THE UNIVERSITY OF BRITISH COLUMBIA
Pharmacists in PCN Program
Faculty of Pharmaceutical Sciences

Victoria PCN Primary Care Clinical Pharmacists

Supporting Patients with Polypharmacy in Victoria PCN

Agenda

- Prescriber experience with Primary Care Clinical Pharmacists (PCCPs)
- Prescriber concerns in the community around polypharmacy
- Case examples from our community
- Q&A

Prescriber Experience – Working with PCCPs

Dr. Sarah Chritchley, Victoria PCN and VDFP Board member:

- “It is one of the BEST more EFFECTIVE services available to our patients and to us.”
- “The pharmacists do not work against you, they work with you and for the patient.”
- “I have found the PCN Pharmacy team to be outstanding.”
- “I’m not frustrated by writing the referral letter now-”

Read Dr. Chritchley’s full statement with 6 patient success stories here.

From My Practice - Patient Case

- 74-year-old female referred by GP to discuss medication options for recent onset of urinary incontinence

- Current medical conditions
  - Essential hypertension, hyperlipidemia, osteoarthritis, depression/anxiety, type 2 diabetes, postherpetic neuralgia, peripheral edema

- Current medications
  - Ramipril 5 mg once daily
  - Rosuvastatin 5 mg once daily
  - Acetaminophen 500 mg QID PRN
  - Escitalopram 10 mg once daily
  - Metformin 500 mg BID
  - Pregabalin 100 mg BID
  - Furosemide 20 mg once daily

Patient Case – What I Did

- Initial one hour consult with patient to obtain detailed history of all medical conditions and medications

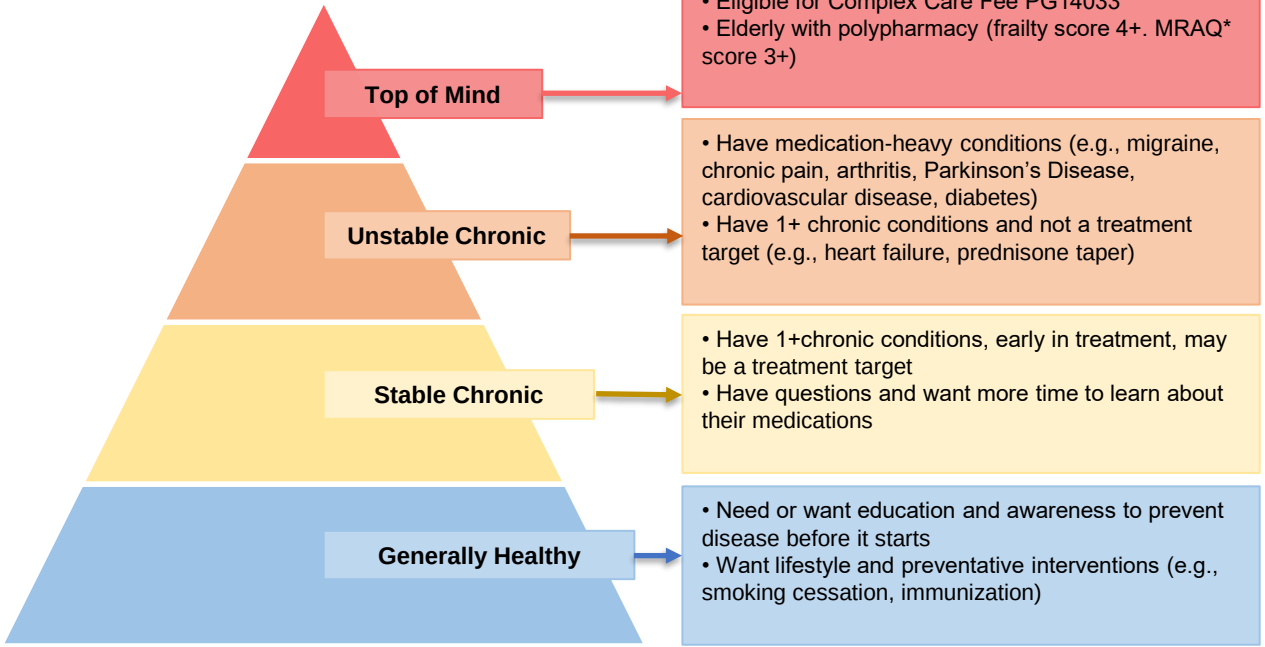
- Determined that symptoms of urinary incontinence started soon after furosemide was initiated by walk-in physician to treat edema of unknown cause

