Innovative pharmacy practice:

Rick Siemens

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Please provide some background information about your practice setting

I am a community pharmacy manager in Lethbridge, Alberta. I've been in this location for about 14 years. We get a lot of rural patients. It's a very busy practice, which has its challenges.

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

My focus tends to be on diabetes. I also practice travel medicine now, as well, but diabetes has kind of been the fundamental piece of my advanced practice. I see a fair number of patients with chronic pain. As my practice is in the community, I deal with many patients with different conditions. This week I prescribed for a UTI [urinary tract infection] for a patient from Denmark. I get referrals from physicians and from other patients. And now that I have my Additional Prescribing Authorization (APA), I am able to take on more responsibility for my patients' care. I try to work with everybody. Even with our local diabetes team, which has historically not been willing to work collaboratively, I have managed to work with the local endocrinologist in a manner that works for her. I get a lot of patients sent to me with very poor control of their diabetes. Many of my patients didn't do well in other programs, but respond to mine. I put a lot of work and a lot of individual time into these patients to get them to reasonable control. The nature of the referrals varies, depending on the physician. I have a couple of physicians who trust me implicitly and just send the patients to me and then I'll do all of the changes and then

let them know what I've done. I have a few who still like me to ask for permission, even though they usually still agree with everything I'm suggesting. With some of the newer physicians, who I don't know as well, I will tell them what I'm thinking and say that I can prescribe it and take responsibility for it. There's a lot that we can do to promote and maintain health.

I used to have technicians who would screen patients for me; however, I have lost a lot of them to the hospital. Right now, however, I get so many referrals and am so busy that I don't really need much screening. It's not as crucial anymore. And what we did with our dispensary format about a year and a half ago is make all patient interaction done by a pharmacist. Because as good as my

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technicians are, you miss a lot of opportunities if you don't get that initial contact with the patient. I had a patient recently who, if he had just seen a technician or assistant at the front, wouldn't have been asked questions about how he's doing. I asked him those questions and he needed lots of help. That's why I believe that the point of first contact should be a pharmacist every time. How do you properly assess a prescription if you just enter it?

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

I've always been involved in advanced practice. In 2007, I was one of the first 15 pharmacists in Alberta to get my APA. I worked hard to create collaborative relationships with the physicians in town. I graduated in 1996 and always wanted to be different; I didn't want to just be a dispenser. When I started at my current location, the pharmacy was underperforming and having lots of pharmacist turnover. So I took it as kind of a challenge to see if I could change the fortunes of the pharmacy by doing the right kind of practice. When I first started here, there was no role for clinical pharmacists. Many pharmacists have mentioned that corporations put too many roadblocks in front of them, which force them into a dispensing role. I was aware of this and still found that you can practise in an advanced manner within the constraints forced upon you by your employer. I had always known that I was going to practise the way that I wanted and if that could not work in a company, then I would leave. And although the company was at times unsure of what to do for me, to their credit, they allowed me to practise the way that I wanted as long as they were completely informed of what my plans were. I was the first pharmacist to gain APA in this company and they were apprehensive about what liability could arise. I had to explain to them what I would be doing and all the checks and balances I would have in place to minimize the risk for the patient, the company and myself. It was much like what I had to do with the local physicians. Once people understand the process of appropriate pharmacist prescribing, then they usually will be comfortable with it.

Before I could prescribe, I would write letters asking for permission to make changes. Now, I can do this without asking for permission, but that doesn't mean that I always do. Some of the physicians and I, we have such a

good relationship that we talk about these things on the phone anyway, and then I just take the responsibility for the prescribing. Some physicians, though, just aren't very collaborative.

Having my APA is very helpful for continuity of care, so that people can get started on therapy right away. Having access to and the ability to order labs is crucial for monitoring. Before, you would have to ask the physician's office for them and some would send them to you and some wouldn't. And this has all allowed us to share responsibility.

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

I think we have mutual respect. It sometimes takes some time to develop that, though. I had one physician who sent me a letter thanking me for prescribing but asking me not to do it again because she's responsible for the prescription. So I sent her a letter saying that no, she isn't responsible for the prescription; that I was just informing her of what I did, and that if she wanted to discuss it further to get back to me. And then, over the years, she started to see other physicians send patients to me and talk about me, and now she has come around. The physicians know what I will do and what I won't, and I think that puts them at ease. I actually got more grief from my own profession back in 2007 when I started prescribing than I did from physicians. Other pharmacists would try to tell me that I shouldn't be doing that.

Some people have criticized the requirement to send a letter to the physician after prescribing, but I've found the letter to be helpful. When I'm writing the letter or thinking about it, it tells me whether I should be doing what I'm doing or not. One physician actually told me that he likes my prescribing better than other health care professionals because if the patient goes to a walk-in clinic or somewhere else, he doesn't find out what happened. When I prescribe, he gets a nice synopsis of what happened.

How have patients responded?

The patients love it. That's my problem—they love it too much. I'll go away for holidays and come back and there will be a long line of people waiting to see me. I had a busy day the other day and there were a few people waiting to see me. One patient asked for a rub for his leg. It would have been easy to just tell him that "it's over there," because I was very busy. But I told him

to just give me a few minutes. I got through the other people and then got to him and asked what was wrong and he said, “My calf is sore.” I then found out that it was also swollen and red. I told him that it could be a clot and sent him to see a physician. He phoned me later that day and he did have a DVT [deep vein thrombosis]. I also administered his low molecular weight heparin later the same day. The following day, they found that he also had emboli in his lungs. It could have ended up being pretty disastrous, but that’s why it’s important to take the time and my patients are appreciative of that.

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

The first part is attitude and how you want your practice to be. The next is being patient. It took

me a long time to get to where I am. You can’t come out of school and expect 100% acceptance. You have to develop the relationship and then build on it. You need to pay attention to how health care providers communicate with each other and adapt your own correspondence. Keep your documentation short and concise and make sure other health care providers know what their responsibility will be and, more importantly, what yours will be. And you can’t get discouraged just because a physician doesn’t take your suggestion or calls you out on something.

Not every prescribing decision is necessarily going to work. Doesn’t mean it was the wrong decision. It was plan A. There’s still plan B, C, etc. Some people get upset over it. Don’t worry about being perfect. Take it in small chunks and go from there. ■