Innovative pharmacy practice: Melanie Danilak

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Please provide some background information about your practice setting

I practice in an ambulatory breast cancer clinic at the Cross Cancer Institute, which is a tertiary cancer centre in Edmonton. I see postmenopausal women with breast cancer in the early or curative stages of disease. These patients may get several treatments for their cancer, and often, the last step in that treatment is endocrine therapy. If patients have hormone receptor-positive tumours, they are offered endocrine therapy. Endocrine therapy (examples include tamoxifen and letrozole) is offered to them for specific durations to prevent breast cancer recurrence and improve survival.

We do have an inpatient unit in the hospital, but this is not the subset of patients that I see.

Describe your practice/role—what do you think makes it unique/valuable?

My practice involves starting patients on either endocrine therapy or other treatment strategies, where we would switch medications partway through the treatment. Or, potentially, if patients are having trouble tolerating their medications, we will work with them and make changes to see which one works the best for them or treat some of the side effects that they are having. I think it is unique because we don't really have other

Pharmacist Melanie Danilak (left) and nurse practitioner Susan Horsman run an ambulatory breast cancer clinic together at the Cross Cancer Institute in Edmonton (photo credit: Jim Dobie Photography).

oncology pharmacists in the country prescribing the endocrine therapy; because of the unique opportunity in Alberta, we've been able to kind of lead that development. The other thing that I think is unique about it is that we do group medical clinics, where you can teach a group of patients all at the same time about the medications. You get the benefit of bringing them together with a like group of people, and they can ask questions together and not feel so isolated in their cancer journeys. I've heard of other providers doing that in primary care, but I haven't heard a lot of it in oncology.

When patients receive a cancer diagnosis, they are assigned an oncologist. With breast cancer patients, when they get their diagnosis, the breast group meets at multidisciplinary rounds and a care plan is decided upon. I used to attend the rounds regularly but not as much anymore—I just review the documentation from them. So there's a pretty clear treatment plan from the patient's oncologist. And endocrine therapy is kind of the last piece of that plan, in most cases. If I actually need direct collaboration with the oncologist, I have the ability to do that—we're all in the same building, and we all know each other. The closer collaboration is probably with the nurse practitioner, because we run the clinic together. We actually take turns leading the group session, because it doesn't necessarily need to be both of us, and we can both take on that role. And we usually bring in about 8 to 10 patients at a time. The independent piece is when we see the patients individually. We basically split up our patient list after the group session, and I'll see half and the nurse practitioner will see half. That way, the patients aren't stuck here waiting for their one-on-one time for extended periods of time. It gets them out quicker, because it's already a long morning. And if there are patients who I feel might be out of my scope—they may need diagnostic imaging or something like that—those patients would be sent to the nurse practitioner. Likewise, if there happens to be a patient on a lot of medications that might have some complex drug interactions, we would probably say ahead of time that the pharmacist should see that patient. Most often, either one of us could see any of the patients, but sometimes we do streamline who sees whom. What I also think is valuable about the practice is that it is a good idea for patients to have access to a pharmacist at the point of care versus having a pharmacist review things after the fact—after

the prescribing and decisions have already been made. So if there are drug interactions that are relevant, I can deal with those before any decisions get made. And the more of us providing this care, the better care we can provide. Also, a lot of my patients are close to being discharged or have been discharged to the care of their GPs; depending on the comfort of their primary provider with breast cancer treatment, they could sometimes use extra support from someone who is specialized in cancer treatment.

How did you come into this practice/role, and how did you prepare for it?

The most important thing that prepared me for this role was doing my residency here at the Cross Cancer Institute—one of my clinical rotations was breast cancer. At the time, they didn't have an established role for a pharmacist in breast cancer, and they didn't have specific funding dedicated to that. So I was actually able to do a residency rotation semi-independently. I spent a lot of time with medical oncologists, with nurse practitioners, and went to a lot of the breast clinics that we have. I was able to develop a lot of relationships that way, as a learner, and start integrating into the group. After residency, when I was employed as a pharmacist, my director gave me this amazing opportunity to take 1 day out of my week and develop a role for a pharmacist in the breast cancer clinics. It was a really unique opportunity to be able to do that. And because I had done the residency, I felt confident being able to develop something that wasn't there before. At first, I started going to some of our new patient clinics and tried to do medication reconciliation and things like that, and I found that there wasn't a huge role in that area. Lots of our patients aren't on a lot of other medications and didn't really need extensive medication histories. As I spent more time with the group and in clinics, I was talking to people assessing needs, and the idea came up that endocrine therapy would be a great place for a pharmacist. It's medication that you can manage and prescribe. The diagnosis is clear. The therapy is clear, according to guidelines. And, really, it's a lot of just managing that medication with the patient and figuring out what's working and what's not. I asked the nurse practitioner if I could join her clinics, because we just had a nurse practitioner doing this independently before, and it worked