- Reviewed if any medications could be the cause of edema - pregabalin causes edema in up to 16% of patients
  - Patient confirmed that edema had begun around the time she started pregabalin and had gradually worsened over time
  - Pregabalin was started about one year ago to treat postherpetic neuralgia

Patient Case - What I Did Continued

- Agreed on recommendations in collaboration with the patient and communicated that with the physician via faxed consult note
  - Discontinue furosemide (was not effective for edema and may be causing symptoms of incontinence)
  - Taper pregabalin by 50 mg each week until discontinued (may be causing edema, postherpetic neuralgia resolves in most patients within a few months so may be unnecessary)
  - Reassess need for medication for urinary incontinence, edema and postherpetic neuralgia in 4 weeks

- Provided follow up at 2 and 4 weeks
  - At 2 weeks: symptoms of urinary incontinence had resolved
  - At 4 weeks: edema had mostly resolved, no return of symptoms of postherpetic neuralgia



Patients We See Most Often

*MRAQ= Medication Risk Assessment Questionnaire

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Patients Can Self-Identify using the Medication Risk Assessment Questionnaire

To find out if you could benefit from this service, please answer the following questions as best you can:

		NO	YES
Do you take **5 or more** different medications? *(including prescription, non-prescription, vitamins, and herbal therapies)*		☐	☐
Do you take **12 or more** pills each day? *(including prescription, non-prescription, vitamins, and herbal therapies)*		☐	☐
Do you take **any** medications for:	Nerves, stress, anxiety, or depression	☐	☐
	Blood pressure or heart disease	☐	☐
	Arthritis or pain	☐	☐
	Diabetes	☐	☐
	Lung Disease	☐	☐
Does **more than 1** physician or nurse practitioner prescribe medications for you on a regular basis?		☐	☐
Are you taking medications for **3 or more** medical conditions?		☐	☐
Do you get your prescriptions filled at **more than 1 pharmacy**?		☐	☐
Have your medications, or the instructions on how to take them, changed **4 or more times** in the past year?		☐	☐
Do you have difficulties taking your medications as prescribed?		☐	☐
Do you sometimes worry about the long-term effects of your medications?		☐	☐
Do you have any unanswered questions about your medications?		☐	☐

If you answered **YES** to **3 or more questions** we encourage you to ask for an appointment with the on-site clinical pharmacist.

From My Practice - Patient Case

- ID: 69-year-old female discharged from hospital with fragility fracture to right hip
- PMHx: T2DM, Diabetic Retinopathy, HTN, Osteoporosis, Fragility Fracture, Hyperlipidemia, Depression
- Referred for medication reconciliation and follow-up post hospital discharge

Indication	Medications Prior to admission:	Medications following discharge:
HTN	Ramipril 10mg PO daily	Ramipril 10mg PO daily Amlodipine 5mg PO daily
T2DM	Metformin 500mg PO BID	Metformin 500mg PO BID Gliclazide ER 60mg PO BID Linagliptin 5mg PO daily
Constipation		PEG 17g PO daily
Osteoporosis		Alendronate 70mg PO weekly

Patient Case Cont'd

- 5 days after hospital discharge - Medication reconciliation and education with PCCP

