Applying the guidelines for pharmacists integrating into primary care teams

Arden R. Barry, BSc, BSc(Pharm), PharmD, ACPR; Robert T. Pammett, BSc, BSP, MSc

ARDEN R. BARRY

ROBERT T. PAMMETT

Community-based pharmacy practice continues to evolve beyond the dispensary and into primary care clinics. The impetus for this review was to provide a real-life approach to implementing the recommendations from the guidelines for pharmacists integrating into primary care teams.

L'exercice de la pharmacie communautaire continue d'évoluer au-delà de l'officine et au sein des cliniques de soins primaires. Cet examen avait pour but de présenter une approche pratique pour la mise en œuvre des recommandations tirées des lignes directrices à l'intention des pharmaciens se joignant aux équipes de soins primaires.

© The Author(s) 2016

DOI:10.1177/1715163516649621

ABSTRACT

Background: In 2013, Jorgenson et al. published guidelines for pharmacists integrating into primary care teams. These guidelines outlined 10 evidence-based recommendations designed to support pharmacists in successfully establishing practices in primary care environments. The aim of this review is to provide a detailed, practical approach to implementing these recommendations in real life, thereby aiding to validate their effectiveness.

Methods: Both authors reviewed the guidelines independently and ranked the importance of each recommendation respective to their practice. Each author then provided feedback for each recommendation regarding the successes and challenges they encountered through implementation. This feedback was then consolidated into agreed upon statements for each recommendation.

Results and Discussion: Focusing on building relationships (with an emphasis on face time) and demonstrating value to both primary care providers and patients were identified as key aspects in developing these new roles. Ensuring that the environment supports the practice, along with strategic positioning within the clinic, improves uptake and can maximize the usefulness of a pharmacist in primary care. Demonstrating consistent and competent clinical and documentation skills builds on the foundation of the other recommendations to allow for the effective provision of clinical pharmacy services. Additional recommendations include developing efficient ways (potentially provider specific) to communicate with primary care providers and addressing potential preconceived notions about the role of the pharmacist in primary care.

Conclusion: We believe these guidelines hold up to real-life integration and emphatically recommend their use for new and existing primary care pharmacists. *Can Pharm J (Ott)* 2016;149:219-225.

Introduction

In 2013, Jorgenson et al.¹ published guidelines for pharmacists integrating into primary care teams. These guidelines outlined 10 evidence-based recommendations designed to support pharmacists in successfully establishing practices in primary care environments. As the model of community-based pharmacy practice continues to evolve from a focus on dispensing medications to a patient-centred collaborative role, these guidelines will become increasingly relevant.

In 2014, the Faculty of Pharmaceutical Sciences at the University of British Columbia established 2 primary care pharmacist partner appointments (non-tenure track) jointly funded by 2 health authorities in British Columbia: Northern Health Authority (based in Prince George) and Fraser Health Authority (based in Chilliwack). The mandate of both positions is to provide clinical pharmacy services to patients in an interdisciplinary primary care team environment through collaboration with primary care providers (PCPs) such

KNOWLEDGE INTO PRACTICE

- The guidelines developed by Jorgenson et al., published in 2013, have played an important role in the successful integration of 2 primary care pharmacists (and likely many more) into their respective practices.
- Pharmacists aiming to integrate into primary care teams should initially focus on building relationships and demonstrating their value to primary care providers and patients. As well, it is important to maintain consistent, effective clinical and documentation skills.
- The importance of ensuring that the primary care clinic environment and infrastructure support the pharmacist's practice should not be underestimated.

as family physicians and nurse practitioners. The pharmacist in Prince George (R.T.P.), who began in August 2014, currently provides services to 2 clinics: a fee-for-service family physician office and a sessional clinic that is jointly funded by Northern Health and the Prince George Division of Family Practice.* As well, he provides consultative services to an interprofessional team composed of nurses, mental health clinicians, occupational and physical therapists, and other health care professionals. The pharmacist in Chilliwack (A.R.B.), who started in May 2015, is responsible for providing services to 2 health authority-affiliated clinics: a primary care clinic and a referral-based seniors' clinic, both located at the Chilliwack General Hospital. In addition, he provides consultative services to all of the general practitioners within the Chilliwack Division of Family Practice.

