

RETHINK: PHARMACY

THE CLINICAL COMMUNITY PHARMACIST

4 TENANTS OF THE CLINICAL COMMUNITY PHARMACIST

- Chronic care oriented
- An integral member of the healthcare team
- Utilize creative technology
- Intentional in marketing

CHRONIC CARE ORIENTED

- Chronic diseases are responsible for 7 of 10 deaths each year
- About half of all US adults have a chronic disease
- Accounts for 86% of nation's healthcare costs
- More than 2/3 of US adults are overweight or obese
- Almost 3 in 4 men are overweight or obese

YOU CAN PLAY A PRIMARY ROLE IN PREVENTING AND IMPROVING CHRONIC DISEASE RATES AS A CLINICAL COMMUNITY PHARMACIST

HEART FAILURE

- 5.7 million people in the U.S. have heart failure
- ~50% of people with heart failure die within 5 years of diagnosis
- Primary cause of more than 55,000 deaths each year
- Contributing cause in more than 280,000 deaths in 2008
- Costs the U.S. \$34.4 billion each year

Is your
pharmacy
chronic care
oriented?

DIABETES

- 25.8 million people in the US have diabetes, representing 8.3% of the population
- 7 million are undiagnosed
- Another 75 million people have pre-diabetes
- Accounts for \$245 billion in total healthcare costs in 2012
- \$176 billion in direct medical costs
- \$69 billion in reduced productivity

- Patients living with diabetes have 2.3 times higher health expenditures

CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)

- Third leading cause of death in America
- 15 million US adults were officially diagnosed, although the actual number may be higher
- Represents \$29.5 billion in direct health care expenditures (2010)
- 80% of all COPD deaths are caused by smoking

THE CLINICAL COMMUNITY PHARMACISTS ROLE

GO BEYOND ADHERENCE TO INCLUDE CLINICAL DATA

Ef-fec-tive / ə-fektiv/

adjective

1. successful in producing a desired or intended result



Medication adherence must be paired with clinical endpoints, such as blood pressure, in order to ensure effectiveness.

EXAMPLE

Compare these two examples:

#1: Mary is a 54 yo WF. She calls and requests a refill on lisinopril 20mg. Her adherence rate on the lisinopril is 95%.

Based on the data given (which is very little, yet typical), would you assume any intervention was needed?

#2: Mary is a 54 yo WF with diabetes. She calls and requests a refill on lisinopril 20mg. Her adherence rate on the lisinopril is 95%. Her blood pressure has been consistently above 160/100 for the past few weeks. Additionally, her nutrition has included a daily minimum of 3000mg of sodium intake, her BMI is 34, and is exercising minimally.

Based on the data given, would you assume any intervention was needed?

INTERVENTIONS FOR EXAMPLE #2:

- **Medication Synchronization:** Why is the patient only refilling lisinopril? By having the ability to view and refill all medications at the same time, you will more easily see gaps in therapy, spot reasons for non-adherence, and be able to maximize therapy.
- **Consistent Monitoring:** By having the consistent data of blood pressure, you will be able to make the determination that a consultation with the physician is needed
- **Lifestyle Modification:** Knowing her sodium intake and weight allows you to have a conversation with your patient regarding lifestyle modification. You determined she was a candidate for diabetes self-management education, where you can connect with her in a small group setting to learn proper nutrition, exercises, and more. You also enrolled her in your weight management program.

ENHANCING YOUR PRACTICE

Circle the areas you're ready to explore in the next 6-12 months for your practice.

MEDICATION SYNCHRONIZATION

PAIN MANAGEMENT

DIABETES MANAGEMENT

TRANSITIONS OF CARE

COPD MANAGEMENT

SMOKING CESSATION

POINT OF CARE TESTING

HIV MANAGEMENT

HEART FAILURE MANAGEMENT

OBESITY COUNSELING

BLOOD PRESSURE/HEART MANAGEMENT

THE NEW PHARMACY WORKFLOW

INITIAL CONSULTATION WITH PATIENT

MEDICATIONS REVIEWED FOR CLINICAL
CONGRUENCY

COMPREHENSIVE IMMUNIZATION REVIEW
COMPLETED

MEDICATIONS FILLED/PATIENT COUNSELED

⋮

FOLLOW UP WITH PATIENT VIA PHONE/
ELECTRONIC METHODS ON SCHEDULED BASIS

⋮

PATIENT ASSIMILATED INTO DISEASE STATE-
SPECIFIC OR HABIT-SPECIFIC SOLUTIONS

⋮

MONTHLY PATIENT CHECK-INS DURING REFILL
PROCESS TO DETERMINE EFFECTIVENESS/
LIFESTYLE MODIFICATION EFFORTS

⋮

INFORM HEALTHCARE TEAM OF PROGRESS, DATA

- Define disease states
- Goals set (clinical and lifestyle)
- Technology given to track clinical measures
- Assimilation into educational classes based on need
- Clinical measures of efficacy defined
- Define whether medications are in line with national guidelines, patient needs
- Immunizations are scheduled at initial consultation and are reviewed frequently

- Select specific clinical measures (BP, A1c, PHQ-9) to determine effectiveness of the treatment

- Examples include weight loss management, diabetes education, smoking cessation treatment

- The refill process should screen for:
 - Effectiveness of medications
 - Progress towards reaching goals
 - Adverse events/adherence barriers

NEXT STEPS

- Now that you've read this portion, you are ready to view the ReThink: Pharmacy Video #1. Visit the CE link to view the video and take the CE quiz.

ABOUT THE WRITER

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