to ask additional questions as per Step 6, to clarify the issue and to determine how it may affect their medication management.

TIP
See Sample Review of Systems Questions (Appendix C) for exact questions you may want to use for the Review of systems- Step 8.

Step 9: Conclude the "Comprehensive Patient Interview"

- Finish the formal part of the interview by asking the patient/caregiver if they have any last questions or concerns.
- Summarize in writing or verbally, any advice and instructions provided to the patient during the interview, as needed. For example:
    - *Stop taking a supplement that was interacting with a prescription medication.*
    - *Take your thyroid medication first thing in the morning, one hour before eating.*
- Provide instruction on what will happen next. For example:
    - *You are done, and nothing has changed. I will interview you again next year or sooner if required.*
    - Give any additional information or follow-up is required and why.
    - Provide information about additional appointments with you and/or doctor.
    - For example:
        - *I need about another 15 minutes with you to complete this interview, when will you be available to chat next?*
        - *Once I consult with your doctor about X, I will call you and let you know how to proceed.*

TIP
Several sample patient interviews created by the Medication Assessment Centre can be viewed at:
Patient 1 Episode 1 ***https://www.youtube.com/watch?v=p_XD9mUDIHI***
Patient 1 Episode 2 ***https://www.youtube.com/watch?v=DEU52gTvrqc***
Patient 1 Episode 3 ***https://www.youtube.com/watch?v=988f5VSfR-o***

Chapter 5: Complete and provide a copy of the "Personal Medication Record" to patient/caregiver

- It is a mandatory requirement of the SMAP to provide the patient with an up-to-date Personal Medication Record (Appendix B) of what they are currently taking, at the conclusion of the interview.
- You may fill out each required detail as you clarify them though out the interview process.
- This is the list you will also provide to the practitioner if/when you make a recommendation for a change, as described in the next steps.
- A new list should be provided to the patient each time their medication profile changes and/or at every SMAP interaction such as a follow-up when a change is made.

Section 3: SMAP Care Plan

Chapter 6: Request relevant information from patient's practitioner, if applicable

- The key to performing a high quality medication assessment (and to formulating strong recommendations) is to collect a thorough and complete patient history.
- Even after completing an excellent patient interview that includes information from PIP and the eHR Viewer, there still may be gaps in the patient history that the patient's family practitioner can sometimes provide. Skipping this step may result in uninformed or unsafe recommendations.
- Therefore, contact the patient's family practitioner for information such as to:
    - confirm diagnoses or medical conditions,
    - obtain other diagnostic test results, only if results are necessary to identify any drug therapy problems (eg. spirometry, bone density, echocardiogram),
    - specialist consultation letters, only if the results are necessary to identify any drug therapy problems (cardiology, psychiatry),
    - hospital discharge summaries,
    - discuss socio-economic situation, cognition, or any other relevant information to complete the patient history.

Case Study
Your patient knows they have breathing problems, but they are not sure if they have asthma or COPD. They also recall being in the hospital for heart problems, but they do not know what the diagnosis was and you have no record of the hospital stay.

In this case, you should never identify the patient's drug therapy problems or make recommendations about their medications without first requesting more information. As a part of the history, contact the patient's family practitioner and explain that you are completing a medication history for a Saskatchewan Medication Assessment and that you require some additional information to complete the history. For this particular instance you can request information such as the patient's respiratory diagnosis, recent spirometry results, the hospital discharge summary and any other relevant information to help make an informed and complete history.

TIP
To request information from a practitioner:

- ***Explain briefly and clearly why you need the information.***
- ***Be judicious about what you request; only ask for the information you need and that that you are not able to access elsewhere to complete a patient's history.***
- ***Include the signed Declaration of Consent form.***

Chapter 7: Document/complete the "SMAP Care Plan Form" (using 4 steps)

Step 1: Document medical condition and medications

- Use the SMAP Care Plan Form (Appendix B) to document.
- Record all medical conditions when you can confirm the correct diagnoses, noting associated medications when a medication is used to treat that condition.

Step 2: Determine goals of therapy

Goals of therapy are individualized patient targets that are set for each medical condition. These targets are used as a measurement to assess whether or not the medical conditions are controlled or adequately managed.

Goals of therapy are established by using a combination of:

- evidence based recommendations found in literature and/or clinical guidelines and
- what is considered to be reasonable and acceptable for that particular patient (which may require some discussion or negotiation with the patient).

Some goals of therapy will be objectively based (eg. following a condition specific Canadian guideline), such as LDL cholesterol less than 2.0 mmol/L or a systolic blood pressure less than 140mmHg, or they may be subjectively based (how a patient feels, such as mood or pain). Consequently, all goals of therapy should be individualized, discussed and then modified for, or confirmed with the patient.

Why are goals of therapy so important?

- Setting goals with the patient is one of the most important steps to reach a desirable and achievable outcome.
- It also provides tangible evidence of movement, change or "success" in the specific issue.
- By identifying a goal and a process to address an issue, the patient and pharmacist are able to track outcomes (and adjust when/if needed) while managing each medical condition.
- Patients are appreciative and more likely to achieve goals or outcomes when they are a more active participant in co-creating goals and managing their medical conditions.

Some categories of clinical goals of therapy may include:

- curing a disease (eg. pneumonia),
- improving symptoms (eg. pain, mood),
- slowing the progression of a disease (eg. COPD,)
- preventing a disease from being contracted (eg. primary prevention of stroke), and
- normalizing a lab value (eg. blood glucose).

Suitable and useful goals of therapy MUST include:

1. A parameter that is observable and measureable (eg. blood pressure, more energy and alertness, better mood)
2. A specific target, objective or subjectively based (eg. less than 140mmHG systolic, be able to comfortably work into the late afternoon without having to lay down)
3. A timeframe to achieve the goal (eg. within 6 weeks, within 2 weeks)

Specific examples of goals of therapy:

- Reduce the patient's HbA1c to less than 7% within 3 months (based on the Canadian Diabetes Association (CDA) Guidelines for a young low risk patient).
- Reduce a patient's HbA1c to less than 8% within 3 months (adjusting the CDA Guidelines for an old, frail patient).
- Reducing chronic lower back pain by 50% (from an 8/10 severity to a 4/10 severity) within 60 days.
- Improving mood so the patient can make it through a work day without becoming tearful in front of her colleagues within 3 months.
- Cure the patient's cellulitis within 7 days.
- Reduce asthma symptoms and PRN salbutamol use to less than 4 times per week, within 4 weeks (as per Canadian asthma Guidelines).

Step 3: Identify drug therapy problems

Once you have set reasonable and specific goals of therapy, you need to determine if the patient's medications are optimally managing their medical conditions and contributing to the achievement of these goals of therapy (by identifying drug therapy problems). A drug therapy problem (also referred to as a drug related problem, or "DRP") is any undesirable event experienced by a patient that involves, or is suspected to involve, drug therapy, and that interferes with achieving the desired goals of therapy and requires professional judgment to resolve. (Pharmaceutical Care Practice, by Cipolle, Strand and Morely, 3rd edition)

Pharmacists should use a formal, *systematic thinking process* to identify drug therapy problems for all patient assessments. If you do not think systematically, you may miss problems especially in complex patients and for obscure therapy problems.