	Med Rec	Assessment	Actions
HTN	NOT taking newly prescribed amlodipine	• BP @ home 120-130/80 • No hypotension • No ADRs to current regimen	• Hold amlodipine • Monitor BP daily • Reassess in 1 week
Osteoporosis	NOT taking newly prescribed alendronate	• Appropriate treatment	• Discussed risks and benefits of alendronate • Discussed potential ADRs and how to minimize • Patient desire to re-address medication in future • Discussed calcium + Vit D intake/supplementation
T2DM	Taking newly prescribed gliclazide and linagliptin	• BG taken 3x/day @home = 5.4-8 • No symptoms of hyper/hypo • No ADRs (diarrhea incidence ~5%)	• Discussed administration and potential ADRs and how to minimize • Decrease BG monitoring to once daily (rotating time of day)
Consitipation	Taking PEG	• Now experiencing loose BM • ?ADR vs unnecessary therapy	• Hold PEG • Reassess in 1 week

Review:

- Potential benefits for patients referred to PCCP following discharge from hospital
  - Opportunity for patients to have their questions answered
  - Indications for new medications clarified
    - Improved patient confidence and understanding of medications prescribed
  - Review the long-term appropriateness of medications prescribed while in the acute care setting [eg. HTN related to acute pain?/ Constipation related to immobility?]
  - Reduce occurrence of polypharmacy and ADRs associated with polypharmacy [eg. hypotension, Loose BM]
  - Review, update, and provide practical monitoring parameters for the patient were appropriate
    - [Directed patient 'okay to reduce BG testing from TID to once daily alternating throughout the day, with BG testing likely to be eliminated with future follow up']
  - Opportunity to review medication coverage
    - submission for special authority or discussion of covered alternatives where appropriate

Poll #3

How often do you have patients discharged from hospital on new medications **WITHOUT** a clear care plan or next steps?

- Often
- Occasionally
- Rarely
- Never
- Other (please describe in chat)

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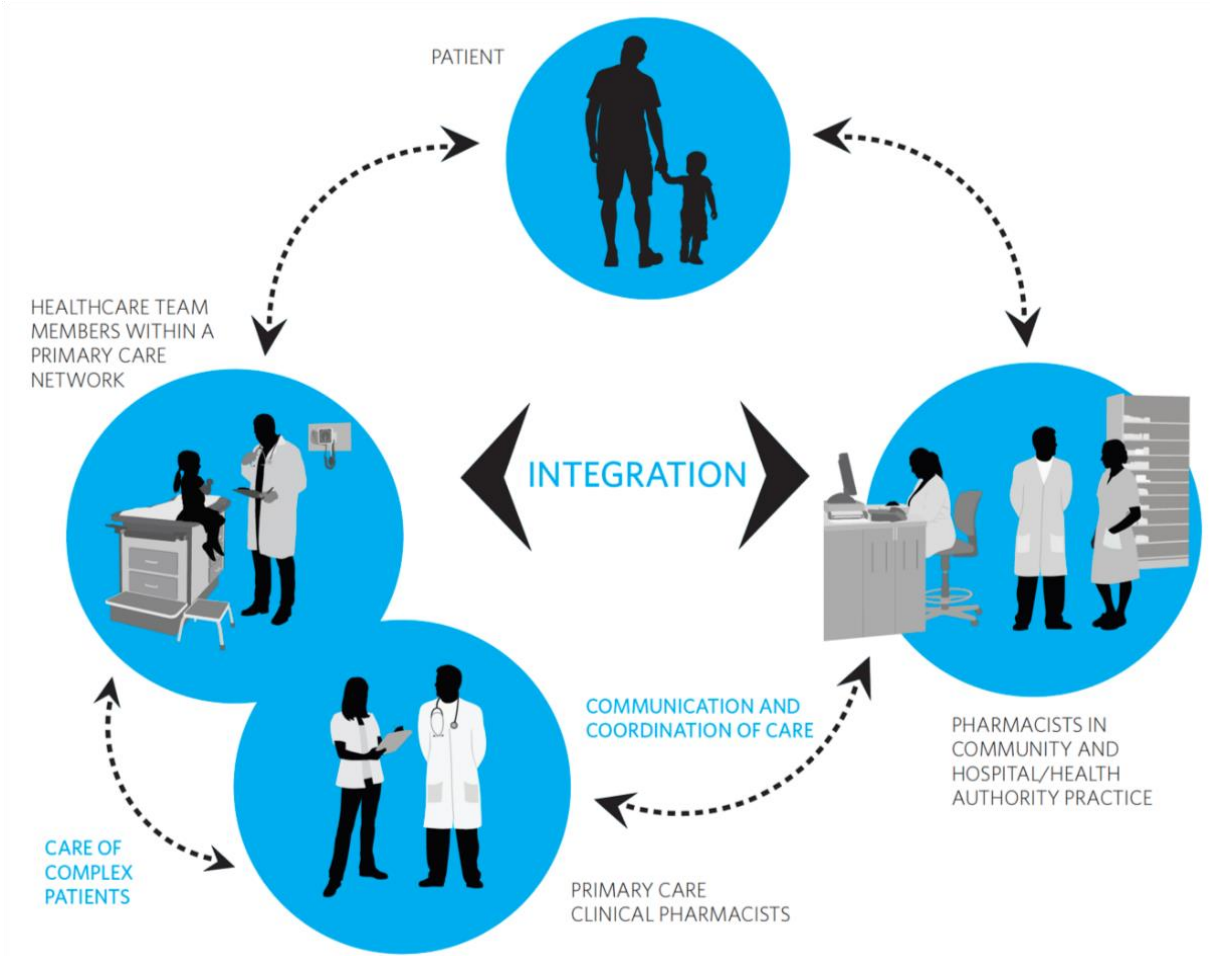
Consistent Care and Communication



