Prioritizing intraprofessional collaboration for optimal patient care: A call to action

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Introduction

Patients benefit when pharmacists work together.¹ Studies have shown that increased collaboration between pharmacists across the care continuum of hospital, primary care and community practice settings results in improved patient health outcomes, reduced wait times and costs, and increased patient satisfaction and trust in their health care team.²⁻⁴

Patients suffer the consequences of miscommunication or missed communication between health care professionals.⁵ Patients report getting “mixed messages” from different sources, leading to frustration and confusion that can compromise understanding, motivation and adherence to treatment. Patients are more receptive to medical advice when they know that their health care team, including pharmacists, is working together to optimize their pharmacotherapy outcomes.

Patients are not the only ones who desire collaboration. Pharmacists want and need access to patient information and other members of the health care team so they can optimize their contributions to patient care.⁶ The National Association of Pharmacy Regulatory Authorities (NAPRA) highlights the importance of collaboration in pharmacist practice. Standard 2 in the Model Standards of Practice for Canadian Pharmacists describes in detail the expectations for pharmacists to work respectfully, ethically and in a timely manner with colleagues to develop and maintain relationships for the benefit of patients.⁷ This standard applies not only to

pharmacist collaboration with other health care professionals but also to pharmacist collaboration with other pharmacists.⁶ A parallel may be drawn with our physician colleagues who are expected to uphold professional standards to ensure safe and effective care of patients across family, hospital and specialty practice settings. Explicit guidelines for conducting referrals and consults are provided jointly by the College of Family Physicians of Canada and the Royal College of Physicians and Surgeons of Canada.⁸

Despite the regulatory standards that exist and the general consensus that intraprofessional collaboration is a “good thing to do,” in our experience, the application of effective pharmacist-pharmacist collaboration from theory into practice is challenging.

Case study 1

Mrs. Sun, an 82-year-old woman who lives alone, presents to the emergency department with severe hypoglycemia. Medication reconciliation is completed by the emergency department pharmacist. Based on the pharmacist's recommendation, Mrs. Sun's glyburide is discontinued and her basal insulin dose is decreased. On discharge, Mrs. Sun is provided with new prescriptions generated from the hospital's electronic medical record specifying to take insulin “as directed” and that the glyburide was stopped. When presenting her prescription to her community pharmacy, Mrs. Sun's insulin is filled with the directions based on her old prescription, resulting in her

resuming her previous, higher basal insulin dosing. Mrs. Sun continues to experience frequent episodes of symptomatic hypoglycemia in the days to come and is brought back to the emergency department by her daughter.

This scenario could have been avoided had the hospital pharmacist liaised with the community pharmacist regarding Mrs. Sun's course in hospital. Furthermore, the community pharmacist did not have contact information for a pharmacist at the hospital to inform them of what happened for Mrs. Sun in the community setting. Intraprofessional collaboration (e.g., a faxed note or phone call) when Mrs. Sun transitioned from hospital to community could have avoided this situation.

Challenges

Our different workplace cultures, ways of managing information and different perceptions of our roles make it difficult to collaborate. Despite evidence and expectations, pharmacists in different care settings can have difficulty establishing effective patient relationships. For example, when pharmacists present themselves in business or technical roles instead of clinical roles, patients may be reluctant to share clinical information with them.^{9,10} Patients can feel uncomfortable sharing personal health information with the community pharmacist because of privacy concerns with the business environment or a lack of attachment to a pharmacist within the pharmacy.¹¹

It is also difficult to fit new pharmacist roles into old ways of doing things. According to a recent survey by Penm et al.,¹² 85% of pharmacists face challenges with the workplace and pharmacy culture when looking to advance their professional role. For example, pharmacists struggle with competing interests between staff and management, insufficient time and resources to implement advanced services and lack of business models that support patient care roles compared with traditional technical roles.¹¹ Faced with these challenges, some pharmacists state they have difficulty undertaking any activities beyond those related to dispensing.^{5,13} When pressed for time, pharmacists also struggle to prioritize collaboration, which can lead to delayed, inconsistent or incomplete information exchange among pharmacist colleagues.^{14,15}

Another challenge is that the profession is fraught with inconsistent definitions of what constitutes relevant clinical information, inadequate

systems for storing and retrieving clinical information and few options for the timely sharing of clinical information.^{13,15,16} Even when pharmacists want to collaborate with other pharmacists, they are challenged in trying to figure out how to share the "right" information in a format that colleagues can easily use.¹⁷ Too much or too little information sharing can also be problematic and discourage collaboration.

Approaches to collaboration

Two examples of intraprofessional collaboration among Canadian pharmacists illustrate useful perspectives.