> ***NOTE***
> ***Be sure to document all actual and potential drug therapy problems, for a comprehensive assessment.***

The two *systematic thinking processes* that are most commonly used and taught around the world to identify drug therapy problems are the *Therapeutic Thought Process* and the *Pharmacotherapy Work-Up*.

- There is no evidence that either process is superior to the other.
- Therapeutic Thought Process may work better for patients with several poorly controlled medical conditions
- Pharmacotherapy Work-Up may be preferable for patients without any obvious issues or complaints.
- Both processes can work well for any patient and most often is personal preference for use.
- Try both processes for several patients before you decide what works best for you.

Therapeutic Thought Process

The Therapeutic Thought Process (TTP) requires that you identify and address each of the patient's medical conditions, one at a time, and ask yourself these four standard questions (in order) about each medical condition separately:

1. Is the problem/symptom caused or worsened by any other medication(s)?
    - Is the patient taking a drug that has been reported to cause or worsen the problem?
    - Is the problem due to an adverse drug reaction, drug interaction or too high a dose?
        - If yes, is the time frame of the problem consistent with other drug therapy start dates?
    - Could the complaint be more likely caused by one of their other diseases or conditions or diagnoses?

2. Is drug therapy (of any type) really needed for the problem/issue?
    - Is the patient already taking drug therapy for the problem?
    - Is any drug therapy indicated for the problem OR is there evidence that any drug will benefit the problem?
    - What are the potential implications of not taking drug therapy for the problem?

3. Is the patient taking the best/most appropriate drug(s) for the problem/issue?
    - If drug therapy is indicated, is the patient taking the most effective / evidence based drugs for the condition?
    - Is there evidence that the drug the patient is currently taking is actually working for the individual patient?
    - Is the patient taking the best drug formulation or dosage form?

4. If the problem/issue requires drug therapy and the patient is already on the best/most appropriate drugs, why are their current drugs not working?
    - Is the patient's dose too low?
    - Is the drug just ineffective in this patient?
    - Is additional drug therapy needed?
    - Is the patient adherent to the drug regimen?

The Pharmacotherapy Work-Up

To use the Pharmacotherapy Work-up, systematically consider the patient's entire medication history (eg. all of the medical conditions and associated medications) and complete the following four steps, answering the associated questions in order:

1. Evaluate the appropriateness of the indication
   - Is there a valid indication for all of the medications being taken by the patient?
   - Are there any medical conditions that could benefit from drug therapy that are not currently being treated?
   - Are any of the patient's current problems being caused (or worsened) by their drug therapy?

2. Determine drug effectiveness
   - Is the patient's current drug therapy regimen achieving the goals of therapy for each medical problem?
   - Is the most effective drug, dose and drug regimen being used for each of the patient's medical problems (based on the most recent evidence)?
   - Is there evidence in THIS patient that their drug therapies are effective?
   - If goals of therapy are NOT being met:
     - Is it because the drug is just not working?
     - Is it because the dose is too low?
     - Is additional drug therapy needed?

3. Establish safety of the drug regimen
   - Is the patient experiencing any side effects?
   - Is the patient on a dose of any drug that is too high for their age, weight, renal function, etc.?
   - Are there any actual or potential drug interactions?
   - Are there any contraindications?

4. Ensure patient adherence
   - Does the patient prefer not to take their drugs?
   - Does the patient ever forget to take their drugs?
   - Does the patient understand all the directions?
   - Are the drugs too expensive for the patient to afford?
   - Can the patient swallow/properly take all of their medications?

Once you complete your systematic thinking process questions (after having completed a thorough history), identify and document all Drug Therapy Problems within the 8 categories on the patient's SMAP Care Plan Form:

1. Patient is taking an unnecessary drug/a drug that is not needed
2. Patient requires additional drug therapy
3. Patient is taking a drug that is not working
4. Patient is taking a dose that is too low
5. Patient is taking a dose that is too high
6. Patient is experiencing an adverse drug reaction/side effect
7. Patient is non-adherent
8. Patient is experiencing a drug-interaction that requires intervention

Step 4: Develop solution-focused recommendations

Sometimes there is only one reasonable or obvious option to resolve a drug therapy problem (eg. the dose of the drug is too low, therefore you recommend a specific dose increase). Other times, however, there may be multiple reasonable alternatives to resolve the drug therapy problem (eg. patient with poorly controlled depression who has never received drug therapy before, and who agrees to try a medication).

To efficiently assess all the possible options, begin by:

- Addressing one drug therapy problem at a time.
- Research therapeutic information and options from a variety of recognized sources (when needed) such as:
    - various clinical practice guidelines,
    - eTherapeutics,
    - RxFiles,
    - Lexicomp,
    - etc.

- Create a list of <u>all</u> of the reasonable alternatives to resolve the specific drug therapy problem, which can achieve the goal of therapy.
    - For example, in the patient suffering from depression scenario above, the goal of therapy could be to improve the patient's mood so that the patient can make it through the workday without becoming tearful in front of her colleagues, within 3 months.
    - Therefore, the reasonable alternatives to reach this patient's goal could be: (1) SSRI (2) SNRI (3) bupropion (4) mirtazapine.

- Compare and contrast alternatives to identify the best option for this individual patient, considering specific medical history and individual goals of therapy using the following four questions:
    1. Which options are most likely to be effective at achieving this patient's goal of therapy?
    2. Which options are most likely to be safe and well tolerated for this particular patient?
    3. Which options are more convenient for this particular patient?
    4. Which options are the most cost-effective, considering this particular patient's ability to pay and their drug coverage?

- Choose the best option for this particular patient, based on the answers from the four questions.
- Note educational needs for disease state and lifestyle management.
- Formally write up the recommendation(s) for approval by a practitioner or when you have the authority to make the change yourself.
    - **When a recommendation needs approval by a practitioner,** be sure to use language that is clear and direct.
    - A **"solution-focused"** recommendation is very specific about:
        - what needs to be done (suggesting specific drug and dose),
        - when it should be done, and
        - who is responsible for making the change.

      Be sure to also include the rationale for the change in the recommendation.

      Assuming you have appropriately applied a systematic approach to finding drug therapy problems, compared and contrasted alternatives to find the best option for your patient based on what you know, a solution focused recommendation with one alternative should be suggested.

    - **When you have the authority to make a change,** be judicious, efficient and selective with your recommendations to practitioners. If you have the authority to change something (and you feel confident in the suggested alternative):
        - Inform the physician about the solution focused change you made.
        - Include that you are taking responsibility for the follow-up on the change that you made.
        - Include the rationale for the change.
        - Be sure to educate the patient on disease or lifestyle, as needed.