Sabina Choi, BScPharm, PharmD, RPh
Primary Care Clinical Pharmacist – Victoria PCN

- BScPharm University of Alberta 2014
- PharmD University of Alberta 2015
- Clinical Pharmacist at Surrey Memorial Hospital 2015-2022
  - Neonatal and Pediatric Pharmacy
  - Child and Adolescent Psychiatric Unit
- Interest in practicing in team based primary care after rotation in Primary Care Networks in Edmonton

From My Practice – Medication Adjustments

19-year-old female referred by GP for adverse effect from medication (nosebleed) and ADHD medication effect not long enough

Medical History

- ADHD - inattentive type
- Generalized Anxiety Disorder
- Insomnia – initial
- Iron Deficiency Anemia

Social History

- Lives with parents
- Attending university - 1st year
- Sexually active - uses condoms
- Drinks socially (1-2 drinks per week)

From My Practice – Medication Adjustments

Current Medications

Methylphenidate (Biphentin) 40 mg PO QAM	Melatonin IR 5 mg PO QHS
Sertraline 100 mg PO QAM	Vitamin D 1000 units PO QAM
Quetiapine IR 25 mg PO BID	Ferrous sulfate 300 mg PO QAM
Quetiapine XR 50 mg PO QHS	

Medication History

- Tried short-acting methylphenidate (Ritalin) as a child
- Sertraline not effective on 75 mg, increased to 100 mg 4 weeks ago by a walk-in doctor
    - Quetiapine IR also added 4 weeks ago to help with generalized anxiety disorder
    - Nosebleed started since these medication changes
- Quetiapine XR for insomnia and generalized anxiety disorder