In this narrative, we aimed to deconstruct the 10 recommendations from the guidelines drawing from our own experience in establishing these primary care practices. In general, this narrative provides a detailed, practical approach to implementing these recommendations in real life, thereby aiding to validate their effectiveness. In addition to the recommendations, we agree with the statement by Jorgenson et al. that "the importance of individual pharmacist assertiveness and confidence cannot be overstated and is a key factor for successful pharmacist

*Divisions of Family Practice are community-based groups of family physicians who work collaboratively with community and health care partners to enhance local patient care and improve professional satisfaction for physicians. More information is available at: www.divisionsbc.ca/provincial/aboutus.

integration."¹ While tools exist to evaluate the development and reporting of clinical practice guidelines (e.g., the Appraisal of Guidelines for Research & Evaluation II Instrument), no such tool exists to validate the implementation of guidelines in practice.² Our narrative is based entirely on our own experience and thus is limited by our opinions and biases.

Methods

Both authors reviewed the guidelines independently and, at the time of writing, ranked the relative importance of each recommendation respective to their practice based on their experience to date. Each author then provided feedback for each recommendation regarding the successes and challenges they encountered through implementation. The feedback was then consolidated into agreed upon statements for each recommendation. We do not recommend attempting to implement each recommendation in order, as most are ongoing and dynamic.

Results

With respect to the ranking of the relative importance of the recommendations, there was general concordance between the authors (Table 1).

Recommendation 1: Determine the needs and priorities of the team and its patients

We have found that one of the most effective forums to achieve this is structured clinical rounds. These meetings provide an opportunity for all members of the team to discuss individual patients or common disease states, which can facilitate the identification of areas of focus. We also advocate taking every opportunity to determine the needs of your team through more informal interactions (e.g., lunchroom, staff lounge), which may actually generate referrals; these so-called "water cooler referrals" can be key to developing rapport with your PCP colleagues, especially early on. Finally, in the absence of formal referrals, we advocate reviewing the charts of the patients to be seen in the clinic that day to identify those who might benefit from a pharmacist consultation (e.g., multiple medications, poorly controlled chronic disease states). Inviting these patients to meet with you either by appointment or simply while they are waiting to see their PCP (so long as you do not disrupt workflow) can start the medication therapy management process. At the very least, one

TABLE 1 Ranking of the guideline recommendations (from highest to lowest importance)

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

can perform a best-possible medication history with the patients that can be used to update their health records. We have not used the Medication Use Processes Matrix,¹ as more informal methods to identify medication management processes in need of improvement were sufficient.

Recommendation 2: Develop a pharmacist job description

We believe this is required for any pharmacist starting in a primary care practice, if only to allow one to set clear personal goals and functions. Start with the basics—schedule, hours, location and contact information, including preference (e.g., text messaging, email). Further, it is worthwhile to provide a generic outline, but understand it will develop over time and must be revisited often. Although it is necessary to define your role, do not be too restrictive upfront. Use the information gathered through the first recommendation to identify key areas of interest that will initially prompt referrals. For example, state you would like to focus on a certain condition (e.g., diabetes, asthma, cardiovascular disease) but would be happy to see other patients at the discretion of your colleagues. As a practical point, while it may be necessary to have a written copy (e.g., a 1-page handout), it is more vital to communicate this job description verbally—do

not underestimate the value of face-to-face interactions. Finally, do not set a precedent that you will be unable to continue over time, such as monitoring all of the international normalized ratio values for all patients on warfarin and providing dosing recommendations—if you are in the clinic only part-time, you will not be able to fulfill this responsibility.