      Use your prescriptive authority scope of practice when appropriate (eg. interim supplies, minor ailment or collaborative practice prescribing)

Examples of solution-focused recommendations:

Complete solution-focused recommendations

- ***Practitioner approval recommendation:***

"Our patient told me that you diagnosed her with major depressive disorder 6 months ago but that she preferred to try some non-drug interventions first. After my discussion with her today, she informed me that she wants to now try medication, which seems reasonable to me (the "rationale").

I suggest starting her on paroxetine 20mg once daily in the morning (the "what"). I have asked the patient to make an appointment with you in the near future (the "when") to discuss this suggestion and get a prescription if you agree with the change (who is responsible).

I would be happy to follow up with her soon after she starts on the paroxetine to see how she tolerates it and to encourage adherence while we wait for it to start working.

- ***Pharmacist authority recommendations:***

I recommended that the patient take 1000mg of acetaminophen every 4 hours (maximum of 2000mg a day) for the chronic pain in their knee. I will follow-up with them in 2 weeks to assess the recommendation.

Incomplete recommendations which are not solution- focused:

- ***"I suggest starting the patient on an SSRI"***
- ***"Suggest starting an antidepressant"***
- These are examples, showcasing how not to make a recommendation. Be sure to develop a "complete" recommendation as noted above.

Chapter 8: Discuss potential interventions/recommendations with patient/caregiver

It is important to allow sufficient time to discuss potential interventions/recommendations with the patient/caregiver **prior to communicating with their practitioner**. Patients who understand and agree with the rationale behind a recommendation to change their medications are much more likely to have long term adherence.

Discussing recommendations with patient/caregiver before sending them to the prescriber:

- Ensures that the patient/caregiver agrees with and supports the recommendation(s)
- May save you and the prescriber time if the patient does not support the recommendation.
- Acts as a second check to prevent making a suggestion that may have already been tried unsuccessfully in the past (the discussion may trigger their memory on something they forgot about before).
- Enhances patient centered care though patient engagement.

You may be able to complete this step during your initial appointment, or you may require a separate appointment to discuss recommendations. Be sure to provide the patient with time to think about the recommendation(s), and encourage them to ask questions.

Options on how to proceed with a recommendation, once the patient/caregiver agrees with the suggested recommendation(s):

a) Instructing them to initiate the change immediately if you have the authority to make the change.
b) Communicate the recommendation to the practitioner, if you do not have the authority to make the change.
c) Contact the practitioner (even if you have the authority to make the change), but would like to discuss and confirm the recommendation.

How to best communicate the recommendation to the practitioner:

- Discuss verbally (over the phone or in person) for all recommendations that are urgent.
- Discuss verbally (over the phone or in person) for non-urgent recommendations that are simple and can be discussed in a very short period of time (if you have convenient communication access to the practitioner).
- Communicate in writing (usually via fax) for non-urgent recommendations that are complex or numerous (to allow the practitioner sufficient time to read and thoughtfully consider your suggestions when they are not busy).

What to tell the patient about what will happen next if you are contacting their practitioner in writing/via fax:

- Tell the patient that you will be providing their practitioner with a copy of the recommendation(s) that you just discussed.
- Instruct them to make a new appointment with their practitioner to specifically discuss recommendations and have the possible changes assessed, approved and implemented.
- Explain that sometimes the practitioner knows extra details about their medical history that you may not know about (which could make your recommendations inaccurate) which is why it is important to see their practitioner BEFORE making any changes to their medications.
- Be very clear that no changes should be made until they discuss your recommendation(s) with their practitioner.

TIP
There are two reasons why it can be useful to instruct the patient to make a new appointment with their practitioner to specifically discuss your faxed recommendations:

1) ***Most practitioners have a policy to not discuss things like this with patients over the phone (unless it is urgent), so when they read your fax they may assume that the patient has already been instructed to make an appointment to discuss your report. If the patient was NOT instructed to make an appointment, the fax may unintentionally never be addressed.***

2) ***Some patients will wait until they go and see their practitioner for some other reason (e.g., headache, flu, etc.) and then will ask the practitioner to make the changes suggested in your fax. This can be frustrating and difficult for the practitioner who may not have adequate time to properly consider and address your recommendations, in addition to the patient's other complaint, in one appointment.***

Chapter 9: Collaborate with practitioner to address drug therapy problems, as needed

Most often you will be sending written communications about the assessment and recommendation(s) to practitioners, unless you have identified an urgent issue that requires immediate verbal discussion. Therefore, written communication is paramount to this process.

There are several different formats for writing pharmacist consultation/recommendation letters to practitioners, which is beyond the scope of this Guide (eg. SOAP Note Sample Template, Appendix E). However, below are some suggestions for writing consultation/recommendation letters that are helpful, regardless of which format you prefer to use.

Be sure to include the following in communications to the practitioner:

- Patient identifiers (eg. age, HSN).
- Reason for your consultation with patient:
    - It is a requirement in the Policy that you note that you performed a Saskatchewan Medication Assessment Program consultation.
    - It is also suggested that the SMAP logo be added to the letter head.
- Updated copy of SMAP Patient Medication List (practitioner can use to update patient's medication list in chart).
- The actual recommendation(s), in boldface font (or some other way for it to stand out).
- Brief rationale for each recommendation.

- Any changes you made already, as an FYI.
- Any actions you suggest they make, should they agree with the recommendation(s).
- See Sample Pharmacist Recommendation Letters (Appendix D) for several examples

NOTE

It is very important that you clearly communicate exactly what the practitioner is expected to do when you communicate to them. Write each letter with a succinct action item. For example:

- ***Does she need to fax a prescription to your pharmacy for the changes she agrees with?***
- ***Does he need to respond to this fax?***
- ***Is the patient coming in to discuss the recommendations with them?***

TIP

Try to avoid pharmacy terms or jargon when talking to health care providers, many of them have not heard of the terms before, and/or it may infer judgement. For example Instead of "drug therapy problem" or "drug related problem" use the term "recommendation" instead.

Additional tips for practitioner communication:

- Make sure your communication is clear, concise and easy to read
- Assume that practitioners will not read every word in your letter, therefore make the most important information visually stand out; recommendations may be identified using **boldface**, underlining or highlighting.
- It is appropriate to use either bullet points or full narrative. However, ensure narratives are concise.
- Generally notes are 1 or 2 pages at most. If you find you have more than 2 or 3 pages, consider prioritizing recommendations and sending letters a couple weeks apart, if appropriate, reserving non-urgent recommendations for future letters.
- If you have many recommendations, you might consider including all of them together in a "Summary Box" at the top of the letter, with rationale to follow.
    - See Sample Pharmacist Recommendation Letters Appendix D, Sample 2.
- Avoid sending hand written letters. Type your recommendations.
- Always sign your name and include your phone number if the practitioner wants to contact you to discuss recommendations.

NOTE

There is an area on the upper right hand corner of the SMAP Care Plan Form where pharmacists are asked to track "Time spent on assessment". This area was included at PAS's request so that the approximate amount of time being spent on SMAPs can be analyzed against the current payment model.