really well. When I started, I didn't have my APA [Additional Prescribing Authority], so what I did was set myself up to kind of train under the nurse practitioner. I would work alongside her, so that's how I was able to develop my care process and documentation to be able to apply for APA. And once I had it, I was able to see patients independently. APA is vital to my practice; otherwise, I would have to sit in the room with the nurse practitioner, and we wouldn't be able to see as many patients as we do. We're in roles where our scopes are really overlapping.

How have the other members of the health care team responded?

When I initially proposed this role to the breast team, I kind of prepared myself for a lot of opposition. I thought to myself, "These are a lot of people who have never worked with a prescribing pharmacist or perhaps have never worked with a pharmacist, period." I went to one of our monthly meetings and basically outlined what I wanted to do and how I had prepared for it, and they just said, "That's great!" and moved on and didn't really give me any roadblocks. There might have been a couple of providers who were a bit skeptical at first about why all of a sudden a pharmacist would be more involved in the patients' care. But as I've worked with those people, I feel that the ones who were the most skeptical at first have become my biggest advocates. When you start out, these providers are kind of doing their thing and you're doing your thing. But as you start to form relationships and they get to know you well, they start referring more cases to you. I find that, at least once a week, I'll get an email from one of my physicians about a specific drug interaction or where they want my opinion about something. That is really what tells me that the group has embraced my role as a pharmacist on the team.

How have patients responded?

When patients have already had an oncologist or practitioner whom they've been seeing for a while and then they come to clinic and they're seeing somebody new, sometimes they can be a little caught off guard. I will often get patients who will say, "Am I going to see my doctor today or not?" and they may be a little reluctant. But I find that after we spend the time with them and do all the education and all the really involved one-on-one care, they are satisfied. We always tell patients that, should they want an appointment

with their oncologist after the session, we're happy to arrange that. Very few patients actually ask for that. They often leave feeling that their needs have been met. And in some cases, we're able to spend more time with them than their oncologist might be able to in their busy clinic; so, the patients are appreciative of that time. And overall, I feel that the patients have had a positive response. Breast cancer patients are very informed; they do a lot of reading on the Internet and know other patients with breast cancer, because it's so common. So, they come with a lot of tough questions, but I think if you're able to answer those and give that really personalized care to each patient, they're happy.

Any advice for other pharmacists who want to advance their practice?

I feel like pharmacists are their own worst critics, in a lot of ways. Sometimes I see that we put up our own roadblocks of thinking, "I can't do that," or "That would be too hard for me," or "I think I would get resistance." So I just encourage people to try not to do that. What's the harm in just trying something? If it doesn't work, go back, tweak your process, and try it again. I was surprised, looking back, that it wasn't really that hard to go into this practice and to set it up. I didn't get as much resistance as I thought, and had I been scared to try, I would never have known. The other thing is that pharmacists need to be patient. I remember when I was done with residency, I was very eager and impatient to get some kind of clinical assignment. I was in the dispensary checking chemo and thinking, "I did all this residency training and I want to be doing more than this." Another pharmacist who had a lot of experience and had been here a long time told me to just be patient—something would come up. And I'm really glad that I did wait, because the thing that came up a few months later was perfect for me. If I had jumped on something else right away, I wouldn't have gotten this opportunity. Pharmacists also need to be flexible and versatile. We're in a situation where practice is changing fast. We need to be open to new ideas and new ways of doing things. I think it is really hard—we're working alongside pharmacists who have done things very, very differently for a very long time. So it's not always easy to make these big changes, but it kind of comes back to being patient. Give people time to wrap their heads around these things, and keep taking small steps towards where you want to be. ■