Recommendation 3: Educate the team about the pharmacist role

While a job description is more formal and comprehensive, this recommendation is about selling yourself and your role on the team. It is essential to acknowledge that most PCPs are not used to working in an interprofessional team environment, even in a group practice. You have to be confident and proactive in communicating your role but also be available and approachable—once again, do not underestimate the value of in-person discussions. As well, brevity is crucial. One recommendation is to develop an “elevator speech”—a 30-second summary about your role and the benefit you bring to patients and the team. This is especially useful for when new providers or residents are present in the clinic. Do not make it entirely about you (although it is essential to share some details regarding your experience and skills), but rather focus on how you can help

MISE EN PRATIQUE DES CONNAISSANCES

- Les lignes directrices élaborées par Jorgenson *et al.* et publiées en 2013 ont joué un rôle important dans la bonne intégration de deux pharmaciens de soins primaires (et probablement beaucoup plus) dans leurs pratiques respectives.
- Les pharmaciens visant à se joindre à des équipes de soins primaires devraient d'abord s'efforcer de créer des liens et de démontrer leur valeur aux fournisseurs de soins primaires et aux patients. Il est également important de maintenir des compétences cliniques et des techniques de documentation cohérentes et efficaces.
- L'importance de veiller à ce que l'environnement et l'infrastructure cliniques de soins primaires appuient la pratique des pharmaciens ne devrait pas être sous-estimée.

patients and reduce other providers' workloads. For example, this can be achieved through good documentation: a concise and timely problem-based medication assessment can allow a PCP to focus more on the issues rather than collecting data and searching for therapeutic alternatives. This also demonstrates your unique competence and clinical skills to other members of your team. Education about your role should not be isolated to PCPs but directed to all members of the clinic, including the medical office assistants (MOAs). Much like pharmacy assistants/technicians, MOAs are on the frontlines and receive a variety of medication-related inquiries from patients, community pharmacists, and other health care providers, many of which are best directed to a pharmacist. This can be a mutually beneficial relationship, as MOAs can in turn advocate your role to both patients and PCPs. It can be helpful to inform patients about your role either through direct interactions or display media (e.g., posters, screensavers), if only to introduce the concept that a pharmacist that is not associated with a community pharmacy is working in the clinic.

Recommendation 4: Educate yourself about the roles of the other team members

We strongly advocate arranging time to shadow your PCP colleagues, as well as any other health care professionals and MOAs in your clinic. This is extremely valuable—not only does it assist in developing rapport but also has the mutual benefit of demonstrating your skills and knowledge. One can also gain an understanding of how other members of the team practice by reviewing their documentation in the health record.

Recommendation 5: Ensure clinic infrastructure supports the pharmacist role

This recommendation should not be underestimated. Integration is not possible if you do not have basic infrastructure, such as access to an examination room and workspace in the clinic. This can be a contentious issue, as fee-for-service clinics are businesses and more space equals higher overhead. Most office infrastructure is handled by MOAs. They often are delegated the responsibility to arrange workspace, coordinate examination rooms, set up access to electronic medical records and a variety of other activities. We advocate setting up a scheduling process that mirrors the other clinic PCPs for continuity among providers. Having a shared clinic calendar (e.g., Google Calendar) can be helpful in ensuring there will be adequate space in the clinic. Securing a dedicated examination room is ideal but not always feasible. When not seeing patients, working from a shared workspace or common area (i.e., on a networked laptop) is preferable than a dedicated office because it allows for increased visibility and collaboration. A formalized referral process can also be advantageous, particularly in practices where you accept external referrals or are not co-located. Many electronic health records have a process for generating referrals, but a personalized referral form can be helpful—it can provide your contact information, as well as highlight your area of practice interest as a possible reason for referral. We strongly advocate using an evidence-based screening tool such as a Medication Risk Assessment Questionnaire (MRAQ) to help identify patients who may benefit from pharmacist consultation.^{3,4}

Recommendation 6: Be highly visible and accessible

The simple, but invaluable, concept that the guidelines refer to as “strategic loitering” highlights one way to remain visible and accessible to other PCPs. For example, many PCPs in Chilliwack frequent the physicians' lounge at the hospital—many physicians emphasized this location as the most impactful site for strategic loitering in the whole city. Another quintessential location, although potentially obtrusive in some offices, is near the printer used to generate prescriptions—it provides a timely and opportune moment to influence prescribing. Other opportunities for collaboration include

local hospital grand rounds or journal clubs, and we strongly advocate offering to present at these events. Sending out a periodic newsletter on a recent or challenging therapeutic topic has many benefits—it increases your visibility, demonstrates your clinical expertise and provides you (and others) with a continuing education opportunity. Some topics we have discussed in our newsletters include recent landmark clinical trials, new pharmacologic agents or controversial areas of practice. In these instances, it is crucial to be brief, objective and unbiased.