Section 4: Monitoring and Follow-up

Chapter 10: Create and document a monitoring plan

After a change has been made to a patient's medication profile either by you or by a practitioner, it is vital to monitor that change, to prepare for the direct follow-up interaction with the patient and to create an action plan to assess:

- **Effectiveness** *(Did the change that you recommended achieve the goal of therapy that you intended?)*
- **Safety, adverse effects and tolerability** *(Did the patient tolerate the change?)*
- **Adherence** *(Did the patient implement the change and have they continued to adhere to it?)*

> ***TIP***
> ***Do not assume that the patient has implemented your suggested change(s), even if the practitioner has agreed to make the change and you dispensed the new medication. Many patients will change their minds, for a variety of reasons, and never make the suggested change.***

Who is responsible for monitoring?
It depends on the scenario:

- If you made any medication changes independently (within your scope of practice), you are completely responsible for monitoring the outcome (effectiveness, safety and adherence) of those changes.
- If you made a recommendation that was approved and implemented by the practitioner, you will have shared responsibility for monitoring those changes.

What can I monitor?
Some monitoring currently isn't within the scope of practice for a pharmacist (eg. ordering labs without a collaborative practice agreement). However, there are many opportunities to assess physical and behavioral response to recommendations.

Shared monitoring parameters
When a practitioner approves your recommendation(s), monitor the following:

- **Effectiveness:** Did your recommendation work?
- **Safety, adverse effects and tolerability:** Were there any unanticipated negative consequences of your recommendations (eg. hypersensitivity, adverse reactions, side effects)?
- **Adherence:** Has the patient actually made the changes and successfully complied with the recommended changes?
- Anything that you and the practitioner have agreed to in a signed Collaborative Practice Agreement (for example, ordering labs).

Pharmacist led monitoring parameters
When a pharmacist is able to recommend a change that is within their scope of practice they may monitor:

- Any parameters that the patient can provide on their own.
- Blood sugars and blood pressure, for example, are great options for the pharmacist to lead on their own, sharing relevant results with the practitioner when needed.
- Level of patient understanding of disease state and lifestyle.
- Effectiveness, safety, adverse effects, tolerability and adherence of any recommendations that was independently made to the patient.

When should I monitor?

- Consider a reasonable timeframe for when and how often to monitor the parameters that would be appropriate for the individual patient.
- It may be slightly challenging to predict the best time to assess.

- Use relevant clinical guidelines and/or your professional judgement to help determine timeframes to contact the patient and ask them pharmacist led and shared monitoring questions.

What elements do I need to create and document a monitoring plan?

- Which exact parameters you plan to monitor (based on shared or pharmacist lead monitoring parameters).
- When you plan to begin to monitor it.
- How often to monitor it.
- Approximately when you plan to follow-up directly with the patient/caregiver, if necessary.

EXAMPLE

You have just completed a medication assessment for a patient and identified the drug therapy problem that the patient has elevated blood pressure and requires additional drug therapy, in addition to their perindopril 8mg tablet, which they are taking once daily. You suggested to the practitioner to add on hydrochlorothiazide 12.5mg once daily and she agreed and provided you with a verbal prescription for the new drug. Your shared monitoring plan (which should be documented in the SMAP CARE PLAN FORM) might look like this:

- ***Patient will check his blood pressure twice daily at home and record results.***
- ***Patient to come back to pharmacy for follow up appointment in TWO WEEKS and pharmacist will: (1) review patient's home blood pressure readings and will also check it on store machine, (2) ask patient about common side effects, (3) ask patient about adherence.***
- ***Patient will make an appointment with family doctor in ONE MONTH to review blood pressure and have serum creatinine, electrolytes and urea checked (since thiazide diuretics can cause abnormalities in these parameters).***

Chapter 11: Follow-up with patient

Following-up directly with the patient continues to develop patient rapport and engagement and enhances the likelihood of recommendations being considered by a practitioner. Also, it ensures that the recommendations already in place are safe and effective, as per the previous chapter.

When and how should I follow-up with the patient?

- Similar to a monitoring plan, choosing when to follow-up directly with a patient may be a difficult clinical decision.
- Consider the likely timeframes of when the results of a change may <u>improve</u> (eg. enhanced effectiveness of medication, improved labs), or <u>deteriorate</u> (eg. adherence challenges, adverse effects) patient outcomes.
    - Choose the shorter of the two timeframes to follow-up with the patient.
- Set up an appointment with the patient/caregiver for a follow-up appointment, based on the best timeframes as identified.

What exactly can I ask the patient when I follow-up with them?

- Ask if they have met with their practitioner to discuss your recommendations, and if the practitioner made any of those recommended changes (if you don't already know).
- Ask if they have implemented all of the changes the practitioner approved.
- Assess the effectiveness, safety, side effects, tolerability and adherence to the changes that were made by you or approved by the practitioner.
- Ask if they would like to review any educational items on disease state or lifestyle, if needed.
- Ask if they have any new problems, issues, questions, clarifications needed or concerns that have emerged since you last spoke.

What if there are continued issues, unresolved or new drug therapy problems?

- Remember that this is a continuous and non-linear process.
- Each time you follow-up with the patient you will attend to each of the medication assessment steps, as required.

- Essentially you complete the entire process outlined in this Guide each time you see the patient; however, subsequent appointments are generally much quicker since often you are usually simply updating the information that you collected during your initial appointment, and then assessing for the presence of any new drug therapy problems.

What does the Policy require for an eligible SMAP Follow-Up Fee?

- The Policy requires that the follow-up be done with the patient/caregiver and that it be done in person. See Policy for more details.
- Follow-ups with practitioners are not eligible for an SMAP Follow-up Fee at this time.

Chapter 12: Securely retain copies of all documentation on file

- Securely retain documentation including but not limited to the Comprehensive Patient Interview, Personal Medication Records, SMAP Plan additional interview notes, care plan work up, PIP profile, etc.

- Specific organizational requirements:
    - **Saskatchewan College of Pharmacy Professionals**
        - stipulates retention of patient records for 2 years from the most recent entry therein.
    - **Drug Plan and Extended Benefits Branch**
        - require pharmacies to retain all the documentation for 2 years as per the SMAP policy.
    - **Canada Revenue Agency**
        - If using the SMAP as a financial record, CRA rules apply which are retention for 6 years including the current tax year, a total of 7 years.

    - **HIPA requirements**
        - PART III Duty of Trustee to Protect Personal Health Information
            - **Duty to protect**
                - 16 Subject to the regulations, a trustee that has custody or control of personal health information must establish policies and procedures to maintain administrative, technical and physical safeguards that will:
                - (a) protect the integrity, accuracy and confidentiality of the information;
                - (b) protect against any reasonably anticipated:
                    - (i) threat or hazard to the security or integrity of the information;
                    - (ii) loss of the information; or
                    - (iii) unauthorized access to or use, disclosure or modification of the information; and
                - (c) otherwise ensure compliance with this Act by its employees.
                  1999, c.H-0.021, s.16.