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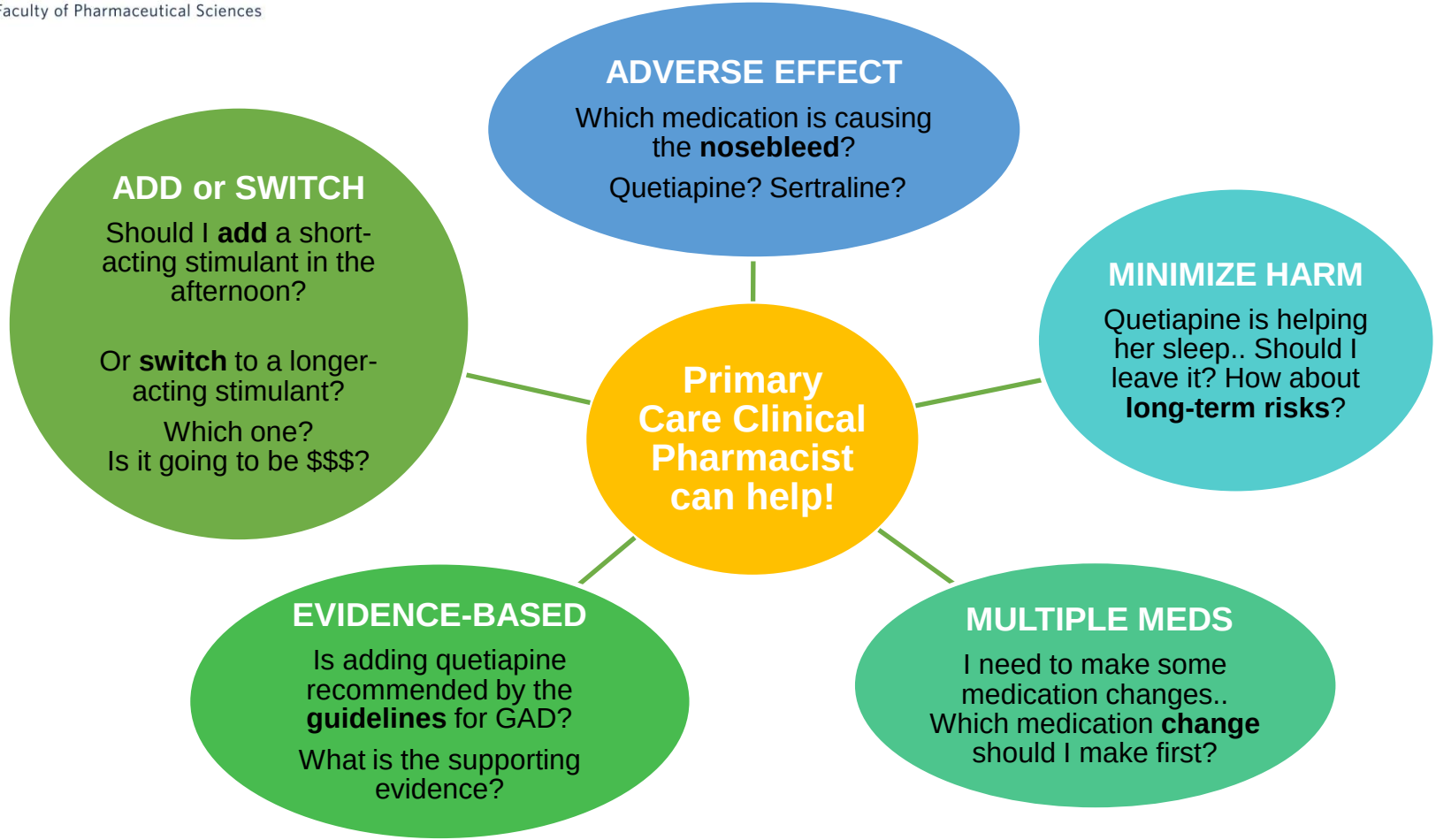
Should I refer this patient to the PCCP?



From My Practice – Medication Adjustments – What I Did

ADHD

- Recommend switch to longer acting stimulant (i.e. **Lisdexamfetamine** (Vyvanse) 30 mg PO QAM)
  - Patient meets special authority criteria
  - Low risk of withdrawal (fatigue, mental depression, irritability) with direct switch

Generalized Anxiety Disorder

- Recommend cross-titration of sertraline to **escitalopram**
  - Nosebleed: Likely culprit sertraline; lowering dose not possible due to history of lowered efficacy
- Recommend **tapering off quetiapine IR** once on escitalopram for 2-4 weeks
  - Adjunct quetiapine is third line and possible long-term risks (e.g. weight gain, metabolic)