Recommendation 7: Ensure your skills are strong

Primary care practice requires a fairly substantial breadth and depth of clinical knowledge. Thus, the learning curve can be steep. However, establishing a niche based on an area of interest will allow even a pharmacist with entry-to-practice credentials to work effectively in a specific area, thus providing a good foundation to develop other skills. With respect to therapeutic recommendations, from our experience, most PCPs strive to practice evidence-based medicine, so it is mandatory to have good critical appraisal skills. Communicating one's recommendation succinctly is equally important—many PCPs want a quick, bottom-line recommendation (e.g., “I need something now” or “just tell me what I need to do”). While we acknowledge that clinical proficiency is essential, the so-called “soft skills” (e.g., listening, demonstrating empathy, motivational interviewing) are also extremely important to both colleagues and patients. In many cases, patients have 5 to 10 minutes with their PCP, whereas we often book 30- to 60-minute consultations. Even if you do not make any therapeutic recommendations, patients often perceive these appointments to be valuable, as it gives them an opportunity to discuss their values, preferences and health goals, and it may be the only time they have received personalized medication education. Primary care practice offers an excellent opportunity to use expanded scope of practice legislation (province dependent) and advanced clinical skills (e.g., prescribing, ordering and interpreting laboratory values, performing physical examination). Some examples of physical assessment that pharmacists can perform regularly in primary care include measurement of blood pressure, heart rate, respiratory rate, assessment of peripheral edema,

diabetic foot examination and cognitive screening. A working knowledge of validated clinical tools is also required for obtaining objective measures of subjective conditions (e.g., general anxiety disorder, pain, depression) and is critical for monitoring.

Recommendation 8: Provide proactive care and take responsibility for patient outcomes

To fully integrate into a health care team, one must provide proactive care. We, as pharmacists, must take responsibility for the authority we have been granted. For example, incorporating an MRAQ into intake packages for all new clinic patients can help identify those who may benefit from a pharmacist referral before they have seen a PCP. Generating a best possible medication history with the patient also helps their new PCP, as they do not need to spend their meet-and-greet appointment performing this element of the intake. Ensuring there is consistent follow-up with patients (particularly if you have made an intervention) is crucial in providing pharmaceutical care. That being said, one must be cognizant of a patient's time—pharmacists have a tendency to be risk averse, which may result in follow-up overload. We advocate for simplifying the patient journey through efficiency. For example, if you do not need to see a patient in person, follow up over the telephone. If you do not have anything to monitor, do not schedule a follow-up. Many patients, particularly the elderly, may have difficulty attending in-person appointments, and too many health care appointments can be overwhelming. One technique we advocate is to schedule pharmacist appointments consecutively with appointments with other PCPs (either directly before or after) allowing you to proactively provide any recommendations regarding their medications on the same day.

Recommendation 9: Regularly seek feedback from the team

This is a simple process but very necessary. As stated in the guidelines, feedback can be sought either through formal (e.g., meetings) or informal (e.g., after seeing a patient, over lunch) processes. We advocate scheduling regular meetings (e.g., every 3 to 6 months) with key stakeholders to solicit feedback and address any ongoing issues. Online surveys (e.g., FluidSurveys) are a simple and easy way to garner feedback from both

colleagues and patients and can help to facilitate honest responses through anonymity. We advocate asking stakeholders open-ended questions (e.g., “What am I doing well and what can I do to improve?”), as well as close-ended questions about specific activities (e.g., “Do you find my documentation to be concise and easy to follow?”).