            - **Retention and destruction policy:**
                - 17(1) Not yet proclaimed.
                - (2) A trustee must ensure that: (a) personal health information stored in any format is retrievable, readable and useable for the purpose for which it was collected for the full retention period of the information established in the policy mentioned in subsection (1); and (b) personal health information is destroyed in a manner that protects the privacy of the subject individual.
                  1999, c.H-0.021, s.17.

Section 5: Extras

Chapter 13: Additional tips and suggestions

Give the medication assessment process appropriate time and attention

- A medication assessment and care plan development requires a thorough, methodical and systematic process that takes time and attention to do well.
- If you are new to this process, it will take you much longer than others that have been using it for years. Be patient with yourself, you will become much more efficient and effective in your assessments.
- Allow yourself time to learn the process on your own. Reading this Guide and making your own notes and observations prior to an appointment is recommended rather than learning the process during the patient interview.
- Find a mentor, shadow or call someone that has been effectively using this process.
- Ensure you block an appropriate amount of time for patient interviews, being more generous when you first start, and planning for increased efficiency as you do more assessments.
- Try to create time where you will be minimally or undisturbed when providing assessments.

Resist the urge to "fix everything" in one appointment, especially for complex patients

- It may be impossible to address all of the drug therapy problems in a single visit. It is generally impossible to address them all in a complex patient (eg. those who are taking 10 medications).
- For a complex patient, use the initial appointment to collect a thorough history and address only the most urgent problems, staying within your time limit.
- After the initial appointment, plan to address the non-urgent issues one at a time during subsequent follow-up visits.
- Aim to eventually address all of the non-urgent issues, even if it takes a couple years.

Triage patients most in need, and based on your skill level

- Use your judgement to identify the highest risk patients that you will have the time and expertise to manage.
- If you only provide the service only to non-complex patients, overall these patients will benefit the least.
- Similarly, if you pick patients that are too complex for your experience and expertise, you may spend endless hours assessing.
- If the patient is very complex and you do not feel comfortable providing the assessment, seek out either at another pharmacy, a primary care team or through the Medication Assessment Centre (MAC) to provide the assessment.

What should I do if I do not hear back from the practitioner after I make a recommendation?

- Phone the receptionist at the clinic to make sure they received your communication and that it did not get misplaced, especially in very busy clinics. You may need to re-send the communications.
- Ask the receptionist to alert the practitioner that you and the patient are waiting on their comment and that you would be happy to discuss the letter verbally if that would be preferred.
- Ask the patient to make an appointment with the practitioner to specifically discuss the recommendations that were detailed in your letter.

Chapter 14: Additional resources

Canadian Pharmacists Association (CPhA) Online Education Programs

CPhA has several web-based continuing education programs which support pharmacist practice.

The Medication Assessment Management program is an 8 CE online education program that models the content of this Guide. It can be found at
https://www.pharmacists.ca/education-practice-resources/professional-development/medication-reviews/

Medication Assessment Centre

The Medication Assessment Centre (MAC), founded in 2011 is a not-for profit patient care clinic that is located within the College of Pharmacy and Nutrition at the University of Saskatchewan.

MAC is managed by the faculty within the College and was created primarily to provide undergraduate students high quality medication assessment training with real patients that have been referred for an assessment, from across Saskatchewan. It was also created to help support practising pharmacists to provide high quality medication assessments and to perform research on optimal pharmacist-led patient care services.

MAC has created several demonstration videos that are available at no-charge to practising pharmacists, to illustrate how to perform a medication assessment:

Patient 1 Episode 1 ***https://www.youtube.com/watch?v=p_XD9mUDIHI***
Patient 1 Episode 2 ***https://www.youtube.com/watch?v=DEU52gTvrqc***
Patient 1 Episode 3 ***https://www.youtube.com/watch?v=988f5VSfR-o***

Community and hospital pharmacists from anywhere in Saskatchewan, in addition to physicians and nurse practitioners, may refer a patient to MAC for an assessment if they do not meet SMAP criteria, are not able to pay for an assessment or if they are highly complex. Patients who do not live in Saskatoon will have their assessment completed by phone.

To refer a patient to MAC, contact them at http://www.usask.ca/pharmacist/ or call 306-966-6392.

Pharmaceutical Care Practice, by Cipolle, Strand and Morely, 3rd edition

This textbook is the gold standard of the patient care process and for performing medication assessments. It is very practical and provides additional details on each chapter in this Guide. It can be purchased at the University Bookstore or online at:
https://accesspharmacy.mhmedical.com/book.aspx?bookID=491
https://www.amazon.ca/Pharmaceutical-Care-Practice-Patient-Centered-Medication/dp/0071756388

Patient Care Process June 2011- Version 1.1
This document, which was developed by the Faculty of Pharmacy and Pharmaceutical Sciences University of Alberta, Edmonton Alberta Regional Pharmacy Services, Alberta Health Services, uses a similar process as this Guide.

It can be found at:
http://www.pharmacy.ualberta.ca/PreceptorResources/docs/Patient%20Care%20Process%20Document.pdf

Appendix A
SMAP Checklist

SMAP Checklist

Collecting Essential Patient Information

- ☐ Obtain consent prior to the start of SMAP
- ☐ Print off and review patient PIP profile and review eHealth Viewer (or equivalent)

Comprehensive Patient Interview and Medication Record

- ☐ Arranging the Interview
- ☐ Beginning the Interview

- ☐ Gather/confirm general patient background information
- ☐ Determine the patient/caregiver's primary concern(s)
- ☐ Collect a complete list of medications and associated indications
- ☐ Collect a detailed history of each medical condition
- ☐ Assessment of medication understanding and adherence
- ☐ Review of systems
- ☐ Conclude the "Comprehensive Patient Interview"

- ☐ Complete and provide a copy of "Personal Medication Record" to patient/caregiver

SMAP Care Plan

- ☐ Request relevant information from patient's practitioner, if applicable
- ☐ Document medication conditions and medications
- ☐ Determine goals of therapy
- ☐ Identify drug therapy problems
- ☐ Develop solution-focused recommendations

- ☐ Discuss potential interventions/recommendations with patient/caregiver
- ☐ Collaborate with practitioner to address drug related problems, as needed

- ☐ Note "time spent on assessment" on "SMAP Care Plan Form" (will be used for program economic analysis)

Monitoring and Follow-up

- ☐ Create and document a monitoring plan
- ☐ Follow-up with patient/caregiver
- ☐ Securely retain copies of all documentation on file

- ☐ Update and provide the "Personal Medication Record" to patient/caregiver and their practitioner, as needed

Appendix B
SMAP Mandatory Documentation
Declaration of Consent

Declaration of Consent

DATE:

Patient Consent
I, _____ consent to participating in the Saskatchewan (printed name of patient) Medication Assessment Program.
Signature of Patient:

Caregiver Consent *If patient is unable to consent, a caregiver, legal guardian/power of attorney may provide consent for the patient's participation in the Saskatchewan Medication Assessment Program.*
I, _____, care provider/legal guardian/power of attorney (printed name of care provider/legal guardian/power of attorney) for _____, consent to participating in the Saskatchewan (printed patient name) Medication Assessment Program.
Signature of care provider/legal guardian/power of attorney for patient:

Note: An individual's health information may be shared with another healthcare provider as necessary for their care.