The first example is the Pharmacy Communication Partnership (PROMPT) program being evaluated by a team from the University Health Network and Leslie Dan Faculty of Pharmacy, University of Toronto.¹⁸ PROMPT builds on what we already know about successful and meaningful medication management interventions at patient care transitions. With PROMPT, the most responsible hospital pharmacist practising on an internal medicine unit shares a package of discharge information with the community pharmacist of a patient's choice and is also available to that community pharmacist for follow-up, if needed. The discharge package includes the discharge prescription, medical discharge summary (when available) and contact information for the most responsible hospital pharmacist. The patient brings the community pharmacist directly into their circle of care. The community pharmacist then has the information needed to guide patients and families through medication changes at the time of hospital discharge. In early evaluation work, 99% of community pharmacists found the package useful. Sharing information provides more time to prepare prescriptions, simplifies the process for posing questions and reduces the burden on newly discharged patients who are often left to act as the sole intermediary between their hospital and community health professionals.

The second example is the collaborative approach used at the Pharmacists Clinic at the Faculty of Pharmaceutical Sciences, University of British Columbia. Based on 4 years of experience, the team at the UBC Pharmacists Clinic has developed a standard approach to intraprofessional collaboration. As in many other provinces and territories, pharmacists in BC have limited access to electronic health records, which has prompted the clinic team to create procedures

TABLE 1 Standardized approach to pharmacist intraprofessional collaboration at the UBC Pharmacists Clinic

Step	Description
Mind-set	<ul style="list-style-type: none"> • Patient care is our top priority. • Each pharmacist is part of the larger team of pharmacists with shared responsibility for patient care across the care continuum. • Each pharmacist is committed to contributing positively, respectfully and collaboratively to the maximum of their scope and ability for the benefit of their patients.
Awareness	<ul style="list-style-type: none"> • Each pharmacist knows the patients they care for also receive, will receive or have received care from other health care team members (including pharmacists). • No pharmacist practises in a vacuum. Each action by each pharmacist has potential impacts on prior, current and future care of a patient.
Identification	<ul style="list-style-type: none"> • Pharmacists need to know who else is in a patient's circle of care (including other pharmacists) and how to connect with them. • Members of the patient care team are identified and recorded in the patient record as part of the patient intake process. • Patients are told that standard practice is for health care professionals within the circle of care, including the community drugstore-based pharmacist, to share information for optimal patient health outcomes.
Curiosity	<ul style="list-style-type: none"> • When something does not make sense in a patient's care, suspend judgment of another professional's practice, avoid making assumptions and ask clarifying questions to understand the situation better. • Patient cases are dynamic and what worked yesterday may not work today, and a whole array of patient circumstances can interfere with aligning treatment with best practices. • Real patients are complex and don't always follow the rule book.
Connection	<ul style="list-style-type: none"> • Despite a lack of integrated documentation and communication systems within the circle of care, connections and information sharing with others need to occur. • Pharmacists in community pharmacies can make notes in the patient profile (of the provincial drug record, where available) of all services (as a claim for payment or as a nonbenefit claim). • Include the name and phone number of the pharmacist and pharmacy so other health care professionals know who to contact for information on a mutual patient. • Preparing for a patient appointment involves checking the provincial drug record and contacting the pharmacist who provided prior care or will provide follow-up care. • Pharmacists caring for patients in hospitals or other facilities may not have the ability to make entries in the provincial drug record, so they need to make their involvement in a patient's care known to others via discharge notes or a phone call. • Unless a patient explicitly states to not share information with a specific party, information about care plans and patient progress are shared by phone, fax or other secure means.
Collaboration and trust	<ul style="list-style-type: none"> • The pharmacist who saw the patient previously has context, and the pharmacist currently seeing the patient has knowledge of the current situation. • Both context and current situation need to be considered for patient care, so these pharmacists must talk and work together. • Part of this conversation is who is in the best position to continue care for the patient. • Care plans include who will undertake specific actions and follow-up monitoring. • Individual health professionals must be able to trust each other and be worthy of that trust to accurately and appropriately fulfill their role.¹⁹

for sharing accurate, relevant and detailed information securely with community pharmacists. Patient encounters are not considered complete until communication with the care team (e.g.,

family physician and community pharmacist) occurs and is documented in the patient record. Table 1 further describes the approach to care taken by the clinic that prioritizes awareness and

TABLE 2 Key messages for pharmacists and patients

Audience	Key messages
Pharmacists	Intraprofessional pharmacist collaboration is good for patients.
	Intraprofessional pharmacist collaboration is an ethical and legal requirement.
	Collaboration starts with asking, learning and understanding the roles and responsibilities of others in different work settings.
Patients	Pharmacists have the most drug therapy training of any health professional.
	Pharmacists specialize in finding, preventing and solving drug therapy problems.
	All patients are encouraged to find a pharmacist who best meets their needs.
	Pharmacists are required by law to ensure personal health information is private and secure.
	Information shared with a pharmacist is shared within the patient's circle of care only when medically necessary.

identification of the patient care team, suspending judgment, making connections, building trust and collaborating with pharmacist colleagues.