Recommendation 10: Develop and maintain professional relationships

Rapport building is essential to fully integrate into a primary care team. One of the most effective ways to accomplish this is through mutual learning. We advocate attending every available continuing education opportunity, such as journal clubs, continuing professional development events (both local and national, e.g., the Family Medicine Forum), electronic medical record training, academic half-days, grand rounds or small-group problem-based learning sessions. One such opportunity, which is a bit more controversial, is drug industry-sponsored events. While we advocate not attending these events because of conflict of interest, we acknowledge they may provide a good opportunity to demonstrate your knowledge and build rapport. If you choose to attend these events, we suggest you come well prepared to critically discuss the literature surrounding the topic or drug and buy your own meal. We have found it valuable to attend community outreach programs, such as the Doctors of BC “Walk with Your Doc” event, as well as less formal events (e.g., holiday gatherings, clinic potlucks) to increase your exposure and solidify your place on the team. Engaging with family medicine residents through involvement with their academic residency program can provide opportunities to build rapport and demonstrates the unique competencies of pharmacists, along with promoting your individual role. We advocate offering to have the family medicine residents shadow you for a day, which allows them to observe your approach to patient care. It also facilitates the opportunity to have their preceptor reciprocate by allowing one of your pharmacy students to shadow them for a day.

Additional recommendations

There are other challenges we have encountered in our practices that were not specifically addressed in the guideline recommendations. Finding opportunities to communicate with

PCPs can be problematic, as most are booked solid with patients throughout the day. Thus, even when a PCP is physically in clinic, they may not be readily accessible to discuss patient-related concerns. One must develop efficient ways (potentially provider specific) to communicate with PCPs. One strategy is to schedule a few minutes with the PCP before or after clinic hours to quickly discuss their patients en masse. Another method is to use a messaging service through an electronic medical record. Unfortunately, other forms of electronic communication (e.g., text messaging, email) are often not secure; however, they can be used to efficiently inform a provider about the need to discuss an issue. Another challenge is the potential preconceived notion among PCPs regarding what a pharmacist can and cannot do, based on their previous interactions with community pharmacists. Further, primary care pharmacists may find themselves in the middle of a disagreement between a PCP and a community pharmacist—often this is due to a lack of effective communication. It is important not to be defensive but rather view it as an opportunity to educate the PCP about the role and responsibilities of a community pharmacist. This also may be an opportunity to communicate the therapeutic plan to the community pharmacist to aid their understanding and enlist their collaboration.

Conclusion

The guidelines developed by Jorgenson et al. in 2013 have played an important role in the successful integration of these 2 primary care pharmacists into their respective practices. Focusing on building relationships (with an emphasis on face time) and demonstrating value to both PCPs and patients were identified as key aspects in developing these new roles. Ensuring the environment supports the practice, along with strategic positioning within the clinic, improves uptake and can maximize the usefulness of a pharmacist in primary care. Demonstrating consistent and competent clinical and documentation skills builds on the foundation of the other recommendations to allow for the effective provision of clinical pharmacy services. We believe these guidelines hold up to real-life integration and emphatically recommend their use for new and existing primary care pharmacists. ■

From the Faculty of Pharmaceutical Sciences, University of British Columbia, Vancouver, British Columbia. Contact arden.barry@ubc.ca.

Acknowledgments: The authors thank Dr. Peter Zed, Professor and Associate Dean (Practice Innovation), Faculty of Pharmaceutical Sciences, University of British Columbia, for his assistance with reviewing this article prior to submission.

Author Contributions: A.R. Barry initiated the project, wrote the first draft of the manuscript, reviewed each draft and revised the final manuscript. R.T. Pammatt contributed to the writing of the manuscript, reviewed each draft and revised the final manuscript.

Funding: This review was unfunded. The authors have no financial or other conflicts of interest related to this work. Both authors have approved the content.

References

1. Jorgenson D, Dalton D, Farrell B, et al. Guidelines for pharmacists integrating into primary care teams. *Can Pharm J (Ott)* 2013;146:342-51.
2. Appraisal of Guidelines Research and Evaluation (AGREE) II instrument. AGREE Enterprise website. Available: www.agreetrust.org/agree-ii (accessed Dec. 21, 2015).
3. Makowsky MJ, Cave AJ, Simpson SH. Feasibility of a self-administered survey to identify primary care patients at risk of medication-related problems. *J Multidiscip Healthc* 2014;7:123-7.
4. Pammatt RT, Blackburn D, Taylor J, et al. Evaluation of a community pharmacy-based screening questionnaire to identify patients at risk for drug therapy problems. *Pharmacotherapy* 2015;35:881-6.