Appendix B
SMAP Mandatory Documentation
Comprehensive Patient Interview, Section I: Medical History

Comprehensive Patient Interview

SECTION I: MEDICAL HISTORY **DATE:**

Patient Name:					
Address:					
Male ☐ **Female** ☐	**Weight:**	**Height:**	**Date of Birth:**	**Age:**	
Health Services Number:					
Family Physician:					

Allergies/intolerances in the past (what happened, and when):
Immunizations: **Influenza:** **Tetanus:** **Pneumococcal:** **Other:**

Social History		
Smoking/tobacco Use ☐ Yes ☐ No **Amount Used:**	**Caffeine Use** ☐ Yes ☐ No **Amount Used:**	**Medicinal Cannabis Use** ☐ Yes ☐ No **Amount Used:**
Alcohol Use ☐ Yes ☐ No **Amount Used:**	**Recreational Drug Use** ☐ Yes ☐ No **Type and Amount Used:**	

Family History Has a 1st degree relative (mother, father, sister, brother) ever experienced any of the following?	
Heart Attack ☐ Yes ☐ No	**Mental Illness** ☐ Yes ☐ No
Stroke ☐ Yes ☐ No	**Diabetes** ☐ Yes ☐ No
Other family member medical conditions?	

Medical Conditions/ Surgeries	**Additional Comments**
Relevant Lab Data (e.g. CrCl, HgbA1C)	
What are your concerns regarding your health?	

Appendix B
SMAP Mandatory Documentation
Comprehensive Patient Interview, Section II: Medications

Comprehensive Patient Interview

SECTION II: MEDICATIONS

What are your concerns regarding your medications?				
Current Medications *(include prescription, non-prescription/OTC, herbals, vitamins, patches, drops, inhalers, creams etc.)*	**Strength and Doses**	**Indication** *(what medical condition is this medication being used for)*	**For Approx. How Long**	**Notes** *(e.g. how well medication is working, relevant labs)*

Do you have any medical conditions for which you are not currently taking medication?	**Have you taken any medications in the past which you have now stopped taking (include why, and when stopped)?**

Appendix B
SMAP Mandatory Documentation
Comprehensive Patient Interview, Section III: For Pharmacist Use Only

Comprehensive Patient Interview

SECTION III: FOR PHARMACIST USE ONLY

Assessment of Medication Understanding and Adherence	
☐ Yes ☐ No	Does the patient prefer not to take any of their drugs?
☐ Yes ☐ No	Does the patient ever forget to take any of their drugs?
☐ Yes ☐ No	Does the patient know the indication of each drug they are taking?
☐ Yes ☐ No	Does the patient understand how to take their medication? (e.g. demonstration of devices)
☐ Yes ☐ No	Can the patient swallow / administer all of their drugs?
☐ Yes ☐ No	Can the patient read the labels?
☐ Yes ☐ No	Can the patient open medication bottles?
☐ Yes ☐ No	Is the storage of this medication appropriate?
☐ Yes ☐ No	Does the patient have bottles of unused/expired medications?
☐ Yes ☐ No	Are the patient's drugs too expensive for them?
☐ Yes ☐ No	**Is compliance packaging recommended for this patient?** If yes, provide proof of consent: _____ Patient's Signature

Review of Systems
EENT (vision, hearing, or nasal problems):
Cardio (chest pain, heart problems, HTN, lipids):
Pulmonary (breathing problems):
GI (stomach problems or pain, nausea, constipation, trouble swallowing):
Skin (any skin troubles):
Endocrine (diabetes, thyroid history):
Hepatic (any history of liver problems):
Renal/Urinary (urinary frequency, renal dysfunction):
Hematology (bruising, bleeding):
MSK (pain):
Neuro (numbness, tingling, balance or falls, headaches, memory):
Psych (mood problems):
Reproductive (incontinence, impotence, hot flashes):
ID (any infectious diseases like HIV Hep C, TB etc.):
Diet (general diet, weight changes):

Appendix B
SMAP Mandatory Documentation
Comprehensive Patient Interview, Section III: For Pharmacist Use Only…Continued

Comprehensive Patient Interview

SECTION III: FOR PHARMACIST USE ONLY…CONTINUED

Any additional diagnoses/issues not discussed?

Appendix B
SMAP Mandatory Documentation
SMAP Care Plan Form

SMAP CARE PLAN FORM

The following must be completed:
PIP profile reviewed: ☐ Yes (attach PIP profile to form) Time spent on assessment: _____
eHR Viewer (or equivalent) reviewed: ☐ Yes
Patient requires compliance packaging: ☐ Yes ☐ No Reason for Compliance Packaging: _____
Document ALL Drug Related Problems (DRP) – Actual and Potential

Medical Condition and Medications (if applicable)	Goals of Therapy	Drug Therapy Problem (DTP) Actual and Potential	Recommendation(s) and Monitoring Plan	Practitioner Accepted Recommendation (Yes/No)	Follow-up and Dates	DTP Resolved (Yes/No)

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Appendix B
SMAP Mandatory Documentation
Personal Medication Record

Page __ of __

PERSONAL MEDICATION RECORD

Patient Name:	Using Compliance Packaging: ☐ Yes ☐ No
Date of Birth: HSN:	Pharmacy Name: Phone Number: Fax Number:
Allergies and Intolerances:	Family Practitioner Name: Phone Number: Fax Number:

Name of Medication (prescription and non-prescription)	Strength and Dose	Instructions for Use	Indication/ Goals of Therapy	Prescriber	Notes or Follow-up/Action Required

I confirm that the information provided above is accurate to my knowledge. It remains my responsibility to advise the pharmacist of any changes(s).

Signature of Patient (or Caregiver) _____ Date: _____

Pharmacist Name/Signature: _____ Date: _____

Additional Comments:

Appendix C
Sample Review of Systems Questions

Assessment Questions:

Are there deviations from normal that could be due to drug therapy (side effects)?
Are there deviations from normal that should be incorporated into the care plan or follow up evaluation?

Eyes, Ears, Nose and Throat

- Do you have any problems with your eyes?
- Are you being treated for glaucoma, eye or ear infections, cold sores or dental pain?
- Are you experiencing coughs, colds, sore throats, sinus infections, or seasonal allergies?
- Any dizziness?
- Any forgetful or memory problems?

Cardiovascular

- Have you had any trouble with your heart; any abnormal rhythms, chest pain, dizziness, blood pressure problems?
- Have you ever had your cholesterol checked? What are your cholesterol levels?

Pulmonary

- Are you having any problems with your lungs?
- Do you experience shortness of breath that bothers you?