Collaboration enablers

As more pharmacists seek opportunities to collaborate, enablers such as electronic communication, administrative support, the “most responsible pharmacist” approach and consistent messaging about pharmacist practice are becoming increasingly important across all practice settings.

Administrative systems

Most electronic record systems (pharmacy software systems, hospital systems, primary care and specialty clinic record-keeping systems) have the ability to record health care team members. This functionality can be used to record the names, roles and contact information for the people within a patient's circle of care.²⁰

Although in-person or telephone communications are the most direct, they are not always possible in practice. Integrating other communication tools such as fax, e-fax, secure e-mail, file transfer sites and electronic medical record integrators can facilitate sharing of information within a patient's circle of care.²¹

Administrative support

In addition to pharmacy technician staff, pharmacists who are increasing their commitment to detailed documentation can benefit from hiring administrative staff with medical office assistant (MOA) roles and training. MOA professionals have skills and expertise in the management of

clinical communication, record keeping, medical terminology, billing and service scheduling.^{22,23}

In a pharmacy or clinic setting, the MOA can play a critical role collecting information from the patient, receiving patient information from others, adding information to the patient record, distributing information from the patient record to others, reconciling information, transcribing information and archiving information.

“Most responsible pharmacist” approach

In the same way that patients have a “most responsible physician,” patients benefit from having a “most responsible pharmacist” (MRP) who is the main point of contact for a particular patient's care.²⁴ Although this is standard practice for pharmacists in hospital and primary care environments, it may be a new concept for those in community pharmacy practice.²⁵

The MRP provides the ongoing clinical services (medication review, MedsCheck, etc.) to a subset of patients (complex or with specific medical conditions), acts as the point person for communication (information in and out) about a patient's care plans and progress and is known to the patient as their pharmacist. Other pharmacists regularly cover for the MRP within the work schedule, but the MRP is always informed of any clinical interventions involving their patients. Examples of the MRP approach in current community pharmacy practice are pharmacists who monitor and adjust international normalized ratio levels and pharmacists who are certified diabetes educators.

The MRP approach enables pharmacists in community practice settings to use a

patient-focused mind-set in their work day and be explicitly identified as part of the patient's circle of care.¹³

Consistent key messages

To increase buy-in and recognition of the importance of including pharmacists in information-sharing efforts, consistent messaging across the care continuum is needed. Key messages for pharmacists and patients are summarized in Table 2.

Case study 2

Mr. Smith is an 89-year-old retired construction worker attending his yearly appointment with his physician and primary care pharmacist at the local medical clinic. Mr. Smith states that he would like to take fewer medications, and, together with his team, a decision is made to taper and stop lorazepam for insomnia. The primary care pharmacist prepares and faxes the stepwise plan to Mr. Smith's usual community pharmacy. The community pharmacist reviews the plan with Mr. Smith, blister packs the lorazepam according to the taper schedule and follows up with him every 2 weeks either in person or by telephone to assess how well he is tolerating the taper.

During a subsequent appointment, shortly after a dose reduction, the community pharmacist identifies that Mr. Smith is having rebound insomnia and a tremor and asks the primary care pharmacist and physician to slow the taper. The primary care pharmacist meets with

Mr. Smith and, after an assessment, faxes a slower taper regimen to the community pharmacy.

A call to action

While different professional cultures, work environments and responsibilities create inherent challenges to effective interprofessional collaboration (e.g., pharmacists and physicians), many pharmacists have figured out how to thrive in these interprofessional settings.^{19,26} Furthermore, all pharmacists speak a common language, have similar foundational training and approach patient care from a common perspective.¹⁹ These commonalities provide a solid foundation that should also enable seamless intraprofessional collaboration (e.g., between pharmacists).²⁶ Why then, are examples of successful intraprofessional pharmacist collaboration the exception rather than the rule? Have we put the horse before the cart by focusing our efforts enthusiastically outwards, while ignoring our professional responsibilities with our own colleagues?

Patients, pharmacists, other health care professionals and the health care system as a whole need the pharmacy profession to make intraprofessional collaboration a priority. Our siloed, fragmented approach to patient care is doing our patients and our profession a disservice. Intraprofessional collaboration should not be a "nice to have" but rather a "need to have" to fulfill our professional duty of putting patients first. ■

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Author Contributions: B. Gobis, A. Yu and J. Reardon wrote the first draft. J. Reardon, M. Nystrom, K. Grindrod and L. McCarthy provided input, review and edits. B. Gobis prepared the final manuscript for submission.

Declaration of Conflicting Interests: The authors declare no potential conflicts of interest with respect to the research, authorship and/or publication of this article.

Funding: The authors received no financial support for the research, authorship and/or publication of this article.

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