Contraception

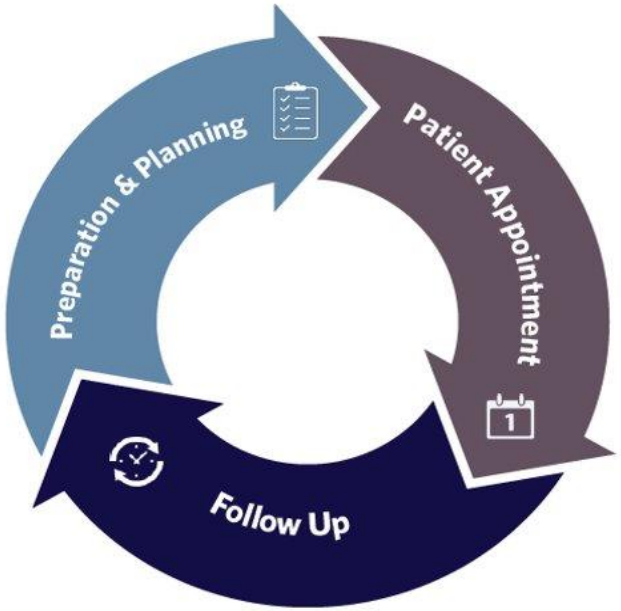
- Patient **not interested in hormonal contraceptive** but will think about it
  - Provided resources on pregnancy risks and contraceptive methods

Insomnia

- Recommend **increasing melatonin IR** to 10 mg PO QHS if insomnia worsens with lisdexamfetamine
- Recommend **tapering off quetiapine XR** after tapering off quetiapine IR
  - Quetiapine XR – lowest strength is 50 mg thus change to IR formulation for taper
  - Patient agreeable to trial tapering only if done gradually

The Role of a Primary Care Clinical Pharmacist

- 1:1 care of adult patients with medical complexity
- Team-based care
  - ✓ Hallway consults
  - ✓ Consultation summary is entered in MRP's EMR
  - ✓ PharmaNet entry (MR-PCN)
- Shared care
  - ✓ Across the care continuum (Hospital, PCN, Community)
  - ✓ Preserving and respecting existing care relationships
- Other
  - ✓ Educational in-services
  - ✓ Patient group education



Out of scope: dispensing, patient home visits, long term care patients

Ways We Can Work Together:

- Refer patients for virtual care (PCN HUB)
- Refer patients for in-person care (on-site in clinic)
    - Benefits of on-site
        - Case conferencing
        - Corridor consultations
        - Organic collaboration
        - Timely decision-making

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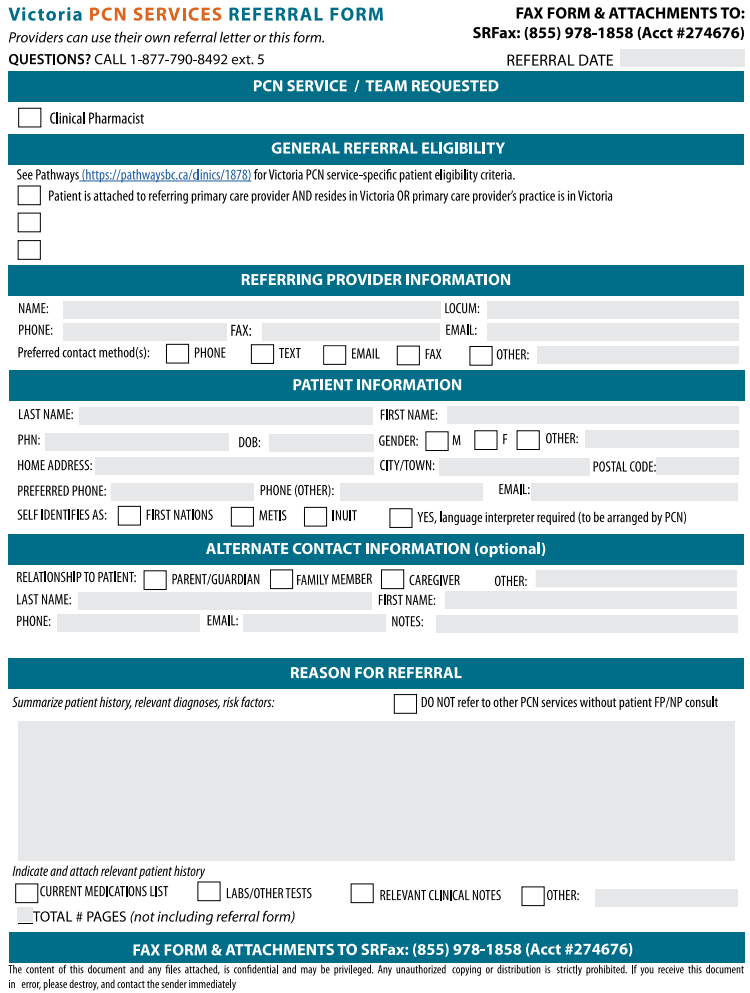
We accept EMR Generated Consult Notes, Referral Letters or the PCN Services Referral Form