Digestive

- Are you experiencing trouble with your stomach, heartburn or ulcers?
- Any stomach pain, trouble with your bowels, nausea, diarrhea or vomiting?
- Do you experience constipation?
- Any unexplained weight loss or gain?

Endocrine

- Do you have any thyroid problems?
- Have you ever had your blood glucose checked?
- Have you ever been told you have high blood glucose or diabetes?

Genitourinary

- Are you having problems urinating?
- Any pain or urine discoloration?
- Are you experiencing yeast infections, dysmenorrhea or urinary tract infections?
- Do you have any complaints about your libido or sexual health?

Kidney

- Have you had any problems with your kidneys?
- Have you been told you have kidney disease?

Liver

- Have you been told that you have liver disease?

Hematological

- Have you ever been told you have anemia?

Musculoskeletal

- Do you have any problems with your joints or muscles?
- Any pain anywhere in your body?
- Do you have arthritis?
- What are you doing to prevent osteoporosis? Have you ever had your bone density measured?
- What is your daily calcium and vitamin D intake?

Neurological

- Any problems with anxiety, mood, depression, panic disorder?
- Do you experience headaches or falls?

Skin

- Do you have any problems with your skin?
- Are you bothered by itching, rashes, acne, eczema or sores?

From with adaptations: Cipolle RJ, Strand LM, and Morley PC. *Pharmaceutical Care Practice: the Patient Centered Approach to Medication Management*. 3rd ed. USA: The McGraw-Hill Companies Inc., 2012.

Appendix D
Pharmacist Recommendation letters
Sample 1 (Partial note addressing one issue)

Attention: Dr. T. Mohammed

Re: John Doe
Date of Birth: Jan 1, 1965
HSN #: 12345678

John received services under the **Saskatchewan Medication Assessment Program (SMAP)**. As a result I have some recommendations for your consideration that may help to optimize John's medication management. I have discussed these suggestions with John and he is agreeable, however I have made it clear to him that I would discuss them with you first, since you know him better than I do and consequently may not find all of these suggestions to be advisable.

Please review the recommendations below. I have asked John to make an appointment with you within the next 2 weeks to discuss this with you in person. Feel free to contact me by phone if you would like to discuss any of these with me prior to your appointment with John.

Urinary Frequency:

- John continues to have difficulty with bladder control, particularly at night. I understand this is complicated by his history of bladder and prostate cancer.
- He is up about once an hour throughout the night to urinate.
- He currently takes oxybutynin 5mg once daily and is not experiencing any side effects.
- We discussed that he may see improvement by increasing his oxybutynin to twice daily dosing.
- He was agreeable to try, and stated he would discuss this with you and with Dr. D. Smith at his follow up appointment in April.

Updated medication list, attached.

Recommendation(s):
Increase oxybutynin to 5mg in the morning and 5mg at bedtime.

Follow-up Plan:
I plan on following up with John in the coming weeks to see how he tolerates any of the changes you decide to implement. I would be happy to continue to meet with him as long as I can provide value regarding his medication therapy.

If you would like to discuss any of the above in more detail call me at (123)456-7890.

Sincerely,
Pharmacist Joe

Appendix D
Pharmacist Recommendation letters
Sample 2 (Complete note using SOAP format and "Summary Box")

Re: Mr. AB
DOB – 01/01/1940
HSN – XXXXXXXXX

May 10, 2016

Mr. AB received services under the **Saskatchewan Medication Assessment Program (SMAP)**. As a result I have some recommendations for your consideration that may help to optimize John's medication management. I have discussed these suggestions with John and he is agreeable, however I have made it clear to him that I would discuss them with you first, since you know him better than I do and consequently may not find all of these suggestions to be advisable.

Please review recommendations. I have asked Mr. AB to make an appointment with you within the next 2 weeks to discuss this with you in person. Feel free to contact me by phone if you would like to discuss any of these with me prior to your appointment with John.

SUMMARY OF RECOMMENDATIONS

Switch metformin from 500mg QID to 1000mg BID today

Diabetes

Subjective:
- Pt feeling fine and has experienced no sxs of hyperglycemia OR hypoglycemia
- Pt states he takes his gliclazide regularly, but often forgets up to 2 doses of metformin each day (prescribed QID but misses lunch and supper doses as he has a busy lifestyle).

Objective:
- Pt taking gliclazide MR 120mg QD and metformin 500mg QID for years.
- A1c elevated on last 2 readings (8.2-8.3%) and home FBG in range of 8-10mmol/L.

Assessment:
- Pt has poorly controlled diabetes likely as a result of poor adherence with metformin.

Plan:
- I have already asked pt to start taking his metformin 1000mg BID with food.
- Pt thinks he will be able to remember better with this new dosing regimen.
- Pharmacist will phone pt in 1 week to assess tolerability of the new regimen.

If you have any questions or would like to discuss further contact me at (123)456-7890.

Sincerely,
SF. Doe BSP

Appendix D
Pharmacist Recommendation letters
Sample 3 (Complete note using SOAP format and "Summary Box")

Pharmacist Note re: Mr. BB
(DOB – 25/09/1932, HSN – XXXXXXXXX)
20/October/2015

Pt referred by family member for complete Saskatchewan Medication Assessment consultation

Pharmacist met with pt for ~30 min for med assessment. Pt was concerned about feeling "tired and crappy" since summer 2015. Otherwise he felt fine. A current list of medications is attached to this letter.

Pt has been instructed to make an appt with you before making any changes.

SUMMARY OF RECOMMENDATIONS *(complete rationale below)*

1. Discontinue metoprolol (lower dose to 12.5mg BID today then stop in 1 week)
2. Start amlodipine 5mg once daily today

1. Hypertension

Subjective:

- Pt feels fine and has no complaints re: his HTN – states that he takes his HTN meds regularly

Objective:

- Metoprolol 25mg BID started July, 2015; also taking Ramipril HCT 10/12.5mg QD for years.
- I am unsure of his BP prior to the metoprolol start, but his current home BP is consistently ~120/75mmHg.

Assessment:

- Pt has well-controlled HTN but may not be on the most optimal antihypertensives (beta-blockers not recommended in Cdn guidelines in pts >60yo). Pt is also experiencing side effects from the metoprolol (see "Fatigue" issue below).

Plan:

- Suggest stopping metoprolol slowly (↓ to 12.5mg BID today and then d/c in 2 weeks)
- Suggest to start amlodipine 5mg once daily starting today
- Pharmacist can phone pt in one week to assess tolerability, but suggest pt return to your clinic in 1 month for BP measurement. Pt to continue regular daily home BP testing.

2. Fatigue

Subjective:

- Pt states that he has had no energy and feels tired all the time since July 2015.
- Sxs are severe and affect his function, but are getting slightly better in last few weeks.
- No complaints of muscle pain/weakness, no insomnia.

Objective:

- LFTs fine, other labs all appear normal.

Assessment:

- Pt is likely experiencing beta-blocker induced fatigue since this side effect is common for beta-blockers and the onset of the complaint corresponds closely with the initiation of the beta-blocker.