Fax: 855-978-1858



Victoria PCN SERVICES REFERRAL FORM

Providers can use their own referral letter or this form.

QUESTIONS? CALL 1-877-790-8492 ext. 5

FAX FORM & ATTACHMENTS TO:
SRFax: (855) 978-1858 (Acct #274676)

REFERRAL DATE

PCN SERVICE / TEAM REQUESTED

☐ Clinical Pharmacist

GENERAL REFERRAL ELIGIBILITY

See Pathways (https://pathwaysbc.ca/clinics/1878) for Victoria PCN service-specific patient eligibility criteria.

☐ Patient is attached to referring primary care provider AND resides in Victoria OR primary care provider's practice is in Victoria

☐

☐

REFERRING PROVIDER INFORMATION

NAME: LOCUM:

PHONE: FAX: EMAIL:

Preferred contact method(s): ☐ PHONE ☐ TEXT ☐ EMAIL ☐ FAX ☐ OTHER:

PATIENT INFORMATION

LAST NAME: FIRST NAME:

PHN: DOB: GENDER: ☐ M ☐ F ☐ OTHER:

HOME ADDRESS: CITY/TOWN: POSTAL CODE:

PREFERRED PHONE: PHONE (OTHER): EMAIL:

SELF IDENTIFIES AS: ☐ FIRST NATIONS ☐ METIS ☐ INUIT ☐ YES, language interpreter required (to be arranged by PCN)

ALTERNATE CONTACT INFORMATION (optional)

RELATIONSHIP TO PATIENT: ☐ PARENT/GUARDIAN ☐ FAMILY MEMBER ☐ CAREGIVER OTHER:

LAST NAME: FIRST NAME:

PHONE: EMAIL: NOTES:

REASON FOR REFERRAL

Summarize patient history, relevant diagnoses, risk factors:

☐ DO NOT refer to other PCN services without patient FP/NP consult

Indicate and attach relevant patient history

☐ CURRENT MEDICATIONS LIST ☐ LABS/OTHER TESTS ☐ RELEVANT CLINICAL NOTES ☐ OTHER:

__TOTAL # PAGES *(not including referral form)*

FAX FORM & ATTACHMENTS TO SRFax: (855) 978-1858 (Acct #274676)

Working with Multiple Prescribers in Victoria

- 57-year-old female referred by GP to create a comprehensive list of every medication trial, efficacy and adverse effects
- Complex medical history including:
  - Chronic debilitating migraines
  - Insomnia unresponsive to CBT
  - Severe depression
  - Under the care of 2 psychiatrists
- Medication history took at least 3 hours to create between two appointments with the patient, her community pharmacy, consultation notes, and PharmaNet
  - Framework for further decisions for the physicians involved in her care

Future Sessions

What topics would you like to see discussed at future sessions?

- Cannabis
- Diabetes
- Heart Failure
- Kidney Disease
- Liver Disease
- Neurodegenerative Diseases
- Cerebrovascular Diseases
- Safe Medication Use in Older Adults
- Other

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Summary

- PCCPs can help you manage polypharmacy patients

- You can refer patients through any one of the following:
  - EMR generated consult notes
  - Referral letters
  - PCN Services Referral Form

- We look forward to working together!