Plan:

- See suggestions above for HTN re: stopping the metoprolol.

Contact me at (123)456-7899 to discuss further if necessary.

_____*Signature_BSP*_____

Appendix D
Pharmacist Recommendation letters
Sample 4 (Letter from MAC to practitioner for complex patient)

MAC
Medication Assessment Centre

[redacted]

Dear Dr. [redacted]

Thank you for providing the requested patient history. It was very beneficial in completing my medication assessment. I met with [redacted] recently for follow up to discuss my recommendations contained within this letter, and I have asked her to schedule an appointment with you in the near future to discuss them with you, prior to making any changes.

1. Allergies

- [redacted] had reported increased frequency of hallucinations after initiation of cetirizine 20 mg daily.
- At our initial appointment, as mentioned in our previous letter, we recommended [redacted] decrease the dose of cetrizine to 10 mg daily.
- On follow up (April 30) [redacted] stated that she has had no hallucinations after decreasing cetirizine dose.
- [redacted] allergy symptoms have worsened slightly with the decreased cetirizine dose but are tolerable.

Assessment / Recommendation:

- [redacted] is content at the moment, but if her allergies become intolerable in the future, she may need to try a different antihistamine, with fewer CNS effects, such as loratadine (Claritin) 10mg once daily.

2. Pain/Restless Leg Syndrome

- [redacted] experiences back pain that she rates at 10/10 severity at worst and 6/10 after using Acetaminophen/Codeine 300/60mg or acetaminophen 500mg.
- She is currently using acetaminophen/codeine or acetaminophen TID prn 3-4 days per week.
- [redacted] states her pain is inhibiting her activity and is worsened by walking.
- [redacted] states she is also taking gabapentin 900mg TID for restless leg syndrome, which has improved her symptoms and she now has only occasional symptoms (once monthly).
- Estimated CrCl is 58ml/min and the recommended gabapentin dosing for this range is ~700 mg BID.
- [redacted] has complaints of confusion, malaise and forgetfulness, which are all common symptoms of gabapentin accumulation in renal dysfunction.

Assessment:

- [redacted] may be experiencing symptoms of gapapentin accumulation (confusion, forgetfulness, malaise)
- [redacted] pain does not appear to be adequately controlled and she may benefit from regular dosing of acetaminophen, rather than PRN dosing.

Recommendations:

1. Initiate acetaminophen arthritis 1300mg TID
2. Discontinue acetaminophen/codeine
3. Decrease gabapentin dose. I would initially decrease to 600mg TID, with further reductions after 2-3 weeks, if needed to resolve her confusion, forgetfulness and malaise.

3. Cardiovascular Health

- As noted in [redacted] history, she has previously experienced a stroke and MI.
- An ACEI/ARB is notably omitted from her CV meds esp considering she also has renal insufficiency.
- [redacted] had been prescribed ramipril in the past, but it was discontinued. [redacted] does not remember having an adverse reaction to it, and the cardiology / nephrology consults did not mention a contraindication or a reason for previous discontinuation. We suspect it may have been stopped unintentionally.
- Based on [redacted] BP (~130/80 on home readings, 144/78 in our office), electrolytes (potassium in low range of normal), and stable SCr, I suspect she should tolerate an ACEI.
- [redacted] also states that she takes ASA 325 mg once daily. Since lower ASA doses have slightly lower bleed risks, 80-160mg daily is recommended in most guidelines.

Assessment:

- [redacted] may benefit from an ACEI for CV and renal protection.
- [redacted] could probably take a lower dose of ASA.

Recommendations:

1. Unless you are aware of a contraindication that we missed, initiate ramipril 2.5mg once daily. Increase dose every 2-3 weeks to target 10mg daily (if BP, potassium, SCr remain stable).
2. Consider decreasing dose of ASA to 81mg once daily.

4. Diabetes

- [redacted] last A1C was 8.5% (Jan/15).
- [redacted] does not test her blood glucose consistently, but has recently experienced more hypoglycemic episodes than usual (once every 1-2 weeks BG is in range of 3-4, with mild symptoms).
- She states that when she does monitor her blood glucose it can be in the range of 3 - 16 mmol/L.

Assessment:

- [redacted] diabetes does not appear to be well controlled and increased self monitoring of blood glucose is required to determine necessary drug therapy changes.

Recommendations:

1. [redacted] has agreed to start self monitoring several times per day for the next few weeks. I will follow up on her readings and make any suggestions back to you regarding insulin dosing, if necessary.

5. Respiratory

- [redacted] describes shortness of breath and difficulties breathing at night that appear to be related to her sleep apnea.
- [redacted] has been using her Advair and salbutamol inhalers very infrequently and stated that when they were started she was told they were for COPD, however there is no note of this in her history. Indeed, her symptoms do not sound consistent with COPD.

Assessment / Recommendation:

- Since she is not using Advair consistently to allow it to be effective, and since it is not really first line for COPD, I would suggest stopping it.
- If she indeed is confirmed to have COPD, initiation of Tiotropium or a long acting beta-agonist would likely be much more effective than Advair.

Medication Assessment Centre

6. Hair Loss

- At our initial appointment [redacted] stated that she was concerned about recent thinning of her hair.
- Letrozole, which [redacted] is using for history of breast cancer, can cause alopecia (3-5%).
- We discussed with [redacted] the potential medication cause and suggested she discuss this concern further with you to rule out any medical causes of her alopecia, but that if it is due to the Letrazole, it is likely a necessary evil for the coming few years.

I plan to follow up with [redacted] in the weeks to come to look at her glucose readings and to see how she tolerates any of the changes you decide to implement. If you would like to discuss any of the above in more detail, please do not hesitate to contact me.

Thank you for the opportunity to contribute to [redacted] care.

Kind Regards,

Derek Jorgenson, PharmD
Pharmacist
Medication Assessment Centre

Appendix E
SOAP Note Sample Template

S - Subjective Data	Observations (ie. limping, agitated, etc.) or the patient's own assessment (ie. character of pain, alleviating and aggravating factors, timelines, relevant past medical history and family history, etc.) usually gathered through patient/caregiver interview.
O - Objective Data	Vital signs (ie. heart rate, blood pressure), physical findings (ie. bruising), lab results (ie. potassium, creatinine), measurements (ie. height, weight, age) and list of current medications.
A - Assessment	Drug-therapy problem(s) related to the subjective and objective information. If more than one drug-related problem is identified, either use multiple SOAP notes or number the problem list.
P - Plan	Recommendations for resolving identified drug therapy problems (ie. adding or stopping a medication), timing for further follow-up and monitoring, and can include patient education, health promotion and disease prevention strategies. Plans should be numbered and matched to identified drug-therapy problem.

An additional support document can be found at Communicating Care in Writing: A Primer on Writing SOAP Notes by Teresa O'Sullivan, PharmD, BCPS, Peggy Odegard, PharmD, CDE, FASCP.

PHARMACY
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